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Changing Gears:

A guide to effective HIV service programming

for gay men and other men who have sex with men in Asia

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for gay men and other men who have sex with men in Asia

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Glossary

Caseworker Sometimes also called a "patient navigator", a caseworker refers to an HIV service worker who takes responsibility for a limited number of people who are newly diagnosed with HIV and ensures that they are linked to antiretroviral treatment as well as other health and social support services they may require. Caseworkers find new cases via outreach workers or via referrals by staff at HIV counselling and testing facilities.

Comprehensive package An agreed-upon set of HIV-related interventions that should be available for men who have sex with men. The package should include HIV information, condoms, lubricants, in-depth HIV prevention or transmission education, sexually transmitted infections information, diagnostics and treatment, testing services, enrolment into HIV care treatment for those testing positive, pre- and post-exposure prophylaxis and referrals to services dealing with syndemic conditions, including mental health care services and legal support against stigma, discrimination and violence.

Cyber dating Dating via the internet. This happens via social media, especially specialized gay dating applications and websites, such as PlanetRomeo, Grindr, Hornet and Jack'd.

Cyber sex Sexual experiences via the internet, usually making use of a webcam. For MSM, this often entails visual erotic stimulation and mutual masturbation.

Dating apps Gay dating applications and websites widely used for sexual and social networking by men who have sex with men in Asia. Most of them operate via smartphones. The most popular apps are: Blued, PlanetRomeo, Grindr, Jack'd and Hornet.

Heteronormativity The tendency to assume that everybody in society is heterosexual. This assumption renders people with a different sexuality or different-from-the-mainstream gender "invisible" and often occurs in health care- and education settings.

Hotspots Locations where men who have sex with men meet to initiate sexual encounters.

Key populations People who are at higher risk for HIV infection, such as people who engage in unprotected male-to-male sex, unprotected sex in exchange for money, favours or goods (sex work) or people who engage in unsafe injecting-drug use.

MSM Men who have sex with men (MSM) is an inclusive public health term used to define sexual behaviour between males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular community. The words "man" and "sex" are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place.

Young MSM "Young men who have sex with men" in this document refers to males aged 10–24 years, including adolescents aged 10–19 years.

Outreach worker An outreach worker is tasked to find people at hotspots or in cyberspace who are not yet connected with HIV services. An outreach worker aims to help a targeted audience to prevent HIV transmission by providing information and education and to help them access HIV counselling and testing services. The ultimate goal of HIV outreach is to ensure that previously undiagnosed people living with HIV are supported in accessing antiretroviral treatment as well as social and support services.

Respondent-driven sampling A strategy for sampling (to conduct research or provide services) that uses incentives to reach previously unreached clients or research participants, making use of a social network of a number of initial "seeds", leading to numerous referrals.

Social media Media that require the participation of their audience, produced and consumed mainly via the internet. Examples include Facebook, chat applications, online platforms for discussion and interactive news websites.

Syndemic A set of health problems or social conditions that strengthen and are linked to each other. HIV among MSM is often linked to mental health problems and drug or alcohol abuse. Syndemics often occur under situations of poverty, stigma and discrimination or among populations with limited or no access to health or other essential services.

Unique identifier code A way to identify and track service users without recording their name or other identifying information. This is usually done by creating a unique code based on, for example, the initials of a client's father or mother or a client's date of birth. If a network of services in a city or country agrees to use the same coding system, it becomes possible to derive information on the success of referrals from one service to the next as well as trends in coverage of service use.

Unreached MSM Previously called hidden MSM, unreached MSM refers to men who have sex with men who have yet to be connected with comprehensive HIV services. Often there is a need to adjust the strategy or modus of delivery of HIV services in order for them to become acceptable for unreached MSM.

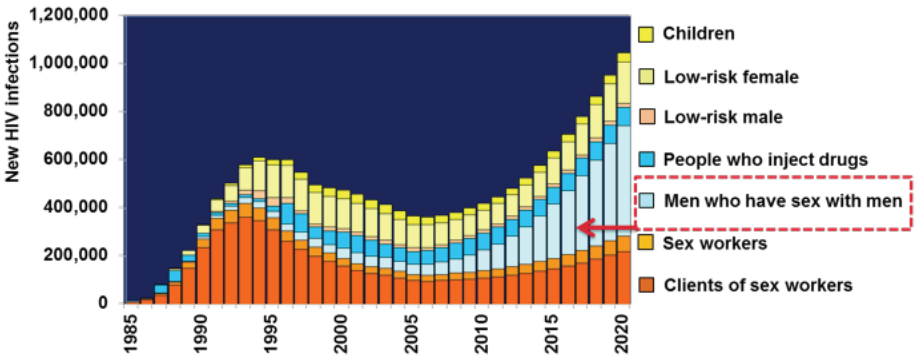
Acronyms

ART	antiretroviral treatment
CDC	Centers for Disease Control and Prevention (US)
FHI	Family Health International
HCT	HIV counselling and testing
KHANA	Khmer HIV/AIDS NGO Alliance
KP	key population
MSM	men who have sex with men
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
STI	sexually transmitted infection
SWING	Service Workers In Group
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organisation

Background: What this framework document is about

This document provides a framework for programme implementers and stakeholders to design or assess comprehensive HIV services for men who have sex with men (MSM)[1] in any Asian city, territory, region or country, incorporating recent innovations and the latest science on what works. Designing and implementing new approaches for reaching out to MSM are important—it is estimated that a majority of all HIV infections in Asia will soon be contributed by male-to-male transmission.[2] In many Asian countries it is already the main transmission route, despite male-to-male sex often being underreported as a mode of transmission due to societal stigma. For example, 73% of the cumulative number of HIV cases in the Philippines as of August 2015 and 48% of newly reported HIV cases in Singapore in 2014 were via male-to-male transmission. [3]

Figure 1. The HIV epidemic among Asian MSM is projected to expand further



Note: In 2008, a group of scientists developed the Asian Epidemic Model, which projected that male-to-male transmission would be the most important route of transmission for HIV in 2020. Unfortunately, the model has not been updated in recent years.
Source: AIDS Data Hub from regional Asian Epidemic Model developed and published in *Report of the Commission on AIDS in Asia*, 2008 (www.aidsdatahub.org).

By summarizing scientific evidence in lay language, it is hoped that this document is accessible to and useful for a broad coalition of stakeholders in their attempts to reanimate HIV responses for MSM. The document is also intended as a resource for advocacy with local authorities, specifically advocacy to expand HIV services for MSM and advocacy to bring down structural barriers, such as stigma, discrimination, violence and legal persecution, which still affect the access of MSM to essential HIV services in many Asian countries, territories, regions and cities.

This guidance document focuses on MSM and has deliberately left out transgender people. Transgender people are often unhelpfully lumped together with MSM at the policy and the programme level. Transgender activists have repeatedly asked that MSM and transgender people stopped being viewed as one group. Their rationale is that transgender people have distinct and different health needs in general and HIV risks and contexts in particular and are usually part of different social and sexual networks than gay men and MSM, thus justifying a distinct, specific approach. A recent review found that the access to health services of transgender people was even more limited than that

Background: What this framework document is about *(continued)*

of MSM in most Asian countries. [4] Fortunately, recently detailed guidance for transgender policies and programmes was published by a coalition of agencies to address their specific needs; some of the priorities identified in this report are also a call for legal recognition and protection from discrimination, including in health service settings, and for equal access to general health services for transgender people, including to medically necessary gender-affirming health services. [5]

This document consists of four components: The first deals with strategic information and evidence; the second with a comprehensive package of interventions; the third component zooms in on the special and urgent needs of adolescent and young MSM, and the final component discusses the need for links to and integration of HIV services into a broader package of health and social services for MSM. At the end of each component, the framework includes a checklist that can be used to assess the state of HIV responses for MSM at the city or national (or other) level, and it provides recommendations for what can be done if particular elements of a comprehensive HIV response for MSM are not yet there.

It is hoped this guidance will strengthen ongoing national and regional efforts to reinvigorate HIV responses for MSM, in line with the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) resolution 66/10[6] calling for universal access to HIV services in 2011 and resolution 67/9 reinforcing this call[7] and the 2015 regional road map agreed during an ESCAP intergovernmental meeting.[8] And ideally this guidance can help HIV responses across the region contribute to the goals of the Joint United Nations Programme on HIV/AIDS (UNAIDS) strategy for 2016–2021, which aims for 90% of MSM to be reached with prevention services; 90% of those reached to be tested for HIV; 90% of MSM diagnosed with HIV to enrol in antiretroviral treatment; and 90% of those enrolled to achieve full HIV viral load suppression. [9]

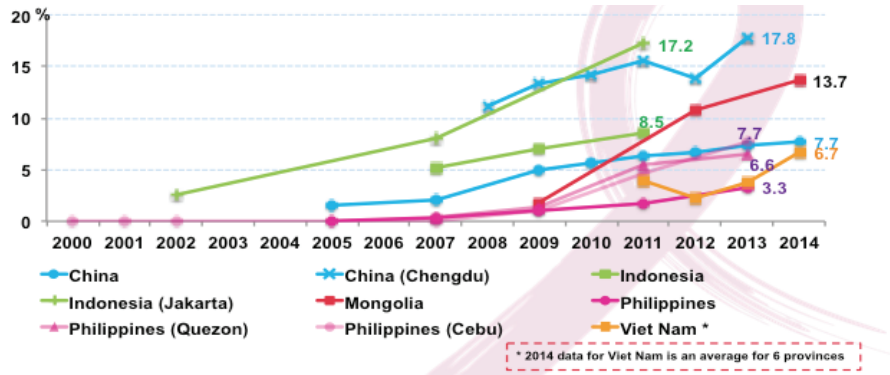
HIV among MSM in Asia

HIV epidemics among Asian MSM are present in virtually every country and seem to be concentrated mainly in larger urban areas. Additionally, while HIV epidemics in Asia have generally reduced in severity, HIV epidemics among MSM in Asia continue to either be stable at unacceptably high levels (for example, Thailand, Indonesia and Myanmar) or are getting worse (China, Philippines and Mongolia).

Where recent (2011 or later) data are available, seven Asian countries have a national HIV prevalence among MSM that is greater than 5%: Myanmar 6.6% (2014); Viet Nam 6.7% (2014); China 7.7% (2014); Indonesia 8.5% (2011); Malaysia 8.9% (2014); Thailand 9.2% (2014) and Mongolia 13.7% (2014). [10]

Background: What this framework document is about *(continued)*

Figure 2. Countries and select cities with rising HIV prevalence trend among MSM, 2000–2014



Source: AIDS Data Hub, based on HIV sentinel surveillance reports; integrated biological and behavioral surveillance reports; China's Global AIDS Response progress reports; Chengdu Center for Disease Control and Prevention. Intensifying HIV response among MSMs with city approach in Chengdu city, China, 2014; and www.aidsinfoonline.org (www.aidsdatahub.org).

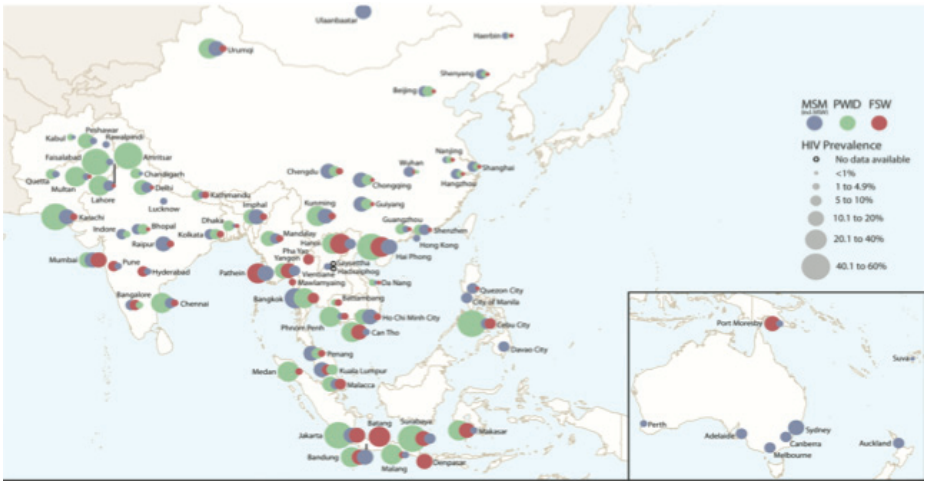
These national estimates mask much more severe epidemics in certain cities in these countries in recent years. For example: Ulaanbaatar, Mongolia at 13.9% (2014); Ho Chi Minh City, Viet Nam at 14.8% (2014); Mumbai at 12.4%, the region of Chhattisargh at 15%, Nagaland at 13.6% and Andhra Pradesh at 10.1%, all in India (2010–2011); Pathein, Myanmar at 15% (2014); Jakarta at 17.2% and Bandung at 10.4%, both in 2011 in Indonesia; Taiyung and Chengdu, China, at 18.9% and at 17.8% in 2013, respectively; Kuala Lumpur, Malaysia at 22% in 2014 and Bangkok, Thailand at 24.4% as of 2012. [11] Epidemics among MSM are also starting to expand rapidly in the Philippines, where the HIV prevalence among MSM rose from 0.4% in 2007 to 6.6% in 2013 in Quezon City.[12]

For various reasons, the incidence of HIV is highest among adolescent and young MSM, and it is important that more effective interventions for this population are designed and implemented as a matter of urgency (see Component three). [13] For example, in Bangkok, HIV prevalence among MSM aged 15–22 rose from 12.9% in 2003 to 22.2% in 2007; the estimated incidence in this group rose from 4.08 per 100 person-years in 2003 to 7.69 in 2007, meaning that more than 7 of every 100 adolescent MSM were getting infected each year. [14]

Despite decades of interventions, the HIV epidemic is far from under control. The disproportionate burden of HIV in MSM in comparison with the general population can be partly explained by the high probability of HIV transmission per sexual act through receptive anal intercourse. HIV can spread through large MSM networks at great speed, with network size and density as well as structural factors having a large role in the severity of HIV epidemics. [15] Despite this, efforts to contain HIV are more often than not delivered at the individual level, with network and structural factors not given due importance. [16] What is also increasingly clear is that HIV is interlinked with a number of other social, psychological and health issues, many of which need to be tackled in tandem. [17]

Background: What this framework document is about *(continued)*

Figure 3. National prevalence masks high prevalence in localized geographical areas



Note: Pakistan data for hijra sex workers. MSM=men who have sex with men; MSW=male sex workers; PWID=people who inject drugs; FSW=female sex workers.
Source: AIDS Data Hub, based on latest available data between 2009 and 2013 from national HIV sentinel surveillance surveys, integrated biological and behavioural surveys and other published survey (www.aidsdatahub.org).

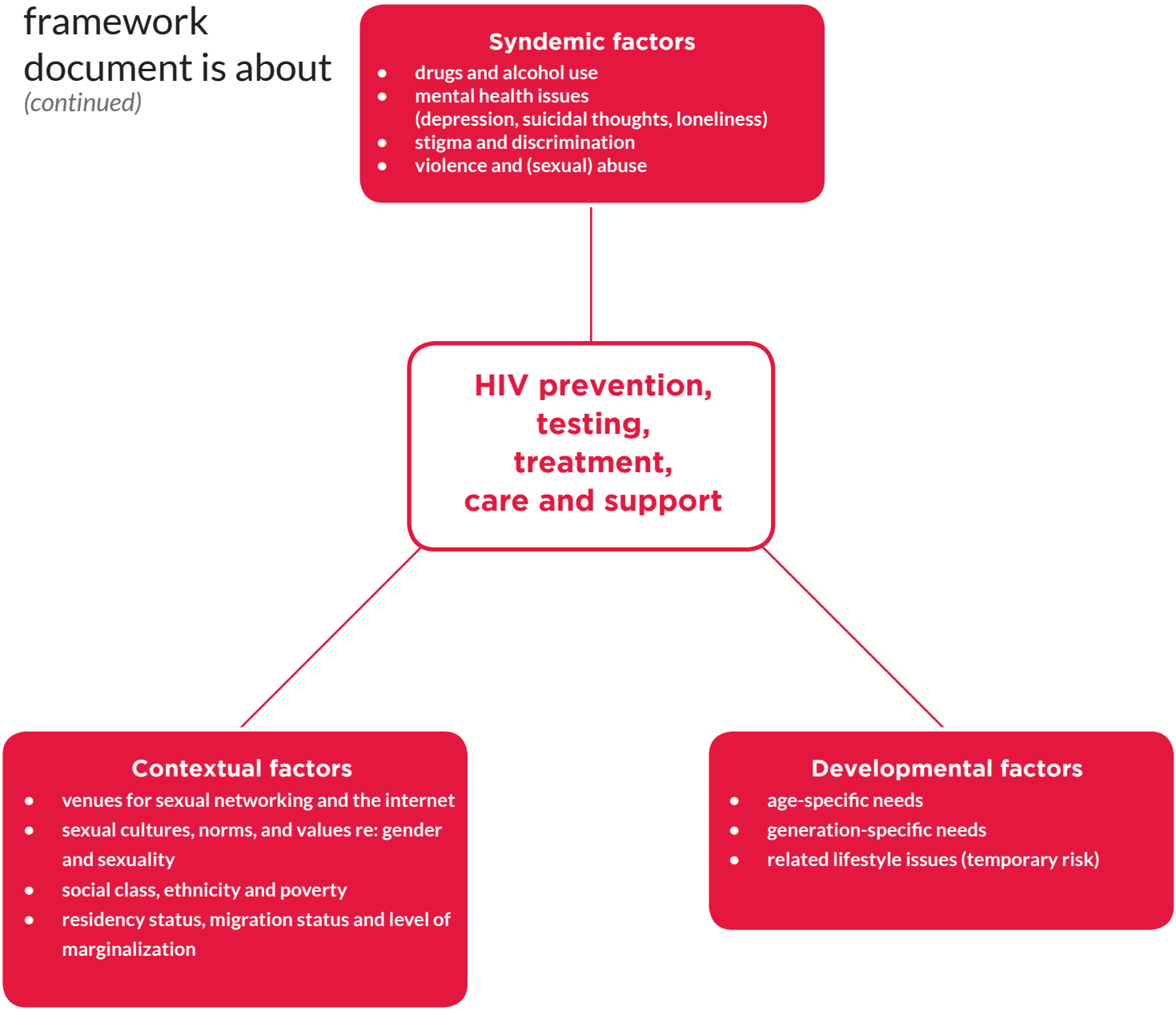
Perry Halkitis, [18] referring to North American MSM, has noted that a "new framework for HIV prevention must give voice to gay men; [it] must consider the totality of their lives; must delineate the underlying logic, which directs their relation to sex and HIV; and must concurrently respect their diverse life experiences".

Halkitis calls for a "biopsychosocial paradigm", informed by both theory and practice, and directed by three theoretical lenses for understanding HIV disease and the way it is spread. First, he proposes to draw on theories of syndemics, which are related psychological and physical health problems and social conditions and are sometimes referred to as social determinants (see Component four). Second, there is a need to incorporate developmental theories that indicate the importance of age, generation and life phase in designing prevention strategies (see Component three), recognizing that MSM are not all at the same level of risk at all times during their lives. Third, he points to the need to understand different contexts in which HIV transmission occurs. This insight refers to basing HIV services on social settings (structure and/or environment), including the prevalence of violence and stigma but also marginalization based on status as a migrant or being in an ethnic minority, as well as the networks and settings in which MSM are found.

Successful HIV interventions and programmes reflect these three lenses (spheres), as Figure 4 illustrates.

Background: What this framework document is about *(continued)*

Figure 4. Complementary theoretical lenses through which to analyse HIV epidemics and design HIV services for MSM



Background: What this framework document is about *(continued)*

Should we be standardizing responses or should programmes reflect the diversity of human cultures and societies?

It is important to realize that homosexuality is expressed, lived and received differently across cultures and societies in Asia and in comparison with countries in the West. While this document aims to be a regional guideline, due to the variety and diversity of (and within) countries and cultures, it is important not to assume that providing HIV services to MSM should be done in exactly the same manner everywhere in the world. What this document suggests, however, is that there are seven targets that are universal:

- reducing HIV transmission via male-to-male sex;
- increasing coverage of and access to HIV services (prevention, testing, treatment, care and support) for MSM in need by improving service quality and scope and their level of integration;
- reducing the number of deaths due to AIDS among MSM;
- increasing coverage of and access to diagnostic and treatment services for sexually transmitted infections (STIs);
- improving the quality of life for MSM, especially MSM living with HIV, by reducing stigma and violence;
- refocusing our efforts on adolescent and young MSM, where incidence is relatively high (partly because the number of uninfected MSM is larger in this age group); and
- placing the HIV epidemic and responses to it into a wider framework of health, human rights and development goals as we move from the Millennium Development Goals to the 2030 Sustainable Development Agenda.

The ways to reach these targets most effectively are not universal and may differ widely between countries and even between cities and regions or territories within the same country. What this document thus aims to do is present evidence of successful approaches and experiences in Asian settings and suggest standard questions to ask in a setting so that these approaches can provide inputs or advice about improving and innovating the response to HIV among MSM in Asian countries, territories, regions and cities.

The document thus offers itself as a follow-up to the 2009 Comprehensive Package of Services that was jointly developed for the Asia–Pacific region [19] and the 2009 global UNAIDS Action Framework. [20] While this document is specific to the Asian region, it also draws from the most recent global World Health Organisation (WHO) guidelines[21] and the 2016–2021 UNAIDS strategy as well as from specifically Asian examples and settings.

There is an urgent need to scale up and improve the quality of primary HIV prevention efforts. Add to that, there is need for a strong focus on promoting the treatment of undiagnosed HIV infection as the most effective way to prevent HIV at the population level. This requires efforts that strongly increase the uptake of HIV testing via a diverse array of modalities and immediate access to antiretroviral treatment once someone tests positive. This means overcoming the many barriers in many places for the smooth transition between receiving a positive result and treatment. Finally, there is a need for ongoing support for MSM already on antiretroviral treatment to ensure that its effects are maximized.

Background: What this framework document is about *(continued)*

Basic principles underpinning HIV services for MSM

1. The design of policies and the scaling up of programmes and services dealing with the sexual health of MSM should be conducted with their involvement. This involvement should start with participation in formative research (if any), in which they should be not only providing information but be part of the data collection process.
2. HIV is linked to other health problems and social and psychological inequities faced by MSM and should be addressed as part of a holistic approach towards the varied health problems that MSM experience, such as the use of alcohol and recreational drugs, depression, loneliness, suicidal thoughts, stigma, discrimination, violence and abuse.
3. MSM, like all human beings, are varied and different. It is important to ensure that the opinions and needs of different groups and networks are heard when designing policies, programmes and services with MSM. In particular, it is important to avoid allowing community-based MSM to dominate the allocation of resources available for service provision to the detriment of MSM who do not want or are unable to connect to or to be part of such communities.
4. It is important to assume a developmental view on HIV vulnerability and risk among MSM. Not every man who has sex with men is equally at risk at every phase or stage of his life. HIV services should take this into consideration and be responsive to the different needs of MSM of different ages and lifestyles.
5. Compulsory or mandatory HIV testing of individuals is a violation of human rights under all circumstances. Its occurrence is counterproductive to the public health goal of promoting access to HIV services.
6. New delivery models for HIV counselling and testing should be piloted to increase access to services. However, all forms of HIV counselling and testing have to adhere to the five Cs: consent must be properly obtained before a test is taken; confidentiality must be upheld; counselling should occur both pre- and post-test; test results should be correct and connections should be in place to treatment, care and prevention services.
7. The interest of individual clients always comes first and supersedes any other interests that may be in play during programme implementation (for example, reaching a target for the number of people tested).
8. For males younger than 18, testing and counselling services need to consider the best interest of an adolescent or child, including their right to non-discriminatory and welcoming services for HIV, sexual health and related issues.
9. Rather than continuing to develop pilot projects or model development approaches that can be taken to scale (but in practice rarely are), donors and development partners should provide pooled or joint funding as part of a long-term package that is centred on sustainability and gradually increasing the share of government funding. This is a general flaw in development that needs to be addressed and also applies to scaling up HIV service responses for MSM.
10. A supportive and conducive legal and policy environment are essential for the effective and acceptable provision of HIV services to MSM. It is important to improve the human rights situation of MSM, because stigma, discrimination and violence have proven to have a strong negative impact on their access to HIV and other health services.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Component 1
Target - The need for evidence

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men

Introduction

This section focuses on the proper use of evidence to inform local HIV programming for MSM. It proposes four important questions that should be answered for every city, region, territory and country in order to make HIV services for MSM successful. It is important to find the right balance between scaling up programmes and focusing on additional research to further improve or fine-tune existing services, making them more effective, especially if it has been found that existing services fail to reach particular subgroups or segments of the MSM population.

In many Asian cities, there already is sufficient evidence to inform HIV services for MSM and/or there are promising models that have yielded good results in recent years. In such instances, no precious time should be wasted on conducting research if that means a delay in the immediate expansion and scaling up of these existing HIV services for MSM.

This component starts with an introduction of the cascade of HIV services as a tool to diagnose, monitor and evaluate the response to HIV in a city or region. Creating an HIV service cascade requires data from different sources and different methodologies.

The cascade of services and how it should guide the response to HIV among MSM

The cascade of HIV services is a useful tool for diagnosing, monitoring or evaluating the HIV situation and response among MSM in a city or territory. It can point to and prioritize ways for improvements. [22] An HIV service cascade lists the levels of HIV services through which a person with HIV moves, starting with prevention and testing and, for those who test positive, enrolment in and adherence to antiretroviral treatment and care and support, followed by the final level, which is the achievement of viral suppression (meaning a person has obtained the maximum health benefits of his HIV treatment and is no longer likely to pass on HIV to other people).

Developing an HIV service cascade helps visualize the extent to which MSM are being reached for testing and enter into treatment and care services after diagnosis with HIV. The cascade is often depicted as a pyramid or a flow, with bars of decreasing height to indicate the loss to follow-up HIV services from one level to the next.

Figure 5. HIV service cascade

Source: Consolidated strategic information guidelines for HIV in the health sector. Geneva: WHO; May 2015 (www.who.int/hiv/pub/guidelines/strategic-information-guidelines/en/).

Component ONE:

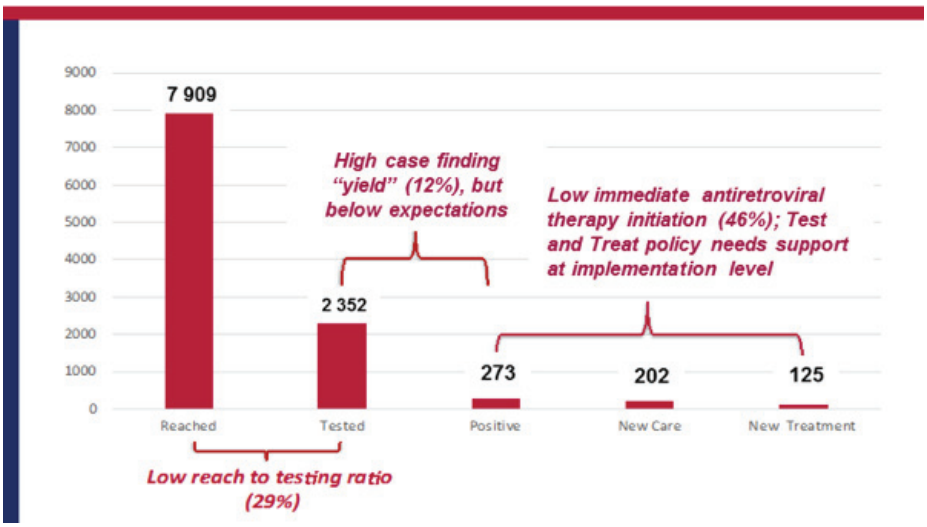
Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

To develop a cascade of HIV services for a country or city, the following data are needed:

1. The estimated total number of MSM in need of HIV services.
2. The estimated proportion of (1) who lives with HIV.
3. The proportion of (2) whose HIV infection has been diagnosed (those who have been tested and received the result).
4. The proportion of (3) who has successfully made contact with HIV care and treatment services.
5. The proportion of (4) who has initiated treatment with antiretroviral medicines.
6. The proportion of (5) who is adherent to treatment.
7. The proportion of (6) who has attained viral suppression. [23]

The treatment cascade data can be represented in the form of a series of bars (as shown in Figures 6 and 7) or as FHI 360/USAID's so-called leaking pipe, as depicted in Figure 8.

Figure 6. 90-90-90 among MSM and transgender women: Programme experience in Thailand, 2015 (Q2–Q3)



Source: FHI 360, USAID LINKAGES programme.

The development of an HIV service cascade is important not only to allow for better adjustment and improvement of services and interventions for MSM but also to enhance shared accountability for reaching 90% of MSM with combination prevention services by 2020[24] as well as the 90-90-90 treatment targets (by 2020, 90% of all people living with HIV will know their HIV status; by 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and by 2020, 90% of all people receiving antiretroviral therapy will have achieved viral suppression). [25]

Component ONE:

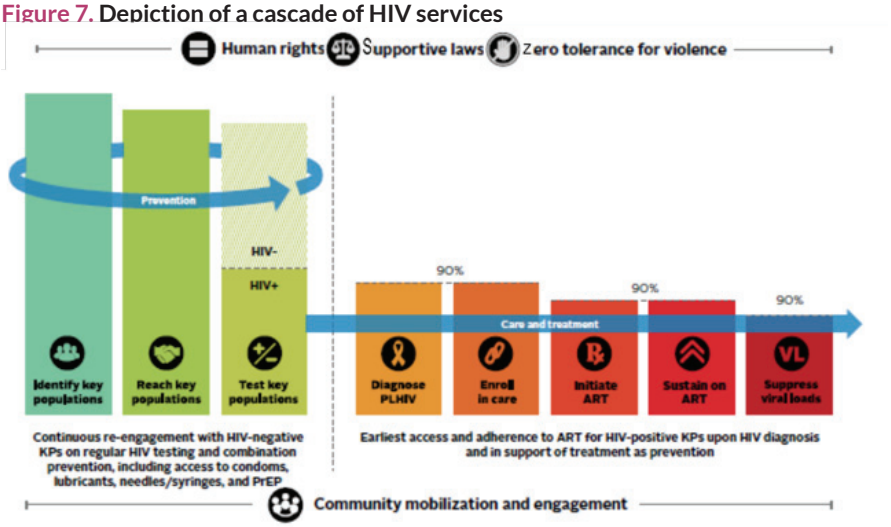
Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

When building an HIV service cascade for MSM, it is useful to start with the five questions suggested in the HIV cascade framework for key populations:

1. Where? Distinguish the geographic area of focus or scope. Knowing the focus of a specific cascade will help implementers determine data needs and steer them towards appropriate data sources.
2. Which service area will be emphasized? Will focus be on the full HIV service cascade and all its components? Or will there be more focus on outreach or on care and treatment?
3. Who? Determine who the focus of the programme will be. Will collected data be disaggregated by sex, gender or sexual identity, age group or some other population characteristic? Or will total population figures be used? Because there are differences in access, acceptability or utilization of services within the MSM population, it is recommended that implementers use disaggregated data whenever possible.
4. When? Plot the time period, clearly specifying the start and end dates (month and year). Ensure that the time period reflects an official reporting cycle, such as the end of the month, quarter, semi-annual or annual episode.
5. How? Distinguish presentation format. Will a cascade graph be used or another representational style, such as a dashboard or trend graph?

In this process it is important to agree on a set of indicators that would constitute the cascade and to facilitate data collection and analysis. Additional guidance in developing and applying cascade indicators can be found in the LINKAGES framework,[26] *WHO's Consolidated strategic information guidelines for HIV in the health sector*, [27] released in 2015, and the *Metrics for monitoring the cascade of HIV testing, care and treatment services in Asia and the Pacific.* [28]

Figure 7. Depiction of a cascade of HIV services



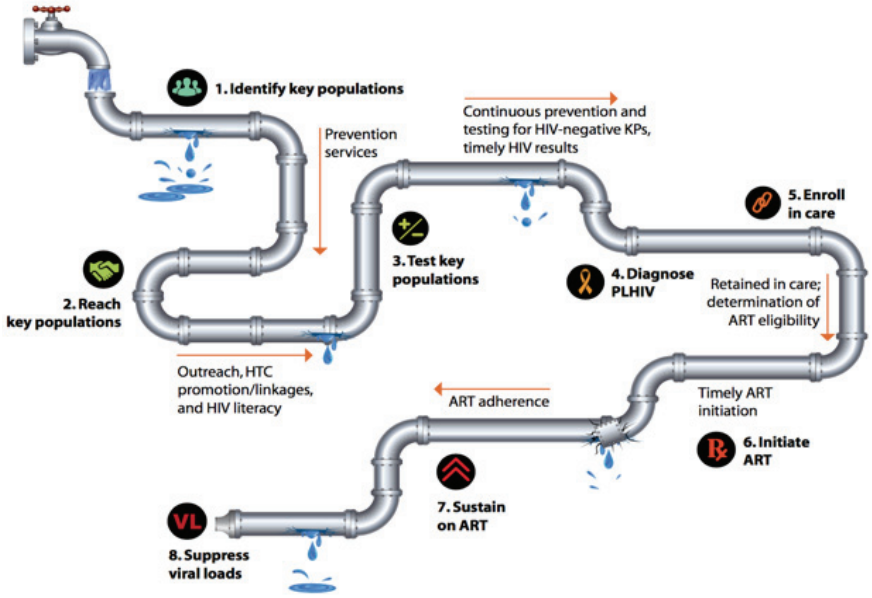
Note: KPs=key populations; PrEP=pre-exposure prophylaxis; PLHIV=people living with HIV; ART=antiretroviral treatment.
Source: USAID, FHI 360, PEPFAR and LINKAGES. HIV cascade framework for key populations. Arlington, VA: FHI 360; 2015.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Figure 8 illustrates the flow of clients from identification and outreach towards the point at which those with HIV achieve suppressed viral load. FHI 360 has likened this process to a leaky pipe that loses people along the way. The challenge is to stop the leaking.

Figure 8. Flow and loss of clients from identification to viral suppression



Note: KPs=key populations; HTC=HIV testing and counselling; ART=antiretroviral therapy; PLHIV=persons living with HIV.
Source: USAID, FHI 360, PEPFAR and LINKAGES. HIV cascade framework for key populations. Washington, DC: FHI 360; 2015.

In the United States, the Centers for Disease Control and Prevention now recommends developing a consistent system to track the reach and coverage of HIV services provided to different subpopulations so that the HIV service cascade can be used as a joint monitoring tool. This expansion of surveillance to include both HIV infection and AIDS cases is a necessary response to the impact of advances in antiretroviral therapy, the use of new HIV treatment guidelines and the increased need for epidemiologic data regarding persons at all stages of the HIV disease. Expanded surveillance can provide additional data on HIV-infected populations to enhance efforts to prevent its transmission, improve the allocation of resources for treatment services and assist in evaluating the impact of public health interventions. [29]

Monitoring and evaluation systems may need to be tweaked and harmonized to ensure that different services and organisations use the same parameters and indicators while tracking MSM in their use of HIV services and programmes. This means all organisations must agree to use the same goals and objectives and, linked to this, the same way to measure to what extent their objectives are being reached. To maximize its effectiveness, such a system needs to continuously and confidentially track the pattern of service use and programme access by different subsets of MSM (stratified by age, social class, religion, engagement in sex work, etc.) in real time, with the findings accessible to all collaborating service providers so that the information can be used to increase access and quality and to address bottlenecks, if they occur, immediately.

Component ONE:

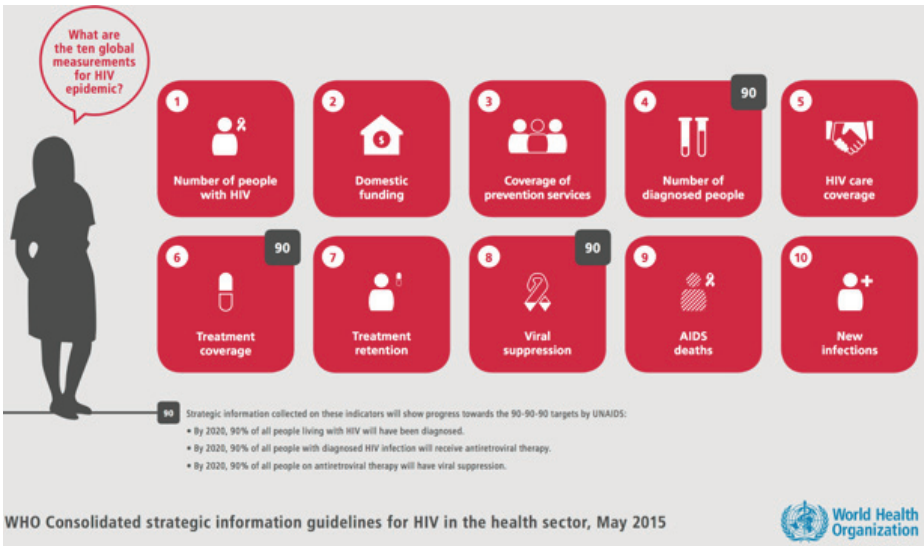
Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

In many countries, a unique identifier code has been agreed upon as a starting point by all parties involved in the cascade of services. The identifier code is a way to track service users almost in real time, without recording their name or other identifying information. This is usually done by creating a unique code based on, for example, the initials of the service user's father or mother or his date of birth. If a network of services in a city or country agrees to use the same coding system, it becomes possible to derive information on the success of referrals from one service to the next as well as trends in coverage of service use. Such a system has the potential to lead to increased engagement of key populations with health and outreach services; improve the focus of services on key populations; and help to verify or establish population size estimations and deliver programme coverage data at the population level.

Most importantly, however, such a system can assure confidentiality and anonymity and can help establish trust between service organisations and their MSM clients, thus strengthening demand. [30]

Recently, WHO suggested a set of 10 core global indicators that can be used to monitor the health sector response to HIV, [31] as depicted in Figure 9.

Figure 9. Ten global indicators for measuring the progress of health sector responses



Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Question 1:
Is there agreement about the baseline parameters of the HIV service cascade?

To establish an HIV services cascade, the first step is to agree on the number of MSM in need of services in a city or region and to assess the HIV prevalence and incidence among MSM. This can help in planning for setting up sufficient HIV services to meet demand. [32]

The number of MSM at risk can be assessed using two types of methods: a survey and a mapping. One popular mapping-based strategy is time-venue sampling, [33] also called time-location sampling. It is a mapping of venues where MSM meet and counting the numbers of MSM present at each venue at particular times of the day or the week, resulting in an estimate of the MSM population present across a city or region, based on these venues. In countries where venues are losing in importance to internet-based dating, the process of counting people at physical cruising venues may become less and less effective as a method to assess the number of MSM at high risk, because the men encountered at such venues may be less representative of the MSM population as a whole.

Other sampling approaches include capture–recapture and multiplier methods. [34] A newer sampling strategy to reach or assess the size of a population at risk is respondent-driven sampling.[35] This strategy has been particularly helpful in accessing MSM who are less likely to frequent typical venues, such those not identifying with their same-sex behaviour (heterosexual and married MSM and freelance (often straight) male sex workers), often referred to as "hidden populations". [36] The method has been widely praised for being smarter, cheaper and easier to implement than time-location sampling surveillance.[37] This way of assessing can also access people who operate only or mainly via online networks because recruitment into the study does not depend on face-to-face contact. However, other scientists are pointing out that respondent-driven sampling has significant weaknesses and biases when applied in particular settings.[38] To better assess the number of young MSM, excellent guidance was recently developed by a coalition of UN organisations. [39]

If there is no size estimation data available or if there is no funding for a data collection exercise, often used is a consensus figure of 3% of the male population aged 15–49. This is a figure accepted in many countries that make use of the influential Asian Epidemic Model.[40] The figure of 3% is a lower estimate from studies on the prevalence of homosexual behaviours across countries and populations.[41] The age range of 15–49, however, was derived from reproductive health practice, reflective of the ages at which women are fertile. For MSM, this figure is obviously not relevant because there is no reason to assume that MSM stop having sex after age 49. It thus makes more sense to set the baseline population for the prevalence of same-sex attraction at 3% of the entire sexually active male population nationwide, or everyone aged 15–64 (or even older).

There is reason to believe that in certain countries, cities and settings, MSM are sexually active before the age of 15. Recent guidelines from the United Nations Population Fund (UNFPA) suggest a lower age of 10 to include sexually active boys in need of social protection services. [42]

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

In most countries, same-sex attracted men are more likely than their heterosexual brethren to migrate to larger cities, often in an effort to escape the stigma and heteronormative expectations of their family and village.[43] To account for this, it makes sense to assume that the number of MSM is bigger in cities and smaller in rural areas, which countries such as the Lao People's Democratic Republic and Myanmar have done. Exact percentages then depend partly on how a group of stakeholders decides to agree on them. It could be 1% of men in rural areas and 5% of men in urban areas, for example, or a slightly closer range of 2% in rural areas and 4% in cities. If there is agreement that the overall percentage of MSM in the population should remain at or around 3%, in line with global estimates, it is important to take the level of urbanization into consideration when estimating the number of MSM.

If there is agreement to make an estimate of MSM according to the percentage of the male population, it is important to realize that the number of men who regularly engage in unprotected anal intercourse is actually far lower than the population-based percentage of 1–5%. Thus, rather than spreading scarce prevention funds across the entire MSM population, it is the subgroup at highest risk that should be targeted. Having interventions focus on this smaller group has a far greater benefit than sprinkling interventions across a larger number of MSM.

How significant or established is HIV among MSM? This question is important for advocacy purposes, for determining the extent to which a focus should be on prevention and testing versus treatment, care and support and to target efforts on populations or cities or regions where the prevalence of HIV among MSM is highest. Initially, in countries where the epidemic is just starting, there will be indications of this by an increased number of new HIV cases found at HIV counselling and testing services. The absolute number of new and total HIV cases and the self-reported mode of transmission are useful starting points; for instance, it provided initial indications of the existence of significant HIV epidemics among MSM in Singapore, Hong Kong (China) and Manila before other research data were available.

The question of the burden of HIV can be answered more precisely by conducting integrated biological and behavioural surveillance (IBBS) surveys that assess the prevalence of HIV and of related risk behaviours, such as unprotected anal sex. The prevalence of a disease measures the number of people that have a disease or health condition in a randomly recruited representative sample of a certain population. Being able to also assess the HIV prevalence among certain subgroups of MSM, for example, age groups, income groups or social class or prevalence by city, location and region, is important for targeting and prioritizing, especially in situations in which funding for HIV services is limited. There are different methods for ensuring that such an assessment can be made. In many if not most major Asian cities (including Bangkok, Beijing, Dhaka, Ho Chi Minh City, Hong Kong (China), Jakarta, Karachi, Kathmandu, Kuala Lumpur, Mumbai and Phnom Penh), such studies have been conducted in the past decennium so that estimates of the number of MSM living with HIV in a city or region can be made by multiplying the prevalence to the estimated total MSM population.

The question of the speed at which the HIV epidemic is expanding can be obtained by researching HIV incidence and conducting cohort studies, which look at the number of new infections in a certain population over a certain time period. These studies are often combined with an assessment of the effectiveness of innovative interventions.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men

(continued)

Box 1:

Multiple sector collaboration in Cambodia and Thailand

In Cambodia in 2010–2012, the National Centre for HIV/AIDS, Dermatology and STD and a coalition of NGOs (FHI 360, the Khmer HIV/AIDS NGO Alliance (KHANA), Men's Health Cambodia and Men's Health Social Services) jointly conducted a study on male sexual risk behaviours. [44] The study was jointly designed, implemented and analysed, and as a result, the data it generated helped inform programmes and policies from all participating organisations.

In Bangkok in 2002–2003, the Ministry of Public Health (MOPH), the Thai Red Cross, the Thailand MOPH–US CDC Collaboration, and the NGO Rainbow Sky Association of Thailand established a similar collaboration, [45] resulting in widely acknowledged and shared HIV prevalence research, an advocacy push in funding and effort to expand access to HIV services among Thai MSM, including for the highly successful Silom Community Clinic.

Frequent sharing of experiences and discussions about new directions, joint advocacy and critical reflection with all stakeholders were important ingredients of the collaborative efforts in both instances.

Recommendations

1. Agree on a baseline population estimation of MSM in the country and city, based on size-estimation studies in urban areas of high HIV risk, using one or a combination of size-estimation methodologies. Then agree on a figure that lies somewhere in between the results of each.
2. In countries with a large population of unreached MSM, consider respondent-driven sampling as the method to assess the size of this population as well as their access to services. This method, however, only leads to reliable estimates if MSM are sufficiently socially networked, because it depends on chain referrals and social network size for the recruitment of participants and for proper analysis.
3. If there is no funding or no time for size-estimation research, an alternative is to agree on a percentage of all men aged 15–64 who are regularly sexually active with other men; possibly, a different percentage can be used for the rural and urban populations. The baseline figure is often set at 3%.
4. Assess venue-based dating versus internet or social media-based sexual networking, and develop HIV interventions and programmes that reach MSM who use geolocation dating applications.
5. Estimate the number of MSM living with HIV in a city or region by multiplying the prevalence of HIV found in IBBS surveys by the estimated total size of the MSM population.
6. Establish the number of MSM who have been diagnosed with HIV and have enrolled into an antiretroviral treatment programme. In combination with the number of men calculated under the fifth recommendation, assess how many unreached or undiagnosed MSM there are in the city or region. Reducing this number by a certain percentage per year should serve as the main goal or purpose of a city's or region's HIV programme for MSM.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

7. If not already in place, bring together all significant HIV service providers in the city or country and agree on a common system for monitoring and evaluation (M&E), including the use of a unique identifier code to track access and coverage and to assess the success of referrals in real time across the HIV service cascade. Guidance and examples are available from WHO,[46] PSI[47] and APMG.[48]
8. Conduct a citywide or countrywide workshop to jointly fill in the data required to thus create a graphic depiction of the local HIV cascade of services, possibly making use of the WHO guidance produced for this purpose. [49]

Question 2:
What barriers hamper access of MSM to the cascade of HIV services?

Unfortunately, even in cities with well-established HIV epidemics among MSM, coverage of interventions remains far too low to make a serious impact on transmission (meaning that not enough MSM are reached by prevention programmes and not enough undiagnosed MSM are discovered via testing and assisted in accessing antiretroviral treatment). A global survey conducted among 3748 MSM from 145 countries found that condoms and lubricants were accessible by just 35% and 22% of respondents, respectively; HIV testing was accessible by 35% of HIV-negative respondents; and just 43% of HIV-positive respondents said that antiretroviral treatment was easily accessible. The study found that homophobia, the extent to which respondents were hiding their sexuality and (perceived) health care provider stigma were associated with reduced access to services. [50]

Even among MSM who initially manage to access HIV prevention and testing services, large numbers of men who test positive for HIV do not access follow-up tests or access HIV treatment services in the general health care system immediately after they are diagnosed with HIV. This indicates that there are significant barriers to accessing services, which often include stigma, the perceived cost of treatment, fear of disclosure and/or fear of side effects of the antiretroviral drugs. MSM often face (or fear they will face) discrimination and stigma at the hands of health care providers, resulting in their being hesitant to access services. Especially for young MSM, there is the issue of self-stigma that leads them to not access the services they need.

It is important to assess which barriers or other factors hamper access of MSM to essential HIV services; addressing these will improve the outcomes and results of an HIV programme for MSM by (i) finding more undiagnosed HIV cases and (ii) enrolling more undiagnosed HIV cases into life-saving antiretroviral treatment. Several of the factors impeding access to services for MSM can be summarized under the umbrella of problems related to quality. In other words, if services are not friendly (or worse, if they are hostile) towards MSM, if they do not respond to the needs and concerns of MSM or if the location is not safe in terms of confidentiality or not acceptable in terms of location, cleanliness, waiting hours, etc., MSM are unlikely to access such services. Services should also be comprehensive, with a minimum number of referrals. [51]

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Recommendations

1. Discuss reasons for "leakage" of clients between the different levels of the HIV service cascade. Discuss whether there is a need to conduct qualitative research of MSM at different levels of the HIV service cascade to explore these reasons further by assessing problems and barriers they perceive or have experienced in accessing services. This could be done as a rapid assessment or as a brainstorming workshop with representatives of MSM living with HIV.
2. If there are indications that stigma or unfriendly services are a factor in explaining users who drop out of HIV services, consider conducting a study among HIV service and other health care providers to assess their attitudes, knowledge and behaviours towards MSM clients. The findings of the study should feed back into in-service and pre-service training of medical personnel and nurses.
3. Consider the implementation of a rating system for different HIV services in a city or region in which clients can provide anonymous feedback via an online rating mechanism, with ratings for perceived quality, waiting time, friendliness, convenience and/or other parameters. This may help these services make adjustments and improvements.
4. It may be necessary to include other services to which MSM need access in order to reduce HIV transmission (see Component four), for example, alcohol dependency reduction services, harm reduction services, mental health services and/or peer support groups for people living with HIV.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Question 3:
Where and how can most unreached MSM be reached with HIV services?

To increase the uptake of HIV testing and increase case finding of undiagnosed MSM, it is important to assess and map locations and networks through which MSM meet each other for sexual encounters. Sexual networks and nodes in these networks should be analysed in tandem with other networks of risk, for instance, those around recreational drug use, alcohol or substance use and sex work.[52] Those at highest risk for HIV are likely to be linked into multiple networks of risk.[53] Understanding these networks and how they overlap and how the members of such networks communicate (for instance, online and offline) is important because it is at these locations or virtual spaces where outreach should be conducted to provide prevention education, distribute condoms and lubricants, promote HIV testing and ultimately connect undiagnosed MSM to HIV testing services. From there, if they are found positive, MSM can be connected to HIV treatment services as well as other health services that affect HIV vulnerability, such as mental health services, alcohol and harm reduction services, sex and sexuality counselling and social support services.

In the past, mapping of sexual networks of MSM was often done as part of size estimations, and outreach took place in parks, saunas and street corners. But in the time of the internet and social media, it is perhaps even more important to map cyber networks via which MSM meet each other and through which they obtain access to drugs and to underground sex parties. Then attempt to design interventions that reach people who depend on such online channels.

Because it has been found that men using social online media may have higher levels of HIV risk than those meeting in offline venues,[54] it makes sense to design interventions that aim to link the online world with the offline world, where services such as HIV testing and related health care are available.

It is important not to see the mapping of MSM venues and network as a one-off exercise. As the expansion of online sexual networking illustrates, changes can occur suddenly and rapidly. Venues open and close; websites are established and removed; apps gain popularity and are usurped by newer and better apps—thus, it is imperative to repeat mapping exercises at least every three to five years or more often if resources permit or if there is anecdotal evidence that major changes are occurring.

In recent years, innovative new strategies have emerged to ensure that implementing partners respond to changes in the field by making use of continuous research and reflection processes. Successful NGOs like the AIDS Council of New South

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Wales in Sydney and The Humsafar Trust in Mumbai have formed dynamic research partnerships with universities that allow them to feed a whole range of information back into programming in real time. UNAIDS and The Global Fund to Fight AIDS, Tuberculosis and Malaria have been working with the Sydney-based think-tank APMG and others on developing the practice of results-informed contracting (now called "funding for results"), which means that implementing agencies must keep moving and shaping their programmes in line with the results they are achieving as well as with research findings that reflect on these results because they will only continue to receive funding by doing so.[55]

This process goes hand in hand with the development of monitoring systems for project implementation that use real-time data, which can provide much more useful and timely information about the burden and distribution of HIV in the diverse communities of MSM in need of services and what factors are associated with incident infections. They also can guide HIV services in delivering more immediate, more appropriate and more acceptable services.

Modern HIV service organisations must become learning organisations. This can be done, for example, by instituting monthly reflection meetings with staff or workers to assess progress and determine whether the work they do continues to be relevant and effective and, if not, in which direction to move. An example of this is using the HIV prevalence in a city to assess whether outreach efforts are reaching those most at risk. For instance, if the prevalence among MSM in a city is 15%, the percentage of people who are tested positive by the HIV service organisation should also be around 15% (preferably higher). If outreach workers continue to test people who end up being HIV-negative, this should serve as an indication for the organisation to move its outreach efforts elsewhere.

Box 2:
Mapping for impact in Thailand

After its establishment, the Thai NGO Service Workers In Group (SWING) undertook an extensive mapping of male sex work venues to understand in great depth the population it was going to serve. The team walked and documented every square mile of Patpong, Bangrak, Sukhumvit and Saphan Kwai areas in Bangkok to record the locations of bars and entertainment places where male sex workers were working. The maps of each area were drawn, and other essential information was recorded, such as the number of sex workers at each venue and the name and contact of venue owners and managers (mama-sans). This mapping exercise was later replicated in other HIV interventions. SWING was one the main contributors in the development of a mapping manual, supported by the Thai Ministry of Public Health–United States collaboration with the Centers for Disease Control and Prevention. Later, a SWING team was invited to conduct training on mapping exercises for both government and non-government agencies in the provinces of Khon Kaen, Udon Thani, Lopburi and Rayong, among others.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Recommendations

1. In each city or urban area, conduct a mapping of venues and locations where MSM meet for friendship or sex, looking at when these locations are in use (night time, day time and which days of the week) and approximately how many men are typically present or using each location. If there is more than one organisation conducting outreach, this should be a collaborative process; a common map and database should be agreed upon that all relevant partner organisations can access and update.
2. The mapping process should be repeated and updated regularly; it is possible to envision a system in which outreach workers are put in charge of keeping the map updated as a "living document". For this to happen, it is probably necessary to have one person managing and promoting the regular updating and daily use of this document among participating partner organisations.
3. The mapping process should include a search and listing of internet chat rooms and websites (including hidden and open Facebook groups and pages) that MSM use. The extent to which online networks are overlapping or separate from those in physical locations should be assessed as well.
4. The extent to which there are different segments of MSM using online and offline venues and networks should be assessed, including variations in the levels of HIV risk in different online and offline environments. This can help to focus outreach activity towards those with the greatest need. For example, MSM operating mainly via online networks may be more hidden and less willing to connect to community-based services. They may be younger and/or more vulnerable, which should have implications for the kind of services designed for and offered to them.
5. Organisations implementing HIV services should be supported in becoming learning organisations with instituted processes of reflection and sharing to assure that the service they are providing remains effective and relevant and that they are reaching those most in need.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men

(continued)

Question 4:
Do we have sufficient knowledge about sociocultural diversity and market segmentation of MSM?

Same-sex behaviours are universal—they occur in all cultures and throughout history.[56] How they are understood, valued and expressed, however, differs across and even within cultures and societies. Even within the same country or city, there are multiple differences, partly determined by social class, age or generation, ethnicity and religion. Even within the life of a single individual, there are differences over time in the way a person relates to sex and HIV; often HIV risk and vulnerability varies sharply over a person's lifetime as well.

Rather than viewing all MSM as a homogenous group, it is important that HIV prevention, care and support strategies take sociocultural aspects (as described in this section) into consideration, including social class, rural or urban background, level of education, age and generation and concept of self in terms of gender and/or sexuality. Current approaches tend to be far too rooted in epidemiology and fail to apply the strengths and depth of understanding that ethnographic research can provide. Epidemiologists and medical doctors tend to believe that only the fact that the targeted men practise unprotected anal sex counts and often propose to reach men engaging in such behaviour using a one-size-fits-all approach with simplistic slogans, such as "Don't be silly, put a condom on your willy" or "No condom, no sex".

It is important to understand the transmission, prevention, treatment and care of HIV in its social and cultural contexts. This is important for the targeting of resources and understanding where (among which age group or subgroup) the epidemic is most severe. Second, it is important to determine the right tone or language used in talking about HIV and linking it to the lives of different subgroups of MSM, including in terms of age and generation, in terms of identity or membership in a community and in terms of ethnicity, social class, religious background and other factors. Such research then needs to be fed back into the consequent design and delivery of accessible and acceptable HIV services that go beyond a one-size-fits-all approach.

Whereas most prevention outreach efforts are managed by community groups that often have among their stated aims to organise and empower MSM around a common sexual identity, the extent to which Asian same-sex attracted men are willing (or able) to organise in such sexual identity-related communities is doubtful. This is especially the case in religious and conservative societies like Bangladesh, Pakistan and the Philippines where same-sex behaviours are often hidden and go hand in hand with a so-called public straight life, often as a married husband and father. The extent to which men organise in communities might be partly linked to social class and wealth; many poorer men remain dependent on family support and cannot afford to go against social and cultural norms and expectations of parents or community elders; the same can be the case for men of higher social status, who often have to preserve the reputation of a particular family name or clan. Such MSM may not feel confident or comfortable accessing services under a community banner.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

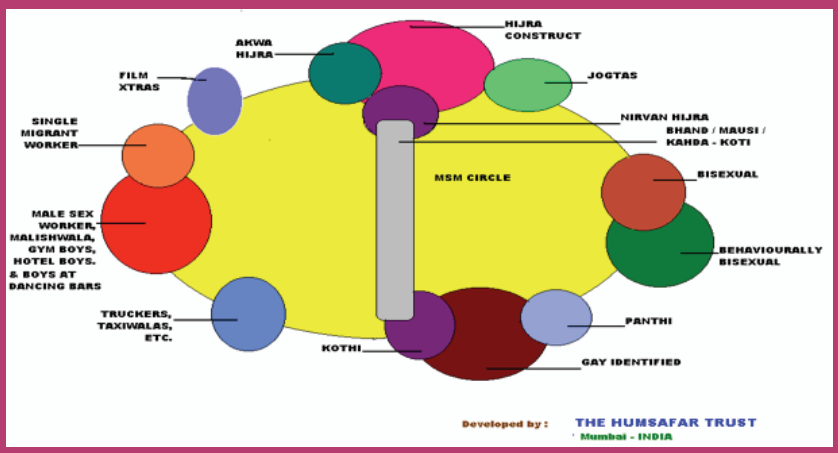
It is important to also reach MSM outside community networks, for example, by integrating HIV services for MSM into the mainstream health system.[57] These are important possibilities to consider when designing strategies, policies and programmes that deal with HIV transmission among men. Unfortunately, in most countries, little qualitative and ethnographic research on these topics has been conducted, and much of our current efforts to respond to HIV are based on imported assumptions.

At the same time, young cohorts of self-identified gay men are starting to emerge in Asian cities, such as Bangkok, Hong Kong (China), Kuala Lumpur, Manila and Singapore, who are creating new sexual identities and who feel comfortable leading more open lives as part of newly emerging communities that operate to an important extent online. For these young men, old-fashioned community-based intervention models, such as peer outreach, may be more effective, although they should be adapted to the modern times.

Questions to consider for ethnographic research include what is the role of power differentials in sexual encounters (in terms of age, sex, wealth or social position)? In other words, is the use of condoms the decision of one or both partners? What is the role of exchange in sexual encounters or longer-term relationships and how is this linked to condom use? It is also important to understand how MSM view and value themselves and other partners and then find ways to link positive attributes to positive health-seeking behaviours, such as using condoms or getting tested for HIV.

Box 3:
Understanding diverse needs in India

The Humsafar Trust in India conducted qualitative research to assess the diversity of the population it was trying to serve. It developed this MSM circle, which was used to assess the appropriateness and quality of its own programmes for MSM with the different characteristics thus identified.



Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

It is important to move away from thinking of the practice of unsafe sex as a product of cognitive, rational decision-making. There is a need to obtain and carefully analyse knowledge about the sociocultural context, including the dangers some MSM face while operating in strictly heteronormative social and family contexts. Not enough is understood about the way homosexuality and non-normative gender identities play out across generations, age groups, social classes and other societal distinctions of MSM and how this affects or explains the levels of HIV risk and vulnerability. Knowing this in detail is likely to result in more effective prevention, care and support interventions. Well-conducted and analysed ethnographic research sheds light on such questions and is essential for improving HIV services.

Box 4:
Acknowledging and responding to cultural diversity in Indonesia

In promoting HIV awareness and increasing the use of HIV testing centres, the Indonesian NGO Yayasan Intermedika, based in Jakarta, employs different strategies for four stratified target groups of MSM: first, there are general MSM, whom they call yimers; second, there are male masseurs and male sex workers, whom they call yimpist; third, there are young MSM, whom they call yimoet; and finally, they have services for MSM living with HIV who are referred to as yimmie. For MSM who do not want to participate in community activities, the project has linked to an MSM-friendly health centre for the general population (puskesmas), where events are organised occasionally to promote HIV testing, which is announced mainly via Facebook. For more economically advantaged MSM reached via the internet, a film screening event is organised at a private testing facility; participants can have an HIV test after the film for 20 000 rupiah (around US$ 1.50). For people with HIV, there is a monthly support group meeting, but most MSM do not want to attend this and rely on support groups via LINE and WhatsApp messenger.

Recommendations

1. Bring together a group of social scientists, representatives from subgroups of MSM and other stakeholders who are aware of the extent to which qualitative research about male-to-male sexuality exists in the country or city of interest.
2. Summarize the available data, determine gaps (in terms of the topics that have been researched as well as the populations that were studied) and how they can be filled. Summarize the gaps in order of priority in a qualitative research agenda.
3. Based on what is available, discuss the extent to which this data have informed current strategies and HIV services for MSM. In many instances, it will become apparent that it has not.
4. Discuss and assess improvements that could be made to services based on the available data with service implementers, programme designers and government stakeholders.
5. Advocate with donors and/or universities to conduct relevant sociocultural research that will further inform HIV policies and programming and help in translating existing information into better services.

Component ONE:

Collecting or analysing the data we need to guide an effective response among men who have sex with men *(continued)*

Checklist 1: Evidence	Score			
	No	Partly	Mostly	Fully
Data on prevalence of HIV among MSM are available				
Data on prevalence of HIV by age group are available				
Data on prevalence of HIV per city are available				
Data on prevalence of HIV over time are available				
Data on incidence of HIV are available				
Data on incidence of HIV by age group are available				
Data on incidence of HIV per city are available				
Data on the burden of STIs among MSM are available				
Data on the burden of human papillomavirus (HPV) and hepatitis B and C among MSM are available				
Data on the total population of MSM are available				
Data on total population of MSM per city are available				
Agreed estimate on the number of MSM at high risk is available				
Agreed estimate on the number of MSM at high risk is available per city				
There is an updated mapping of venues for MSM				
Sexual networks in cyber space are mapped				
Qualitative data on homosexuality are available				
Qualitative data on homosexuality have been analysed and used in the design of interventions and services				
Qualitative data on transgender women are available				
Qualitative data on transgender women have been analysed and used in the design of interventions and services				
Qualitative data on young MSM are available				
Qualitative data on young MSM has been analysed and used in the design of special interventions or services				
Qualitative data on young transgender persons are available				
Qualitative data on young transgender persons have been analysed and used in the design of special interventions or services				
Qualitative data on the use of recreational drugs and prevalence of sex work is available for MSM				
Evaluations and documentation of successful interventions for MSM are available				
Qualitative knowledge about obstacles to accessing different levels of the cascade of services is available				
There is a commonly agreed M&E system for tracking clients using a unique identifier code				

Component 2
Improving and reanimating HIV services for MSM

Component TWO:

Putting in place the elements of a second-generation HIV service response for men who have sex with men

Introduction

This section outlines the components and basic principles that should be in place for a reinvigorated and more effective HIV response for MSM, based on experiences in several Asian countries and the latest HIV science.

For the first decade or so of the global HIV epidemic, promoting abstinence, being faithful and condom use—the ABCs—was considered the only viable prevention strategy against HIV infection. Gay men in some Western cities showed the way, embarking on an initially successful collective project of behaviour change around reduced numbers of sexual partners, increased condom use and less penetrative sex.[58]
Abstinence programmes were vigorously promoted by religious conservatives around the world (though not among gay men) but did not lead to any effect on the incidence of unprotected sex or teenage pregnancy. [59] Condom use and reductions in the number of partners had some effect but were insufficient to halt transmission. [60]

With the advances made in the development of medicines for HIV treatment as of the late 1980s and 1990s, HIV became less of a life-threatening disease. Probably partly as a result of this, condom use among MSM in Western cities began to decline, and unsafe sexual practices increased again. [61] It became clear that finding undiagnosed HIV cases and helping people living with HIV access antiretroviral treatment was the most effective measure to prevent onward transmission of HIV, simply because people who have suppressed viral loads are much less likely to be infectious. As a result, the concept of "treatment as prevention" was born. [62]

At the same time, it was discovered that MSM found other ways to reduce their HIV risk that did not involve condom use, especially in settings in which high percentages of gay men test for HIV regularly. [63] Recently, strong evidence emerged indicating that antiretroviral medicines can be effectively used as a prophylactic against HIV (pre-exposure prophylaxis, or PrEP).[64] Behavioural programmes and condom promotion remain effective tools as well.[65]

There is no silver bullet for HIV prevention. But there is growing awareness that combining different prevention strategies can lead to a much higher likelihood for success in reducing the incidence of HIV. [66] This means there is a need to stop seeing prevention as separate from HIV testing and treatment, care and support.

In addition, it is important to realize that one size does not fit all; HIV services need to be based on ethnographic knowledge about different subpopulations of MSM and need to be carefully calibrated (see Component one).

This section follows, approximately, the different levels of the HIV service cascade, which starts with (i) HIV prevention and awareness outreach, followed by (ii) HIV testing and (iii) enrolment into antiretroviral treatment, (iv) care and support to attain treatment adherence and (v) the achievement of viral suppression. The importance of agreeing on a standardized package of services across HIV service providers is first discussed, followed by the urgent need for stronger integration of services that are part of the HIV service cascade.

Component TWO:

Putting in place the elements of a second-generation HIV service response for men who have sex with men

(continued)

Agree on a comprehensive package of HIV services and ensure that all organisations and service providers accept and use it

For an individual MSM client, it should not matter which service provider he chooses in terms of the quality and range of HIV services that he can expect to receive. Whether an outreach worker is paid for by NGO A or NGO B or government agency C, the availability and quality of the services should be the same. Therefore, there is a need to standardize and agree on a comprehensive package of HIV services made available across service providers in a city or region.

But, to emphasize, not all HIV service providers have to provide all elements of a comprehensive package of HIV services by themselves. Instead, they need to have effective collaboration across the network of service providers in a city or region to ensure seamless referral and access for MSM clients.

The comprehensive package of HIV services recommended by UNAIDS and WHO includes condoms and lubricants, HIV counselling and testing (preferably via different modalities) and treatment for STIs. In addition, the latest recommendations suggest that the comprehensive package needs to include PrEP as well as the possibility to access post-exposure prophylaxis (PEP) after accidental exposure to HIV. The package should also include diagnostic tests and treatment for common STIs, such as syphilis, gonorrhoea, chlamydia and herpesvirus infections, and provide the option for vaccinations against hepatitis B and C and, especially for sexually inexperienced adolescent MSM, the vaccine to prevent several prevalent strains of the human papillomavirus (HPV).

The comprehensive package of HIV services should include the prevention and management of HIV co-infections and other comorbidities, including viral hepatitis, tuberculosis (TB) and mental health conditions, and the whole range of HIV care and treatment services. In countries where alcohol and recreational drug use are important determinants for unsafe sex among MSM, WHO and UNAIDS recommend that harm reduction interventions for substance use are put in place as part of the comprehensive package.

Rather than the one-size-fits-all condom that is promoted in most Asian cities, MSM should have access to at least three sizes and types of condoms and possibly different types of lubricant. This will help to increase the effectiveness and decrease the discomfort of using condoms. This is already done by SWING and Rainbow Sky Association in Bangkok, where three sizes of condom are generally available for clients; in Cambodia, PSI developed handy pocket-sized packages that contained a condom and a sachet of lubricants.

Not included in the comprehensive package of interventions but important as an add on, possibly with a user fee, are services to promote general rectal health, including the diagnosis and treatment of warts, haemorrhoids, fistulae and other common problems that provide discomfort for MSM and also may have an impact on HIV risk.

Component TWO:

Putting in place the elements of a second-generation HIV service response for men who have sex with men

(continued)

Box 5:

The Time Has Come: Setting standards for health care providers

The United Nations Development Programme (UNDP) and World Health Organisation (WHO) jointly developed a regional training package aimed at building the capacity of health care providers in the Asia–Pacific region to address prevention, care and treatment of sexually transmitted infections (STI) and HIV among MSM and transgender people and reduce stigma in health care settings. The package is called The Time Has Come: Enhancing HIV, STI and Other Sexual Health Services for MSM and Transgender People in Asia and the Pacific[67] and was formally launched in 2013.

The training package was jointly developed and based upon recommendations of the Global Commission on HIV and the Law report HIV and the law: Risks, rights and health (2012), the WHO Prevention and treatment of HIV and other STIs among MSM and transgender people: Recommendations for a public health approach (2011) and two UNESCAP resolutions. UNDP supported the development and pilot testing of this training package under the ISEAN-HIVOS Multi-Country Global Fund Programme.

The package offers a dynamic, interactive training programme designed and delivered by expert peer trainers. Based upon best-practice adult education principles and methods, it draws on the latest research, policy and strategy related to HIV prevention, treatment, care and support among MSM and transgender people to deliver training on the cutting edge of new thinking and innovation. The training aims to impart practical, sustainable knowledge and skills to programme managers, front-line service managers and health policy professionals that can enhance their leadership capacity and improve programming and service delivery. It is designed to be particularly relevant for health care workers as well as selected staff from donors, national and provincial HIV programmes, Global Fund project managers, policy-makers, front-line managers and advocates.

See www.asia-pacific.undp.org/content/rbap/en/home/presscenter/articles/2013/11/20/-the-time-has-come-.html

It is important to reduce fear and improve the attractiveness of HIV testing and other services, especially for young MSM. Branding has been shown to be important: a brand can be a sign of quality. The brand comes to reflect the fact that the service carrying it is friendly for MSM, has a fixed package of services of high quality, does not stigmatize, discriminate or judge clients in any way, and respects clients' dignity and confidentiality. This has happened successfully in several countries, such as the Blued programme in China [68] and the MStyle programme in Cambodia.[69]

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Putting in place the elements of a second-generation HIV service response for men who have sex with men

(continued)

Recommendations

1. Bring together all stakeholders from government, donor and community organisations in a city or country, and agree on what should be a comprehensive package of interventions that should be available for all MSM.
2. Make sure the package includes the essential components needed for interventions for prevention, testing, treatment, care and support, as recommended by WHO and UNAIDS:
   - condoms (preferably in different sizes) and lubricants;
   - HIV counselling and testing (preferably via different modalities);
   - information and education about HIV via outreach, both online and offline;
   - information and education about STIs via outreach and at health care facilities;
   - information and education about important health and social determinants that are associated with HIV transmission;
   - harm-reduction interventions for substance use, in particular needle and syringe programmes, opioid substitution therapy and naloxone;
   - diagnostic tests and treatment for common STIs;
   - vaccinations for hepatitis B and C;
   - vaccinations for adolescent MSM against HPV;
   - pre- and post-exposure prophylaxis;
   - TB screening and treatment;
   - baseline health tests for people recently diagnosed with HIV;
   - antiretroviral treatment for all people living with HIV;
   - social support for people living with HIV;
   - treatment of opportunistic infections and other comorbidities for people with HIV; and
   - treatment monitoring and adherence support.
3. Ensure that this comprehensive package of services is available regardless of the service provider or the area, city or neighbourhood where MSM access services.
4. Develop effective (well-thought-out and well-tested) messages promoting different aspects of the package, ensuring that HIV is positioned as something that affects all MSM and avoiding an attitude of "we are healthy, you are sick".
5. Not all service providers have to provide all components of the package, but they must have effective collaboration across the network to ensure seamless access for MSM clients. And there should be an articulated and agreed division of labour on who provides what, with accompanied links between services that are clear.
6. There should be regular meetings by the network of service providers to discuss cooperation and assess whether accompanied referral systems are working and to respond to changes and new developments.

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(continued)

Integrate prevention outreach, testing, treatment, care and support services

Most national HIV programmes have separate units and directors for departments focusing on prevention, on HIV testing and counselling and on HIV treatment, care and support. Most NGOs and HIV service organisations working in Asian countries similarly have a focus on one of these three areas. Prevention organisations provide a prevention and referral model of service delivery: the service stops after referral to an HIV counselling and testing (HCT) centre. HCT centres use a test and referral model to get patients on antiretroviral treatment; usually no system is in place to ensure that newly diagnosed MSM actually access CD4 and baseline testing facilities or enrol into antiretroviral treatment. And organisations focusing on treatment of HIV usually have no idea about prevention.

It is important to move HIV services towards becoming one-stop shops or a least to make them more integrated and linked to each other, from the perspective of clients. Agreeing on a standardized comprehensive package of HIV services that spans the prevention versus the care and support divide, as described above, is an important first step. In terms of the delivery of this package, once a client enters into an HIV service (be it via online or offline outreach or by visiting an HIV testing centre), he should have direct or accompanied access to (i) a rapid HIV screening test, (ii) a confirmation test if found positive, (iii) CD4 test (if the country still requires this [70]) and/or other baseline tests and (iv) antiretroviral treatment and access to viral load testing and monitoring.

If these services cannot be provided at the same service or location, they should be delivered by different organisations or actors in the response. But then they should be linked and seamlessly integrated to keep clients from dropping out. For this, caseworkers are needed (see further on) who accompany clients between different service locations.

The integration of HIV health care services has progressed in many Asian cities in recent years. Ultimately, this requires good collaboration and referral systems between government-run health services and the services provided by community groups and NGOs. What remains missing in many places is a stronger and direct connection of HIV health care services to the MSM populations they serve via accompanied outreach and case management to support adherence and facilitate access to mental health services, social support groups and to related health services, such as those dealing with alcohol and drug addiction.

There is an urgent need to overhaul the overall strategic approach to address HIV among MSM by breaking down the silos in which prevention, testing, treatment, care and support are still operating. At the same time, because HIV is so closely related to other health and social problems that MSM experience, HIV responses need to be embedded into services dealing with a wider range of health and social services (see Component four on social determinants).

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(continued)

This requires a paradigm shift. HIV service organisations need help to move towards a much broader, more holistic, more client-centred and fully integrated model of HIV service delivery. That model must be based on finding undiagnosed cases of HIV and on client-oriented case management, where, apart from being given prevention information and condoms, clients are actually accompanied and supported until they are able to access and are successfully retained in HIV treatment services.[71] This means they are accompanied by the outreach worker to the HIV testing centre; if they test positive, they are then accompanied for the confirmation test and CD4 test; then they are accompanied for the first contact with the doctor and other medical personnel to ensure their enrolment in an antiretroviral treatment programme as well as support services for people with HIV (optional). In Bangkok, such a system, implemented by The HIV Foundation (Box 6), has proven to be an unprecedented success: the number of newly diagnosed people who were dropping out upon obtaining a positive test result and consequently disappeared fell to zero cases after more than 10 months of project implementation.

HIV service providers should establish a system in which they can maintain contact and keep providing services to clients rather than referring them and gradually removing them from their HIV prevention programme as soon as they turn HIV-positive, as is currently the case. The target and outcome indicators of HIV interventions should no longer be indicators, such as the number of prevention education contacts conducted or the number of condoms distributed in the field (these can remain as process indicators), but instead focus on what really has an impact on the epidemic, such as:

1. The number of clients accompanied for HIV testing and counselling (which includes HIV prevention education).
2. The number of new HIV cases discovered.
3. The number of newly diagnosed HIV-positive clients successfully enrolled in treatment and care services.

This requires, first and foremost, that HIV organisations become welcoming and safe for people living with HIV. All too often, a person who seroconverted is conveniently removed from an HIV service organisation by referring him to a network for people living with HIV—as if a person with HIV had somehow lost the battle against HIV and is now a lost case. As well, many people living with HIV work for HIV organisations that focus on prevention but they usually do not feel safe enough to disclose their status, even to colleagues. This needs to change. HIV has to be normalized, especially in cities and countries where a significant proportion of MSM are living with the virus.

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(continued)

Box 6:

Implementing integrated HIV services in Bangkok and Jakarta

The HIV Foundation and its partnering clinics piloted an HIV service model for MSM in Bangkok, Thailand that incorporated all levels of the HIV cascade of services (see Figure 5), introducing performance-based pay for outreach workers and a more intensive (see Box 16) and comprehensive package of services to clients.

The programme improved its targeting, focusing outreach efforts on networks with high levels of HIV positivity and dropping those that yielded lower numbers of new cases. In this model, Foundation staff establish contacts with prospective clients, encouraging them to have an HIV test. If a client agrees, the outreach worker accompanies him to the testing centre, where he is handed over to a colleague, a so-called caseworker also employed by the Foundation. If a client tests positive, the caseworker accompanies him for additional tests and to enrol in antiretroviral treatment. The caseworker provides 24/7 support via social media chat channels and telephone. The client is urged to participate in a special half-day workshop for newly diagnosed MSM, for which he receives a monitoring incentive.

This approach has resulted in more than 1363 MSM being newly diagnosed with HIV in a 12-month period, with zero losses to follow-up interventions (from initial diagnosis to enrolment in
treatment services).

Since 2013, Yayasan Intermedika has managed to move from just a prevention–outreach organisation to become more integrated in the range of services it delivers in Jakarta, Indonesia. It is starting to have programmes that help people access antiretroviral treatment after having been newly diagnosed, and it is planning to strengthen links with support groups for people living with HIV. In doing so, it is trying to overcome the gap that often exists between prevention and care/support programmes in Indonesia. Rather than counting the number of people reached with prevention messages and basing its achievements on this, it now focuses on finding new HIV infections among MSM and transgender persons. Working in three districts (western, southern and central Jakarta), it accompanied approximately 3000 people to HIV testing sites between May 2014 and February 2015; approximately 500 of them tested positive for HIV, 250 were eligible for antiretroviral treatment, and 200 are currently on treatment. Only 50 people were not recorded in the follow-up interventions, partly because some died and others moved away.

Source: Lessons learned 2014 2015: behavior change strategies to drive HIV counseling and testing among MSM in Thailand. Bangkok: PSI Thailand; 2015. And de Lind van Wijngaarden JW. Aide memoire for UNAIDS Indonesia on how it can strengthen its support to HIV responses among MSM in Indonesia. April 2015; unpublished.

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(continued)

Recommendations

1. Review policy documents and programming guidelines and remove any conceptual distinctions between prevention on the one hand and treatment, care and support on the other. Instead, introduce and promote the concept of integrated and holistic HIV services that include a range of interventions, starting from prevention education and outreach via HIV testing towards identification of undiagnosed HIV cases and consequent enrolment into antiretroviral treatment.
2. Establish strong collaboration between HIV services at the different levels of the cascade in order to integrate existing services. Ideally, implementing organisations should be capacitated to become jointly responsible for delivering the comprehensive package of HIV services for a defined group or geographic area in a city or country rather than clients having to deal with two or three or even four providers when accessing services. If this is not feasible, MSM NGOs should be invited into a network of services that, as a group, takes responsibility for the full range of interventions set out in the comprehensive package of services.
3. The target and outcome indicators of HIV interventions should not report on the number of prevention education contacts made or the number of condoms distributed in the field but instead should focus on the results that really count: the number of clients accompanied for testing, the number of new HIV cases discovered and the number of newly diagnosed HIV-positive clients successfully enrolled in treatment and care services. Focusing on reaching a significant proportion of MSM with condoms and lubricants should no longer be a definition of success—at most, this can be an intermediate process indicator, but it should not be indicative of outcome or impact.
4. Ensure that messages provided by outreach workers and during awareness-raising events do not strengthen a "we are healthy, you are sick" attitude. HIV should be positioned as part of life of all MSM—this will strengthen the integration of prevention, testing and treatment services and also help to reduce the stigma that often remains attached to living with HIV.

Professionalize outreach: Make it performance based, higher quality and in line with agreed standards, and provide higher pay

At the entry point into the cascade of HIV services is awareness about HIV and access to prevention services, including information, education, condoms and lubricants. For these services, many MSM depend on outreach workers employed by NGOs, community groups or, occasionally, government-run health services. Outreach workers are the backbone of HIV work and are often an essential link between government-run health services and the work of community groups and NGOs. If outreach workers are passionate about their work, well motivated, well trained and well paid, they are much more likely to achieve results in terms of reaching clients and helping them towards safer sexual behaviours, less potential exposure to HIV, greater willingness to regularly test for HIV and, if positive, to enrol in antiretroviral treatment.

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(continued)

Yet, in most Asian countries and, indeed much of the world, outreach work is poorly valued and paid. Outreach workers are often called 'volunteers' and paid a small allowance rather than a salary. As a result, there is typically high turnover. If a volunteer becomes too competent and effective, they tend to be snapped up into a more lucrative, better-paying job. Leaving outreach to poorly paid volunteers does not do justice to the importance of their role. Outreach workers should be paid a baseline salary and should be given the opportunity to raise that salary further if they achieve certain results. The maximum pay of effective outreach workers should be the same or higher as that of a programme officer in an NGO.

No national standards exist in most countries for what a peer educator or outreach worker should know or be able to do. No standards or performance indicators or commonly agreed terms of reference exist on how they should be recruited (based on which criteria), how long and on what they should be trained and how they should be monitored and re-trained regularly. There is no consistent definition of what a contact between an outreach worker and a client should entail. Often, outreach workers provide messages and information that are not well tailored to the specific needs of a client: the messages are too simplistic and too uniform. MSM subpopulation-specific messages and resources need to be adapted or developed.

Outreach workers need to be of high standard in terms of their knowledge and skills. If the pay is higher, it is likely that better-qualified individuals will be interested to apply for these positions than is often the case. After their recruitment, outreach workers need to be well trained to do HIV prevention education; in addition to focusing on the promotion of condom use (including providing knowledge about the sizes, shapes and tastes of condoms that exist and the need to find the right size or type, which may differ per individual), they need to be trained in other HIV risk reduction options, including PrEP, PEP, negotiated safety, strategic positioning, serosorting and sexual behaviours that do not require condom use.

An example of a country where this is successfully happening is the Lao People's Democratic Republic, where FHI 360, under the USAID LINKAGES programme, is recruiting and training professional health navigators who are well paid and whose pay is partly dependent on their performance. The HIV Foundation in Bangkok is implementing a similar structure, working in teams and rewarding those that jointly achieve the best results in terms of finding and enrolling newly diagnosed MSM into treatment provided by the regular Thai health care system.

Outreach should be organised in teams of four to eight people who are linked to a caseworker. Each team of outreach workers should test a certain minimum number of MSM in a month to qualify for their base salary—this minimum number should be easy to achieve. However, for each additional person they bring in for HIV testing after they have reached this number, they are paid an extra amount of money, up to a maximum amount. It is hoped that working in a team will provide mutual encouragement and some peer pressure to achieve and surpass the basic targets set for testing and referral. There may also be some healthy competition between outreach teams, if more than one is set up. There should be regular training events and new information materials to motivate outreach workers that appreciate their professionalism and their capacity to make a difference.

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(continued)

If more funds are invested into outreach by paying outreach workers more, it is important to ensure that their focus is not only on finding people for testing but on finding undiagnosed cases of HIV in the environments or networks where they work. The consensus HIV prevalence in a city or region should be the benchmark. If prevalence is 15%, outreach workers who test 100 people should find around 15 new cases of HIV. If they find far fewer than that, they should move to another area or environment where HIV is more prevalent.

Because there is much misinformation about HIV and AIDS on the internet, including individuals or groups who claim to be able to cure HIV, there is a need to develop and circulate plain language information on HIV, the availability of HIV treatments, the need for antiretroviral treatment adherence and management of side effects and nutrition and emotional health, and preferably posted to a trusted website. Outreach workers should be aware of the latest science in HIV prevention, treatment, care and support.

Box 7:

A commonly agreed MSM and HIV outreach reference manual

In an attempt to professionalize and standardize outreach, Family Health International (FHI), supported by the United States Agency for International Development, developed a standardized HIV reference tool comprising more than 200 questions about HIV issues that outreach workers encounter while doing their work. The manual was updated in 2015 with support from UNAIDS Regional Support Team. The idea for this outreach reference manual emerged from a regional workshop of outreach workers from five Mekong countries in 2005, where many complained that they had no such reference material with which they could easily look up additional information on topics related to their work in their own language. FHI and UNESCO collaborated in conducting a regional peer review process, in which PSI, the International HIV Alliance, Pact, UNDP and UNAIDS participated. In 2015, UNAIDS Regional Support Team took on the role of organizing a peer review of the fully revised manual. In exchange for their participation, all involved organisations received copies of the manual for free, provided they adapt it to be relevant and appropriate for the country or countries where they use it and that they lead a similarly inclusive process with all potential users at the country level. As a result, the 2006 manual was translated and put to use in several languages, including Burmese, Cambodian, Chinese, Lao, Mongolian, Nepali, Thai and Vietnamese. The manual is being used across organisations in the same country, as intended. The Thai Ministry of Public Health officially adopted the Thai version of the manual and paid for printing and distribution to all provinces. The manual was seen as a first step in a process of standardization of what outreach workers should do and know. Common training materials, common testing materials and common behaviour change materials will follow.

Source: Reducing the burden of HIV on men who have sex with men and transgender people in Asia: a self-study and reference manual for outreach workers, case workers and other HIV service providers. Bangkok: UNAIDS Regional Support Team, FHI 360, 2015, forthcoming.

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(continued)

Recommendations

1. Agree on much higher standards for what outreach workers, caseworkers and possibly facility-based HIV workers should know or be able to do (skills).
2. Outreach workers and caseworkers must cease to be volunteers. They should be rewarded for the professional service they are expected to provide. This should include a standardized terms of reference, with recruitment criteria that can be used during recruitment.
3. Agree on targets for outreach workers and caseworkers in terms of the number of new HIV cases they should find and enrol into an antiretroviral treatment programme. Teach NGOs to use the assumed prevalence as a way to monitor whether outreach workers are accessing the right networks, such as networks with high levels of seropositivity.
4. Agree among stakeholders to increase the remuneration of outreach workers, in line with mid-level NGO officers, and make remuneration partly performance based, with agreed performance indicators. Then, if possible, re-recruit outreach workers based on the new criteria and evaluate them every quarter, using previously agreed performance goals.
5. In countries where this position is not yet common, recruit caseworkers who are tasked to take care of and accompany a small group of recently diagnosed MSM to ensure their access and enrolment into the health system, enabling them to access antiretroviral treatment.
6. Organise teams of four to eight outreach workers, linking to one caseworker who is based at one or more testing facilities, allowing for seamless accompanied referrals.

Increase access and use of pre-exposure prophylaxis for MSM most at risk

Even the most successful behaviour change programmes that promote the use of condoms for anal sex rarely manage to raise consistent condom use to levels higher than 60–80% (Figure 10). While impressive and important, this is not sufficient to turn HIV epidemics around. A highly effective prevention tool has emerged in recent years: pre-exposure prophylaxis. PrEP refers to the use of antiretroviral medicine commonly used for the treatment of HIV by uninfected individuals to prevent infection. In other words, HIV medicines are used as a prophylaxis, or a prevention pill.

This prevention strategy has shown promising results in several recent studies (Box 8), but its effect strongly depends on uptake (a sufficient proportion of the population of MSM have to take it in order to have effect in reducing HIV incidence at the population level) and adherence (for the protective effects to work, adherence to taking PrEP needs to be sufficient among those taking it).[72] In most Asian cities, there is no knowledge on how the introduction of PrEP would work out in these terms. It is important to conduct assessments of the acceptability of and existing misconceptions about PrEP to inform campaigns raising awareness about it.

The introduction and roll out of PrEP among MSM can only work if men using it are willing to undergo regular HIV testing, typically once every three months, to ensure they only take PrEP as long as they are HIV-negative. Testing is required because providing PrEP without knowing whether a person has seroconverted may lead to the development of drug-resistant strains of HIV. In addition, regular risk reduction counselling,

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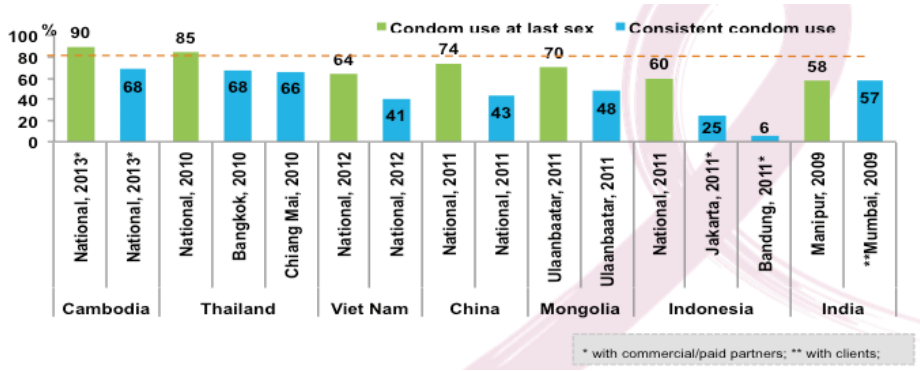
provision of condoms and lubricant and monitoring kidney function are all important components of a comprehensive HIV prevention package that includes PrEP. The testing infrastructure in a city, territory or region should be well developed and well prepared to deal with an increased number of MSM showing up for regular counselling and testing. Consistent condom use in selected Asian countries and cities is mostly lower than 80%, which is the level considered necessary to halt transmission of HIV at the population level. This means PrEP, as an additional prevention strategy, becomes essential.

Figure 10. Condom use at last anal sex and consistent use among MSM, 2009–2013



Source: AIDS Data Hub, based on country AIDS response progress reports, 2012; integrated biological and behavioural surveys; and behavioural surveillance surveys (www.aidsdatahub.org).

PrEP is particularly relevant for groups and individuals who are at a temporary or continued risk of acquiring HIV with the currently available prevention approaches—this can be people who are often drunk or high on drugs while engaging in anal sex, sex workers, people who are HIV-negative but in a relationship with an HIV-positive partner, or young MSM who may not have the experience or knowledge to use condoms regularly. The advantages of PrEP, compared with condoms: PrEP is under individual control, it is invisible at the time of sex, and the decision to take it is separate from the sex act. Because PrEP can be expensive, especially in cities where no generic antiretroviral drugs are on the market, it is important to target the introduction of PrEP towards groups of MSM who are most likely to reap the benefits of it.

Structural barriers that block access of MSM to health services in general (including the criminalization of homosexuality, discrimination by health care providers, poor service coverage and quality and low awareness about the availability of health care services) need to be addressed as a matter of urgency to allow marginalized MSM access to PrEP.

Nonetheless, PrEP as a prevention option should only be promoted for people who really want to use it. Because people reluctant to PrEP are not likely to be adherent, and this means they should be counselled on other HIV prevention methods, such as condom use and safer sexual practices. PrEP can be one of a number of prevention methods that can be offered to at-risk individuals at the time of HIV counselling and testing, with the individual and counsellor working together to decide which prevention tools are appropriate for their lifestyle and level of risk.

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(continued)

Box 8:
The iPrex study

A well-known ground-breaking study called iPrex found that among those receiving PrEP, HIV incidence was 1.8 infections per 100 person-years, compared with 2.6 infections per 100 person-years among those who concurrently did not choose PrEP and 3.9 infections per 100 person-years in the placebo group of the previous randomized phase. The importance of adherence became clear by studying the group in the PrEP group in more detail. The researchers found that HIV incidence was 4.7 infections per 100 person-years if clients had not taken PrEP recently; it was 2.3 infections per 100 person-years if drug concentrations in the blood were low (at levels suggesting that fewer than two tablets per week were taken rather than a daily dose); incidence fell to 0.6 per 100 person-years for those who were found to use two to three tablets per week, and incidence was 0 per 100 person-years for use of four or more tablets per week (p=0·0001). This suggests that while adherence is important, it does not have to be 100% to achieve a highly protective effect. The authors concluded that PrEP uptake was high when made available for free by experienced providers and that the effect of PrEP increased with greater uptake and adherence during periods of higher risk.

Source: Grant RM et al. Uptake of pre-exposure prophylaxis, sexual practices, and HIV incidence in men and transgender women who have sex with men: a cohort study. Lancet Infect Dis. 2014;14.9: 820-829.

UNAIDS [73] noted that scaling up the provision of services providing PrEP to those who need or want it is synergistic with scaling up treatment to everyone living with HIV who wants it, with harm reduction services for people who inject drugs and with other evidence-informed HIV interventions, including promoting condoms and lubricants. Stakeholders, including WHO, UNAIDS, the US Centers for Disease Control and Prevention and the Asia-Pacific Coalition on Male Sexual Health, now agree that a combination of promoting condoms and sexual behaviour change, promoting regular HIV testing to find undiagnosed MSM and enrol them in antiretroviral treatment and making PrEP available for uninfected MSM at risk who want to use it is the best way forward in turning HIV epidemics around.

PrEP should therefore be included in the agreed comprehensive package of HIV services for MSM previously discussed and should be available for MSM at high risk for HIV who want to use it.

In a few Asian cities, such as Bangkok and Hong Kong (China), PrEP is delivered through sexual health clinics and HIV services. In cities where PrEP is being initiated, potential users should be involved in developing the service to support access, adherence and demand. A PrEP service needs trained, non-stigmatizing staff to provide high-quality HIV counselling and testing that will identify people who are HIV-negative but at substantial risk of HIV and are ready to have ongoing follow up and regular HIV testing, which is a requirement for enrolment into a PrEP programme.

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(continued)

Box 9:

A sustainable model for pre-exposure prophylaxis service delivery in Thailand

The Thai Red Cross AIDS Research Centre launched the PrEP-30 project in December 2014 to provide pre-exposure prophylaxis to at-risk individuals as part of a comprehensive HIV prevention package. The PrEP-30 service is funded through user fees of 30 Thai baht, or less than US$ 1 per day, and without any public or private subsidy. Client costs are made affordable through the procurement of locally produced generic medication and minimizing the use of costly laboratory testing. HIV antibody testing is performed at the first visit, after one month and then every three months thereafter. Hepatitis B screening is performed at the baseline stage, and renal function is monitored regularly. Other services, such as screening and treatment for STIs and hepatitis B vaccination, are offered as indicated.

Through October 2015, a total of 127 individuals had initiated PrEP-30 at the Thai Red Cross Anonymous Clinic. The majority of clients were male (98%) and MSM (93%). Most were referred through HIV testing counsellors or through the Adam's Love website, which provides online health education and counselling to gay and bisexual men in Thailand. Risk factors as indications for PrEP included unprotected anal intercourse (34%), multiple sex partners (28%), known HIV-infected sex partner (23%), previous non-occupational post-exposure prophylaxis use (13%) and/or sex work (7%). Among those who completed follow-up HIV testing, no new HIV infections were detected.

Source: Dr Donn Colby, Thai Red Cross AIDS Research Centre, personal communication.

Other needs identified by UNAIDS include reliable systems for prescribing and dispensing medicines; links to HIV treatment services for those found to be HIV-positive; appropriate laboratory facilities (or referral systems) for monitoring renal function (which can be a side-effect of PrEP medicines); and links to other HIV prevention services, including the provision of condoms and lubricants.

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Recommendations

1. Advocate with the local or national food and drug administration office so that they approve the use of the antiretroviral medicine tenofovir or emtricitabine for prevention purposes (using recent international recommendations in favour of PrEP as an advocacy tool).
2. Assess the knowledge about and demand for PrEP among MSM at high risk for HIV (for instance, MSM in serodiscordant relationships, MSM using party drugs and MSM engaged in sex work), including awareness, acceptability, misconceptions and attitudes about its use and preferred modalities for delivery.
3. Ensure that HIV-testing services are up to standard before rolling out a PrEP programme, because regular testing is a requirement for enrolling.
4. Train health care providers and outreach workers providing HIV services to MSM about PrEP and its benefits and drawbacks. Many MSM might be more inclined to enrol in a PrEP programme if trusted health care providers recommend it.
5. Promote PrEP among MSM at high risk for HIV using different media channels and possibly advocacy events using popular or effective (well-tested) messages.
6. If demand for PrEP is greater than the supply, it will become necessary to prioritize enrolment based on the highest risk or need. MSM engaged in sex work, MSM who regularly use recreational drugs (such as crystal, or ice, methamphetamine and/or participate in private sex parties) and HIV-negative MSM who are in long-term relationships with a partner who lives with HIV should be given priority.
7. PrEP services should be integrated within broader sexual and reproductive health services, including those managing STIs and providing contraceptives to women. Again, this requires training and awareness raising among health care providers.
8. Good referral pathways or integration with social and legal support, counselling and harm-reduction services are also important for many people who might benefit from PrEP.

Create a balance between online and offline programmatic efforts across the HIV cascade of services

Peer outreach workers in most Asian countries have started to use the internet as a way of reaching MSM and as a way to refer them to different levels of the HIV service cascade via online or cyber outreach. The effectiveness of such efforts remains unknown, with few rigorous evaluations having been done.[74]

Coverage of internet-based interventions probably remains low compared with the large MSM population making use of internet-based mobile phone applications for dating. The quality of outreach is often limited because there has been no targeted training that uses common standards on how to conduct cyber outreach. There is a need for guidance, also in the area of ethics and safety. For example, cyber outreach workers may use their private accounts in chatting and communicating with clients. As a result, the boundary between professional outreach and private dating may not always be clearly defined; at the same time, outreach workers may expose themselves to bullying, violence and blackmailing.

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Social media that are relevant for sexual networking among MSM can be hard to identify. In several countries, there are members-only (closed or secret) Facebook pages where people list their contact details. There are also chat platforms online that are not easy to find or access. Nevertheless, several important and innovative projects and experiences in the past decade have harnessed the potential of the internet (Box 10).

Box 10:

Internet-based outreach in Indonesia, Philippines and Thailand delivery in Thailand

In Indonesia, the NGO Yayasan Intermedika (www.intermedika.org/) in Jakarta focuses strongly on social media in its attempts to reach adolescent and young MSM; it has a fan page on Facebook and uses a YouTube channel. It has also organised short courses on HIV and sexual health entirely online.

In the Philippines, the NGO LoveYourself (www.loveyourself.ph/) in Manila promotes testing via several social events and campaigns on social media. It also operates two state-of-the-art community-run HIV and STI counselling and testing clinics and relies on more than 250 volunteers. It also provides the Platinum Testing service outside office hours for people of certain social class who often refuse to visit community testing centres for fear of being exposed.

In Thailand, www.adamslove.org is a website that offers comprehensive HIV and AIDS information to MSM and encourages men to adopt safer sex practices and more frequent HIV testing. The website and linked social media networks offer attractive fashion photography and engage famous people and celebrities to de-stigmatize MSM and HIV. It provides online counselling, expert advice on HIV and AIDS and related subjects via videos podcasts and forums, games and quizzes. The website is linked and refers to a range of anonymous clinics that offer free testing, medical consultations and treatment, care and support services for those living with HIV. The website engages MSM to participate in online as well as offline activities.

It is likely that interventions will be most successful if they combine online activities and campaigns with an offline venue for testing and other HIV services, preferably in a one-stop-format (HIV counselling, testing, CD4 testing, STI screening, TB screening and hepatitis tests (among others), and enrolment in and monitoring of antiretroviral treatment are all done at the same location). Even more success can be expected if, like Love Yourself and Yayasan Intermedika (Box 10), different strategies are employed for different segments of the MSM population, based on thorough analysis of their life situations and health needs.

While there are several advantages to online outreach work compared with offline, online work is certainly not without risk. Peer educators working online must be aware of the possibility of cyber bullying, trolling and violence. The geolocation-based functionality of the mobile apps poses some security risks, especially in settings where homosexuality is criminalized. Police in many countries are becoming more adept at

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monitoring these online spaces, and there are anecdotal reports of entrapment, especially in relation to anti-drug police tactics. Training and security protocols to mitigate the risk of hacking and security breaches are important for any organisation that is considering implementing online engagement strategies.

Box 11:
A public–private partnership between a dating website and HIV services in China

Blued is the world's largest gay dating smartphone application and is run by the Danlan gay men's network, a non-profit organisation. Blued has more than 15 million users, mostly in China, but its popularity is growing outside the country. As a service to its users, it provides information on the risks of unsafe sex and the rights of MSM. Users are asked questions aimed at increasing their knowledge of HIV treatment, prevention tools and care options. In addition, they are pointed to locations where they can access HIV testing and counselling; these services have been vetted by Danlan for being friendly to MSM and of sufficient quality. Danlan runs a free HIV rapid testing outlet, which provides services to MSM in partnership with public health agencies. It also provides subsidized condoms and lubricants to its clients. Danlan has organised campaigns against discrimination and gives technical support on web-based HIV prevention and treatment initiatives. It is expanding into other countries and is currently establishing offices in Thailand and the United States.

Source: See http://unaids-ap.org/2015/05/07/chinas-dating-application-for-gay-men-to-expand-hiv-prevention-among-users/.

Recommendations

1. Review ongoing HIV services, especially outreach, and assess the extent that they do or do not take online sexual networking and online health care seeking into consideration and the extent to which the internet and social media are complementing interventions occurring in the physical world.
2. Keep in mind that people using traditional hotspots for dating and those who date via the internet may be different populations. The latter, for example, is usually younger, more urban based and either more or less open about their sexuality.
3. Based on the review of services, bring together a group of experts (including experts of experience) to discuss how the potential of the internet can be further harnessed for the purpose of promoting HIV testing and enrolment in or adherence to HIV treatment and care.
4. Establish written guidelines on how cyber-based outreach should be conducted, and integrate the use of the internet and social media into the training that outreach workers and caseworkers receive. Organisations using the internet or social media should have protocols in place about safety and security of its personnel.
5. Design a code of conduct for outreach workers who make use of the internet for their work, clarifying ethical principles and good practices. Many MSM using the internet or social media for dating are young and sometimes underage; it is important to have proper ethical measures in place to protect them.

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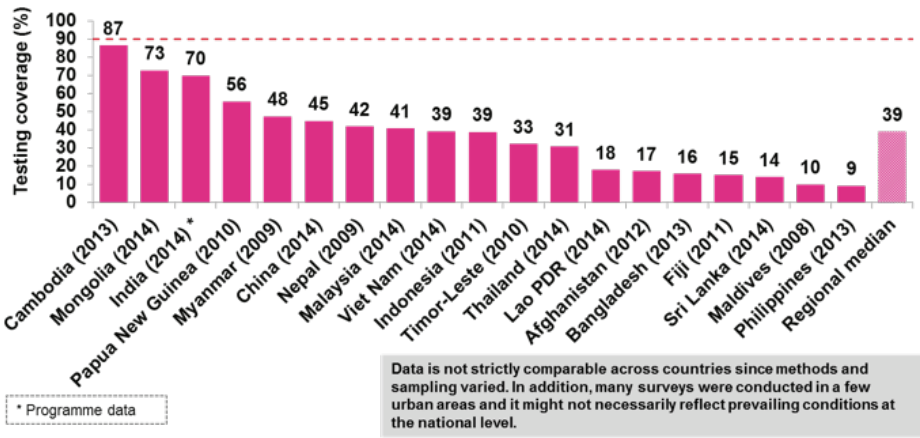
6. Make sure outreach workers understand and take precautions for the specificities of apps using geolocation data and potential dangers in countries where homosexuality is either illegal or an often-used ploy for blackmail by law enforcement.

Promote different modalities and options for HIV testing

It has been argued, using epidemiological modelling, that dramatically increasing the uptake of HIV testing and consequent enrolment into antiretroviral treatment could be the long-term solution to eliminate HIV epidemics. [75] At the entry level and to increase case finding and access to treatment for undiagnosed MSM, it is important to take HIV testing closer to where MSM are found by promoting mobile testing services, peer-delivered testing by trained outreach workers and self-testing. These innovative HIV-testing strategies should only be employed if it can be ensured that MSM newly diagnosed with HIV can be directly linked and accompanied to treatment services. In addition, for strategies like PrEP and risk reduction approaches in which condoms do not have a major role (such as strategic positioning, serosorting and negotiated safety), regular HIV testing is also a requisite. Flexibility in terms of opening hours and testing delivery modalities is critical, as is the assurance of confidentiality and quality.

HIV testing levels remain too low across the region (Figure 11). Raising testing levels significantly is needed for biomedical interventions, such as PrEP, to become feasible.

Figure 11. Proportions of MSM who received an HIV test in the past 12 months and know their results, 2006–2014



Source: AIDS Data Hub, based on and *MEN Fiji, draft report of 2011 IBBS of transgender and MSM in Suva and Lautoka*. In *Global AIDS response progress report*, 2012 online report; Ministry of Health. Recalculated HIV testing coverage presented at the UNAIDS Regional Management Meeting, Jakarta, 2014, using integrated biological and behavioural surveillance data, 2011; and www.aidsinfoonline.org (www.aidsdatahub.org).

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To create more demand for testing so that larger numbers of MSM enter the HIV service cascade, WHO and UNAIDS now promote and recommend different modalities for testing in order to reach MSM, transgender people and other members of key populations who do not want or are unable to access clinic-based services.[76] The most important new development is community-based testing, where an initial screening test is conducted in the field by a trained outreach worker using a finger-prick rapid screening test.[77] The same blood sample can also be used to test for syphilis.

Although there can be concerns regarding confidentiality when an outreach worker diagnoses a person living with HIV, it is more likely that persons will be newly diagnosed who would otherwise not have been found by using community-based or community-led testing. For this reason and in countries where this has not happened yet, it is suggested to conduct a pilot project with different modalities for testing outside of medical settings to assess the added value of these services and their cost-effectiveness.

In many countries, the first step towards community-based testing is for the health ministry to approve finger-prick testing by non-medical personnel. After this, so-called lay counsellors (outreach workers) should undergo training that focuses on the technicality of taking the test as well as on improving skills for counselling and—perhaps most importantly—on ethics and the enormous importance of confidentiality. Consider carefully whether the outreach worker should be the one conducting the test or whether it should be the caseworker, who would then have to be called in at whatever location the MSM client would like to be tested.

Box 12:

Community-based or community-led peer-initiated HIV testing in Cambodia

Organisations led by the Khmer HIV/AIDS NGO Alliance (KHANA) conducted peer-provided HIV rapid finger-prick testing among MSM and other key populations in Cambodia. The availability of HIV testing at the locations where MSM meet each other was highly appreciated by the clients, and being involved in providing this additional innovative service was also much liked by the outreach workers. The project has led to the normalizing of HIV testing among key populations. Initially, newly diagnosed persons were often lost to follow-up interventions; since then, referral mechanisms have been strengthened. Even so, the number of new cases remains small: of 29 296 most-at-risk people tested in January–June 2014, 131 of them (0.5%) were newly identified as HIV-positive. More recently, the percentage of newly diagnosed cases rose beyond 5%.* It is possible that a concern about confidentiality leads to self-selection, meaning that clients who have been at high risk prefer not to be tested by a peer. Even so, peer-provided testing will increase awareness about the need to test regularly; is useful in that it affirms the HIV-negative status of clients participating and may indirectly also lead to increased uptake of testing of other more-at-risk people who might choose to take a test at a facility rather than be tested by a peer. Therefore, peer-provided rapid finger-prick testing is recommended as a component in a wider range of testing options to be provided to MSM.

*Source: See www.khana.org.kh/publicationimages/publican_pdf/KHANA-semi-annual-mini-report.pdf. * Tony Lisle, UNAIDS Regional Programme Adviser, personal communication.*

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A second testing modality is aimed at finding MSM from certain social classes who might be more concerned about confidentiality and would prefer not to access HIV testing in the context of an MSM-specific organisation or clinic. For such men, a special service called Platinum Testing could be considered, based on a successful pilot in Manila by the NGO Love Yourself (See Box 13 below). These men can, for a fee, access a clinic outside office hours and receive one-on-one service without any other people present. This is likely to be later in the evening or during weekend days, when the clinic is closed for other clients. A second option is for an outreach worker to visit the MSM client at a location of his choosing (but outside the clinic) to perform the screening test; if it is positive, a second test can then be planned outside office hours at a clinic of the client's choosing.

A third possibility is home-based testing, for which MSM can order a home test kit via the internet or a telephone hotline (this service could also be promoted by outreach workers). This is currently possible in Europe and the United States, where oral test kits have now been approved and with which people can swab their own saliva and do a test in the safety and confidentiality of their home. In some countries, upon request, an online counselling session (or via the phone) is organised before a client tests himself. If the counsellor is convinced that the prospective client is ready to receive the test result, he will then send or deliver the test kit to him. The client then conducts the test on himself while on the phone (or in a Skype call) with the counsellor. In Bangkok, this modality is currently under consideration for a pilot mode by the Thai Red Cross.

Box 13:

Platinum Testing in the Philippines

The Philippine NGO LoveYourself found that MSM from certain social classes do not attend their HIV counselling and testing facilities due to fears of being exposed and unwillingness to associate with the so-called gay community. As a result, LoveYourself promotes Platinum Testing services on their website, where such men are charged a fee to make an appointment to be tested outside office hours. Theoretically, if the Philippine National AIDS Program approves the idea of community-based testing, volunteers of LoveYourself could even go out to meet a client at a location of his choosing and conduct a screening test. By generating income, the Platinum Testing initiative pays for itself. The model can be easily implemented in other parts of the world, considering the problem of high-income earning MSM not using community-based clinics and services is also an issue in countries like Indonesia, Malaysia and Thailand.

Source: See the LoveYourself website (http://www.loveyourself.ph/).

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A fourth modality that can work in certain circumstances is the deployment of a mobile HCT team, especially in settings where there are relatively few prospective clients, such as Cebu Plus in Cebu, the Philippines, where vans have been successfully deployed as mobile testing and counselling clinics. The most important advantage of mobile testing is that by bringing the service closer to potential clients, it provides a much lower threshold for HIV testing, something that is also acknowledged by WHO in its new guidelines for HIV testing.[58] Such mobile services can be used in large cities, for example, during events or parties, although there are certain ethical considerations when doing this. Often oral swabs of saliva are used for testing because such samples are easier to take and less invasive than drawing blood. Initial results from an FHI 360 intervention show the effectiveness of a well-prepared and carefully implemented HIV testing campaign using oral fluid testing in the Lao People's Democratic Republic. A drawback of oral fluid testing is that it is far more expensive than the more common blood tests, and under certain circumstances, there are problems with their specificity and sensitivity. Mobile HCT van routes and opening hours should be carefully announced and prepared by volunteers living in these areas to ensure that a sufficient number of MSM uses the service. In addition, it is important to fine-tune a mobile HCT service with peer outreach activities so that outreach workers or caseworkers can help clients read their results.

A fifth modality tries to reach less easily accessible networks of MSM by using respondent-driven sampling for HIV testing. In this approach, an incentive is provided to MSM who show up for testing at a certain event or clinic. Each of them is given three coupons to be distributed within their social or sexual network. If these coupons are returned to the clinic or mobile voluntary counselling and testing (VCT) team, the person who handed them out is given an additional reward.

Box 14:

Mobile testing in a sauna in Jakarta

Apart from adolescent and young MSM, another underserved group are MSM of the higher middle-income and higher-income strata, who are often less open about their sexual preferences. This makes them particularly worried about accessing HIV services run by community organisations because they think it might compromise their confidentiality. FHI 360 supported a mobile testing team that visited gay saunas in Jakarta recently. Contrary to their expectation, the demand for tests among sauna clients was surprisingly high; a line formed and the mobile team soon ran out of test kits. Around 14% of those tested were newly diagnosed with HIV. This example shows that taking a service closer to a potential client can have big effect. The key word for successful approaches is "creativity" and an awareness of the desires and fears of your client population.

Source: Steve Wignall, FHI 360, personal communication.

In short, assuring quality, confidentiality and options and being flexible in how testing is offered to prospective clients seem to be the most important factors behind creating higher demand for it.

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Recommendations

1. Provide a mix of options for HIV counselling and testing beyond clinic- or facility-based services. Examples are outreach worker-provided HIV screening and testing, testing at special events, testing for special audiences at facilities but outside office hours, incentive-based testing using coupons (similar to respondent-driven sampling) and home testing. This way it becomes possible to reach as wide an audience as possible and to create higher demand for testing among different segments of MSM. With mixed approaches, it becomes possible to meet the needs of a variety of clients.
2. It is important to ensure that effective systems for accompanied referral are in place for each modality via which testing is delivered to avoid people who test positive from dropping out of the HIV cascade of services. Ideally, HIV testing should only occur if the next level of service (the confirmation test) is immediately available.
3. The quality and procedures for HIV testing should be similar across all modalities and be governed by strict guidelines.
4. Conduct evaluations of testing modalities to assess which works best.

Promote a case-management approach

Passive referral of MSM by outreach workers to attend HCT is often unsuccessful This can be for several reasons: prospective MSM clients may not see the need; they may think that a positive diagnosis would only increase their marginalization or disadvantage; the HIV counselling and testing centre may be far away and costly to reach; it may not have convenient opening hours; it may not be friendly or could be perceived as unfriendly by the prospective client; and there may be fears about entering an unknown facility all alone.

Caseworkers are tasked with helping clients navigate health services and literally accompanying them to facilities or to services within the same facility or between different counters or departments. Helping people reach into the health system and linking them to services and care is sometimes called “inreach”. The caseworker is responsible for assisting men in accessing the test and understanding the result. They are also responsible to ensure that newly diagnosed cases take a confirmation test, a CD4 test (depending on the country) and other baseline tests and that the person gains access to and is enrolled into antiretroviral treatment and other services, such as TB screening and treatment for STIs.

Programme data from The HIV Foundation in Bangkok indicate that if an outreach worker accompanies a client to the testing facility and takes care of the follow-up services if a client tests positive, he no longer drops out of the services he needs. Alternatively, the outreach worker can refer clients to a caseworker if present, and the caseworker can then be the one to accompany clients to a testing facility and ensure their subsequent enrolment into HIV treatment, care and support services.

If a client attends a testing facility by himself, the doctor or nurse who has to disclose a positive test result should suggest that a caseworker is available, if the client desires, to help him further in the trajectory towards treatment and viral suppression. It is desirable if the caseworker is also a person who is living with HIV and can speak from experience

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while supporting the newly diagnosed client. The caseworker should provide several ways for the client to stay in touch: via online applications (such as LINE, WhatsApp and Facebook messenger, SMS or telephone calls), depending on availability and preferences for each country. In some countries, there are special apps under development to help in case management. Caseworkers should be provided with name cards that contain different channels and methods for contacting them. The caseworker should be available to provide timely, consistent and regular information, encouragement and support. The caseworker needs to accompany a person newly diagnosed with HIV to his initial visits to doctors and should be particularly close by during the initiation of antiretroviral treatment.

By checking with clinics, this will enable the M&E officer from the employing NGO or service organisation to check whether reported testing cases actually make it to the HCT service. After an agreed period (usually six months), MSM who were found negative should be invited to test again; repeat testers may be counted for the quota of the outreach team. It is important for NGOs to set separate goals for the number of repeat testers and the number of newly reached MSM to avoid a slowdown in the number of MSM who are newly reached.

Box 15:

Bali Medika Clinic in Indonesia

Bali Medika Clinic is a private STI and HIV clinic embedded in a private medical practice in Kuta, Bali and is operated by the NGO Yayasan Bali Peduli. It offers testing and treatment services, including antiretroviral therapy, and hence is a one-stop shop. Clients are predominantly MSM. Anyone diagnosed positive is linked to treatment at the clinic (nationally, only 22.5% people diagnosed with HIV are on antiretroviral therapy). Bali Medika Clinic guarantees a confidential, anonymous service and is client-friendly. The nurses are not recruited from within the community to safeguard confidentiality. The clinic is part of a regular doctor's practice, and there is no signage that identifies it as an HIV and STI clinic. All clinical staff have received HIV clinical training as well as STI training from the Department of Health and Yayasan Bali Peduli. Service is rapid: HIV counselling and testing takes 20 minutes if the result is negative, and 40–60 minutes if positive. Clients who test positive are immediately offered a CD4 test. All HIV-positive clients are offered antiretroviral treatment (but patients need to have lived in the catchment area for at least three months). To date, there has been a 100% acceptance rate.

The cooperation between the Bali Medika Clinic, bars and an MSM community service organisation has been successful in referring MSM to the clinic for HCT and STI services. Other than this, the clinic does not generate demand through outreach. New clients typically learn about the clinic through word of mouth and social media. Details of the services provided are also on the Yayasan Bali Peduli website.

Source: Documentation of best and promising practices in HIV service delivery for MSM in Indonesia. Jakarta: UNAIDS Indonesia; 2015.

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Recommendations

1. Establish or strengthen case management systems in a city or country because it is the most effective manner to reduce the incidence of clients dropping out between levels of the HIV services in the cascade.
2. Caseworkers should be well trained and well remunerated and should operate in tandem with a group of four to eight outreach workers. Caseworkers should be based in HIV testing centres to be available to enrol newly diagnosed clients, both via outreach workers and via clinic-based counsellors.
3. Agree on a terms of reference for the position of caseworker, which would include taking responsibility for an agreed number of newly diagnosed MSM for an agreed number of months and taking an accompanying role in guiding clients to access CD4 and other baseline tests before enrolling in antiretroviral treatment and other care and support services.
4. Adopt, use or set up systems to monitor or case manage through mobile devices or smart phones (such as ComCare, iPeer and SHIP).

Provide social and moral support for MSM living with HIV using healthy life workshops and links to social support groups

Linking newly diagnosed people with HIV to each other for support, under the guidance of a person who has been living with HIV for some time, is an effective strategy for reducing the trauma associated with a positive diagnosis and supporting enrolment in treatment and ongoing clinical care. Workshops for MSM newly diagnosed with HIV address the double stigma that MSM with HIV encounter: having a non-normative sexual orientation and having HIV. The workshop should be modelled on the Good Life Workshops organised successfully by The HIV Foundation in Bangkok.
It is recommended that a special training be organised for two caseworkers (with participation of the nurse and doctor of the HIV testing centre and other health care professionals involved in treating HIV) on how to implement this workshop.

There are also several good websites where people who are newly diagnosed can find answers to most of their urgent questions. It is important to have reliable sources of information for people living with HIV; in case of websites, it is equally important that this information is regularly updated.

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Box 16:

Good Life Workshops in Bangkok

The Good Life Workshop is a USAID-funded initiative under the CAP-3D Programme providing a one-day, support and education session for MSM newly diagnosed with HIV in Bangkok. The workshop provides a group-styled peer-support session so that newly HIV diagnosed participants can share their feelings, fears and concerns about living with HIV and make friends with others in a similar circumstance. It then delivers an information session focused on how to disclose of HIV status to others, safe sex, the range of HIV treatment available and how to access free public health services. It aims to provide skills for living well with HIV. The workshops have been favourably received by participants, many of whom had never openly shared or discussed their HIV status with anybody and were full of fears, doubts and questions. The workshop runs every two weeks and has a waiting list for new participants. The overall goal of the project is to try new approaches to HIV prevention, care and support in collaboration with local organisations and then support the transfer of these activities into local services.

Source: See http://psiimpact.com/2013/08/good-life-workshop-peer-support-for-msm-and-tg-people-with-hiv-in-bangkok/.

Recommendations

1. As soon as an integrated outreach or case management system is available, study the possibility of conducting one-day workshops that bring together groups of MSM who have recently been diagnosed, guided by strict guidelines around confidentiality.
2. It is possible to follow up after the workshop by creating LINE or closed Facebook groups consisting of the participants or by adding the participants to existing LINE or closed Facebook groups of previous participants. This will foster a sense of community and solidarity among MSM who have been recently diagnosed with HIV and give them a platform to ask or share information or express concerns.
3. Existing MSM community organisations need to be trained on how to build up self-help support groups for their constituencies.

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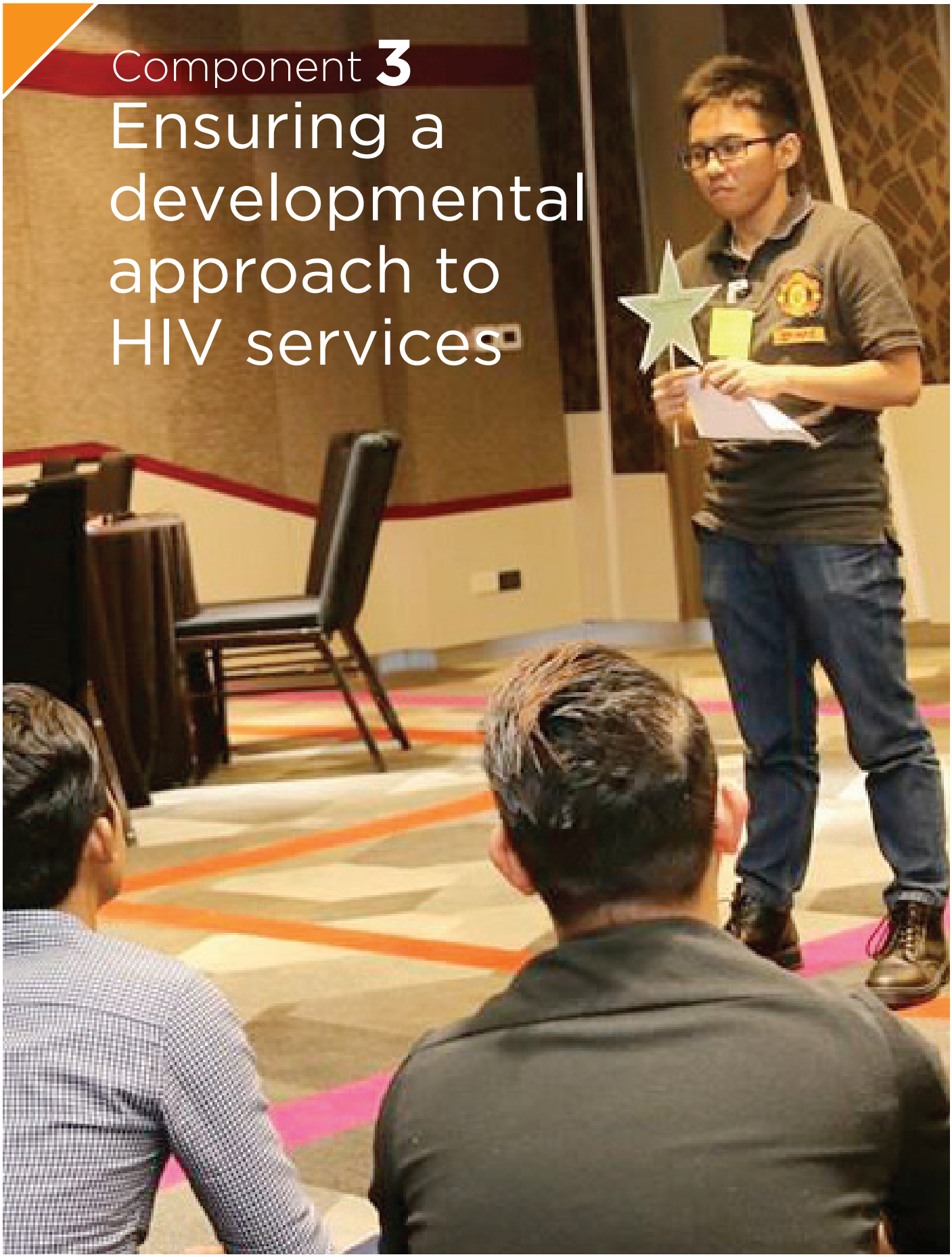
Checklist 2: Innovative interventions	Score			
	No	Partly	Mostly	Fully
HIV services are integrated: there is no gap between outreach, testing, treatment, care and support services				
HIV testing by outreach workers is allowed and available				
HIV testing outside opening hours is available for MSM who are less open about their sexuality				
Home testing for HIV is available				
Incentive-driven HIV testing via coupons is available				
HIV testing is available during special events with MSM using mobile testing facilities or outreach workers				
Those who test positive are immediately provided with or accompanied for further care				
MSM in major cities have access to a reliable and free supply of condoms				
MSM in major cities have access to a reliable and free supply of lubricants				
MSM in major cities have access to a reliable and free supply of condoms of at least three sizes				
MSM in major cities have access to a reliable and free supply of at least two types of lubricants				
MSM in major cities have access to appropriate IEC materials about HIV prevention, testing and treatment				
MSM in major cities have access to PrEP and PEP				
There are agreed standards for what outreach workers should know and the skills they should have				
There are agreed standards for what caseworkers should know and the skills they should have				
Remuneration for outreach workers is at least partly based on performance				
HIV services have agreed on finding undiagnosed HIV cases as their ultimate goal				
Social media and internet-based outreach has an important role in HIV outreach				
Social media and internet-based care and support have an important role for MSM living with HIV				
There are social healthy-living support workshops in place for MSM who have just been diagnosed				



Component 3
Ensuring a developmental approach to HIV services

Component THREE: Reaching young MSM

Introduction

Ensuring a developmental approach to providing and promoting HIV services refers to the importance of life phase or age in understanding a person's attitude towards and likelihood to engage in risky behaviours or to access HIV services. In terms of the HIV epidemic, this means, first and foremost, focusing on reducing the incidence of HIV among young MSM (aged 10–24) because it is in this age bracket that incidence is highest.

In 2008, more than 95% of all new HIV infections among young people (aged 10–24) were estimated to occur among key populations (people engaging in unsafe injecting-drug use, sex work or male-to-male sex).[79] The large majority of these infections was among young MSM. Recent evidence from Thailand has highlighted that young MSM are at increased risk of acquiring and transmitting HIV. In large samples of men recruited from gay entertainment venues in Bangkok, HIV prevalence among 18- to 22-year-old men was 12.9% in 2003, 22.3% in 2005 and 22.2% in 2007; among 23- to 28-year-olds it was 17.5% in 2003, 30.5% in 2005 and 29.1% in 2007. [80]

A large sample of MSM who came forward for HIV voluntary counselling and testing (VCT) (and thus, were not known to be HIV infected) at the Silom Community Clinic in Bangkok from 2005 to 2011 found HIV prevalence in 15- to 21-year-old males at 22.8%; in those aged 22–29 years, it was 29%.[81] In terms of HIV incidence, during follow-up services in the large clinic-based sample of MSM mentioned above, an incidence of 12.2 per 100 person-years was found among 15- to 21-year-old males, almost double that seen among all ages combined, which was 6.3 per 100 person-years.[82] At the same time, anecdotal reports from HIV community service providers in multiple cities suggest that a significant proportion of young gay men or other MSM acquire HIV early in their sexual lives, typically in their first few sexual encounters when they have little knowledge, personal agency, skill or experience in sexual negotiation.[83]

For young MSM, the stigma associated with HIV as well as with their different sexual orientation or gender identity acts as a barrier to seeking and accessing HIV testing, care and support services. This comes on top of the general challenges that a young person faces when he enters adolescence, a period during which there are profound hormonal and other biological changes in the body as well as changing social expectations regarding the transition from childhood to adulthood. [84] As a result, adolescents, including adolescent MSM, may not always make well-thought-through decisions when it comes to their risk behaviours or health-seeking behaviours.

The legislative environment in many countries and cities is prohibitive for the provision of direct sexual health services and other support services to anyone younger than 18, leading to an amplification of their isolation and vulnerability. For example, a recent review found that despite the importance of key populations (including MSM) to the trajectory of HIV epidemics, there was inadequate inclusion of these groups in national strategic plans on HIV. There was a lack of analysis of young key populations within the sections dealing with strategic information; there was no involvement of young MSM in the development of the plans; there were virtually no plans for future research; and there were no specific goals, targets or basic programmes for young key populations. [85]

Component THREE:

Reaching young MSM *(continued)*

In many countries, there is an age of consent of 18 years for young people in accessing HIV and sexual reproductive health services. This is a major problem for anyone younger than 18 who desires to receive these services. A recent report[83] by a coalition of UN agencies and community service organisations (among which was Youth LEAD, a network of young key populations) recommended that governments in the Asia–Pacific region remove age restrictions and parental consent requirements, which impede access to HIV and sexual and reproductive health services, including testing for HIV and other STIs, condoms and contraception. According to the report, "consistent with the Convention on the Rights of the Child, national laws should recognize the evolving capacity of adolescents to make independent decisions regarding their health. The consent of a parent or guardian to [sexual and reproductive health] and HIV services should not be required if a minor is considered to be sufficiently mature. A young person should be able to consent independently if the young person is capable of understanding the nature and consequences of the service and is able to assess their own best interests. If governments prefer to define a minimum age below which consent of a parent or guardian is required in all cases, this should be set at early adolescence. Children above such a minimum age should be able to consent independently if they are assessed by the health professional offering the service as sufficiently mature."[85]

Box 17:

Allowing adolescent MSM to be tested without parental consent in Indonesia

In a remarkable contrast to the situation in other countries, testing facilities in Indonesia that cater to MSM indicated that they provide HIV testing without parental consent, regardless of age. The Ruang Carlo clinics in Jakarta and Bali do not impose any age limitation on who they can test. As one key informant remarked: "They engage in very adult behaviours, if they come for testing or treatment we should treat them as adults, too." A puskesmas (district health centre) also found a creative way not to block access to HIV testing for adolescents: they allowed their outreach volunteers to sign off for clients younger than 18 as their guardian. A well-known MSM clinic in Bali also does not ask for parental consent when testing adolescent MSM. As a result of this excellent practice, there are 16-year-old MSM and transgender women already on antiretroviral treatment in Jakarta and Bali; again, for enrolling in treatment, no parental consent is required.

In Thailand, the age of consent for HIV testing was formally reduced from 18 to 15 years of age in 2012.

Source: Indonesia=Centers for Disease Control and Prevention (CDC). HIV and syphilis infection among men who have sex with men--Bangkok, Thailand, 2005-2011. MMWR Surveill Summ. 2013;62.25: 518; Thailand= UNESCO, UNFPA, UNAIDS, UNDP, Youth LEAD. Young people and the law in Asia and the Pacific: a review of laws and policies affecting young people's access to sexual and reproductive health and HIV services. Bangkok: UNESCO Bangkok; 2013 (http://unesdoc.unesco.org/images/0022/002247/224782E.pdf).

Component THREE:

Reaching young MSM *(continued)*

There is little evidence about what works for improving sexual health outcomes for young MSM. From epidemiological data it is clear, however, that without increased attention to the sex- and gender-based health and human rights needs of young MSM, interrupting HIV transmission at the population level among all MSM will remain an elusive goal.

Box 18:

Facilitating young MSM's access to health services in Mumbai

Yaariyan is a Humsafar Trust Youth Initiative that was initiated to understand current trends and behaviour of lesbian, gay, bisexual and transgender (LGBT) youth. The Yaariyan Core Team comprises a group of 20 LGBT youth between the ages of 18 and 28 years. Yaariyan was set up to engage with LGBT youth and to facilitate their access to services, such as a safe space for discussions, health and mental health care and legal rights assistance. Youth members of Yaariyan take immense pride in being technology savvy and believe in using technology to the best of its ability to run the group efficiently. All 20 members are full-time employees in their respective vocations, and their contribution to Yaariyan is entirely voluntary.

Yaariyan activities and achievements include movie screenings, outings, bonding events and discussions on issues impacting LGBT youth. It has a Facebook group named Yaariyan with more than 3000 members that serves as a platform for discussions on queer issues. Yaariyan discussions have provided a safe space for youth to address larger issues that may pertain to their sexuality. Yaariyan has a number of online quiz, selfie and creative talent contests that encourage members to become involved in social causes (such as World AIDS Day) and create general awareness. Many young people who attend events speak on such a platform for the first time. Through its endeavours, Yaariyan has become a voice and identity of young LGBT in Mumbai.

Pivotally, Yaariyan has also motivated a larger number of LGBT youth to access health services at The Humsafar Trust. This online support group has had an important role in the Humsafar internet MSM research studies and supports The Humsafar Trust's online outreach work by responding to queries from young LGBT through their online space and via personal networking on the e-group.

Source: de Lind van Wijngaarden JW. Aide memoire for UNAIDS Indonesia on how it can strengthen its support to HIV responses among MSM in Indonesia. April 2015; unpublished.

Component THREE: Reaching young MSM *(continued)*

A proposed model for providing HIV services to young MSM

Determining the best methods for engaging with young MSM should be a public health and human rights priority for all countries with HIV epidemics among MSM. This section discusses specifications needed for a programme to reduce HIV transmission and improve the human rights situation of young MSM (specifically adolescent MSM aged 15–18, defined by UNICEF as 'late adolescents'—which is the age range at which a majority of MSM become sexually active in most countries) and is based on a series of consultations with stakeholders of different sectors in society in Thailand.[86] The study sought knowledge on how to improve HIV prevention and sexuality education, increase the uptake of HIV testing and enrolment in HIV treatment and care services among young MSM in general and adolescent MSM in particular, and reduce the negative health impacts of sex- and gender-based discrimination. The findings and conclusions were updated by the author of this framework, in line with new insights and developments.

Participants in the Thai assessment agreed that reaching young MSM, and particularly those in the age range of 15-18, must be a high public health priority for any country with an HIV epidemic among MSM. From an epidemiologic perspective, there is no other way to slow down the engine of the HIV epidemic; and from a rights perspective, it is among these young MSM where the need for health services and social support is greatest. The following points out the health and human rights objectives for a project or programme aiming to reach young MSM:

- postponing young MSM's sexual debut (or at least first penetrative sex);
- improving knowledge of rights and support available to young MSM if bullied or abused, while being accepting of their personal choice in terms of his sexual orientation;
- imparting information about the risks of HIV and STIs and building skills in negotiating safer sex;
- enhancing skills in negotiating and communicating about safer sex with (potential) romantic partners; and
- instilling a positive attitude towards and a regular habit of testing for both HIV and other STIs.

Considering the importance of non-HIV-related factors in explaining the vulnerability to it among young MSM, it is important to promote a holistic approach to promote their well-being and general health. This means ensuring there are pathways for young MSM to services dealing with syndemic factors (see the previous component), such as mental health (to treat or intervene in depression, loneliness, despair and suicidal thoughts), drug dependence reduction or dealing with bullying or abuse (including sexual abuse).

The effectiveness of older and younger peer-based services should be investigated. In many Asian settings, young people have strong respect for elder peers, who can serve as role models (in either a positive or negative way). Such older peers are often referred to as older brothers and sisters, and their opinion and guidance is more likely to be followed than that of someone who is of the same age or younger: young people may take the words and suggestions of slightly older peers more seriously than those of peers who are of the same age. This mechanism has a role in many societies where communication is hierarchically structured, such as Cambodia, Indonesia, the Lao People's Democratic Republic and Thailand. The use of older–younger dynamics for

Component THREE:

Reaching young MSM *(continued)*

peer-based sexual health education remains unexplored and is recommended for further investigation, for example, by piloting the efficacy of using senior MSM high school students and university students acting as peer educators and supporters to junior MSM high school students in a number of carefully managed and supervised project environments. The Thai study[86] also looked at the feasibility of conducting school-based interventions for young MSM. An exclusive focus on the school setting to reach young MSM was disputed by many participants in that study who believed that a school-based project would only be possible if it focuses on all students and not just those who are same-sex attracted or transgender people. But focusing on all students would likely dilute the quite explicit sexual and HIV transmission content the project should impart to MSM high school students; it is even likely that their specific sexual health needs would not be addressed at all through such a generalized approach. The school setting could be of use in reducing stigma and discrimination, celebrating diversity and in promoting understanding and an atmosphere of inclusiveness, but in-depth education about HIV risk and sexual health will need to be provided to young MSM via other channels. The same is likely to be the case in other Asian settings.

Combining operational research with pilot implementation in the field

To find the best ways to reduce HIV transmission among young MSM, it is important to learn while doing. This is important because there are no data or information about what works to reduce HIV incidence among this group from any country in the region. Operational research objectives may include:

- testing the viability of recruitment, training and supervision of older peers delivering services to younger peers in schools and in other community settings;
- testing the delivery of regular group education and support activities in the school setting, within the health setting and within community service organisations;
- testing the most appropriate combination of services across the education, health and community sectors and documenting both the challenges and opportunities faced in the delivery of the project in each sector; and
- testing the effectiveness of web-based activities and social media to support service delivery as well as to recruit young clients and older peer volunteers.

The documentation and evaluation of these different elements should aim to answer three research questions related to HIV and human rights programming for adolescent and young MSM:

1. In terms of minimizing the number of HIV infections, what is the right combination of services across education, health and community sectors for HIV and human rights programming among adolescent and young MSM?
2. What are the best ways to document and disseminate learning to facilitate change for HIV and human rights among adolescent and young MSM?
3. What types of HIV, sexual health and social services effectively engage and retain young MSM?

Component THREE: Reaching young MSM *(continued)*

Box 19:
Improving the quality and access to services for young MSM in Indonesia

The Fokus Muda project, which operates in the Indonesian city of Bandung, aims to improve the sexual health of young people (aged 10–24 years) in key populations (people who use or inject drugs, female and male sex workers and MSM). Importantly, it aims to improve referral between and the quality of existing interventions rather than starting new interventions. There are three components: First, there is research to document and assess effectiveness, because this project is seen as a demonstration project. Second, there are efforts to increase demand for HIV and other sexual health services among young people of key populations. And third, there are efforts to improve the supply side by making existing service providers friendlier to their needs.

While the aim is not to duplicate ongoing activities by other organisations, the project contributes a social media component as part of efforts to (i) increase demand for testing, (ii) monitor the quality of services using iMonitor (using a rating system) and (iii) pilot models for online counselling.

Source: de Lind van Wijngaarden JW. Aide memoire for UNAIDS Indonesia on how it can strengthen its support to HIV responses among MSM in Indonesia. April 2015; unpublished.

A proposed pilot approach linking schools, communities, health services and the internet

The Thai feasibility study proposed a pilot project that incorporates four elements in combination, each linked to an important setting in which young MSM operate: schools, community or family, health services and the internet (Figure 13). Activities could include using school-to-community networks to enhance access to health services, HIV and human rights peer education and support, online learning, recreational and support activities and the power of web-based social marketing and social media.

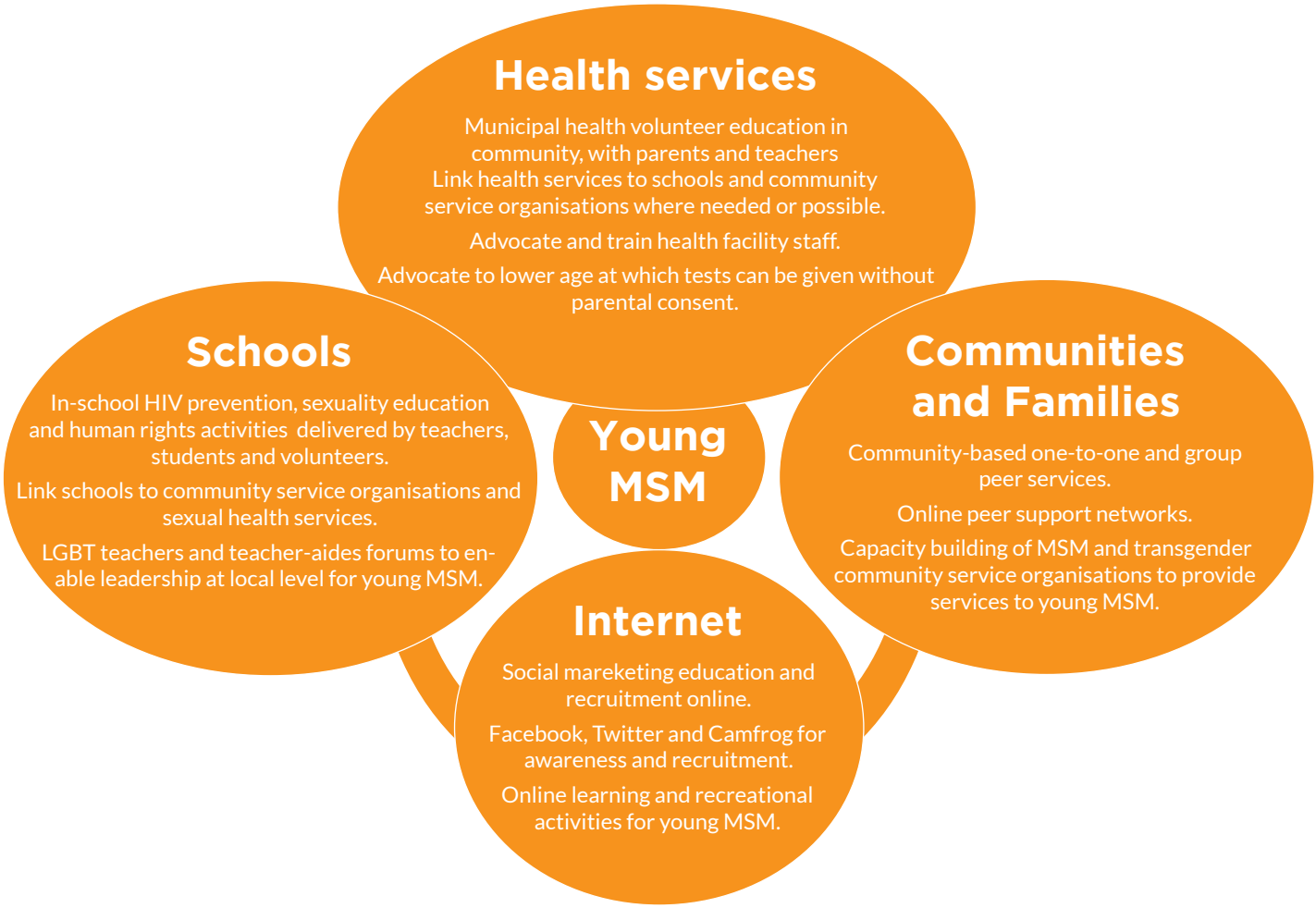
1. Schools: This element of the project would study the feasibility of delivering HIV prevention and sexuality education activities exclusively for young MSM, either in the school setting or partly in and partly out of school, using a combination of in-school educational activities via activity teachers and school clubs, and out-of-school community-based education and support activities implemented via community service organisations, NGOs and health services. There needs to be buy-in from school authorities and involvement of teachers, older peer students, community service workers as well as health volunteers from municipal government sites.
2. Communities and families: This element of the project would involve a combination of one-to-one and group-based support and education services. The use of older–younger dynamics for peer-based sexual health education, advocacy or support in managing and maintaining the relationship between young MSM and their families or guardians and referral to health services remains unexplored and is recommended for further investigation. This element of the pilot project would also examine and strengthen the capacity of MSM community-based organisations to provide education and health services to young MSM by older peers.

Component THREE:

Reaching young MSM *(continued)*

3. Health services: This element of the project aims to improve the quality and youth-friendliness of HIV and sexual health services for MSM in a city or country. This may include advocacy with health service authorities to reduce the age of consent for young MSM to access HIV services or to allow for a health volunteer to sign off as a guardian. Positive attitudes towards regular HIV testing and enrolment in treatment and care services needs to be fostered among young MSM via peer- and internet-delivered information and education-related activities. This will promote better access to sexual health services provided to young MSM where requested by them. At the same time, staff working at HIV and sexual health services often need to receive additional training to ensure a nonjudgemental and friendly attitude towards young MSM clients and to provide services to them in a language that they can understand.
4. Internet: Young people live a tremendous part of their lives online. Thus, online learning about HIV, partly packaged in recreational activities, would provide a neutral and reliable source of information and could complement school-based and after-school activities in supporting the objectives of the project.

Figure 12. Creating a conducive and enabling environment for improved sexual health outcomes among young MSM: Proposed pilot project model



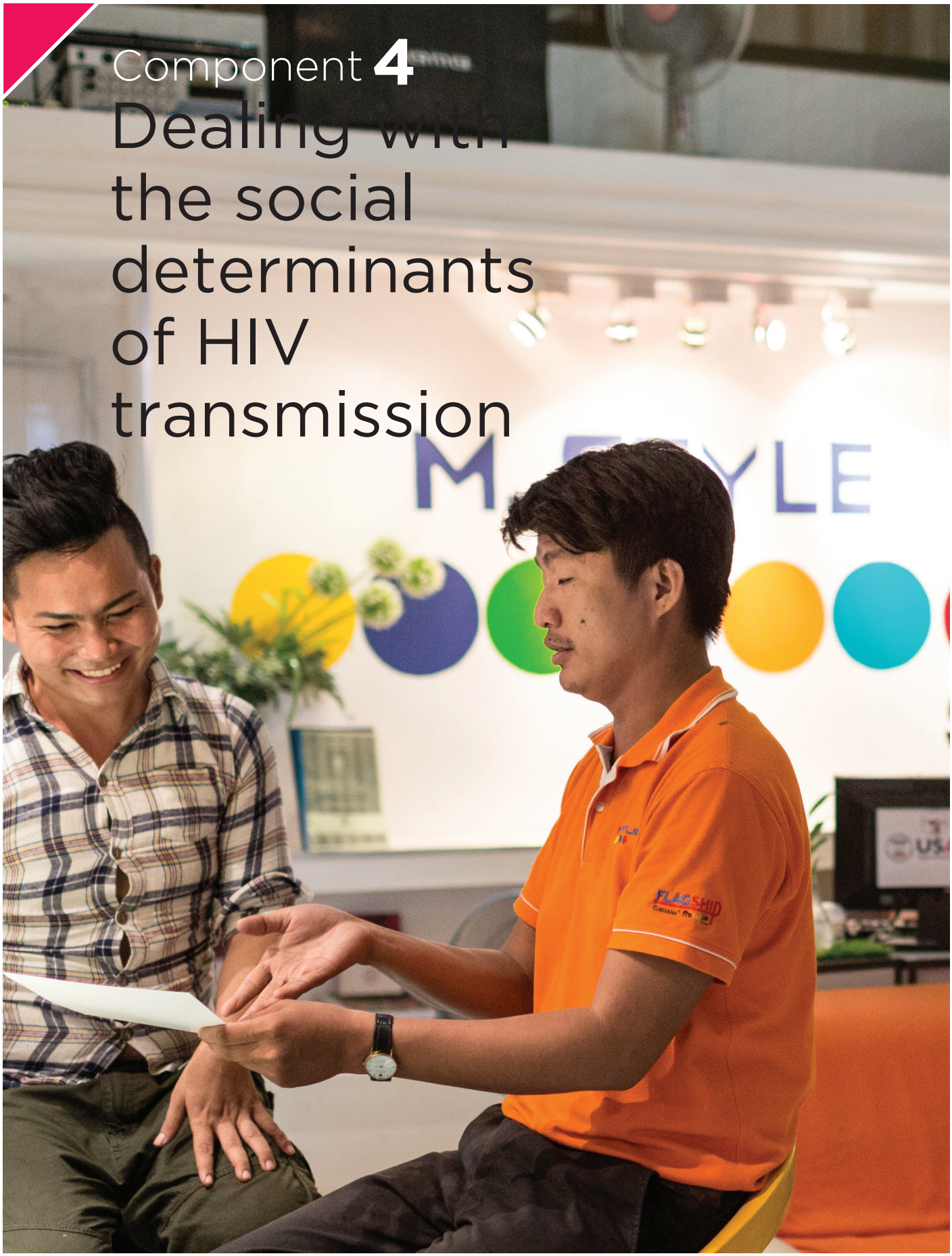
Source: de Lind van Wijngaarden JW, Berry S. Reaching same-sex attracted/transgendered junior high school students to expand access to improve sexual health and improve HIV vulnerability in Thailand: report of a short feasibility study and proposed ways forward. Report produced for UNESCO Bangkok and the HIV Foundation; April 2014, unpublished.

Component THREE:

Reaching young MSM *(continued)*

Checklist 3: Programming for young MSM	Score			
	No	Partly	Mostly	Fully
Outreach workers use different language and messages when talking to adolescent MSM in comparison with adults				
Adolescents aged 15 or older can access HIV services without parental consent				
Adolescents aged 15 or older can enrol in HIV treatment without parental consent				
Adolescent MSM receive sexuality education in or via the school setting				
NGOs and community organizations have special activities or programmes for adolescent MSM that go beyond HIV services				
Health services are sensitized to the specific needs of adolescent MSM				
Adolescent MSM have access to MSM-friendly mental health care services dealing with depression, loneliness, despair and other problems				
Adolescent MSM have access to MSM-friendly alcohol dependency reduction services and information				
Adolescent MSM have access to MSM-friendly drug dependency reduction services and information				
Adolescent MSM have access to adolescent-friendly information online, with clear pathways to service providers				
Adolescent MSM have access to MSM-friendly services for suicide prevention that are linked to HIV services				
Adolescent MSM have access to MSM-friendly services for providing assistance in case of violence and abuse that are linked to HIV services				
Adolescent male sex workers have access to friendly services providing social and psycho-logical support that are linked to HIV services				
Adolescent MSM have access to sensitized sexual health and STI treatment that are linked to HIV services				


STOP
AIDS



Component 4

Dealing with the social determinants of HIV transmission

Component FOUR:

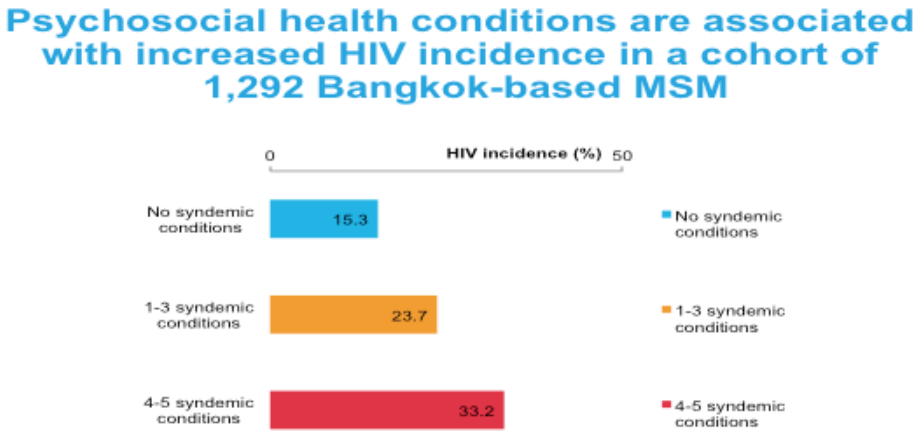
Reducing HIV transmission by tackling related health and social problems that directly worsen the HIV epidemic

Introduction

A syndemic is defined as "synergistic interaction of two or more coexistent diseases and resultant excess burden of disease".[87] In other words, it is a concept describing how certain social situations, health conditions and diseases reinforce each other in a way that they become linked. HIV is often mentioned in relation to other health problems, such as TB, [88] STIs, the use or addiction to alcohol or drugs, violence and mental health problems. Syndemics often occur in situations of poverty, stigma and discrimination or among populations with limited or no access to health or other services.[89] Seeing HIV as a component in a wider set of social determinants and health conditions that influence HIV transmission helps understand why some people have more difficulty changing towards safer sex behaviours than others (Figure 14). And it points to the need to consider other pressing social and health problems of the people we are trying to reach rather than focus only on HIV.

Most people will intuitively understand the link between, for example, being drunk, high on drugs and having unsafe sex, for example. With a person who is always drunk when having sex, addressing alcohol addiction might be a much better way to prevent HIV than only talking about condoms and testing. The same goes for sexual compulsivity or sexual addiction.[90]

Figure 13. Syndemic factors directly linked to HIV incidence



Source: Guadamuz TE et al. Psychosocial health conditions and HIV prevalence and incidence in a cohort of men who have sex with men in Bangkok, Thailand: evidence of a syndemic effect. AIDS Behav. 2014;18.11: 2089-2096.

A recent baseline study in Bangkok found that the number of psychosocial health conditions were associated with increased HIV incidence in a cohort of 1292 MSM: when no syndemic conditions were present, HIV incidence was 15.3%; when one to three syndemic conditions were present, incidence was 23.7%; and when four to five syndemic conditions were found, individuals had HIV incidence of 33.2% over the period of the study. The number of psychosocial health conditions was also positively associated with HIV risk behaviour and HIV prevalence.[91]

This fourth component is the shortest in the framework because, although there is theory and evidence for the importance of syndemics in explaining persistent HIV epidemics among MSM, there is a dearth of examples of best practices in terms of interventions or policies.

Component FOUR:

Reducing HIV transmission by tackling related health and social problems that directly worsen the HIV epidemic

(continued)

Assessing syndemic factors and ranking them

According to the latest research,[92] conditions that decrease the likelihood that a client uses condoms or accesses HIV counselling and testing services might include:

- binge drinking or alcohol use or addiction;
- drug use (especially crystal, or ice, methamphetamine);
- depression, severe loneliness or other mental health issues, often caused by alienation from family, friends or community;
- being sexually compulsive ("addicted" to sex);
- having a history of sexual abuse;
- having a violent boyfriend or intimate partner;
- having considered suicide or having tried to commit suicide;
- having a history or current involvement in sex work; and
- poverty and homelessness.

At the population level, reducing HIV transmission among MSM would be more successful if alcohol addiction, drug use, mental health issues and poverty were addressed at the same time. Unfortunately, little is known about how to implement such a wide and interlinked package of services. Syndemic conditions will be different across countries or cities; it is important to assess the relative importance of the items in the list of possible syndemic conditions. The importance of these conditions can differ strongly between MSM. As part of efforts to professionalize outreach (see Component two), it is important to include awareness about syndemic factors in the training and practice of outreach workers and caseworkers.

Strengthen links to services that address syndemic factors and ensure that they are MSM-friendly

The following discusses some of the most important syndemic factors in more detail.

Alcohol is related to HIV in two main ways. First, under the influence of alcohol, people may do things that put them (or their partners) at risk for infection with HIV, something they may not do if they are sober. Second, people who are living with HIV are less likely to adhere to their antiretroviral treatment if they are addicted to alcohol. Apart from that, alcohol is no better or worse for people living with HIV than for those who are HIV-negative.[93]

It is therefore important both for MSM who are HIV-negative and those who are HIV-positive to address alcohol addiction or frequent binge drinking. Specifically for MSM, alcohol use before finding sexual partners or before having sex can be related to insecurity about one's sexuality, personality or looks, and in this way, alcohol abuse can be indirectly related to internalized homophobia. It is important that services that aim to reduce a client's dependence on alcohol are friendly, welcoming and understanding of people who have a non-mainstream gender or sexual identity. Alcoholics Anonymous or other programmes to tackle alcohol addiction exist in most Asian cities.

Component FOUR:

Reducing HIV transmission by tackling related health and social problems that directly worsen the HIV epidemic

(continued)

There is strong evidence that using recreational drugs, especially crystal methamphetamine, is an important risk factor for HIV transmission.[94] There has been a strong increase in the use of crystal meth in Bangkok[95] and likely also in other Asian cities.[96] It is important that HIV prevention programmes create or strengthen links between services that help people deal with a drug addiction or at least make people who use recreational drugs regularly aware of the risks involved in terms of HIV transmission. HIV services and outreach should assess services that are friendly and welcoming towards MSM and ensure that accompanied referral to such services becomes part of their routine work. In countries like Thailand, services exist, but those of quality are privately run (such as The Cabin in Chiang Mai [97] or DARA in Koh Chang [98]) and are expensive, charging around US$ 7000 for a four-week programme in a luxurious setting. Others, such as the Thamkrabok monastery,[99] are cheap but use harsh cold-turkey methods with traditional medicine and meditation. In many cities and countries in Asia, however, no modern harm reduction services exist to help people who are addicted to crystal meth or other drugs.

Mental health problems constitute a number of important syndemic factors that exacerbate the HIV epidemic among MSM, including loneliness, suicidal thoughts, depression and sexual and other addictions. In many Asian countries, families and one's ability to have a role in the family are important for establishing a sense of self-importance and self-worth. If MSM lose contact with their family as a result of their sexuality, this can be an important factor in causing depression, loneliness and a feeling of alienation.

Unfortunately in most Asian cities, mental health care services needed to address many of these problems are either non-existent or they are not friendly or adapted to provide services to MSM or transgender people. In some countries, services are available but prohibitively expensive. Outreach workers and HIV services should assess and collect the names and addresses of mental health services (possibly of a religious kind) so that clients suffering from mental problems and depression can be accompanied or referred.

For HIV services and associated projects to be successful, it is important to maintain or improve the environment in which they are implemented, first in terms of improving the policy and legal environment related to the legality of homosexuality, the status of transgender persons and, specifically related to HIV, the provision of condoms, PEP or PrEP. [100] Establishing or strengthening relationships with key stakeholders, such as law enforcement agencies and central and local authorities, is an important first step in this process.

Sexual abuse and violence have been found to be associated with HIV transmission [101] among MSM. HIV services for MSM should establish or strengthen links to social welfare, child protection and (sensitized and supportive) law enforcement agencies.

HIV services should strengthen links to STI treatment services and other services that enhance and improve sexual health for MSM. Untreated STIs have been found to strongly increase the chance of HIV transmission.[102] This includes providing HPV vaccination to adolescent MSM who have not yet been sexually active. [103]

Component FOUR:

Reducing HIV transmission by tackling related health and social problems that directly worsen the HIV epidemic

(continued)

Recommendations

1. Bring together evidence and/or a number of experts and key informants to assess which syndemic factors are most important in exacerbating the HIV epidemic among MSM.
2. Look at the nine listed syndemic factors in this framework and assess whether services exist to address them in a particular city or country and how pathways between these services and HIV services can be strengthened.
3. Facilitate cooperation aimed at creating pathways between HIV services and services tackling syndemic factors, such as alcohol or drug dependency reduction and mental health care.

Checklist 4: Links to services addressing syndemic factors	Score			
	No	Partly	Mostly	Fully
There is knowledge available on the most important syndemic factors affecting HIV transmission among MSM				
MSM-friendly services for mental health care are available and linked to HIV services, including for MSM living with HIV				
MSM-friendly services for alcohol dependency reduction are available and linked to HIV services				
MSM-friendly services for suicide prevention are available and linked to HIV services				
MSM-friendly services for providing assistance in case of violence and abuse are available and linked to HIV services				
MSM-friendly services for drug dependency reduction are available and linked to HIV services				
MSM-friendly services providing social and psychological support for male sex workers are available and linked to HIV services				
MSM-friendly services for sexual health and STI treatment are available and linked to HIV services				

Footnotes:

1. According to the Asia-Pacific Coalition on Male Sexual Health's definition, men who have sex with men (MSM) is an inclusive public health term used to define the sexual behavior between males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular community. The words "man" and "sex" are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place.
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We are united in our courage to advocacy issues that affect the lives of men who have sex with men and transgender people, including HIV, rights, health and well being.

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