Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men (MSM) and Transgender (TG) Populations in Asia and the Pacific

REGIONAL CONSENSUS MEETING

29 JUNE - 1 JULY 2009

BANGKOK, THAILAND

UNDP · ASEAN · World Health Organization South-East Asia Region Western Pacific Region · USAID | ASIA FROM THE AMERICAN PEOPLE · UNESCO United Nations Educational, Scientific and Cultural Organization · UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS · APCOM ASIA PACIFIC COALITION ON MALE SEXUAL HEALTH

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Regional HIV & Development Programme for Asia & the Pacific
UNDP Regional Centre for Asia Pacific, Colombo
23, Independence Avenue,
Colombo 07, Sri Lanka

Telephone: +94 11 4526 400
Fax: +94 11 4526 400
Email: rcc@undp.org
Web: www.undprcc.lk

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FOREWORD

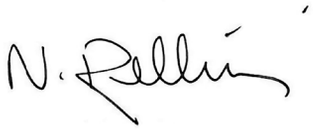
One of the biggest and most immediate challenges in effectively responding to HIV in the Asia Pacific region is confronting the truly startling rates of infection among men who have sex with men and transgender persons. This in a region already mired in challenges from legal and social barriers that inhibit effective programming and resource allocation, to deep-rooted stigma in health care settings that further limits access to services for HIV prevention, care and treatment.

Highly concentrated and severe HIV epidemics among men who have sex with men in urban areas across the region are already well documented. In 2008, the Independent Commission on AIDS in Asia made several key policy recommendations intended to reduce the impact of the HIV epidemic among key affected populations, including men who have sex with men and transgender persons. These include calling for the urgent scale-up of interventions that are known to prevent HIV infection, and to ensure including greater access to treatment, care, and support for those already living with HIV. In addition, the Commission noted that countries, in order for their responses to be effective, need to understand and address what is driving their HIV epidemics, and how to reach populations most at risk of infection.

Addressing the specific concerns of HIV among men who have sex with men and transgender persons is one of the UN family's key priority areas. This requires joint and collaborative efforts by governments, civil society, donors, development partners, and perhaps most importantly men who have sex with men and transgender persons living with HIV. In order to define a rights based, comprehensive response to HIV among these highly marginalized and stigmatized populations, UNDP, WHO, UNESCO and UNAIDS, in partnership with the Association of South East Asian Nations (ASEAN), USAID and the Asia Pacific Coalition on Male Sexual Health (APCOM) convened the "Regional Consensus Meeting on Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men and Transgender Populations in Asia and the Pacific" to review and endorse a comprehensive package of services and programmes to support HIV prevention, treatment and care. We hope this inclusive report and the accompanying evidence based "Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia Pacific "will serve as essential resources for national AIDS authorities and community-based organizations to design and scale up effective responses to HIV among these populations at the national and local level.

We are at a critical moment. An enabling environment is essential for an effective and comprehensive response to HIV among men who have sex with men and transgender people in the Region. In order to achieve universal access to HIV prevention, treatment, care and support and progress towards the Millennium Development Goals, we must first facilitate a conducive legal environment coupled with human rights-based HIV policies and programmes for men who have sex with men and transgender persons. This will mean significantly stepping up our investment in legal and social programmes which effectively address discrimination and stigmatization that are crippling regional, national and local efforts to stem the rapidly rising tide of HIV infection among men who have sex with men and transgender persons.

Secondly, we must support adequate capacity among grassroots organizations in order to undertake a massive scale-up of quality and innovative services to infected and affected community groups; only high degrees of coverage levels could have a significant and rapid impact on the progression of the epidemic.

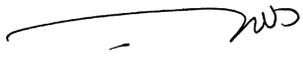


Nicholas Rosellini

Deputy Assistant Administrator and Deputy Regional Director
Regional Bureau of Asia and Pacific, UNDP Regional Center

Shin Young-soo, MD, Ph.D.

Regional Director
WHO Western Pacific Regional Office



J.V.R. Prasada Rao

Director
Regional Support Team, Asia and the Pacific Joint United Nations Programme on HIV/AIDS

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AFAO	Australia Federation of AIDS Organizations
amfAR	The Foundation for AIDS Research
APCOM	Asia Pacific Coalition on Male Sexual Health
APN+	Asia Pacific Network of People Living with HIV/AIDS
APMG	AIDS Projects Management Group
ART	Antiretroviral Therapy
ASEAN	Association of South East Asian Nations
AusAID	Australian Government Overseas Aid Program
CBOs	Community Based Organisations
CDC	Centres for Disease Control
CSO	Civil Society Organisation
FHI	Family Health International
FSWs	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMS	Greater Mekong Subregion
HIV	Human immunodeficiency virus
HPI	Health Policy Initiative
ICAAP	International Conference on AIDS in Asia and the Pacific
IDU	Injecting Drug User
MARPS	Most-at-Risk Populations
MTC	Mother-to-child
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NGO	Non-government organisation
PLHIV	People Living with HIV
PrEP	Pre-HIV Exposure Prophylaxis
PSI	Population Services International
PSN	Purple Sky Network
SAARC	South Asian Association of Regional Cooperation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWING	Sex Workers In Group (Thai NGO)
TB	Tuberculosis
TG	Transgender
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNDP	United Nations Development Programme
UNGASS	United Nation General Assembly Special Session
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

01 FINAL CONSENSUS STATEMENT

Consensus Statement on the Comprehensive Package of HIV Interventions and Sexual Health Services for Men who have Sex with Men (MSM) and Transgender (TG) in Asia and the Pacific.

This Asia Pacific Regional Consensus Meeting recognises that the significant and increasing burden of HIV infection that has been documented among MSM and TG in many countries in the region constitutes an urgent health and development crisis. This Consensus Statement describes the key components of a multi-sectoral, comprehensive package of interventions and sexual health services that will provide a continuum of prevention, care, treatment and support services to reduce the incidence and impact of HIV among the broad range of MSM and TG in Asia and the Pacific.

It is therefore recommended that comprehensive national responses incorporate effective, scaled-up HIV and STI prevention activities, along with care, treatment and support services, all guided by strategic information. The meeting further recognised that enabling environments, strategic partnerships and collaborations that include governments, communities and development partners are essential for the design, costing and implementation of comprehensive responses.

Prevention activities must target the diversity of MSM and TG, including those living with HIV, and address sexual health needs through a variety of approaches and combinations of interventions. Innovative use of mass and targeted media, including the internet, should be an integrated component in the delivery of prevention messages, health promotion and social support services. Commodities, such as condoms and lubricants, should be readily available and widely promoted. Prevention activities should be strengthened using a variety of channels, in locations where high risk behaviour may occur and include structural interventions.

Key issues that should be strongly considered in prevention programming include sexual risk-taking linked to recreational drug use among MSM, as well as access to clean needle and syringes programmes for MSM who also inject drugs and the availability of prevention programmes for male-to-male sexual transmission in prisons and other closed settings.

To maximise service utilisation and coverage, access to STI management, HIV counselling and testing and, where appropriate, structured referral mechanisms to health, social services and peer support groups, needs to be increased. This can be achieved through implementation of interventions such as peer outreach, drop-in centers, and mobile clinics that seek to provide services in addition to standard public health settings.

Addressing stigma and discrimination, enhancing the appropriate clinical skills, knowledge, and sensitisation of health care workers, removing structural barriers to appropriate services delivery, and increasing health seeking behaviours of MSM and TG are also essential to programme success. Consequently, an increased proportion of MSM and TG living with HIV will realise their right to positive health, including access to existing public health ART services, life saving therapies, and targeted prevention and care through community programmes designed and run by and for MSM living with HIV, as well as the provision of clinical management of co-infections such as TB and hepatitis.

The meeting also recognised the potential of existing and emerging bio-medical prevention technologies to increase the impact of prevention programming, and recommends urgent consideration of these developments such as the use of pre- and post-exposure prophylaxis. Similarly, it was recognised that a successful comprehensive response requires specific attention to non-HIV health needs of MSM and TG.

The meeting concluded that strategic information is essential to guide the planning, design and monitoring of appropriate interventions, as well as the allocation of resources. Meeting participants agreed that monitoring and evaluation systems need to be built around programmes in order to provide data that will demonstrate what extent and intensity of coverage of the comprehensive package is required to promote health behaviours and reduce HIV and STI incidence.

While bio-behavioural information is becoming increasingly available, gaps remain in the knowledge base, especially in issues relating to the changing nature of the epidemic, the impacts on affected communities, population size estimates and socio-cultural determinants. Further investment and harmonisation of surveillance, socio-behavioural and operational research, with the substantive

involvement of MSM and TG or affected communities, are needed.

The meeting supports the recommendation of the report of the Commission on AIDS in Asia that comprehensive interventions on HIV among MSM and TG in Asia and the Pacific be fully integrated and costed into national plans. Consequently, monitoring and evaluation processes to address the quality, effectiveness and coverage of comprehensive interventions need to be conducted.

The meeting recognises that an enabling environment is essential for an effective and comprehensive response to HIV among MSM and TG in Asia and the Pacific. The meeting also agrees that the establishment of broad based partnerships, mutual recognition of roles and responsibilities, and commitment to rights based approaches are essential to address restrictive legal and regulatory frameworks, stigmatising and discriminatory social norms, while promoting appropriate policy development and the meaningful engagement and mobilisation of affected communities.

Further, increased investment on the development of organisational and technical capacities of all partners, particularly of community based organisations, is necessary to strengthen an effective response.

The Regional Consensus Meeting concluded that effective action on the recommended key components of comprehensive responses can only move forward with the continued synergy of governments, communities and development partners, working together towards a continuum of prevention, care, treatment and support for MSM and TG in Asia and the Pacific.

Note: At the time of this report's publication USAID endorsement of the Consensus Statement is pending.

02 INTRODUCTION

Background

On World AIDS Day 2008, UN Secretary-General, Ban Ki Moon stated there is a critical need to protect human rights and attain access for all to HIV prevention, treatment, care and support. He called on countries to remove laws that discriminate against people living with HIV, women and marginalised groups, including MSM. Countries are also urged to realise the many commitments they made to protect human rights in the Declaration of Commitment on HIV/AIDS (2001) and the Political Declaration on HIV/AIDS (2006).

In 2008, the Independent Commission on AIDS in Asia released a report entitled "Redefining AIDS in Asia - crafting an effective response" which made several key policy recommendations intended to reduce the impact of the HIV epidemic among key affected populations, including men who have sex with men (MSM).[i] The report calls for the urgent scale-up of prevention interventions that are known or agreed to prevent infection with HIV and include access to treatment, care, and support for those already living with HIV. In addition, it noted that countries need to understand and accept what is driving their epidemics and how to reach populations most at risk of HIV infection in order for their HIV responses to be effective.

Highly concentrated and severe HIV epidemics among MSM in urban areas across the region are already well documented. For example, the estimated HIV prevalence rate in Bangkok is 30.7%[ii]; Phnom Penh - 8.7%[iii]; Mumbai - 9.6%[iv]; and Beijing - 5.8%[v]. Yet, investments in HIV programming for MSM remains limited, ranging from 0% to 4% of the total spending for HIV programming in countries region-wide.[vi] Most other major Asian cities still have a window of opportunity to avoid serious epidemics among MSM, but that opportunity will close soon unless investment and programming are put in place rapidly.

In the majority of the countries in the Asia-Pacific region, there is a lack of HIV interventions for MSM which comprehensively focus on prevention, treatment, care and support. A 2006 survey of the coverage of HIV interventions in 15 Asia-Pacific countries estimated that targeted prevention programmes reached less than 8% of MSM, far short of the 80% coverage that epidemiological models indicate is needed to turn the HIV epidemic around.[vii]

Due to the increased availability of epidemiological data on HIV among MSM in recent years, there is a better understanding of the magnitude of these epidemics, of the rapidity with which they can develop, and of the relative importance of male to male sexual transmission within the HIV epidemics in the region. In some countries this has led to increased political will to address HIV among this behavioural population. Despite this, there is still no widespread consensus on what constitutes a comprehensive package of interventions for MSM and TG, and insufficient information available on evidence-based interventions and costs. This information is critical for governments and donors to assist them to develop, implement and scale-up HIV programmes for MSM and TG.

On 7-9 May 2008, ASEAN, UNDP and APN+ co-organised the ASEAN Regional Consultation Plan of Action for Greater Involvement and Empowerment of People Living with HIV in Vientiane, Lao PDR. In this regional consultation, a suggestion was made to convene a further regional consultation to address HIV among MSM and TG in the region.

In line with this recommendation, the ASEAN Secretariat recognised the urgent need to work with member states, the UN system, donors, civil society and government partners throughout the Asia-Pacific region to scale-up access to comprehensive services for MSM and TG, and in general, recommend advocacy for changing or amending restrictive legal and social environments. They also recognised resource mobilisation, synthesis of data collection and analysis, and strengthening the capacity of health care works and key priorities.

In recent years, several initiatives have begun to support countries address HIV issues among MSM and TG in the Greater Mekong Subregion (GMS). In 2004, the US government (USAID and US CDC), along with Family Health International (FHI),

UNESCO and others organised two consultation meetings of government and MSM community representatives and technical experts that produced six country action plans built around the concept of a comprehensive package of services (labelled a 'conceptual framework' and a 'minimum package of services' at that time).

In 2008, the USAID/Health Policy Initiative, Greater Mekong and China (HPI/GMR-C), in partnership with Burnet Institute, undertook a survey to map donor expenditure for HIV prevention programmes for MSM in the GMS. The survey found that although aid agencies, international NGOs, the UN system and donors are very supportive of interventions targeting MSM in principle, USAID was the only aid agency making significant funding contributions throughout the GMS,[viii] The survey also found that some countries in the region had started to implement HIV programming among MSM through GFATM grants.

In 2009, USAID/HPI, in partnership with APCOM and UNDP is supporting two complementary projects in the region to advocate and assist national governments to prioritise the response to HIV among MSM and TG populations. These projects aim to assess the effectiveness of a comprehensive package of services being implemented throughout the GMS, and provide an advocacy and resource estimation tool for initiating or scaling-up a package of services.

Finally, in February 2009, WHO (WPRO), UNDP, UNAIDS and the Hong Kong Health Department co-hosted a regional consultation aiming to strengthen the health sector response to HIV among MSM throughout the region. This broad-based conference was attended by over 100 participants from the health sector, international NGOs, regional and national civil society networks, academics, bilateral donors and the UN system. As part of the outcomes of the meeting, the participants "recognised the need for a widely endorsed, single, comprehensive regional reference package to better inform national responses"; and "the implementation of a 'highly active' range of interventions was recommended for settings with high HIV prevalence and incidence among MSM and TG".

Furthermore, other bilateral donors and foundations have recently expanded their commitment to address HIV among MSM and TG in Asia and the Pacific. The Foundation for AIDS Research (amfAR) has been supporting community- based responses to MSM and HIV in Asia and the Pacific since late 2007 through a small grants programme and capacity-building assistance. The Foundation for AIDS Research recently submitted a call for proposals for another round of funding, aimed at further promoting innovative HIV services (prevention, treatment and care), research and partnership-building in local responses.

AusAID's newly-released international development strategy identifies a focus on HIV prevention among MSM as an area for expansion of its work. AusAID has recently commissioned a scoping exercise to consider how it will support comprehensive approaches to address HIV infection among MSM in Asia and the Pacific. This scoping exercise will form the basis for further planning by AusAID on how it will implement the focus on MSM in its new strategy, building on the investments it has made in conjunction with Australia Federation of AIDS Organizations (AFAO) in Indonesia, in the Pacific and in Papua New Guinea.

Directly responding to the recommendations from the Health Sector and MSM Regional Consultation, this meeting aimed to come to a consensus about the basic components of a comprehensive package of programmes and services to prevent HIV transmission and to provide treatment, care and support for MSM and TG with HIV in the region. The meeting aimed to provide a platform for discussion to reach consensus between government and civil society partners on the components of a "Comprehensive Package of Services" to reduce HIV incidence among MSM and TG. By reviewing existing interventions implemented in the region over the past several years, this process included an overview of key evidence-based interventions and strategies for preventing HIV and providing treatment, care and support to MSM. The meeting aimed to achieve a consensus from national stakeholders on the components, as well as intervention priorities to prevent HIV transmission among MSM behavioural populations, including TG populations.

A key challenge when reviewing past experiences in responding to HIV among MSM is that most of the current interventions among MSM in Asia and the Pacific have not benefited from rigorous outcome evaluations using behavioural and/or biological outcomes to analyse their effectiveness in Asia.[ix] Despite this, many countries in the region do have a set of interventions that can justifiably serve as the basis for discussion and for the development of consensus.

Objective of the Consensus Meeting

To increase the effectiveness of all of these initiatives, the proposed *Comprehensive Package of Services for MSM and TG Consensus Meeting* with government and civil society representatives aimed to build on collective efforts and experiences of national AIDS responses, INGO and community experiences to achieve the following objective:

- National government decision-makers, multi and bilateral donors, international NGOs and community advocates review, identify priorities and endorse the components of a comprehensive package of programmes and services to support national responses.

Expected Outcomes of the Consensus Meeting

An endorsed comprehensive package of services and programmes to support HIV prevention, treatment and care which is intended to serve as essential tool for national AIDS authorities and community-based organisations to design and scale up effective responses to HIV among MSM and TG at the local and national level.

Structure of the Consensus Meeting

In brief, the consensus meeting consisted of:

1. Presentations on different aspects of the comprehensive response;
2. Small group work to define the services and interventions that make up a comprehensive response; and
3. A final plenary to consider the draft consensus statement on the comprehensive package.

Following opening statements from UNDP, ASEAN, WHO, USAID and APCOM, the workshop heard presentations on the epidemiology of HIV infection among MSM in Asia and the Pacific, key MSM-related findings in the report of the Commission on AIDS in Asia, a report of the recent Consultation on the Health Sector Response to HIV and AIDS among MSM, and the recently released UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People.

The next plenary session heard presentations on challenges and lessons learned in relation to National Frameworks on MSM and HIV in four countries: China, Cambodia, Indonesia and the Philippines.

Following these scene-setting presentations, four sequential sessions looked in detail at each of the four elements of the comprehensive package:

1. Prevention
2. Health sector response
3. Enabling environment
4. Strategic information

In each of these sessions there were:

- Brief presentations on key aspects of the comprehensive response, drawing on the experience of MSM programmes in the region, followed by questions and discussion.
- Small group work to define the services and interventions needed for a comprehensive response, followed by small group reports to a plenary session.

A consensus statement was drafted, based on the main points from presentations and small groups, summarising the key elements of the comprehensive package. The consensus statement was considered and adopted by the final plenary.

The three key products from the meeting were:

1. A consensus statement;
2. A detailed report of the meeting, including an outline of the key elements of the comprehensive package; and
3. A specific report on the health sector components of the comprehensive package

Participants and Participating Organisations

Over 70 participants came from countries in the Asian-Pacific region that have experience in implementing a package of services aimed at MSM and TG, and/or are currently in the process of developing national prevention, treatment and care packages on HIV and AIDS in particular for MSM and TG.

These participants included government health ministry representatives, health service providers, national AIDS programme officers, national MSM focal points, and community members from the following countries: Cambodia, Indonesia, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam (ASEAN member states). Representatives from China, India, Japan and from the Pacific Region also attended the meeting.

Additionally, representatives from APN+, Seven Sisters, international NGOs, UN agencies and technical experts participated in the meeting.

Meeting organisers would like to thank the ASEAN Secretariat, the Purple Sky Network (PSN), and the national MSM networks for identifying and supporting the national participants for this meeting.

03 COMPONENTS OF KEY ELEMENTS OF THE COMPREHENSIVE PACKAGE

The comprehensive package of services and programmes to support HIV prevention, treatment and care among MSM and transgender in Asia and the Pacific.

The comprehensive package of services and programmes to support HIV prevention, treatment and care among MSM and transgender (TG) is a spectrum or framework of inter-connected services, interventions and programmes that is tailored to engage and maintain ongoing contact with MSM and transgender to assist them to reduce their risk of acquiring or transmitting HIV, be aware of their HIV status and, if living with HIV, to access the treatment, care and support services they require. This is done not just through HIV-specific initiatives, but by assisting MSM and transgender to maximise their overall health and wellbeing.

The package covers the continuum of prevention, treatment and care programmes and services, supported by the maintenance of an enabling environment and informed by local and relevant strategic information.

The comprehensive package contains a mix of MSM and TG-specific and mainstream services that are MSM and TG-friendly. The way that services and programmes are delivered under the package is as important as the elements of the package. Some services and programmes are best delivered through MSM or TG CBOs and NGOs, others by government and private sector services. The services and programmes ideally recognize that MSM and TG are not a homogenous population, that programmes and service need to be tailored to meet the specific needs of sub-populations and that the nature and needs of these subpopulations varies from setting to setting. The comprehensive package takes account of the fact that some MSM and TG can be reached through community organisations, whilst others cannot; that some respond well to written BCC materials whist others do not; that some can easily use mainstream health services without stigma and discrimination, whilst others cannot.

The design of services and programmes under the package takes account of factors such as geographical isolation, socio-economic status, literacy, impact of gender norms and issues of the identity that men might or might not place on the sex they have with other men.

Although the elements of the comprehensive package are presented separately below, there are significant overlaps in many places that improve the delivery of the individual elements. For example, some MSM and TG NGOs provide a mix of outreach, drop-in, HIV testing and counselling, legal support and programme advocacy. Some MSM or TG-friendly STI services provide HIV testing and counselling, linkages to HIV treatment and care and participate in programme advocacy.

1 HIV PREVENTION

a Peer outreach, peer education and drop-in services

This is generally carried out through MSM and TG NGOs and CBOs, or attached to MSM and TG-specific clinics. The essential elements of this approach include:

- Supporting the development of MSM and TG communities, by supporting emerging leaders and CBOs, and linking them with stronger communities for ongoing support and mentoring
- Working through community members to understand how MSM and TG can best be accessed, educated and supported
- Training and supporting peers to conduct outreach
- Designing different models for different sub-populations - outreach models for sites and venues were sex may likely occur or gathering places for MSM and TG who will not come to a drop-in centre; specific peer-led programmes for TG
- Establishment of safe spaces (drop-in centres) for MSM and TG who can be accessed this way
- Incorporation of other services (e.g. HIV testing and counselling and STI services) into drop-in centres
- Effective linkages between outreach services and other services (HIV counselling and testing, STI, TB, drug and alcohol, mental health, HIV treatment and care) - including the support for outreach workers to accompany new clients to services; cross-employment between MSM and TG CBOs and these other HIV services

- Production and distribution of BCC and other educational materials in appropriate language and tone for the range of sub-populations
- Education campaigns targeting sub-population at particular risk, or behaviours and contexts that are particularly risky
- Attention to the prevention needs of MSM and TG with HIV in the outreach communities - ensuring that messages and BCC are not just about avoiding HIV but about living with HIV, disclosing to partners and preventing onward transmission

b Promotion of, and access to, the means of HIV prevention

This involves a range of strategies that include:

- Ensuring inexpensive or free access to appropriate-quality male and female condoms and lubricant (with a particular focus on ensuring that inexpensive water-based lubricant is readily available)
- Providing a wide range of access sites for outreach - including outdoor parks, local shops, pharmacies, health clinics, NGOs, CBOs, bars, workplaces etc
- Linking condoms, lubricant and plain-language instructions on effective use in anal sex
- Combining free distribution programmes to build acceptance and social marketing to ensure sustainability of condom use and awareness of increased risk of HIV/STI transmission in anal sex
- Working with NGOs and CBOs on condom-use messages that build a culture of condom use among sub-populations
- Ensuring that MSM and TG who use drugs can access commodities as needed, such as clean needles and syringes - through existing specialized IDU programmes, peer outreach and other strategies including community pharmacies

c STI prevention and treatment and other sexual health services

Good sexual health has a positive impact on HIV prevention, treatment and care. People with untreated ulcerative STIs are more likely to acquire HIV. Untreated STIs also challenge the immune systems of people with HIV.

- MSM and TG need access to effective STI diagnosis and treatment through:
  - STI services provided within MSM and TG CBOs and NGOs
  - mainstream STI services that are MSM and TG-friendly
  - primary care services that are MSM and TG-friendly
  - training for private prescribers in diagnosis and treatment of STIs common in MSM and TG
- Health workers involved in STI diagnosis and treatment need training on MSM and TG STI management that includes:
  - taking a sexual history that includes attention to anal sex (particularly to include this in their history-taking from men who may not appear to be having male-to-male sex)
  - counselling about safer sex, including effective approaches to couple counselling for married MSM
  - sensitivity to MSM and TG - particularly important for TG who have experienced rejection, humiliation and discrimination in health services
  - psychosocial support to increase general health, self-esteem and general capacity to reduce risk of acquiring or transmitting HIV and other STIs
- Adaptation and promulgation of STI diagnosis and treatment guidelines for MSM and TG, and quality assurance processes to ensure that they are being adopted
- Attention to MSM and TG sexual health beyond STIs - including anal health

d HIV counselling and testing

Knowledge of HIV status is an important element of the HIV response, for both people with HIV and those without HIV. For people with HIV it can be life-saving as it can provide them with access to HIV treatment and care. It can also assist them to put strategies in place to protect others. For people who do not have HIV, the process of testing and counselling needs to act to reinforce their need to stay healthy and HIV-free.

The vast majority of MSM and TG in Asia and the Pacific do not know their HIV status. Some have accessed HIV testing and counselling, but have been lost to follow-up. For HIV testing and counselling to take its proper place in the HIV response among MS and TG it needs to be:

- Voluntary, with strict confidentiality
- Provided at a time, place and environment and that MSM and TG will access
  - within an MSM or TG NGO or CBO
  - as a part of outreach services for MSM and TG
  - through a VCT, primary care or STI clinic with MSM or TG staff, or staff trained to work effectively with MSM and TG
  - with attention to the particular needs of sub-populations at greater risk - male sex workers, TG
- Combined with HIV prevention counselling and information, to ensure that people who test HIV negative get more than just a test result and are referred to onward HIV prevention services to maintain their safer behaviours
- Linked directly to ongoing treatment, care and support to MSM and TG-friendly treatment, care and support, with keen attention to minimizing loss to follow up
- Linked to general psychosocial support to reduce isolation and self-stigma and promote general health
- Linked to other prevention services (illicit drug treatment, IDU outreach, sex worker services) for MSM and TG who use drugs and/or sell sex

2 ACCESS TO HIV TREATMENT, CARE AND SUPPORT

The link between HIV testing and counselling and ongoing HIV treatment, care and support needs to be a strong one. The rollout of VCT services in some countries, without this link firmly in place, has led to high rates of loss to follow-up and the late presentation of MSM and TG with HIV to treatment, care and support service. This contributes to unnecessarily high levels of death, costly medical treatments for avoidable opportunistic infections as well as onward HIV transmission. The split in programming between HIV prevention and care in many national and local HIV programmes has also seen the development of some service models that focus on prescribing OI and ART medications without a holistic focus that includes HIV prevention, family/partner care and support, adherence counselling and education, and promotion of general wellbeing.

There are some good examples of effective HIV treatment, care and support services for MSM and TG in Asia and the Pacific that can be scaled-up under this comprehensive package. These include:

- Employment of MSM and TG as expert patients in clinics, to assist in supporting MSM and TG with HIV
- HIV treatment and care provided through clinics in MSM and TG NGOs with good linkages to mainstream ART centres
- Establishment of strong referral links between MSM and TG NGOs and CBOs and clinical services, including systems that allow outreach, drop-in or community VCT workers to bring newly-diagnosed people with HIV into clinics and support their integration into services
- Training of HIV clinical staff by MSM and TG community workers
- Use of 'MSM-friendly clinic' assessment tools
- Adherence support provided by peer educators
- MSM and TG-specific HIV support groups, attached to clinical services or to MSM and TG NGOs and CBOs
- MSM and TG community care services run in collaboration with HIV clinics

The implementation of this comprehensive package of programmes and services requires careful planning and coordination to ensure that it is aimed at geographical areas and sub-populations of MSM and TG at greatest risk, to maximize impact and make the most effective use of resources. This requires an ongoing process of monitoring, evaluation, quality assurance and research to ensure that the package remains flexible enough to deal with changing patterns of HIV risk and vulnerability and changing needs of MSM and TG living with HIV.

A more in-depth review of the health sector response will be defined in the forthcoming *"Priority HIV and sexual health interventions in the heath sector for men who have sex with men and transgender people in the Asia Pacific Region".*

3 AN ENABLING ENVIRONMENT FOR PREVENTION AND CARE SERVICES

An essential part of the comprehensive package is an ongoing programme of work to identify and remove structural barriers that will reduce the effectiveness of HIV prevention and care among MSM and TG.

Areas of work that help to establish and maintain the enabling environment include:

- Harmonize HIV policies, practices with other laws, procedures, policies and laws that might impede the HIV response among MSM and TG, including for example:
  - harassment and arrest of MSM and TG by police, under laws that criminalize sex between men
  - harassment and arrest of peer outreach workers as they attempt to work with MSM and TG
  - arrest of MSM and TG carrying condoms, on the assumption that they are sex workers
  - crackdowns on MSM and TG gathering to meet each other in parks, other public places
  - uneven enforcement and crackdowns on illegal drug use or sex work that affect MSM who use drugs and/or sell sex
  - laws and policies that require TG to use male services (e.g. male prisons, gender-specific clinics) or prevent TG from acquiring identity papers as females
- Reducing harassment, violence, stigma and discrimination experienced by MSM and TG by:
  - training for policy and practice reform among police, prison service and public security forces
  - a particular focus on discrimination in health care - establishing policies on non-discriminatory practice, setting and policing standards of care, training of health care workers, tailoring of service design to the needs of MSM and TG
  - establishing specific community legal services, or MSM and TG capacity within mainstream legal services, to ensure that MSM and TG have a place to take their complaints about harassment, violence and discrimination
  - coordinating efforts with human rights commissions, sexual and reproductive rights organizations and community social services
- Ensuring the continuity and consistency of the programmes and services through advocacy and leadership-building including,
  - enlisting the support of key political, religious and community leaders to educate their peers about the value of programmes and services for MSM and TG
  - establishing clear processes and structures for community participation in planning and decision-making in order to increase support and reduce public confrontation and disagreement
  - training and supporting the media to provide a more balanced coverage of HIV issues among MSM and TG
- Supporting MSM and TG CBOs and NGOs to play a key role in the design and delivery of programmes and services, through:
  - assisting MSM and TG CBOs and NGOs to access stable financial support,
  - building their capacity to carry out the work
  - ensuring their active participation in programme decision-making
- Improving the quality and flow of strategic information on MSM and TG available to programme planners, implementers and leaders by:
  - including MSM and TG routinely in behavioural and biological surveillance studies
  - establishing a social research agenda that contributes to programme design and delivery
  - building the capacity of MSM and TG NGOs and CBOs to monitor, evaluate and research theirs and other's programmes
- Removing structural barriers to the use of services and programmes by MSM and TG by:
  - removing barriers to access to education, to improve literacy, participation in community life and self-esteem
  - ensuring that MSM and TG have identity papers and other official documentation that they need in order to access services
  - minimizing discrimination in employment, to assist MSM and TG to be in a better position to make health-seeking choices

4 STRATEGIC INFORMATION

The response to HIV among MSM and TG needs to be tailored to the particular context or HIV risk, vulnerability and impact for those populations in the context in which they live. This can only be done if policy makers, programme designers and implementers and service providers have accurate information about the populations of MSM and TG they are trying to work with.

Strategic information provides programmes and services with essential information about the size of MSM and TG populations, about the nature of HIV risk and vulnerability, about the way that living with HIV impacts on these populations and about changes in these patterns and driving forces over

time. It is generally collected through a range of strategies including:

- Population size estimation
- Biological and behavioural surveillance
- Social and operational research
- Programme and service monitoring and evaluation
- Policy and legislative review

The connection between strategic information and policy makers, programme implementers and service providers is an essential one. Strategic information needs to be a tool to help answer the questions that policy makers, programme implementers and service providers have about the effectiveness of the policies, programmes and services needed: Who is getting HIV and why? Who most needs access to services? Who is responding to prevention programmes and who is not? Who is accessing HIV testing and who is not? Who is accessing treatment, care and support, who s not, and why?

MSM and TG community organisations have an important role to play in devising the questions to be answered by strategic information, in assisting in the gathering of data and information from MSM and TG, in disseminating the data and information and in translating this into better programmes and services.

04 SUMMARY OF REGIONAL CONSENSUS MEETING

Day One: *Monday, June 29*

Opening Remarks

Mr. Nicholas Rosellini, Deputy Assistant Administrator and Deputy Regional Director, UNDP Regional Bureau of Asia and Pacific thanked all who came from national health departments, donors, researchers and civil society, as well as representatives from MSM and TG advocacy networks and organisations.

He stated that to achieve universal access and to reverse the rates of HIV infection among MSM and TG, the United Nations, governments, affected communities and other actors must work more intensively together to devise and deliver targeted and evidence-informed interventions. Mr. Rosellini stated that the **UNAIDS Action Framework: Universal Access for MSM and TG People**, recently endorsed at the UNAIDS PCB meeting in Geneva (June 2009), will assist the UN system to accelerate and better coordinate its efforts in this area, guided by the following principles:

- Action must be grounded in an understanding of, and commitment to, human rights, the cornerstone to an effective response to HIV
- Action must be based on and informed by an evidence-base on HIV among MSM and TG
- Action is required by a broad range of partners, simultaneously addressing both short- and long-term needs and opportunities to ensure broader and better responses to HIV among MSM and TG

He closed by stating that while human rights protection is a pre-condition for strong responses, it is not enough in and of itself. In the Asia-Pacific region, there are a number of countries that mix tolerance and repression; that often criminalise same-sex relationships, but only rarely enforce these laws; that have effective community-based MSM responses to HIV in some urban centers, yet none at all in other parts of the country. He urged all participants to simultaneously push for legislative reform, wider scale community mobilisation and enhanced human rights protection.

Dr. Bounpheng Philavong, MD, MPH, DR. PH, Assistant Director, Head of Health and Population Unit Bureau for Resources Development, Association of Southeast Asian Nations (ASEAN) spoke on behalf of Dr. Soueng Rathchavy, ASEAN Deputy Secretary-General for ASEAN Socio-Cultural Community. Dr. Philavong extended a warm welcome, noting that this consensus meeting was a follow-up on the agreement made at the 16th meeting of the ASEAN Task Force on AIDS, which was held in November 2008 in Hanoi, Viet Nam.

He took the opportunity to thank UNDP, WHO and all the partner organisations for co-organising and supporting this important consultation. He stated that the ASEAN Leaders in their Declaration on ASEAN Commitments on HIV and AIDS, endorsed at the 12th ASEAN Summit on 13 January 2007 in Cebu, Philippines, recognised that the HIV epidemic brought about by factors such as poverty, gender inequality and inequity, illiteracy, stigma and discrimination, conflicts and disasters, affects groups most at risk like sex workers, MSM, TG and drug users including injecting drug users; and vulnerable groups such as migrants and mobile populations, women and girls, children and youth, people in correctional institutions, uniformed services, communities and populations in conflict and disaster-affected areas. He highlighted that the HIV epidemic continues to threaten the vision, and the lives and futures of the people, especially PLHIV and vulnerable populations throughout the region with socio-economic consequences that pose a formidable challenge to ASEAN community-building.

Dr. Philavong ensured that the ASEAN policies and programmes give ample emphasis to containing the epidemic in vulnerable populations; sharing of lessons, best practices and evidence-informed prevention policies; and moving prevention and education efforts, including public information campaigns, beyond the health sector. They especially address aspirations of children and young people, women, couples and other vulnerable groups to protect themselves against the disease.

Dr. Philavong concluded by expressing his sincere hope that this Regional Consultation would provide a good opportunity to share analysis of gaps in addressing this emerging issue, and to learn from each

other to address the issue more effectively through collaboration, shared policy development, sharing lessons-learned about what works to address specific issue and recommend regional programming where appropriate.

Caitlin Wiesen, Regional HIV/AIDS Practice Leader and Programme Coordinator Asia-Pacific, UNDP Regional Centre Colombo, highlighted the impacts of the epidemics on MSM and TG, and explained that there is a lack of policy guidance for HIV interventions among MSM and TG which comprehensively focus on prevention, treatment, care and support. She explained attention should be given to the coverage of quality and comprehensive interventions. While effective programmes should reach around 50% to 60% coverage levels, in most Asian countries, the coverage levels for most-at-risk populations average around 30%. Coverage rates among MSM are estimated at less than 8%. She emphasised that this is the reason why current strategies have had little impact on halting the progression of these concentrated HIV epidemics.

She stated that any effective HIV programme must address the legal barriers and discriminatory practices that impede effective service delivery to high risk and vulnerable communities. Whilst attention to MSM and human rights concerns is found in most national AIDS strategies, these strategies are often not costed and budgeted and therefore there is a lack of translation into action.

Existing costing and resource estimation tools used by the governments are not currently designed to address these issues. She expressed the need for a comprehensive and complementary national costing and community-friendly resource estimation tool to assure strong alignment with universal access targets and the recommendations of the Commission on AIDS in Asia report. The tool should include new areas such as supporting the enabling environment and addressing human rights and gender dimensions of MSM and TG HIV responses.

Ms. Wiesen recommended the use of tools like the Asian HIV and AIDS Resource Estimation and Costing Model (UNDP-UNAIDS-ADB) to ensure focused and rights-based interventions to HIV among MSM and TG are included and budgeted. She expressed a hope that the key outcomes of this meeting and following USAID/HPI Advocacy and Resource Estimation Workshop would help strengthen the key MSM components in costed national plans.

> "There will be no equitable progress so long as some parts of the population are marginalised and denied basic health and human rights – PLWHIV, MSM, SW, IDUs"
>
> Quote by the UN Secretary General in 2008

Finally, Ms. Wiesen pointed to the unique opportunities ahead:

- The UN Secretary General puts full weight and support behind efforts in addressing the entrenched stigma, discrimination, and laws that criminalise same sex behaviour and impede access to HIV services;
- UNAIDS: Framework for Action on MSM and HIV recently endorsed; and
- Commission of AIDS in Asia Report unequivocally puts the issue of epidemics among MSM as top priority for action

She closed by saying that any effective HIV programme must address the legal barriers and discriminatory practices that stand in the way of getting services to high risk and vulnerable communities. Furthermore, this meeting has an the opportunity to make an enormous impact by pooling the collective knowledge of governments and communities, and mapping the critical responses that will not just shape action and budgets, but make a difference in the lives of people living with and vulnerable to HIV.

Dr. Massimo Ghidinelli, Regional Adviser, HIV/AIDS and STI, World Health Organisation – Western Pacific Region (WHO/WPRO) spoke on behalf of Dr. Shin Young-Soo, the WHO Regional Director for the Western Pacific. Dr. Ghidinelli highlighted some critical factors, including the efforts of the Hong Kong, (China) government who proactively requested the regional Committee of WHO for the Western Pacific to take action to respond to the emerging crisis of HIV among MSM and eventually triggered the start of a series of actions, beginning with the February 2009 health sector response landmark consultation. The second critical enabling factor he mentioned was the Asia Pacific Coalition of Male Sexual Health (APCOM), whose inclusive nature and responsible constructive activism had facilitated the collective progress being achieved

Dr. Ghidinelli referred to the specific recommendations that were unanimously agreed upon in the Hong Kong consultation. He concluded that the health sector has a major responsibility to provide high-quality accessible services to MSM and TG

populations. Availability of these services will require collaborative efforts, including the contribution of WHO collaborating centres in the provision of state-of-the-art technical support. Dr. Ghidinelli invited the participants' contribution and participation to support the scaling-up of the regional response. WHO's recent focus on MSM and HIV in the Region began with the implementation of the regional consultation on the health sector response to HIV among MSM held in Hong Kong (China) in February 2009. That meeting followed on a global consultation that was held in Geneva in September 2008. Strong international consultation partnerships were established to steer an appropriate response to the crisis.

Mr. Clif Cortez, Regional Team Leader, HIV/AIDS, Office of Public Health, Regional Development Mission Asia (RDMA), U.S. Agency for International Development (USAID) shared with the audience that the first discussions that he was a part of between USAID/Washington and UNAIDS/Geneva regarding MSM and TG took place in 1997 but with no official leadership taken on this issue by UNAIDS at that time. In recent years, UN leadership in Asia regarding MSM and TG issues had improved; first under the leadership of UNAIDS Regional Support Team, Asia and the Pacific; as then as a result of the energy provided by UNESCO. Most recently, the greater UN global commitment, as evidenced by UNDP officially taking coordinating responsibility for the UN for MSM/TG-HIV issues may represent a "game-changing" shift towards a cohesive and strengthened UN coordinated approach to these critical issues in Asia and the Pacific.

USAID has supported HIV prevention among MSM and TG in various Latin America and Asia-Pacific countries since the mid-1990's but, like all other donors supporting such HIV prevention, for many years the NGOs and specific services supported were not linked effectively from a beneficiary's perspective, and there was no strategy behind the support. However, since 2003, USAID has supported a strategy of MSM and TG-focused interventions, linked as a network of interventions and services through both community-based organisations and local government services, in specific geographic sites. This includes supportive interventions such as policy, stigma and discrimination reduction, government and NGO capacity building. This approach has been labelled the 'minimum package of services' (MPS).

In 2008, the UNAIDS-supported Independent Commission on AIDS in Asia spoke of essential services for MARPs, and the elements of "essential services" noted were the same as USAID's MPS. USAID supports the move towards a comprehensive package of services for MSM and TG. Mr Cortes expressed a hope that this meeting, with the support of the key regional donor (USAID), in partnership with UNDP, WHO, and other multilaterals, together with government and civil society, will also be a 'game changer' in the response to HIV and AIDS among MSM and TG.

He stated that there was another significant 'game changer' in this region - mobilising the resources provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Until very recently, USAID remained the only significant funder of HIV interventions for MSM and TG both globally and in Asia and the Pacific. This has changed dramatically with GFATM Round 8 (and hopefully future Rounds). But even though most countries included MSM in their Round 8 proposals, not all countries included support for the concept of a comprehensive HIV prevention package for MSM and TG. He hoped that a critical outcome of this meeting would be the use of the comprehensive package concept to engage with GFATM in each country to ensure that Global Fund projects meet minimum standards of quality, and engagement of affected civil society in relation to MSM and TG.

Mr. Shivananda Khan, Chairperson, Asia Pacific Coalition on Male Sexual Health (APCOM) expressed his pleasure at the high-level participation in the meeting. He commented that at the 1992 ICAAP meeting in New Delhi, there was only one session held to discuss MSM issues and no additional space was provided for discussions with MSM affected by HIV. As a result of this, many MSM and TG people were denied access and held their own meeting in a park across the road from the conference.

He went on to say that in 1994 the first community-meetings MSM and TG in Asia were chaired by India's Humsafar Truat and Naz Foundation International on issues affecting the MSM community. He said that MSM have fought for many years to get their issues, needs and concerns addressed and stressed that all communities deserve to be treated with respect, love and support. He expressed his concern related to the sustainability of the community-led interventions and about long-term commitment and leadership on MSM and TG issues in the UN system. Currently, there is powerful support with the presence of certain individuals at the global and regional levels, he emphasised, but there is a need to institutionalise the MSM and TG issues within the UN system. He elaborated that increased holistic thinking is needed and that critical issues need to be tackled. He referred to WHO, who continues to

classify TG as a disease. Mr. Khan concluded that he wanted to bear witness to the millions of people denied the right to live with dignity and social justice in the Region.

> "We must not forget who we are discussing. The need is not only to target HIV support but also to support making society more inclusive for MSM and TG, because unless we address the underlying psychological factors the affect this group, targeted interventions will not work."

He emphasised that critical issues around low self-esteem/self worth, lack of social justice and citizenship rights also affect MSM and TG, but that interventions are not strategically designed to address this. Finally, Mr. Khan stressed that poverty issues are key factors that are not fully exposed and that are undervalued in development approaches. He gave an example that MSM often lack education due early school dropout rates due to harassment and sexual abuse, sexuality and gender preferences. This lack of education leads to poor access to jobs and can lead to sex work and a higher vulnerability to HIV and STI's.

Agenda Setting: HIV among MSM and TG in Asia Pacific

Dr. Frits van Griensven, Thailand MOPH-U.S. CDC Collaboration reported on the epidemiology of HIV infection among populations of MSM in Asia and the Pacific. He explained that current HIV prevention efforts have been unable to contain or reduce HIV transmission in this population and that additional behavioural and biomedical interventions were urgently needed. He noted that while knowledge is growing, little systematic knowledge is available regarding risk behaviours and the prevalence of HIV and STI in populations of MSM in the Greater Mekong sub-region and China.

He noted that the levels of HIV and STI prevalence in the region were high and that continued monitoring, surveillance and targeted preventive interventions were necessary to stop the spread of HIV in this vulnerable population. He discussed new developments in Asia including new data from Myanmar and presented some highlights from the HIV Sentinel Sero-Surveillance survey. The survey presents similar data to that from Thailand showing people acquiring HIV at a very young age. He referred to the currently ongoing HIV prevalence surveys in Kuala Lumpur, Malaysia, and in Bangkok, Chiang Mai and Phuket in Thailand. Results from these studies will be available by the end of 2009.

Dr. van Griensven also presented data from the Bangkok MSM Cohort Study, where about 6% of 1002 HIV negative men enrolled in the study became HIV-infected every year. After three years of the study, the cumulative HIV incidence in the cohort was 24.7%. The annual incidence of HIV infection was higher in those 22 years of age and younger, with about 10% of men becomming infected in this group every year.

Dr. van Griensven drew attention to some of the ongoing chemoprophylaxis trials that may undergo interim analysis later this year. He explained that the use of PrEP looks promising in animal models. If proven effective the placebo arms in the study will be closed and participants will be given the active study drug. He informed that ongoing trials of daily Truvada© amongst MSM, injection drug users and heterosexuals. Finally he presented a timeline overview of ongoing and planned PrEP trials until 2012.

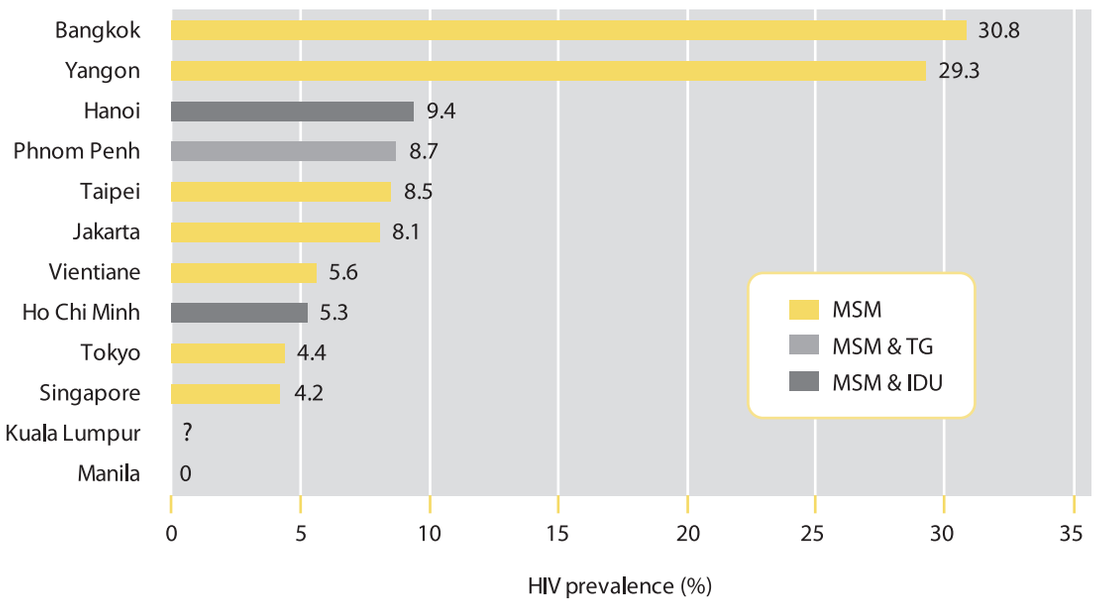
Mr. Jan W. de Lind van Wijngaarden, UNESCO Regional HIV Advisor reported on the Commission on AIDS in Asia report entitled **"Redefining AIDS in Asia – Crafting an Effective Response"** and highlighted the information and the steps to be taken in effective strategic planning to reverse the spread of HIV among MSM and TG in Asia and the Pacific.

> One of the A Commission's report recommendation is to "Define and implement the elements of a full prevention package for each at-risk population […] both on a regional and national basis" (page 191).

Mr. de Lind van Wijngaarden emphasised the following key MSM and TG related issues from the report:

- Link epidemiology/projection models with current HIV responses and investments, placing priority on 'high impact' interventions

HIV prevalence among MSM in Selected Cities in South East and East Asia, 2006 - 2008



SOURCE

Health Sector Response to HIV/AIDS among MSM. Report of the Consultation, 18 – 20 February 2009, Hong Kong SAR (China), WHO, WPRO, Manila, 2009; van Griensven et al, Current Opinion HIV AIDS, 2009; de Lind van Wijngaarden et al, STD, 2009

- Firmly establish that work with MSM/TG is not 'boutique' but must be part of mainstream national AIDS prevention efforts
- In the worst case scenario it is estimated that 50% of all new infections in Asia will be caused by male to male sex in 2020
- Intervention coverage was 5% across the region and must reach 60%-80% to turn the epidemic around, ART coverage is 26% overall (2005 data)
- In terms of resources about US$340 million per year is needed for MSM/TG-specific prevention interventions in Asia, but so far there have been few significant government financial investments in HIV among MSM and TG

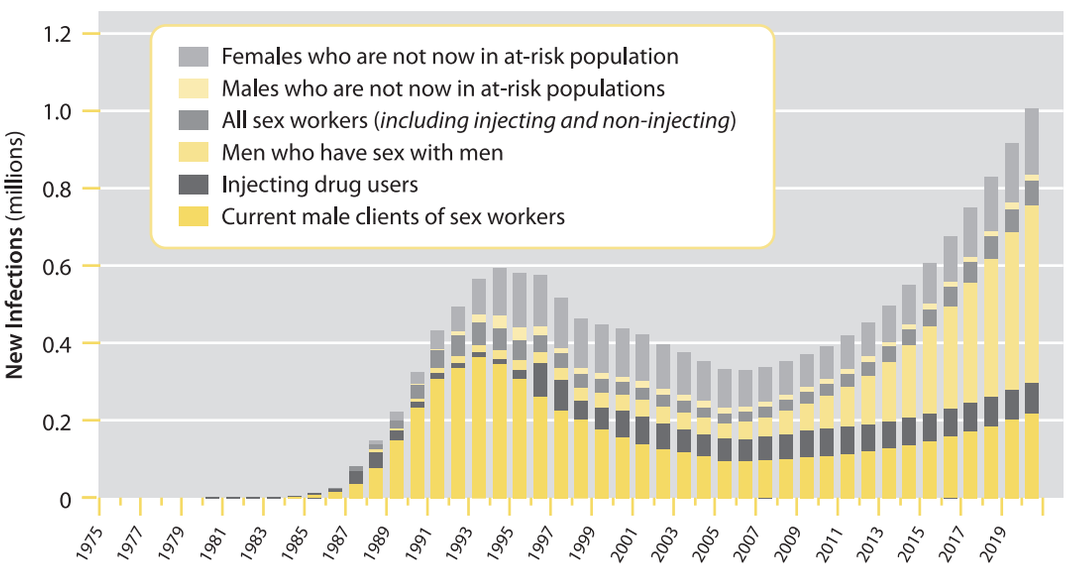
He summarised the four essential components of HIV programmes set out in the report:

- Community engagement for peer education programmes and information and referral sharing
- Access to commodities including condoms and lubricant, as well as antiretroviral therapy
- Care and treatment services for STI, VCT, lab testing (CD4, CD8, viral load)
- An enabling environment that includes supportive policies and legislation to ensure access to services and reduction of stigma and discrimination

Finally, he noted other key points from the report:

- It is important to focus on the social context in which risk and vulnerability occur and to include the 'subjective needs' of the target audience (i.e. not only focus on HIV but also on other needs the population may express)
- Stigma and discrimination undermine Asia's response; leaders should speak out against laws that criminalise or support discrimination of MSM or people living with HIV
- Activism is underdeveloped in Asia and engagement of affected communities is weak
- There is a need to generate quality evidence for what works in different Asian contexts
- Just expanding existing services is not enough; there is a quality issue in that these services need to be tailored and made more MSM and TG-friendly

Annual new HIV infections in adults by population group: a decline from early prevention successes, an increase from current failures



SOURCE Asian Epidemic Model estimates for the Asian region.

- There is a lack of standardisation in peer education and other programmes for MSM, which is crucial if efficient scaling-up is to be achieved

Dr. Fabio Mesquita, Technical Officer, HIV and STI, World Health Organization – Western Pacific Region (WHO/WPRO) presented a **review of the Consultation on the Health Sector response to HIV among MSM and TG (February 2009)**. Principles and recommendations were framed around rights-based approaches, by "knowing your epidemic" and by working through partnerships. He went on to call attention to the following key conclusions and recommendations for the consultation:

There is an urgent need to address the emerging and re-emerging epidemics of HIV and other sexually transmitted infections (STIs) among MSM and TG populations. Strengthening surveillance and implementing interventions for the prevention and treatment of HIV and other STIs for MSM and TG should be considered as priority activities for all countries and regions as part of a range of interventions to ensure universal access to HIV prevention, care and treatment.

Global Consultation on MSM and HIV in Geneva, September 2008, WHO/UNDP/UNAIDS

- Strategic information on MSM and TG including epidemiological and biological/behavioural surveillance data should be collected through existing systems; together with social/anthropological, and operations research.
- There are several promising interventions currently underway in low and middle-income countries in the region, but most are limited in scale and coverage; constrained by accessibility, quality of services, capacity of implementing partners and service providers, availability of resources, and legal and social barriers
- There are, at present, different understandings of labels with regards to a package of services, such as 'minimum', 'comprehensive', 'essential', however, the meeting recognised the need for an endorsed, single comprehensive regional reference package to better inform national responses
- In high HIV incidence settings, additional urgent prevention measures are needed and a "highly active intervention package (HAI)" should be developed in order to break the chain of transmission
- Partnership with APCOM on strengthening health sector responses is essential

- More work is required to provide and maintain enabling environments and the proper allocation of funds

Edmund Settle, HIV Policy Specialist, Asia and Pacific Region, UNDP Regional Centre introduced the UNAIDS Action Framework: Universal Access for MSM and TG people.

> In countries without laws to protect sex workers, drug users and MSM, only a fraction of the population has access to prevention. Conversely, in countries with legal protection and the protection of human rights for these people, many more have access to services. As a result, there are fewer infections, less demand for antiretroviral treatment and fewer deaths. Not only is it unethical not to protect these groups; it makes no sense from a health perspective. It hurts all of us."
>
> Ban Ki-moon, Secretary-General of the United Nations, August 2008

Mr. Settle underscored the urgent need not just for more programming, but also for new and better approaches. Based on local epidemiological and social realities, enhanced responses must combine efforts focused specifically on MSM and TG and attention to their needs in broader HIV responses, and bridge-building with broader efforts to achieve gender equality, promote human rights and protect public health. He further emphasised that countries must be rigorous in monitoring the evolution of their HIV epidemics and recalibrating their responses as needed.

He emphasised that:

- MSM and TG have an essential role to play in launching, sustaining and reinventing community and self-help responses, as well as related cultural and political advocacy efforts
- Other civil society actors are key allies, including AIDS organisations lesbian/gay/bisexual/transgender rights movements, family planning associations, human rights advocates and religious institutions with ethics of caring and inclusion
- Governments are key partners and have an obligation to respond in both public health and human rights. They are at the cutting edge of health service provision, and often overseeing police and education services
- Public and private donors must be convinced to invest in effective and targeted action, based on the evidence of the significant role of these populations in the HIV pandemic

Mr. Settle concluded by stating that the ten UNAIDS cosponsors and the UNAIDS Secretariat have a unique mandate and the ability to work with partners to achieve a stronger enabling environment for HIV prevention, treatment, care and support in the long-term, while taking advantage of multiple entry points and opportunities for impact in the short-term. He argued that far more needed to be done within a broader context, by developing and strengthening partnerships as an essential aspect of regional and national AIDS responses in the Asia-Pacific region.

Following the presentations, the **plenary discussion** also reinforced the need for an expanded response to HIV among MSM and TG in more developed countries (e.g. Japan, Taiwan, Singapore) as strategies should not only focus on lower-income countries. The UNAIDS Action Framework was cited as a good step forward and countries in the sub region were advised to examine the report and adapt its recommendations. Participants expressed that knowledge of what works and an understanding of best practice is still weak and that there was a lock of critical information available on the impact of programmes.

Community groups have supported organisations to point out where to invest, what kind of interventions to choose because high level organisations might be unaware of local realities. Advice was given to link budgets with size estimation and realistic denominators to be better able to convince governments to allocate resources and identify appropriate interventions.

Participants stressed that PLHIV should be involved in all interventions including prevention, treatment care and support. Interventions are needed to try to break silence and to change dynamics. Research and data about the population is required to identify overlaps in need and approach between subpopulations, as well as the specific needs of particular subpopulations. Some of the participants questioned the efficacy of research studies that based their findings on questionable MSM and TG population size estimations. Country representatives expressed the need for recommendation for different countries to be better contextualised, as current packages offered by international agencies do often not fit local context.

National Frameworks on MSM and HIV - Challenges and Lessons

CHINA: Dr. Mi Guodong, M.D., PhD, National Centre for AIDS/STD Control & Prevention (NCAIDS), China Centre for Disease Control presented data from a China study carried out in 2007 that estimated that among 50,000 people newly infected with HIV, suspected mode of transmission indicated: heterosexual (44.7%), MSM (12.2%), IDU (42.0%) and MTC (1.1%). A survey of HIV and syphilis among MSM showed that among 18,101 people in 61 cities, 4.9%, had HIV and 11.9% had syphilis. The HIV/syphilis co-infection level was 1.4%. High-risk behaviours among MSM living with HIV showed that the prevalence of high risk sex in previous six months for male to male sex is 68.15%, heterosexual sex 68.6% and bisexual sex 56.0%.

Dr. Mi gave an overview of the Chinese government response from 2004 to 2006. In 2004, central government funds supported the first MSM NGO. In 2005, central government funds supported 17 projects for MSM, MOH issued a policy paper, set up high-risk intervention team targeting sexual transmission (including MSM), high-level central government officials met with MSM community representatives and a national consultation with MSM communities was held. In 2006, a national technical guideline for the control HIV/AIDS among and from MSM was developed and a national response plan to control HIV and AIDS among and from MSM was developed jointly with MSM communities.

Recent responses involve a second National Consultation with MSM communities that was held in 2007, a joint national survey of HIV infection, prevention and care projects that was conducted in 2008 and the establishment in 2009 of a perspective cohort to evaluate the impact of a comprehensive intervention package implemented in 8 cities with HIV prevalence rates greater than 5%.

Coverage of HIV and AIDS services in 2008 involved education materials, condoms, lubricant as well as access to peer education, testing and counselling and STI management. Dr. Mi Guodong highlighted the challenges as follows:

- Uncertainty about the size of MSM population and the magnitude of HIV epidemic among MSM
- Dual stigmas: sexual orientation and HIV infections
- Insufficient knowledge about what works. What are key elements for effective intervention? What is the minimum coverage to slow down the epidemic? Do high knowledge levels result in lowering risk behaviours
- Balancing human rights between MSM living with HIV and AIDS, their female spouses and same sex partners
- Capacity of MSM CBOs and the health sectors

He closed the session by explaining the next steps and said that the current collaboration with MSM CBOs should continue to expand, new intervention approaches like web-based interventions and a focus on interventions among MSM with HIV should be piloted. He also mentioned the importance of more involvement of the operators of MSM venues, such as bathhouses, bars and clubs. Finally he addressed the need for scientific research into issues surrounding emerging HIV prevention strategies such as circumcision and PrEP.

CAMBODIA: Dr. Ros Seilavath, Deputy Secretary General, Cambodian National AIDS Authority [x] presented the **Cambodian National Frameworks on MSM and HIV** and explained that Cambodia had a HIV prevalence of 0.9% in 2006. MSM is considered as one of the most at risk populations that might be the source of second wave epidemic.

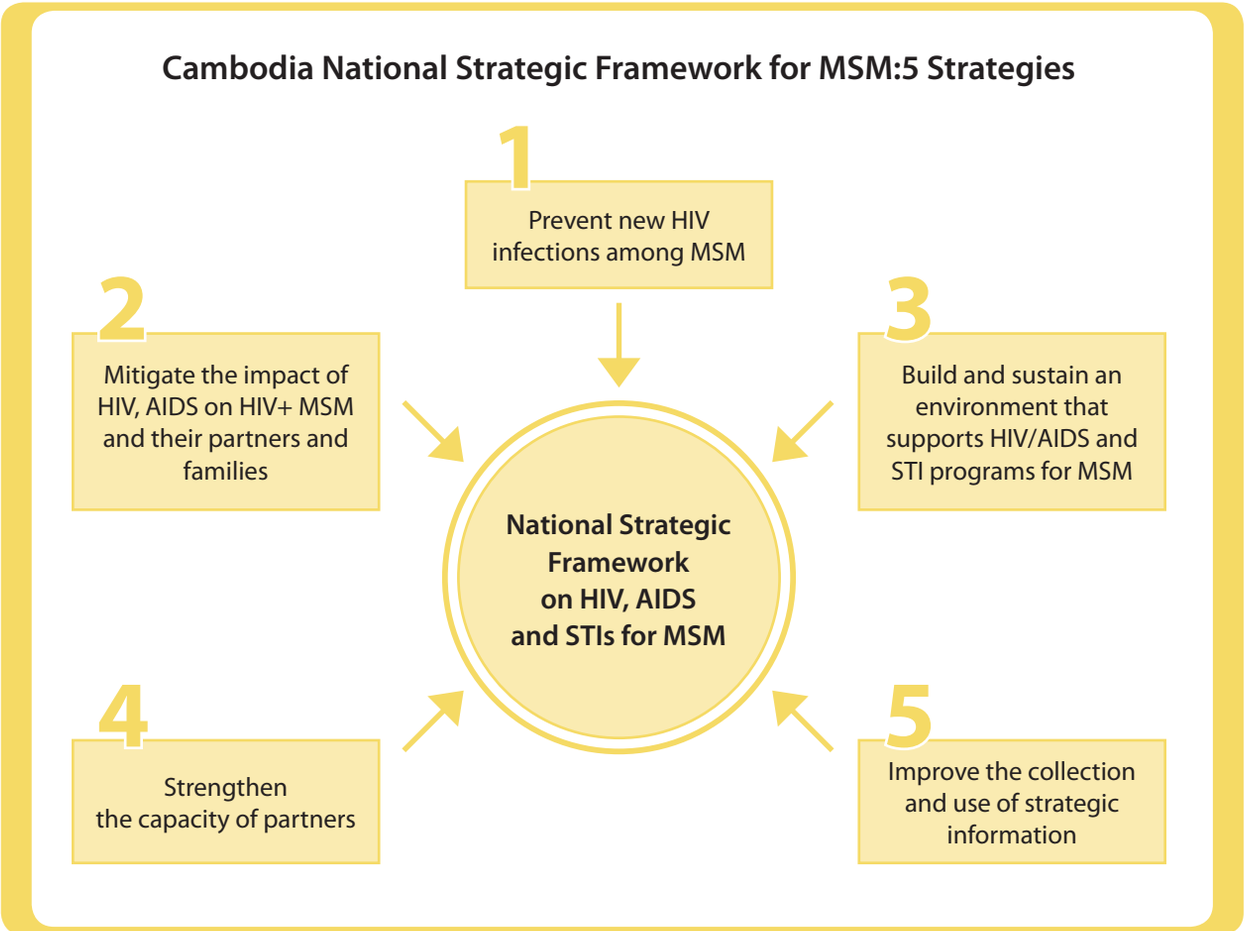
He highlighted the following data:

- HIV prevalence among MSM (8.7% in Phnom Penh and 0.8% in provinces (Battambong and Siem Reap)
- STI prevalence among MSM (9.7% in Phnom Penh and 7.4% in provinces)
- Among MSM, 31% having sex with SW, 5% using drugs and consistent condom use very low especially in provinces

MSM was made as top priority for response in NSP II and university access indicators and target.

NAA's NMSM-TWG has developed a National Strategic Framework and operational plan on HIV/AIDS and STI for MSM (SF & OP) to complement the Cambodia NSP II for HIV and AIDS 2006-2010 which recognises MSM as high risk for HIV.

Dr. Ros Seilavath discussed the activities proposed in the Strategic Framework and Operations Plan covering the three years from July 2008 until June 2011 and described the key priorities to improve the response to HIV and STI among MSM. These

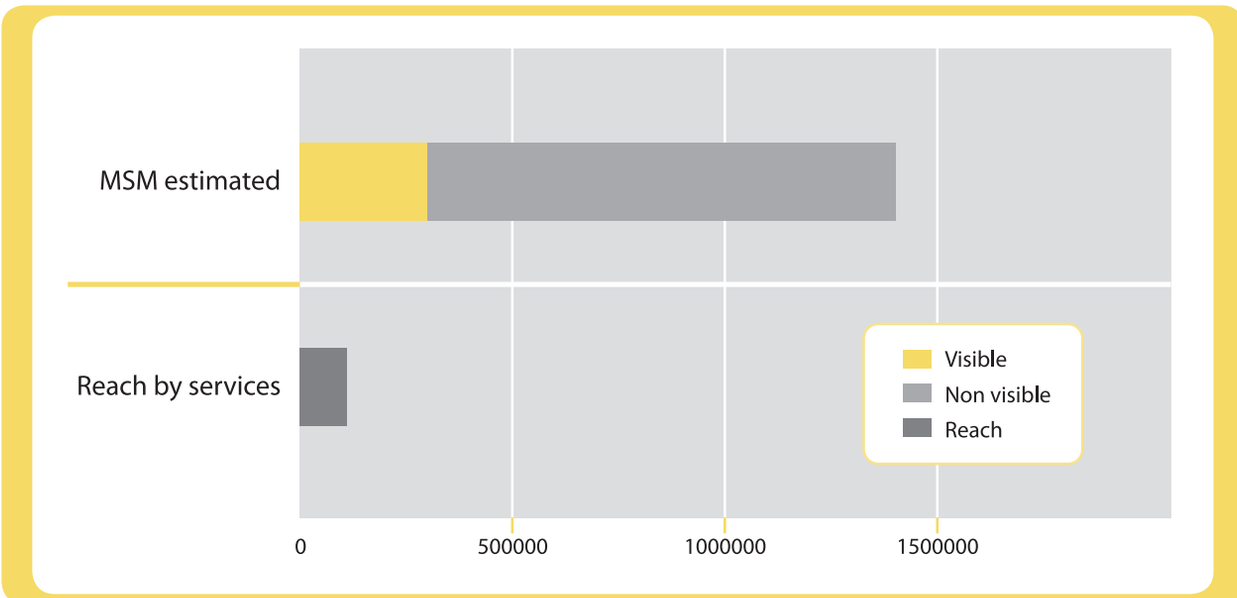


included: the scaling up of a comprehensive prevention package to significantly increase coverage, particularly of hidden MSM; improving the quality of prevention services; and, building the technical skills and organisational capacity of CBOs and the national MSM network. He stressed the importance of strengthening the involvement of MSM in HIV and AIDS response through community development and mobilisation and strengthening the partnership between government, CBOs, MSM and technical assistance providers. He set out priority areas - to reduce stigma and discrimination against MSM and to mobilise sufficient resource for effective responses.

He highlighted the expected results for each of the five strategies (set out in the diagram above) and highlighted the partnership cooperation with NCHADS, governmental institution, (I)NGOs, FHI, KHANA, MSC, PSI, CBOs, Inthanou, and BBCWST, UNAIDS, UNESCO and PACT Cambodia. Finally, he described the challenges as follow:

- Invisible MSM seem not access health services
- No clear idea on MSM population size, can't be sure of level of coverage of services
- Limited coverage of specialised STI clinics
- Limited skilled health staff, due to staff movement
- Limited M&E capacity: referral, follow up
- Limited financial resources for implementing activities set
- Priority of government and implementing NGOs is not priority of donors: some activities set were not fulfilled
- Package of services varies from one NGO to another

INDONESIA: Dr. Bagus Rachmat Prabawa, Coordinator for Care Support and Treatment, MTCT and STI Prevention, from the Indonesia National AIDS Commission,[xi] presented an **overview of the status of HIV among MSM and TG in Indonesia.** MSM Surveillance shows that STI and HIV rates were very high among MSM in Jakarta, Bandung and Surabaya, especially among those who engage in commercial sex. MSM tend to have multiple sex partners, both male and female, and significant numbers also buy and sell sex. Consistent condom use remains low, knowledge of preventive measures against sexual transmission of HIV and other STI was moderate to high in six cities but overall



knowledge was lower. MSM receive information about HIV from a variety of sources, moderate proportions of MSM has recently used STI treatment services and received HIV counselling and testing.

Although drug use affects only a small proportion of MSM, the recent use of amphetamines and similar drugs was reported by sizeable proportions of MSM in some cities. However, few MSM inject drugs. Coverage of programmes compared with national estimation population shows that:

PHILIPPINES: Dr. Ferchito L. Avelino, Director III, Secretariat of the Philippine National AIDS Council (PNAC) stated that in the Philippines in 2007, the Department of Health (DOH) and WHO estimated the number of people living with HIV in the Philippines at 7,490. This shows an increase of 1,490 on the 2002 estimate. MSM registers the highest estimate, with a 0.07 to 0.98 HIV prevalence.

He explained that among the 85 new HIV infections reported for May 2009, the mode of transmission for 88% was reported as sex between men. Some 3,911 cumulative HIV cases were reported to the AIDS Registry, of which is 2,777 (71%) were male and 3,500 (90%), reported as infected through sexual contact. Sexual transmission proved to be the predominant mode of transmission, increasing from one new HIV case detected every three days in 2001, to one case per day in 2007 and two cases detected per day in 2009. The mode of transmission shifted from once predominantly heterosexual to that of homosexual transmission and a sharp increase in the number of MSM with HIV was noted from 2006 onward.

Results of the 2nd Generation Surveillance on HIV and MSM revealed the below findings. Though the surveillance was conducted in 2004, risk factors for HIV identified are still relevant today.

- Multiple sexual partners and diverse sexual networks
- Many have both male and female partners
- Anal sex with male partners is widely practiced
- Low condom use rates , high contribution of alcohol and recreational drug use in sexual behaviour
- Knowledge of HIV and HIV prevention and awareness of interventions is low
- STIs are widespread among MSM, as is failure to act on STI symptoms

Information about the diverse sexual networks of MSMs showed that electronic or internet-based sexual networking and short messaging system (SMS) through mobile phones are currently the leading and widely used communication strategies amongst young MSMs. “Cruising” through the net and through mobile phone have replaced the usual cruising sites like movie theatres and parks. Also, due to the wide use of the internet, young people would rather seek on-line information than face-to-face peer education. Though this may prove helpful, the downside of these communication methods results in a lack of legitimate claim or identification of HIV as a personal issue, since the interpersonal processing of information is not well explored and emphasised. As spelled out in the Philippines’ Medium Term Plan, HIV interventions primarily consist of outreach, information, education, communication,

advocacy and research. Current outreach activities must be reviewed to explore other avenues of reaching out to MSM. Building partnership must go beyond the usual national government, non-government and donor players. Research findings need to draw out information that will provide better understanding of the issue of HIV among MSM. For years the hallmark of HIV response for MSM in the country was based on building knowledge through capacity or awareness building. Referral mechanisms in relation to STI case management have been established. With the increasing trend of infection amongst this subpopulation, Mr. Avelino said, initiatives need to be reviewed.

Challenges in the MSM response are:

- Weak organisational capacity amongst different MSM communities to respond to the needs and challenges that confront them
- Lack of relevant and reliable demographic knowledge on population sise and subpopulation characteristics
- Persistence of homophobia and discrimination
- Health care system not accessible, sensitive and responsive to the needs of MSM an TG
- Insufficient funding and other resources allocated to HIV among MSM and TG

The strategic direction includes a focused on most at risk populations, adoption of a package of services approach in reaching MARPs and the achievement of at least 60% coverage for MARPs (UNGASS report shows only 14% reached). Finally, Mr. Avelino showed examples and budget allocations of the Intervention Package for MSM for specific components:, behaviour change, commodities and services, enabling environment, programme management, investments and monitoring and evaluation.

The **plenary discussion** revolved around social and sexual behaviour (that requires more multi-faced responses), issues around condom use, the need to develop programmes and services for positive MSM and TG. Participants discussed experience on what works, citing examples from both resource-rich and resource-poor countries, where the implementation of a package of interventions has proven to be helpful. This contextual approach has been shown to reduce HIV infection rates. Evidence also shows that if governments reduce their investment HIV transmission rates rise again. Continued investment and increased partnership between the community and government will contribute significantly. Such approaches need to be built into the response. Research experiences of increased internet access and use in Indonesia were shared. Finally, participants expressed that the information from China and Cambodia was inspirational. Having a sub-plan on MSM and HIV, and a very specific framework and costing plan increased coordination and provided useful insights on how the country was responding. They have each provided leadership and a mechanism that created opportunities to mobilise funds.

Session One: Comprehensive HIV Prevention for MSM and TG

Rob Gray, Regional Advisor, Population Services International (PSI) Asia gave a **presentation entitled**

Defining Comprehensive Prevention among MSM and TG.

Mr. Gray noted the importance of developing a comprehensive package of services that also included the mechanisms by which the effectiveness of the services and interventions are measured. He said that too often attention is given to what is needed but not enough is given to operational issues, such as which organisation will deliver what product or service, how, and with what measure of quality.

He gave an example of social marketing of condoms in Laos. Ten years ago condoms, although available, were expensive and difficult to find. Social marketing made condoms widely available and also promoted demand among MSM and other vulnerable groups. As the social marketing campaign continued, the private sector recognised there was a market for condoms, and has begun to fill that demand on their own. Increasingly now, condoms that are both high quality and low cost are available. Eventually, the social marketing project will reduce the burden on donors to fund condom distribution in Laos, as the commercial sector will take much of the burden.

He also emphasised to the need to pay more attention on grass roots project implementation of quality projects to serve the immediate needs of MSM. He said that in SE Asia we have an impressive level of high-level activities from civil society as well as governments and international organisations, talking about the HIV/STI prevention, care, and support needs of MSM/TGs. While this is very impressive, more focus is needed on how to provide on-the-ground programmes.

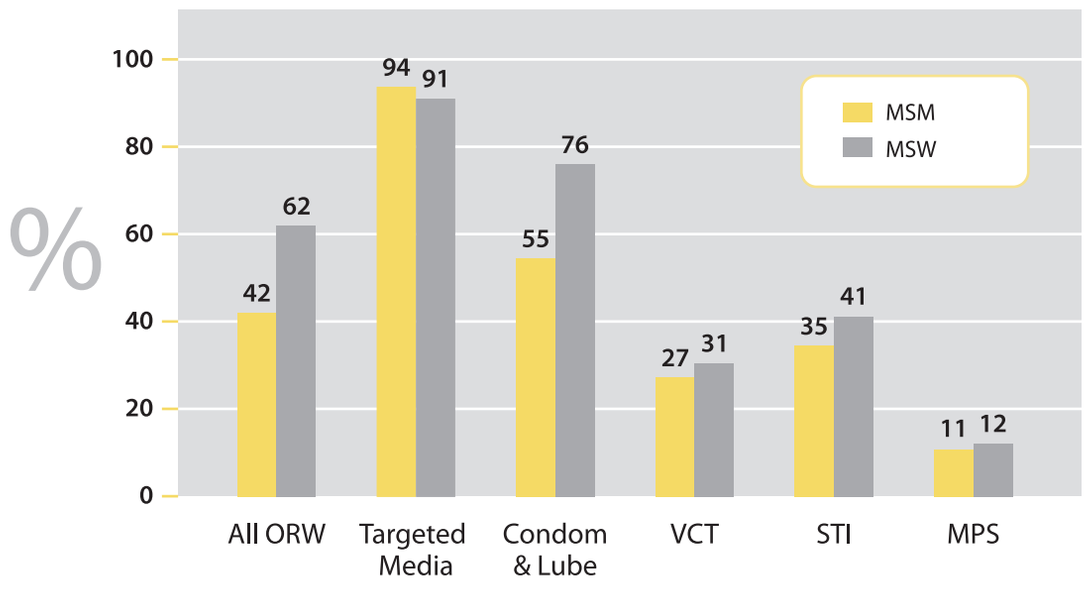
He stressed the need to continue to invest in quality M&E attached to each project so we know what's working to promote healthy behaviours, and what's not working. That data will be crucial in developing strategic information to inform our understanding of best practices. He encouraged organisations to take advantage of the global fund (GF) to scale up quality services for MSM/TG. He encouraged organisations to be prepared to 'think bigger' because the GFATM seeks to fill real gaps wherever they exist and can be demonstrated.

The Minimum Package of Services (MPS) was discussed by **Philippe Girault, Technical Advisor, Male Sexual Health, Family Health International (FHI) APRO**. Mr. Girault noted that the term MPS is now shifting to the term Comprehensive Package. When discussing MPS it is also important to detail the different components, particularly the behaviour change component. In the work that Mr. Girault presented, the minimum package of services included outreach activities i.e., peer outreach, educational sessions, community-based events, targeted media campaigns, access to condoms and lube, voluntary counselling and testing, and diagnosis and treatment for sexually transmitted infections. He noted that some of the implemented interventions of the MPS may contribute to changes sexual and health seeking behaviours but despite a significant increase from 2005 to 2007, access to MPS is still low.

Mr Girault suggested that more effort should focus on developing internet interventions and structural interventions in entertainment establishments, because this could provide a huge opportunity to reach more MSM, particularly "hard-to-reach" MSM. Specific attention should be paid to the access to VCT and STI services for MSM. There is a need to identify relevant strategies to strengthen and scale-up MSM-friendly services to reach different MSM population networks/segments. In addition, community-driven targeted social marketing campaigns should be developed in a more systematic way. All these interventions should be preserved or included in the behaviour change component of the MPS.

Evaluating Community-based Response to HIV prevention for MSM: the amfAR/MSM initiative experience, presented by **Dr Annette Sohn, Director, TREAT Asia/amfAR. Dr. Sohn spoke** about the goal of improved health and well-being for gay men, other MSM and TG. She noted that universal access to HIV services like prevention, treatment and care are key to help bring about a decline in the number of MSM acquiring HIV. She also pointed out that an important benefit of a comprehensive package of services would be to reduce the burden of STIs on individuals, leading to better health and quality of life for MSM with HIV. She shared results of reports from MSM Initiative grantees and an audit conducted by AIDS Projects Management Group (APMG) for amfAR's MSM Initiative to identify operational research priorities for MSM HIV services in the Asia and the Pacific.

Minimum Package Services in Past 12 Months
Bangkok, 2007



SOURCE Thai MoPH, BoE, 2007

The first round of community awards in Asia and the Pacific has included grants to the below organisations in three target areas:

- **Focus on comprehensive services:** Developing HIV clinical and operational research protocols to include MSM (Thai Red Cross) and reaching positive MSM in Myanmar and Nepal (Blue Diamond Society)
- **Focus on behaviour change:** Social support and personal identities (China, APLA) and sexual health diaries (Thailand, SWING)
- **Focus on capacity building of CBOs:** Skills development on research methods and strategic planning for CBOs (Samoa, Pacific Sexual Diversity Network) and participatory governance structures; advocacy skills with local governments (scale-up through UNDP Funding), Philippines, TLF-SHARE Collective

Dr. Sohn outlined current models being used in Asia and the Pacific to increase access to MSM-focused HIV prevention, testing, and clinical services. One example of a missed opportunity was from the Thai Red Cross, where MSM sought care, but were sometimes unable to access certain types of STI treatment due to cost considerations. Another was from the Blue Diamond Society in Nepal, where large numbers of MSM and TG with HIV were reached, but the lack of denominator data made it difficult to know how much more work needed to be done to achieve effective coverage levels. She reviewed four current models for MSM HIV services in use in the region that prioritise:

- Increasing MSM and TG-friendliness of mainstream clinics (private and/or public)
- Taking clinical services to MSM communities (mobile clinics; clinics within community-based NGOs)
- Combining VCT and cohort research study sites
- Integrating MSM into a general MARPs approach

The MSM initiative explores how to identify best practices to be scaled-up and assess their progress and impact over time. Based on their analysis to date, effective models are likely to include a combination of approaches that allow for prevention-based outreach, VCT, treatment, palliative care, and other clinical services, as well as mechanisms

for community support and advocacy. A critical component to this process will be to engage community-based advocates and groups and encourage community ownership of programmes. In addition, working closely with local or state health infrastructure appears to lead to greater success and will be an important component in the effort to expand and sustain MSM-related comprehensive HIV services in Asia and the Pacific.

Day Two: *Tuesday, June 30*

Session Two: Strengthening Health Sector Responses - Treatment, Care and Support

Dr. Massimo Ghidinelli, Regional Adviser, HIV/AIDS and STI, World Health Organization – Western Pacific Region (WHO/WPRO) defined health sector responses.

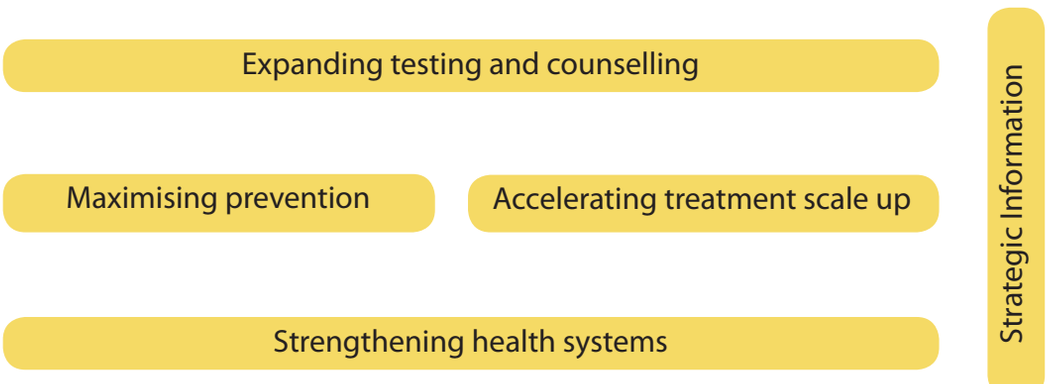
A health system includes all the activities whose primary purpose is to promote, restore or maintain health. Health Services are services for the diagnosis and treatment of disease and the maintenance of health. They are a key component of the health sector but only one aspect of it.

World Health Report, 2000

Definitions: The health sector is wide-ranging and encompasses organised public and private health services, including those for health promotion, disease prevention, diagnosis, treatment and care; health ministry's; nongovernmental organisations; community groups; professional organisations; as well as institutions which directly input into the health-care system (e. g. the pharmaceutical industry,, teaching institutions).

Global Health Sector Strategy for HIV/AIDS, World Health Assembly, 2003

The health sector's contribution to achieving Universal Access is visualised in the below framework:



Strategic information includes components like surveillance data and trends, monitoring the health sector's response and developing estimates and projections. Assessing service delivery in different countries has exposed a wide gap between a high demand and a limited availability of qualified services. This calls for institutional and capacity development approaches and interventions. WHO has guidance documents available that elaborate along the five strategic directions including tools, guidance and case studies.

WHO is intending to produce a document setting out the health sector's priority interventions for MSM and TG in Asia and the Pacific, in line with global tools and publications, but highly contextualised to the specific features of the region. Dr Ghidinelli emphasised WHO's focus on a comprehensive approach and highlighted the need to combine prevention technologies to maximise effectiveness and impact. Guiding principles for the health sector were listed as:

- Rights-based norms and standards for the integration of MSM and TG issues into national AIDS responses
- Evidence-informed and non-discriminatory interventions
- Comprehensive approach linking prevention to treatment, care and support
- Combination of prevention interventions to maximise effectiveness
- Inclusiveness: broad partnerships and involvement of communities
- Linking to interventions in other sectors

WHO's priority includes measures to support mainstreaming of MSM and TG interventions in the health sector to assure community involvement and the establishment of networks and outreach activities. Centres of excellence should be developed and identified and lessons learned should be better captured, documented and disseminated. Sensitive clinical guidelines and operational frameworks and capacity building among health personnel need to be expanded and should include skills in history taking, physical examination, the ability to identify specific STIs, PITC (Provider-Initiated Testing Counselling) and counselling. MSM and TG issues should be included in training curricula of medical and nursing schools and the attitudes of health workers need to be addressed to reduce stigma and discrimination.

Finally, Dr. Ghidinelli shared experiences around monitoring interventions, measuring results and impact by referring to the monitoring framework developed in partnership with WHO, UNICEF and UNAIDS to measure progress in the health sector's response towards Universal Access. The framework has been implemented at the request of member states, and currently WHO is finalising the third global universal access report. He stated that there are five key indicators that refer to MSM-related interventions. Although still not yet finalised, the monitoring of specific interventions has already received a certain degree of attention. Data availability and collection remains a challenge. Not all countries are able to report on these UA indicators.

Improving access and utilisation of STI and VCT services by MSM, was presented by **Dr. Zhao Pengfei, Technical Officer, World Health Organization, Vietnam**. Dr. Zhao Pengfei presented information on improving access and utilisation of STI and VCT services by MSM. He gave examples of innovative service design from selected countries and described the elements of MSM-friendly services.

Dr. Zhao Pengfei explained that there is evidence that people who do not know their HIV status are less likely to take protective measures with their partners; additionally, they will miss opportunities to timely access ART programmes. Only a small proportion of MSM seek HIV testing and counselling, and this contributes to the invisibility of the epidemic among MSM in Asia. He set out options for client-initiated voluntary HIV testing and counselling (VCT) and Provider initiated testing (PITC). Dr. Zhao Pengfei highlighted the challenges of scaling-up HIV testing and counselling. He addressed the need for laboratory testing quality assurance and discussed the challenges if testing QA in community settings. Finally, he announced that a UNICEF/WHO Package of counselling, covering the full spectrum of HIV counselling and testing, is to be launched at the 9th ICAAP in Bali.

Definitions:

VCT involves individuals actively seeking HIV testing and counselling, usually emphasises individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies.

PITC refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a part of a package of services. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status. This testing is also voluntary.

Source: WHO

Access to treatment and care among positive MSM in the region was presented by **Addy Chen, Coordinator MSM Positive Working Group, Asia Pacific Network of People Living with HIV/AIDS.**

Mr. Chen outlined APN+'s access to treatment research, issues relating to HIV+ MSM and TG, key research findings and recommendations for further research.

This research was designed to identify challenges faced by MSM and TG with HIV, as well as HIV-positive women and IDU, while accessing HIV related treatment and care. The MSM-specific research covered six Asian countries (India, Myanmar, Malaysia, Singapore, Indonesia and Nepal) and 897 participants were involved. Methods included individual questionnaires and 17 focus group discussions in a peer-led research process. Research limitations involved the challenges around the recruitment, coverage areas and the fact that TG issues were not clearly separated. The follow results were highlighted in relation to HIV counselling and testing:

- 59.3% of the participants accessed HIV test in government hospitals
- 13.1% reported having been tested for HIV without their consent e.g. Nepal (36.9%) vs. Indonesia (1.6%)
- 81.6% received post-test counselling Among these, 81% disclosed their sexuality to counsellor and among participants who disclosed their sexuality to counsellor, 41.6% reported that counsellors were neutral in terms of friendliness (friendly attitude) towards MSM.

Related to access to ART, Mr. Chen explained that in total, nearly half (46.4%) were in need of ART. Barriers to access included lack of adequate knowledge about ART, fear of side effects, denial of service by doctors and unfriendly HIV service providers. Barriers to accessing HIV-related services were summarised as: the high cost of services; legal issues, travel costs and inconvenience (average travel time: 2.78 hrs); lack of adequate information about services; and, stigma and discrimination. Participants reported that healthcare workers (HCWs) disclosed the participants' HIV status (12.4%) and sexuality (14.5%) to others without consent. There was a fear of discrimination by HCWs if participants were perceived to be effeminate or HIV positive, preventing people from accessing services. Some participants reported denial of services (21.1%) and physical assault (9.6%) by HCWs; most alarming, in Nepal, participants reported denial of services (30.8%) and physical assault (37.7%) by HCWs. Being transgender (53.7%) and being openly homosexual (44.4%) were seen as risk factors that exposed respondents to the risk of refusal of healthcare services.

Other issues reported upon in the research:

- Employment and poverty (type of jobs, joblessness and recruitment)
- Disclosure. Some fears their partner (male or female) might come to know their HIV status prevents initiating, accessing or adhering to treatment
- Alcohol and drug use
- ARV side effects related to skin and physical appearance
- Lack of peer counsellors for positive MSM and TG
- Access to services by rural based positive MSM and TG
- Clinic opening hours are not suitable and MSM specific support groups

Mr. Chen presented the initial recommendations. The full details can be soon found at APN+'s website.

Plenary questions and discussion focussed on the issues of TG – often neglected. There was a call for better arguments, facts, research tools and approaches to expand MSM and TG services. Interventions that only target small numbers of people

were discussed and questions were asked on how to justify mainstreaming approaches. Questions were raised on how develop a sensitive health system in a cost-effective manner and how to deal with issues of income and poverty.. Finally, participants expressed a need for increased engagement with governments to create awareness and to protect rights.

Session Three: Enabling Environment

Don Baxter, Co-Chair, Global Forum on MSM and HIV and Executive Director, Australian Federation of AIDS Organisations (AFAO) presented on the Key Components of an Enabling Environment. Mr. Baxter proposed a simple definition of an enabling environment:

> A social and legal environment that protects the rights of people living with HIV and AIDS and encourages people whose behaviours place them at risk of infection to participate at all levels of the response to the epidemic.
>
> Source: AFAO

He noted that this goal requires enactment and implementation a disparate range of measures extending well beyond the health system – in fact most lie chiefly outside the health system. He then identified the key components required to enable effective MSM and TG programming. These are:

- De-criminalisation of sex between men
- Anti-discrimination legislation protecting people with HIV and specific anti-discrimination legislation protecting MSM and TG
- Anti-stigma campaigns to challenge homophobia and build confidence among MSM and TG to participate fully in society, including engaging actively with the health system
- Community mobilisation among MSM and TG, allowing the formation and operation of independent MSM and TG community organisations and the strengthening of their capacity, particularly in advocacy
- Accessible, user-friendly and high-quality health services sensitive to MSM and TG
- Advocacy and collaboration with commercial sex venues' owners and managers
- Advocacy and collaboration by MSM and TG with the range of government agencies which police the private and public sites where sex between men often, including police, park rangers and local public health officials

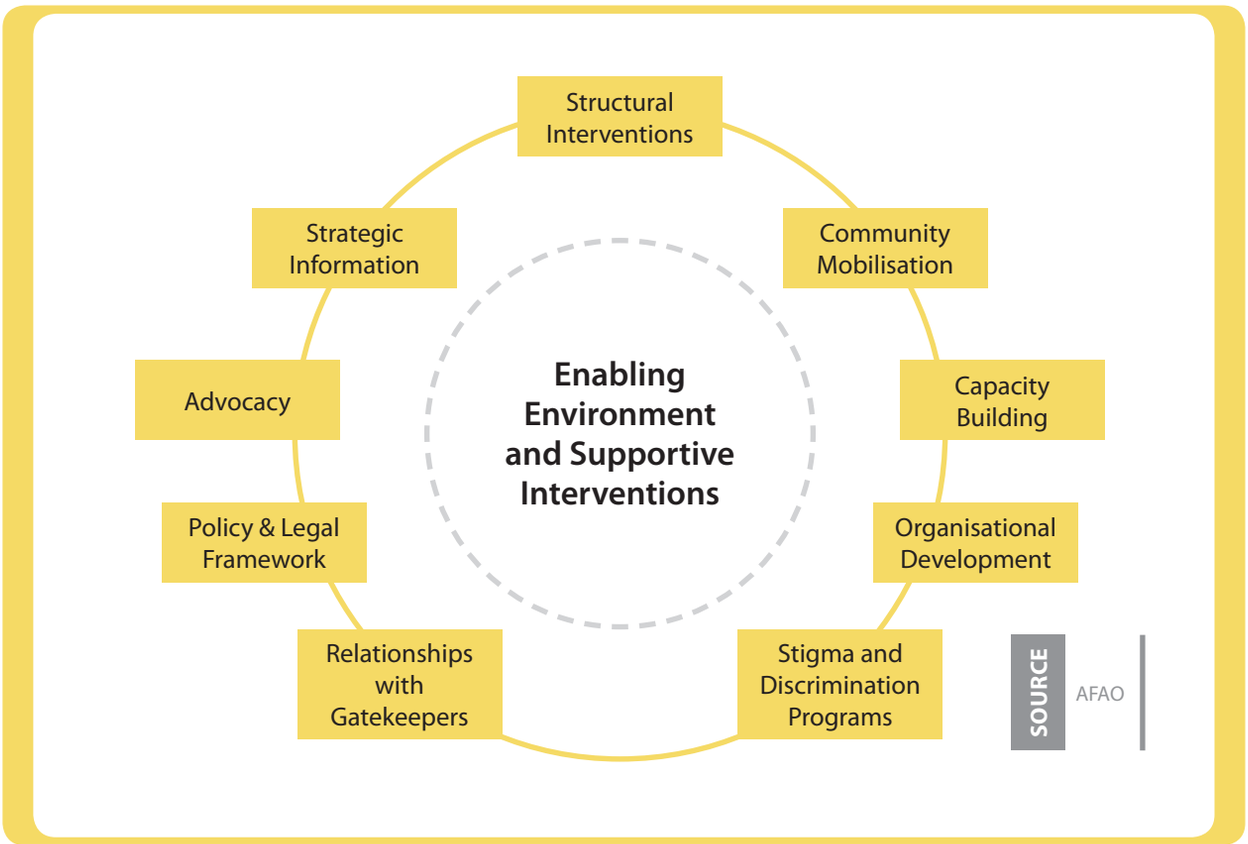
An enabling legislative and social environment for MSM and TG has key characteristics which:

- Promote the rights of the most affected populations to encourage and facilitate participation
- Remove punitive or coercive measures and practices that impede participation
- Apply to all aspects of social life - not just the health system

Mr. Baxter noted that HIV anti-discrimination legislation exists in 60 countries globally, that 52 have specific legislation protecting MSM and TGs. 19 countries in the Asia Pacific region still have laws criminalising male-to-male sex. It is essential these criminal laws are removed in order to allow MSM and TG to participate effectively in society, including engaging with HIV prevention programmes. This will encourage MSM to protect their own health and the health of their partners. He then noted that a range of other laws can also hinder effective HIV programmes, citing three examples. These laws and regulations range from those that treat the possession of condoms as evidence of prostitution; censorship laws or regulations that prevent the use of explicit imagery in targeted HIV and sexual health campaigns; and, the inappropriate use of vagrancy laws when they are used to harass and intimidate MSM, TGs and peer educators in outreach settings.

He urged the decriminalisation of male-to-male sex, along with a systematic review by governments of any laws or regulations which hinder HIV prevention and support programmes. He noted this review and reform is not expensive – saying governments do not have to wait until the next Global Fund grant to undertake it. These reforms are especially important at the local and provincial levels, under whose jurisdiction most high risk sex happens and where most HIV programs operate.

He emphasised the need to a range of anti-stigma measures including, creating space for the general community to talk honestly about sex – and the realities of MSM sex lives – including sex with their female partners. National governments and NAC's should lead this process of reversing stigma in a number of ways including: leading public discussion on these



sensitive issues; ensuring there is realistic sex education in schools; and instituting anti-homophobia campaigns for the general public. Prejudicial religious leaders need to be challenged and constructive ones fostered and encouraged. He noted the leadership provided by the governments in Mexico and Brazil, both implementing national campaigns against homophobia – and doing so in a fairly conservative religious environment.

Finally, Mr. Baxter explained that an enabling environment is not a 'service'; rather it is a part of a comprehensive and multi-faceted comprehensive programme. Another significant component is fostering community mobilisation as core to successful MSM and TG programmes as it is the critical key to changing norms and values – and therefore behaviour – on a substantial scale.

Effective CBO's are essential – and governments should be able to respect the independence and advocacy of the CBO's and to ensure the organisations are able to operate legally; legislative or regulatory change may be needed to ensure this environment. Further, short-term investment should be avoided in favour of long-term support and governments should foster national networks to ensure the views and voice of MSM and TG can be conveyed more effectively to decision-makers.

It is through the protection, promotion and respect of human rights that the prevention and control of HIV and AIDS can take place both by recognising and seeking to address the factors that lead towards HIV transmission and by protecting the human rights of those infected and affected by HIV and AIDS.

Capacity Mapping for Community-Based Organizations was presented by **David J. Dobrowolski, Country Representative, GMR Regional Coordinator, Pact Thailand.** He outlined capacity mapping for CBOs in the MSM Response: **"Activating the Community Response for Results"**. He defined the science and art of OCB for CBO, discussed about Organizational capacity building (OCB) for community-based organizations, illustrated ways to map CBO capacities to deliver the comprehensive package and highlighted some issues and common "traps". He described the large gap in implementation capacity among CBOs targeting MSM and mentioned that the overall goal of interventions should focus on community-led response and community-owned response. Therefore he said we need:

- Strong CBO partnership with essential government health services
- High performing service delivery organizations rooted in the community

- Focused advocacy networks to improve the enabling environment

Another gap, he mentioned, lies in MSM programming on the ground due to the lack of absorptive capacity in the community-based HIV program organizations and local implementing agencies that are needed to scale up services at a high level of quality.

An example from Thailand was illustrated. This program focused strategically focused on CBOs implementing MSM services and is USG funded since 2005 with GFATM Round 8 starting up in 2009. The partner organizations can be mapped out to clarify the programming choices and variables in OCB improvement for CBOs. A format sheet was shown with examples to map out the organization' status, technical/ organizational capacity balance, absorptive capacity on a 1-4 scale, identify elements of quality at the service delivery point, track number of service delivery points in each province, district or locality serving MSM, TG, MSW, hard-to-reach MSM (such as clients), for each service in the comprehensive package and identify prioritized technical and organizational capacity areas. Additional information was shared on the processes of participatory assessment, systems development and skills transfer needed to move cohorts of CBOs along a continuum toward increased capacity.

Mr. Dobrowolski recommended that more innovative responses are required and emphasized that quality services for MSM at scale require functional service delivery points, but also enhanced leadership and management from the community members. Finally, he described the outcomes of organizational capacity strengthening as follows:

- Improved HIV/AIDS program management capacity at the national and provincial level for a scaled up and more comprehensive range of services for MSM. This includes the technical and organizational capacity to deliver a comprehensive package of services for MSM in HIV prevention, care, treatment and support
- Improved organizational management and leadership capacity of CBOs and NGOs working to deliver HIV prevention services for MSM (including TG and MSWs) leading to increased absorptive capacity to manage larger blocks of funding for scaled-up, higher quality services fully accountable to donors and the community

Broadening Partnerships – Reaching Hidden MSM and their female partners, Ashok Row Kavi, Technical Advisor Interventions among MSM, UNAIDS India. Mr Row Kavi presented experiences from linked responses to vulnerable populations related to Humsafar Trust's (HST) operational research data. He explained that India's National AIDS Control Organisation (NACO) identified three main core populations as 'infected and affected by HIV and AIDS' in the NACP III programme. The programme called for starting up and up scaling interventions in the MSM/ TG sector as a priority.

In the new estimates for the HIV+ population, MSM and TG carried the heaviest burden of HIV infection. Mr. Row Kavi reported that the first baseline study revealed high levels of sex between MSM and women, highlighting MSM as a key bridge population for HIV prevention efforts.

Coming from a gay activist background, many practitioners in the MSM community based organisations (CBOs) of such groups, did not realise that working with communities would also require looking at the sexual and reproductive dynamics within the Indian society. In 2000, HST's pilot project was transformed into a targeted intervention program, focussing on increasing consistent condom use in anal sex between men, increasing awareness around HIV transmission, reduction of partners and prompt STI treatment. HST succeeded in all these efforts over six years. The HIV infection among MSM today has been halved from 13.8% to a plateau of 7% in Mumbai as of last year. It can be said that HIV awareness is now very high, consistent condom use has increased and partner reduction was also successful.

Mr. Row Kavi stressed that MSM also have multipartner sex including with women. These men, more often than not, are not reached by traditional government and community interventions and have been overlooked in India's National AIDS Control Programme. He said that it is now well understood that controlling the HIV epidemic needs more attention to the MSM and TG sectors as large subpopulations of these groups are also having sex with women.

Plenary questions and discussion were held around the importance of anti discrimination laws, the role and actions to be undertaken for legislators and the need to focus on implementation of the rule of law. It was felt that the importance of designing a good legal framework was not well understood. Participants felt a need to focus more on rights-based approaches. A discussion was held around how to best create awareness and knowledge in countries where CBOs are not allowed, not legalised and/or do not exist. At least, a minimum enabling environment should exist. In countries where there is a social impasse and no social welfare system, like in Pakistan and Bangladesh, it is very difficult to operate. Better approaches for these countries should be developed. Also approaches on how to work around religious influences like Muslim and Catholicism need to be designed. While operationalising strategies it is important to include the community in decision-making, to design good processes, and also leadership roles need to be assigned to the community.

Day Three: *Wednesday, July 1*

Session Four: Strategic Information

Strategic Information and improving responses to MSM and HIV was presented by **Geoff Manthey, Regional Programme Advisor, UNAIDS Regional Support Team, Asia and the Pacific.**

In compliance with the Declaration of Commitment on HIV/AIDS signed by UN member states in June 2001, countries submit progress reports to UNAIDS. The reports, submitted every two years, reflect the progress made by countries in their response to the AIDS epidemic. Mr. Manthey discussed the UNGASS reports from the region and questioned whether UNGASS indicators can be adapted to MSM strategic interventions. He noted that 25 reports were submitted out of 38 countries in the region (reporting rate 66%), compared with 19 reports in total in 2005 (reporting rate 54%). In presenting the highlights of the report by output, outcomes and impacts indicators from the region he showed that increased reporting takes place on the different formulated indicators.

He explained that through a multi-agency effort (USAID, CDC, UNAIDS, WHO, UNICEF, FHI, MEASURE Evaluation) in 2007 a Framework for M&E of HIV Prevention Programmes for MARPs was developed. The rationale was that existing UNAIDS M&E guidelines were mainly adapted to generalised epidemics and that there was a need to compile existing work from different sources. Also, there is a need to move from project level to systematic M&E at each level and phase within the framework of national M&E systems.

He closed by saying that the HIV epidemic in Asia is mainly concentrated in groups with higher risk behaviour (SW, IDU, MSM). Programmes targeted at these populations are implementing effective strategies, and achieve sufficient sustained coverage and interventions have proven effective in reversing the spread of HIV. Overall, he concluded, MARP coverage is increasing but remains largely insufficient in most settings. Improved M&E of MARP interventions are therefore key to knowing the epidemic and to improve responses. There are a lot of good practices at the programme and project level and the global M&E Reference Group is providing guidance in consolidating these and issuing global standards to address challenges to effective M&E of MARP interventions.

Developing MSM HIV Indicators and Evaluation Processes, Ruth Bessinger, PhD Consultant MEASURE Evaluation. Ms. Bessinger explained that prior M&E guidance, particularly for prevention, was largely developed with generalised epidemics in mind; little focus was paid to settings where HIV is concentrated among high risk populations. Methods and approaches are developed and used for M&E of most-at-risk populations. The MARP guide mentioned earlier was an attempt to systematically compile this information and provide a framework for M&E of MARP programmes. She highlighted the importance of sub national and project-level M&E as part of a national M&E system and addressed some of the key challenges with collecting information about MARP populations (do no harm approach working with highly stigmatised populations, ethical considerations such as confidentiality and respect for privacy). The framework presented in the MARP guide provides the strategic information needed and answers questions related to identifying the magnitude of the (different problems) problem and the identification. Information comes from surveillance, determinants research, and population size estimates. Population size estimates are difficult to come by and approaches used may include census and enumeration (sub-national), population survey methods, multiplier methods, capture-recapture (and multiple capture) methods and compartmental methods. Information is then needed to understand what interventions will work; this comes from formative research, needs assessment, costing and resources analysis. As the focus of this meeting is on a package of services for MSM, the presentation focuses on issues related to monitoring and evaluating the implementation of such a package. Illustrated with examples from FHI Bangkok, she presented a draft list of harmonised project level indicators for MSM projects, 2009. She explained that indicators allow for the routine tracking of priority information about a programme and its intended outcomes. It helps to measures change over time in any of the programme components inputs, processes, outputs, outcomes, impacts and it aims to improve programmes by identifying those aspects that are working according to plan, and those in need of mid-course correction. Below Ms. Bessinger outlined indicators from GFTAM/UNGASS.

Global Indicators (outputs):

- Number of most-at-risk populations reached with HIV prevention programmes (GFTAM): Material on behaviour change communication and consumables (condoms) Counselling from a social worker or other relevant specialist and referral to another specialist or service as appropriate and based on individual client needs
- Number of individuals from the targeted audience reached through community outreach with at least one HIV information, education, communication or behaviour change communication

Coverage, outcomes and impact:

- Percentage of most-at-risk-populations reached with HIV prevention programmes
- Percentage of MSM that both correctly identify ways of preventing the transmission of HIV and reject major misconceptions about HIV transmission
- Percentage of men reporting use of a condom the last time they had anal sex with a male partner
- HIV prevalence among MSM populations

She stressed the importance of service utilisation and coverage data and explained that there is often a lack of good coverage data as questions on use of services are often not included in surveillance/ surveys. She said that there is a lack of good definitions of what "prevention coverage" and "reached" means which makes asking questions difficult. Using service statistics with population size estimates is usually not a feasible alternative for monitoring, she explained.

She highlighted the importance of addressing quality and intensity of services when designing and implementing a package of services. She presented research from Bangkok and Myanmar. Result show that an improved implementation of service package in Bangkok had led to greater implementation and more people received services. She explained that intensity can give info about the quality and that whether programme beneficiaries have access to a package or single service, the proportion of people can be measured. In Bangkok result show that in 2 years time more people got access to services. In Myanmar they used a method that measures how many people have been reached by setting a minimum threshold to measure quality of the implementation of a package of services. Programme evaluations show in general a lack of consolidated evidence although this is important for sustainability of project and measuring cost effective interventions. She said that it is important to assess how the elements of package are linked to risk behaviour, also to be able to track interventions in time.

She asked the participants to think about two questions

- Is there a ***minimum package of interventions*** or services that everyone in the target population should receive?
- Is there a ***minimum intensity*** of services that everyone in the target population should receive?

She stressed that a coordinated effort to define these basic measures will make overall measurement easier. Finally, she highlighted some approaches to programme evaluation:

- Look at trends in STI and HIV in the target population
- Triangulate trend data from programme monitoring systems with data on risk behaviours and HIV STI status
- Look at associations between service use and HIV related behaviours in a cross-sectional survey

She used illustrations from MSM programme beneficiaries in three countries that showed the association between intensity of service use and consistent use of condoms with a paying partner. She closed her session by noting that there are evaluation gaps, in part because of the difficulties in determining the relationship between level of programme coverage or quality of a programme, and the impact that that programme has on behaviour and health status. There is a lack of rigorous evaluations of HIV prevention programmes targeting MSM populations and there needs to be a more coordinated response to evaluation.

Plenary questions and discussions were framed around the different uses and understandings of terminology. Participants expressed a need for clarification on terms. They also mentioned the lack and inappropriate use of terminology like the term 'intensity' and the conceptual difference between coverage and reach. Unpacking and (re)defining terminology that distinguished between reach and intensity was mentioned in particular. Participants expressed that classification and harmonisation of different types of interventions need to be better assessed and identified, and these interventions should be more based on theories, research and best practices.

Participants questioned how much coverage was enough to justify interventions and to be effective and efficient in programming. The amount of coverage required varies from setting to setting and country to country. More modelling work at country level needs to be done. Because of the lack of strong evidence related to areas of prevention, MARPS and behaviour change to guide practitioners, resources should be allocated to building up the evidence basis and disseminating knowledge and best practices.

A dialogue on how to better correlate interventions and indicators to outcomes, and how self reporting could support countries and organisations to link with the response among other MARPSs and indicators was held. Measuring the level of exposure that led to a particular behaviour change and reduction in transmission rate was given as an example. It was also suggested that broader health outcomes needed to be measured, such as outcomes about care and treatment. Therefore a broader understanding about the health sector and engagement with different stakeholders is required. A suggestion to identify broader nominators to include themes like violence and broader social sector issues was made. Participants were invited to think in the group work about how to measure coverage and intensity.

A discussion took place around the MSM and TG content in Global Fund Round 8 and Round 9 proposals in Asia and the Pacific and about how to increase the presence of MSM and TG work in GF programmes. A question was raised about what is meant by coordinated response to evaluation. It was suggested that the comprehensive package should be accompanied by an allocation of resources and a consensus among partners about who supports which components.

Finally, a discussion took place around size estimation issues. Good data is important for strategic prioritisation but because many MSM are hidden, health officials think there are not many MSM to target and allocate a budget for. Planning interventions and programmes is difficult, and better methodologies are needed to link communities and the health sector to improve estimation. UNAIDS announced a meeting to be held in August 2009 on size estimation in Asia with other partner organisations and country teams. Country teams will be asked to come with as much data they have on vulnerable groups. During the workshop, sharing and learning will take place around the combination of methods used. There is no single methodology to solve the problem and therefore the approach will be to combine all the information and to come with best estimates. A new method, the network scaling up method, will be presented and interested countries will be invited to test the tool. The workshop will facilitate participants to apply new knowledge and to advocacy initiatives that will lead to improve quality and to increase global and regional level coordination to increase the move ahead in harmonised manner beyond the technical work only.

Closing Remarks and Next Steps

Shivananda Khan, Chairperson, APCOM thanked all the organising partners and representatives of the different countries. He reminded participants that roughly three times the number of people in the workshop, around 199 people, become HIV-infected each day in Asia and the Pacific.

He argued for a broader definition of health for MSM and TG, beyond 'not HIV infected'.. He requested UNDP and WHO to better define what is understood by health. He stressed that it is important to have a broader sense of health, and to include wellbeing elements and emotional health as well. Wellbeing should be the focus in all programming. He highlighted that the Pacific region often feels ignored and explained that it is important to include them in discussions especially because they have very unique features.

Mr. Khan outlined that developed countries like Singapore, South Korea and Japan are not yet included in discussions and that responses and investments to address HIV and MSM, TG challenges in these countries are often very poor. He asked partner organisations to look at this. Finally, he talked about community engagement and said that the current movement is developing in new areas, new partnerships and includes multi sector responses. He stressed that the beneficiaries must not forget their own responsibility and said that he looked forward to increased coordination and partnership to implement the package.

Edmund Settle, HIV Policy Specialist, UNDP Asia Pacific Regional Centre highlighted two important recent developments in the response to HIV among MSM and TG: firstly, the increased joint collaboration among UN agencies; and secondly, the increase fostering of equal and direct relationships with community partners. He emphasised the importance and commitment of UNDP to continue this process and assured participants that the global framework would be regionalised. He thanked APCOM highlighting the increase in its work with government sector partners and donors on a variety of issues like increasing advocacy, coverage and investment. Mr. Settle illustrated this with

examples from the China and Philippines where national strategies and work plans are developed and resources allocated. Finally, he expressed his gratitude to ASEAN and the national governments that have also approached UN to respond to the epidemic. He applauded ASEAN's commitment and he reaffirmed UNDP's wish for closer and sustained partnership on this important regional issue.

Dr. Massimo Ghidinelli, Regional Adviser, WHO/ WPRO explained that WHO, as a newcomer to the partnership, highly appreciates the harmonised environment and the encouraging way partner organisations are moving forward. He highlighted the importance to deliver the package in partnership and to use the resource tool to jointly respond to HIV among MSM and TG. Dr. Ghidinelli reaffirmed WHO's commitment to the partnership and said that WHO will actively engage and continue to work in close collaboration. He referred to the partnership with APCOM aimed at establishing a sub-committee on health sector responses. Finally, he remarked that the process of implementation should not be forgotten, through the country offices and partner networks.

05 KEY TECHNICAL ASSISTANCE AND ORGANISATIONAL SUPPORT NEEDED FOR EFFECTIVE IMPLEMENTATION OF NATIONAL AND LOCAL RESPONSES

Below is a summary of the key technical assistance and organisational support needs identified by participants for effective implementation of national and local responses.

COMPREHENSIVE HIV PREVENTION FOR MSM AND TG

Partnership building, cooperation and synergies

- Develop cross-sector collaboration or partnerships and ensure effective structural interventions with MSM and TG and the wider community to scale up specialised, generalised and one-stop services that enhance universal access.
- Define appropriate cost of service delivery and price levels for different suppliers.

Resource mobilisation

As the region experiences an economic downturn it is critical to sustain and intensify efforts to ensure MSM and TG response are funded and scaled-up.

- Assure funding for country-level research on population size estimation.
- Advocate with government on the importance to scale up levels of national resource allocation and investment for MSM and TG response, especially to increase investment in Capacity Development.
- Identify investment areas to support e.g. (new) telecommunication and technology strategies.
- Identify specific financial resources for positive networks and other MARP organisations.
- Offer TA to countries on developing GF proposal budgets (i.e. finance specialists seconded to a country for 2-3 months to help develop GF budgets for proposals).

STRENGTHENING HEALTH SECTOR RESPONSES - TREATMENT, CARE AND SUPPORT

Accountability and effectiveness

- Support the development of tools and approaches such as monitoring and evaluation tools, audits, impact assessment to improve accountability, transparency and effectiveness.
- Conduct evaluation, audits, impact assessment to improve accountability and effectiveness.
- Strengthen the capacity of health providers to address all conditions related to the sexual health of MSM and TG.
- Support the development of cost-effective intervention toolkits for MSM. In order to prioritise the allocation of limited resources and maximise impact, targeted interventions should primarily focus on the most vulnerable MSM and TG who are at a higher risk for HIV infection, based on an analysis of the local situation.
- Continue to strengthen the quality and accessibility of HIV treatment, testing, care and support services for MSM and TG as a prevention tool and as a treatment and care strategy.
- Support technical capacity building of both governmental service providers and non-government service providers for delivering non-stigmatising MSM/TG-focused, high quality and confidential voluntary counselling and testing; and, appropriate and high quality STI diagnosis and treatment.
- Build organisational capacity (administrative, governance, finance, human resources, business and programme management) for organisations providing programmes and service delivery to MSM/TG.

Advocacy

- Increase advocacy initiatives to improve STI and HIV testing and treatment coverage and services.
- Provide specialized advocacy training for MSM/TG organisations

Rights based approaches

- Increase the use of human rights based approaches, including human rights indicators as part of monitoring and evaluation of programmes.
- Conduct a regional review on policy implementation of human rights.

Best practices and experiences sharing

Deepen understanding of the linkages between MSM, TG and STI, HIV epidemics and rights based approaches.

- Generate practical and applicable approaches to emerging challenges/issues and translate learning and discussions into real actions for implementation and up scaling.
- Develop case studies that capture (practical) experiences and best practices (also need to make available in local language).
- Develop mechanism for effective knowledge transfer.

ENABLING ENVIRONMENT

Capacity development and institutional strengthening

Strengthen the capacity of individuals, organisations and institutions.

- Conduct capacity needs assessments and support countries and stakeholders to develop capacity development strategies and plans.
- Upgrade skills and knowledge by providing technical capacity building and developing training packages and mentoring programmes for improved access to services.
- Conduct capacity development to increase skills and knowledge on human rights (approaches and advocacy mechanisms).

Advocacy

Advocacy efforts should focus on ensuring that the barriers to MSM and TG HIV prevention care are identified and removed

- Specific advocacy efforts and strategies are needed around law and policy reform and implementation.
- Identify and establish "watchdog" or oversight mechanisms to monitor compliance and collaboration in cross sector and/or ministerial effort.
- Increase the adoption of laws and policies to protect the basic rights of everyone (HIV discrimination, human rights, workplace, housing, immigration/travel)
- Support ways increase the inclusion of all marginalised people – including MSM and TG to participate and decide in the development, implementation and monitoring of programmes.

STRATEGIC INFORMATION

Research and data collection

Significant gaps in knowledge remain in Asia and the Pacific to assist in accurately understanding the dynamics and changing trends in HIV risk, vulnerability and impact in MSM and TG populations.

- Increase in-country skills and knowledge to conduct research and collect data complementary with external technical assistance. Support implementers to better use data to influence and negotiate with policy decision-makers.
- Support to conduct research and relevant studies to increase understanding of MSM/TG population size, characteristics, and coverage of MSM/TG (for planning and targeting), to better understand budgeting needs and requirements. Estimates are also required for other MARPs (IDU, FSW).
- Integrate MSM and TG issues the National AIDS Plan and HIV/AIDS costed operational plan. MSM and TG should also be considered in all cross-cutting sectors, including surveillance, social and behavioural research, M&E
- Develop tools, methods, indicators, targets including locally applicable methods for population size estimation

06 ANNEXES

Annex 1: Agenda

OBJECTIVE: To reach a consensus among government and civil society partners on the components of a comprehensive package of HIV-related services and supportive interventions for MSM in Asia and the Pacific, as a basis for national responses

DAY 1: Monday, 29 June 2009

Time	Topic	Resource Person
08.00 - 09.00	Registration	
09.00 - 09.30	Welcome	**Nicholas Rosellini** Deputy Assistant Administrator and Deputy Regional Director, UNDP Regional Bureau of Asia and Pacific
	Opening statements	**Dr. Bounpheng Philavong** Assistant Director Head of Health and Communicable Diseases Division Association of Southeast Asian Nations (ASEAN) **Caitlin Wiesen** Regional HIV/AIDS Practice Leader & Programme Coordinator Asia & Pacific UNDP Regional Centre **Dr. Massimo Ghidinelli** Regional Adviser, HIV/AIDS and STI World Health Organization - Western Pacific Region (WHO/WPRO) **Clif Cortez** Regional Team Leader, HIV/AIDS Office of Public Health, Regional Development Mission Asia (RDMA) U.S. Agency for International Development (USAID) **Mr. Shivananda Khan, O.B.E.** Chairperson, Asia Pacific Coalition on Male Sexual Health (APCOM) Chief Executive, Naz Foundation International
09.30 - 10.00	Objectives & design of the meeting Participant Introductions	**David Lowe and Paul Causey** Facilitators
Agenda Setting: HIV and men who have sex with men and transgender populations in Asia Pacific **Chair:** Edmund Settle, HIV Policy Specialist, UNDP Regional Center Bangkok		
10.00 - 10.45	Epidemiology of HIV infection among populations of MSM in Asia and the Pacific	**Frits van Griensven** Chief, Behavioural Research Section Thailand MOPH - US CDC Collaboration
	MSM and AIDS commission report	**Jan W. de Lind van Wijngaarden** Regional HIV and AIDS Advisor UNESCO Asia Pacific Regional Bureau for Education
	Consultation on Health Sector Response to HIV/AIDS Among Men Who Have Sex with Men - A Review	**Dr. Fabio Mesquita** Technical Officer, HIV/AIDS and STI World Health Organization - Western Pacific Region (WHO/WPRO)

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DAY 1: Monday, 29 June 2009 *(continuing...)*

Time	Topic	Resource Person
	UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People	**Edmund Settle** HIV Policy Specialist, MSM and Sexual Diversity, Asia Pacific Region UNDP Regional Centre Bangkok
	Questions and discussion	
10.45 - 11.15	Tea Break	
National Frameworks on MSM and HIV - Challenges and Lessons **Chair:** Dr. Ferchito L. Avelino, Director III, Secretariat of the Philippine National AIDS Council (PNAC)		
11.15 - 12.00	China	**Dr. Mi Guodong, M.D., PhD** National Center for AIDS/STD Control & Prevention (NCAIDS) China Center for Disease Control
	Cambodia	**Dr. Ros Seilavath** Deputy Secretary General Cambodian National AIDS Authority
	Indonesia	**Dr. Bagus Rachmat Prabawa** Coordinator for Care Support and Treatment, PMTCT and STI Prevention Indonesia National AIDS Commission
	Philippines	**Dr. Ferchito L. Avelino, Director III** Secretariat of the Philippine National AIDS Council (PNAC)
	Questions and discussion	
12.00 - 13.00	Lunch	
Session One: Comprehensive HIV Prevention for MSM and TG **Chair:** Rob Gray, Population Services International (PSI) Asia, Regional Advisor		
13.00 - 14.00	Defining Comprehensive Prevention among MSM and TG	**Rob Gray** Regional Advisor, Population Services International (PSI) Asia
	Minimum Package of Services	**Philippe Girault** Technical Advisor, Male Sexual Health FHI APRO
	Evaluating Community-based Response to HIV prevention for MSM: the amfAR/MSM Initiative Experience	**Annette Sohn** Director, TREAT Asia/amfAR
	Questions and discussion	
14.00 - 16.30	*Comprehensive HIV Prevention for MSM: small groups* Identify interventions and supportive activities, knowledge gaps and technical assistance needs	**David Lowe and Paul Causey** Facilitators
15.00	Tea Break: to be taken at a time chosen by each small group	
16.30 - 17.00	Brief key points reports from small groups *(3 minutes per group)*	**David Lowe and Paul Causey** Facilitators
17.00	Close of day 1	
18.00 - 19.30	**Welcome reception**	**Pool Side 8th Floor**

DAY 2: Tuesday, 30 June 2009

Time	Topic	Resource Person
Session Two: Strengthening Health Sector Responses - Treatment, Care and Support **Chair:** Dr. Massimo Ghidinelli, Regional Adviser, HIV/AIDS and STI, World Health Organization - Western Pacific Region (WHO/WPRO)		
09.00 - 10.00	Defining Health Sector Responses	**Dr. Massimo Ghidinelli** Regional Adviser World Health Organization - Western Pacific Region (WHO/WPRO)
	Improving access and utilisation of STI and VCT services by MSM	**Dr. Zhao Pengfei** Technical Officer World Health Organization, Vietnam
	Access to treatment and care among positive MSM in the region	**Addy Chen** Coordinator MSM Positive Working Group, Asia Pacific Network of People Living with HIV/AIDS
	Questions and discussion	
10.00 - 12.00	*Strengthening Health Sector Responses - Treatment, Care and Support: Small groups* Identify interventions and supportive activities, knowledge gaps and technical assistance needs	**David Lowe and Paul Causey** Facilitators
10.00	Tea Break: to be taken at a time chosen by each small group	
12.00 - 12.30	Brief key points reports from small groups (3 minutes per group)	**David Lowe and Paul Causey** Facilitators
12.30 - 13.30	Lunch	
Session Three: Enabling Environment **Chair:** Don Baxter, Co-Chair, Global Forum on MSM & HIV and Executive Director, Australian Federation of AIDS Organisations (AFAO)		
13.30 - 14.30	Defining an Enabling Environment	**Don Baxter** Co-Chair, Global Forum on MSM & HIV, Executive Director, Australian Federation of AIDS Organisations (AFAO)
	Capacity Mapping for Community-Based Organisations	**David J. Dobrowolski** Country Representative GMR Regional Coordinator, Pact Thailand
	Broadening Partnerships – Reaching Hidden MSM and their female partners	**Ashok Row Kavi** Technical Advisor Interventions among MSM, UNAIDS India
	Questions and discussion	
14.30 - 16.30	*Enabling Environment: Small groups* Identify interventions and supportive activities, knowledge gaps and technical assistance needs	**David Lowe and Paul Causey** Facilitators
15.00	Tea Break: to be taken at a time chosen by each small group	
16.30 - 17.00	Brief key points reports from small groups (3 minutes per group)	**David Lowe and Paul Causey** Facilitators
17.00	Close of day 2	

DAY 3: Wednesday, 1 June 2009

Time	Topic	Resource Person
	Session Four: Strategic Information **Chair:** Geoff Manthey, Regional Programme Advisor, UNAIDS	
09.00 - 10.00	Strategic Information and improving responses to MSM and HIV	**Geoff Manthey** Regional Programme Advisor UNAIDS Regional Support Team, Asia and the Pacific
	Developing MSM HIV Indicators and Evaluation Processes	**Ruth Bessinger** PhD Consultant Epidemiology, Monitoring, and Evaluation
	Questions and discussion	
10.00 - 12.00	*Strategic Information: Small groups* Identify interventions and supportive activities, knowledge gaps and technical assistance needs	**David Lowe and Paul Causey** Facilitators
10.00	Tea Break: to be taken at a time chosen by each small group	
12.00 - 12.30	Brief key points reports from small groups (3 minutes per group)	**David Lowe and Paul Causey** Facilitators
12.30 - 14.00	Lunch	
14.00 - 15.30	Consideration of a draft outline of the comprehensive package, based on the work of small groups, and development of a consensus on the key components	**David Lowe and Paul Causey** Facilitators
15.30 - 16.00	Tea Break	
16.00 - 16.45	Finalising consideration of the draft outline of the comprehensive package (continuation of previous session)	**David Lowe and Paul Causey** Facilitators
16.45 - 17.00	Closing remarks	**Mr. Shivananda Khan, O.B.E.** Chairperson Asia Pacific Coalition on Male Sexual Health (APCOM) **Edmund Settle** HIV Policy Specialist, MSM and Sexual Diversity, Asia Pacific Region UNDP Regional Centre
	Next Steps	**Dr. Massimo Ghidinelli** Regional Adviser World Health Organization - Western Pacific Region (WHO/WPRO)
17.00	End of meeting	

Annex 2: List of Participants

Cambodia

Ly Penh Sun, M.D, M.Sc
Deputy Director, National Center for HIV/AIDS, Dermatology and STD (NCHADS)
No. 170, Sihanouk Blvd., Phnom Penh, Cambodia, Tel/Fax: 855-23-216515/214556
Email : penhsun@nchads.org

Dr. Ros Seilavath
Deputy Secretary General, Cambodia AIDS Commission
No.226-232, Kampuchea Krom Blvd, Sangkat Mittapheap, 7 Makara District, Phnom Penh, Cambodia,
Office Tel: (855-23) 883 540, Office Fax: (855-23) 884 910
Email: seilavathmd@yahoo.com

China

Mi Guodong, M.D., PhD
National Center for AIDS/STD Control & Prevention, China CDC
27 Nanwei Road, Xuanwu District, Beijing, P.R. China, 100050, Tel: 86-10-63039082
Fax: 86-10-83153701
Email: mgdongcn@gmail.com

Zhang Wanyue
Intervention Group Leader
Center for HIV/STI Prevention and Control, Yunnan Center for Disease Prevention and Control
No.158 Dong Si Street, Kunming, 650022, Yunnan, P.R. China, Tel: 86-871-3630775
Email: ynaidsgy@126.com

Min Xiangdong
Centre for AIDS/STD Control and Prevention
Yunnan Provincial CDC
Email: mingxiangdong@126.com

Zhen Li
China MSM Forum & CIDA Civil Society Programme Coordinator
Room 101,Gate 7,Building 1, Yard 68, Fuchang Street, Xuanwu District
Beijing, China 100050, Tel/Fax: (86-10) 6833 9836
Email: cnmsmngo@gmail.com; li.zhen@cspfc.cn

Hong Kong (China)

Dr. Wong Ka-Hing
Consultant Physician, Special Preventive Programme, Department of Health
5/F, Yaumatei Jockey Club Clinic, 145 Battery Street, Kowloon, Hong Kong
Tel: 852- 2780 4390, Fax: 852-2780 9580
Email: khwong@dhspp.net; kh_wong@dh.gov.hk

India

Shri Subhash Chandra Ghosh
Technical Officer, National AIDS Control Organisation, 36 Chandralok Building, Janpath, New Delhi 110003, India, Tel 0091 11 9212584667.
Email: sgnaco@gmail.com

Vivek Anand
Chief Executive Officer, HST - Centre for Excellence, 3rd Floor, Transit Building
Old Vakola BMC Market, Nehru Road, Santacruz East, Mumbai 400055 India
Email: avivekr@gmail.com

Indonesia

Dr. Asik Surya, MPPM
Head of Standarisation, Sub-directorate of AIDS & STI
Directorare of Directly Transmitted Disease Control, DG, CDC & EH, MoH
Tel: +62-21 4240538, Mobile: +628179197167
Email: kingasik@yahoo.com

Dr. Bagus Rachmat Prabawa
Coordinator for Care Support and Treatment, PMTCT and STI Prevention
Indonesia National AIDS Commission Menara Executive Lt. 9, Jl. M.H. Thamrin Kav.9, Jakarta 12030, +62-21-3901758 ext.121
Email: bagus@aidsindonesia.or.id

Tono Permana Muhamad
Burnet Institute – Indonesia, GWL-INA Network National Secretariat, Menara Eksekutif Building 7th Floor, Jl. MH Thamrin Kav. 9, Jakarta 10330, Tel: +62 21 390 2611
Email: tono@burnetindonesia.org

Japan

Aikichi Iwamoto, M.D.
Regional Representative, Asia and the Pacific Islands, The International AIDS Society Professor Division of Infectious Diseases Advanced Clinical Research Center, The Institute of Medical Science, The University of Tokyo, 4-6-1 Shirokanedai, Minato-ku, Tokyo 108-8639, Japan
Tel: +81-3-5449-5359, Fax: +81-3-6409-2008
Email: aikichi@ims.u-tokyo.ac.jp

Lao PDR

Phengphet Phetvixay
Head of BCC/IEC and MSM focal point, Center for HIV /AIDS/ STI, Ministry of Health
Tel: +856 21 315500, Fax. : +856 21 562034
Email: phetvixay@hotmail.com; totohiv@yahoo.com

Vieng Akhone
Director, Lao Youth Action for AIDS Programme-LYAP
Thatlaung Road, Nongbon village, Xaysettha District VTC, Tel: +856-21-414812
Email: souriyo@lyap.org

Malaysia

Dr. Kanagalingam Kulasingam
Vice Chairman, Pink Triangle Foundation, 7C-1, Jalan Ipoh Kecil, Off Jalan Raja Laut
P.O. Box 11859, 50350, Kuala Lumpur, Tel: 603 4044 4611, Fax: 603 4044 4622
Email: kkkana@yahoo.com

Myanmar

Dr. Kyaw Soe
Divisional HIV/AIDS Officer, Ministry of Health, Mandalay,
Tel: 095-2- 21067, 095-67-411353, 411355 Fax: 096 -67-411016
Email: ihdmoh@mptmail.net.mm

Dr. Thit Sinn
Ministry of Health, Mandalay

Nay Oo Lwin
MSM Programme Manager, Population Services International (PSI) Myanmar, 124, Pyay Road, Mayangone Township, Yangon, Myanmar, Tel: + 95-1-662 927/667 091
Emal: nayoolwin14@gmail.com

Yi Yi Cho
Field Office Coordinator, Care International in Myanmar, 73 Manawhari Street, East Pyi Road Ward, Dagon Township, Yangoon - Myanmar
Email: yycho@care.org.mm

Pacific

Jovesa Saladoka
Behaviour Change Communication Officer, HIV and STI Section, Public Health Programme
Secretariat of the Pacific Community, BP D5, 98848 Noumea Cedex, New Caledonia
Tel: 687-26-20-00, Fax: 687-26-38-18
Email: jovesas@spc.int

Philippines

Dr. Ferchito L. Avenino, MD, MPH
Director III, Secretariat of the Philippine National AIDS Council, 3rd Flr., Bldg 15, Department of Health , San Lazaro Cmpd, Sta Cruz,Manila, Philippines
Email: fl_avelino@yahoo.co.uk

Anastacio Marasigan
Executive Director, TLF Share, Office: 2580 A. Bonifacio Street, Bangkal, Makati,
Tel/Fax: (632) 751-7047
Email: tlfmanila@gmail.com; tacing2401@yahoo.com

Noemi D. Bayoneta-Leis
Project Coordinator, Health Action Information Network, Inc. (HAIN)
26 Sampaguita Ave., Mapayapa Village II, Bgy. Holy Spirit, Capitol District 1127,
Queson City, Philippines. Tel: (+632) 952 6409; 952 6312, Fax (+632) 952 6409
Email: noemi.leis@hain.org

Singapore

Dr. Stuart Koe
Chief Executive Officer, Fridae.com, 26 Kallang Place, #03-10 Singapore 339157,
Tel: 65 9875 7670, Fax: 65 6234 6308
Email: stuart.koe@fridae.com

Thailand

Dr. Pachara Sirivongransan
Director of Bureau of AIDS, TB and STIs, Department of Disease Control
Email: pasirivong@yahoo.com; psirivong@hotmail.com

Yupin Chinsa-nguankeit
Public Health Technical Officer, AIDS cluster, Bureau of AIDS, TB and STIs,
Department of Disease Control
Email: yupin_kyn@yahoo.com

Kanitha Tantaphan
Policy Analysis and Planning, AIDS cluster, Bureau of AIDS, TB and STIs, Department of Disease Control
Email: kanitha@health.moph.go.th

Kosol Chuenchomsakulchai (Owie)
Programme Manager, Rainbow Sky Association of Thailand (RSAT), 159 The Beach Residence Building, Soi-Chokchairuammitr (Ratchadapisek 19), Wipawadi-rangsit Rd., Dindaeng district, Bangkok 10320,
Tel: +66-2-690 7733 (-4), Fax: +66-2-690 7735
Email: kosol@rsat.info

Viet Nam

Nguyen Duc Long
Harm Reduction Section, Vietnam Administration of HIV/AIDS Control
No. 135/3, Nui Truc Street, Ba Dinh District, Hanoi, Tel: (84-4) 736 7130, Fax: (84-4) 846 5732
Email: longyri@yahoo.com

Vu Ngoc Bao, MD, MA
Programme Manager, Family Health International/Vietnam, 3rd floor, 1 Ba Trieu Street
Hoan Kiem District, Hanoi, Vietnam, Tel: 84-4-3934-8560, Fax: 84-4-3934-8650
Email: bao@fhi.org.vn

Representatives and Resource Persons

Asia Pacific Coalition on Male Sexual Health (APCOM)

Shivananda Khan, O.B.E.
Chairperson, Asia Pacific Coalition on Male Sexual Health, and Chief Executive, Naz Foundation International, Regional Office, 9 Gulzar Colony, New Berry Lane, Lucknow 226001, India,
Tel: +91 (0)522 2205781/2, Fax: +91 (0)522 1105783
Email: shiv@nfi.net

Asia Pacific Network of People Living with HIV/AIDS (APN+)

Addy Chen
Coordinator MSM Positive Working Group
Asia Pacific Network of People Living with HIV/AIDS
Email: addy@apnplus.org; chenaddy@gmail.com

Association of Southeast Asian Nations (ASEAN) Secretariat

Bounpheng Philavong
Assistant Director, Head of Health and Communicable Diseases Division, Association of Southeast Asian Nations (ASEAN), Sisingamangaraja 70A – Jakarta 12110,
Tel: +62-21 724 3372 Ext. 423, Fax: +62-21 739 8234
Email: b.philavong@asean.org

Rachmat Irwansjah
Technical Officer, Health and Communicable Diseases Division, Association of Southeast Asian Nations (ASEAN), Sisingamangaraja 70A – Jakarta 12110, Telp: +62-21 724 3372 Ext. 423, Fax: +62-21 739 8234
Email: rachmat@asean.org

Australian Federation of AIDS Organisations (AFAO)

Don Baxter
Co-Chair, Global Forum on MSM & HIV, and Executive Director, Australian Federation of AIDS Organisations (AFAO), Box 51, Newtown, NSW, 2042, Australia, Tel: 61-2-8568-1100, Fax: 61-2-9557-9852
Email: Dbaxter@afao.org.au

Burnet Institute

Brad Otto
Asia Regional Representative, Burnet Institute
Email: blotto@burnet.edu.au

Family Health International, Asia Pacific Regional Office

Philippe Girault
Male Sexual Health, Technical Advisor, Family Health International, Asia Pacific Regional Office
19th floor, Tower 3, Sindhorn Building, 130-132, Wireless Road, Lumpini, Phatumwan,
Bangkok 10330, Thailand, Tel: +66 2-263-2300 (office)
Email: pgirault@fhi.org

Health Policy Initiative Project/Greater Mekong Region-China, RTI International

Felicity Young
Chief of Party, Health Policy Initiative Project/Greater Mekong Region-China, RTI International
Email: fyoung@hpi-asia.rti.org

Tracy Cui Shicun
Policy and Advocacy Officer, Policy Initiative Project/Greater Mekong Region-China, RTI International
Email: scui@hpi-asia.rti.org

Pact Thailand

David J. Dobrowolski
Country Representative/GMR Regional Coordinator, Pact Thailand
Silom Complex Building, 21st Floor, Room 2A, 191 Silom Road, Silom, Bangrak; Bangkok 10500 Thailand, Tel: (+66.2) 231 3402-4, Fax: (+66.2) 231 3406
Email: ddobrowolski@pactthailand.org

Population Services International (PSI)

Rob Gray
Regional Advisor, PSI Asia & Injecting Drug Use (IDU) Technical Expert
Lao office: (856 21) 353-411, Thai office: (66 02) 655-4001, Lao mobile: (856 20) 551-5995
Email: robgray@laopdr.com

Habibur Rahman
Programme Director, Population Services International (PSI) Myanmar, 124, Pyay Road, Mayangone Township, Yangon, Myanmar, Phone + 95-1-662 927/667 091
Email: hrahman@psimyanmar.org

Thailand MOPH-U.S. CDC Collaboration

Frits van Griensven
Chief, Behavioural Research Section, Thailand MOPH-U.S. CDC Collaboration
Email: fav1@th.cdc.gov

TREAT Asia, amfAR – The Foundation for AIDS Research

Annette H. Sohn, MD
Director, TREAT Asia, amfAR – The Foundation for AIDS Research
Exchange Tower, 388 Sukhumvit Road, Suite 2104, Klongtoey, Bangkok 10110, Thailand,
Office: +66 2 663 7561, Fax: +66 2 663 7562
Email: annette.sohn@treatasia.org

Jennifer Ho
Manager, Community Programmes, TREAT Asia, amfAR – The Foundation for AIDS Research
Exchange Tower, 388 Sukhumvit Road, Suite 2104, Klongtoey, Bangkok 10110, Thailand,
Email: jennifer.ho@treatasia.org

Sitthiphan Boonyapisomparn (Hua)
MSM Programme Coordinator (PSN), TREAT Asia, amfAR – The Foundation for AIDS Research
Exchange Tower, 388 Sukhumvit Road, Suite 2104, Klongtoey, Bangkok 10110, Thailand,
Email: hua.boonyapisomparn@treatasia.org

U.S. Agency for International Development (USAID)

Clif Cortez
Regional Team Leader, HIV/AIDS, Office of Public Health, Regional Development Mission Asia (RDMA),
U.S. Agency for International Development (USAID)
Email: ccortez@usaid.gov

United Nations Development Programme (UNDP)

Nicholas Rosellini
Deputy Assistant Administrator and Deputy Regional Director, UNDP Regional Bureau of Asia and
Pacific, UNDP Regional Center Bangkok, 3rd Floor, UN Service Building
Rajdamnern Nok Avenue, Bangkok, Thailand 10200
Email: nicholas.rosellini@undp.org

Caitlin Wiesen
Regional HIV/AIDS Practice Leader & Programme Coordinator Asia & Pacific
UNDP Regional Centre, 23 Independence Avenue,
Colombo 7, Sri Lanka, Tel: +94 (11) 4526400 ext. 150, Fax: +94(11)4526410
Email: caitlin.wiesen@undp.org

Edmund Settle
HIV Policy Specialist, MSM and Sexual Diversity, Asia and Pacific Region
UNDP Regional Centre Bangkok, 3rd Floor, UN Service Building
Rajdamnern Nok Avenue, Bangkok, Thailand 10200,
Tel: +66 (0) 2288 2918, Fax: +66 (0) 2288 3032, Mobile: +66818369300
Email: edmund.settle@undp.org

Alka Narang
HIV Focal Point, UNDP India, New Delhi, India
Email: alka.narang@undp.org

Azrul Mohammed Khalid
UN HIV and AIDS Coordinator, UNDP Malaysia, Kuala Lumpur, Malaysia
Email: azrul.mohd.khalib@undp.org

United Nations Educational, Scientific and Cultural Organisation (UNESCO)

Jan W. De Lind van Wijngaarden
Regional HIV and AIDS Advisor, UNESCO Asia Pacific Regional Bureau for Education
Email: j.wijngaarden@unesco.org

Rapeepun Jommaroeng
Thailand HIV Focal Point, HIV Coordination, Adolescent Reproductive and School Health Unit
UNESCO Asia-Pacific Regional Bureau for Education
Email: r.jommaroeng@unesco.org

World Health Organization (WHO)

Dr. Massimo Ghidinelli
Regional Adviser, HIV/AIDS and STI, World Health Organisation, Western Pacific Regional Office
United Nations Avenue, 1000, Manila, Philippines
Email: ghidinellim@wpro.who.int

Dr. Fabio Mesquita
Technical Officer, HIV/AIDS and STI, World Health Organisation, Western Pacific Regional Office
United Nations Avenue, 1000, Manila, Philippines
Email: mesquitaf@wpro.who.int

Dr. Zhao Pengfei
Technical Officer (HIV Prevention), World Health Organisation, 63 Tran Hung Dao Street
Hoan Kiem District, Ha Noi, Viet Nam, Tel: 8610 65327190 ext. 609, Fax: 844 943 3740
Email: zhaop@wpro.who.int

Dr. Mukta Sharma, PhD.
Technical Officer, Harm Reduction, HIV/AIDS Unit, WHO SEARO, New Delhi, India
Tel: +911123370809-11, Ext: 26639
Email: sharmamu@searo.who.int

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Geoff Manthey
Regional Programme Advisor, Management and UN Coordination,
UNAIDS Regional Support Team, Asia and the Pacific
Email: mantheyg@unaids.org

Ben Bavinton
Regional Capacity Development Officer - MSM, UNAIDS Regional Support Team Asia-Pacific
Email: Email: bavintonb@unaids.org

Ashok Row Kavi
Technical Advisor, Interventions among MSM, UNAIDS India
Email: rowkavi@gmail.com

Albion Street Centre – WHO Collaborating Centre

Dr. Timothy Barnes
Albion Street Centre, 150 Albion Street Surry Hills, NSW 2010 Australia
Tel: +61 2 93329611, Fax: +61 2 93316519
Email: tim.barnes@sesiahs.health.nsw.gov.au

Michael Buggy
Senior Social Worker/Assistant Director, Albion Street Centre, 150 Albion Street
Surry Hills, NSW 2010, Australia, Tel: +61 2 9332 9742, Fax: +61 2 9360 3243
Email: michael.buggy@sesiahs.health.nsw.gov.au

AIDS Projects Management Group

Lou McCallum
Director
AIDS Projects Management Group, Suite 108/1 Erskineville Road, Newtown NSW 2042
Email: lou@aidsprojects.com

Scott Berry
Asia/Pacific Regional Coordinator
AIDS Projects Management Group, Suite 108/1 Erskineville Road, Newtown NSW 2042
Email: scott@aidsprojects.com

MEASURE Evaluation

Ruth Bessinger
PhD Consultant, Epidemiology, Monitoring, and Evaluation, MEASURE Evaluation
337 Iliaina Street, Kailua, HI 96734, Tel/Fax: 1-808-254-5075 (HST)
Email: ruth@bessinger.us

Meeting Facilitators

David Lowe
HIV consultant
Email: davidbkkth@yahoo.com

Paul Causey
HIV consultant
Email: paul@revisionasia.com

Annex 3: Group work

For a full summary of the group work see the **APCOM** website at **www.msmasia.org**

GROUP WORK SESSION 1

Comprehensive HIV prevention for MSM to identify interventions and supportive activities, knowledge gaps and technical assistance needs

Key objectives were listed around the following themes: Universal access – all people regardless of subpopulation should have free access to prevention and care service and the scale up of specialised, generalised and one-stop services to a wider audience (incl. positive MSM, female, TG, "hard-to-reach MSM"). Hence:

- To define the appropriate cost of service delivery and define packages and price levels for different suppliers (e.g. government, NGOs)
- To develop strong community linkages and community leaders, define civil society contribution and increase good governance and transparency practices in communities
- To reduce HIV and STI infection among MSM and to reduce overall risk and vulnerability
- To identify the appropriate level of institutional engagement and interventions that focus on legislators and policy makers, administrators, implementers, national and regional authorities
- Document good practices and case on how to address challenges and overcome obstacles
- Build capacity to increase advocacy skills
- Develop a social marketing and communication strategy and develop targets to monitor impact, effectiveness and efficiency and coverage
- Design a partnership strategy with the government in the use of (new) telecommunication and technology structures and support with resource mobilisation
- Build capacity and give technical advice to media people on MSM, TG and involve CBOs, NGOs and the governments

Several new approaches were suggested like designing internet based strategies to reach more positive TG and MSM, and using internet as a medium for peer support, engagement, networking, research and as communication channel. Also, different ways to improve and increase engagement with the community were discussed. Increased levels of social research among MSM with HIV will increase understanding about social, behavioural, longitudinal issues (eg research to understand how to increase condom use/ safer sex). Research should focus more on contextual country mapping (incl. legislative, policy, cultural, religious and social barriers) and the mapping of actions that governments need to take in order to provide an enabling environment. Other approaches related to the conduct of needs assessments (eg for prevention programmes) and the need to develop a quality measurement system for services. New approaches should increase MSM and TG participation and decision making in the development, implementation and monitoring of programmes.

GROUP WORK SESSION 2

Strengthening health sector responses- treatment, care and support to identify interventions and supportive activities, knowledge gaps and technical assistance needs

Key objectives and areas to increase effective support for implementation of national and local responses were formulated as:

- Clarify definitions (e.g. the health sector should also include elements of physical and mental well-being) and develop universal guidelines
- Develop and upgrade skills and knowledge by providing technical capacity building and facilitating training package) to public health services, doctors, NGOs, counsellors, nurses etcetera to increase access and to improve the quality of MSM/TG friendly services
- Improve linkages between MSM and TG community services
- Conduct evaluation, audits, impact assessment to improve accountability and effectiveness
- Identify a "watchdog" or oversight mechanism to monitor compliance
- Increase advocacy to improve STI and HIV coverage and better service
- Develop cross sector/ multi-ministerial collaboration or partnerships and ensure effective structural interventions. Design a structure which institutionalises cross sector collaboration
- Create awareness and build capacities to address the issues of stigma and discrimination
- Increase the use of human rights based approaches, incl. human rights indicators as part of monitoring and evaluation of programmes

The group report back on HIV counselling and testing highlighted that the package should refer to HIV counselling and testing, not to VCT or PITC only. They highlighted the need for adequate counselling and testing locations within the broad continuum of the response to HIV while focus on the goals:

1. As a prevention tool - to help people understand their risk, reinforce safe behaviour
2. As a treatment and care tool - to provide knowledge of HIV status, channel people with HIV into treatment and care and assist them in avoiding onward transmission

GROUP WORK SESSION 3

Enabling environment to identify interventions and supportive activities, knowledge gaps and technical assistance needs

Key objectives for this area related to self-direction/empowerment (e.g. beneficiaries should stand on their own at the end of the process (planning, implementation, decision making process). Also, the importance of ownership building was mentioned, starting from planning to implementation. Through increased partnership/linkages between communities and governments approaches and decision making processes should be more inclusive, e.g. the MSM/TG community should be represented on government policy-making bodies. MSM/TG community representation should be included on national and provincial/local AIDS Committees. Advocacy should take place with policy makers to ensure that thye interact with MSM and TG populations to better understand their issues by providing evidence and better data and research.

All stakeholders should increase the adoption of general laws and policies to protect everyone (human rights laws, (ILO) workplace laws. Policies should be more culturally sensitive (e.g. push for policies and laws that reflect cultural or religious values/social order) and should address the issues of marginalised groups to protect the rights of people and encourage diversity. Policy implementation needs to be monitored.

Management and leadership development at all levels (among a wide range of stakeholders) should be in place. Currently, capacity development is very service-oriented (like peer outreach, condom distribution

only) but more general organisational development and institutional strengthening is required. Specific capacity development plans and investments should to be developed.

The key knowledge gap was identified as the lack of best practice and sharing of experiences of what works on community mobilisation, how to engage communities to contribute to the reduction in HIV prevalence and how to build strong institutions. Also the lack of availability of resources in local languages and simplified language was felt as a barrier. A particular challenge relates to the lack of MSM/TG skills and knowledge of human rights approaches.

It was suggested that a regional review on policy implementation of human rights should take place. Also, the lack of experiences and skills to design successful approaches for advocacy, especially in countries where many religious leaders are likely to oppose MSM and TG HIV prevention strategies, is an issue. This is equally important for Muslim and Christian faith religious leaders.

GROUP WORK SESSION 4

Strategic information to identify interventions and supportive activities, knowledge gaps and technical assistance needs

Understand coverage of MSM services (for planning and targeting) and to better understanding budgeting needs and requirements were identified as priorities. The group highlighted that more (recent) international discussion focuses on universal access. Therefore a size estimation of MSM and TG populations is crucial to be able to advocate where universal access programmes can support interventions. Size estimation that is country specific and contextualised should provide better baseline information (incl. risk behaviours, mapping of cruising areas). Programmes should be culturally-sensitive and in certain countries, MSM and TG issues should be integrated into the National AIDS Plan and/or HIV/AIDS operational plan. MSM and TG should also be considered in all cross-cutting sectors, including surveillance, social and behavioural research, M & E.

Estimates are also required for other MARPs (IDU, FSW). Stakeholders should have consensus about categories, data collection, approaches for estimating population size and define universal denominators (incl. defining the difference between denominator ranges of MSM in a country and denominators for most-at-risk MSM within that range). Governments cannot always provide guidance. There is a lack of tools, methods and an international standard methodology. There is a need for locally applicable methods for population size estimation that is acceptable to government). Implementers need persuasive methods to influence and negotiate with policy decision-makers (an example was given related to the lack of data collection methodologies to identify the highest-risk MSM using internet).

Group consensus was reached around two issues that need to be separated:

- Firstly, the range of all MSM should be defined as any male engaging in sex with another male
- Secondly, within this larger number, the range of highest risk MSM should receive the focus of HIV targeted interventions and resources. A suggestion was given that this second denominator should focuses on local "hotspot" for MSM behaviour (could be a city, a district or country)

Finally, a demand was expressed to increase in country skills and knowledge to conduct research and collect data complementary with "external / outside" technical assistance (demographers with understanding of MARPs/MSM). Thus, investments should more focus on Capacity Development areas. Key knowledge gaps holding back programme design and development were seen as:

- Information of risk behaviour is not well-understood especially among young people
- Achievements are not well documented and not widely shared (a platform or portal or a hub of information should be built and widely shared)
- Lack of guidelines for STI testing, no standardisation
- Lack of tracking systems for individuals rather than just using contacts like using cards, asking people to recall
- Gaps in knowledge about the effectiveness of programmes or packages

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Regional HIV & Development Programme for Asia & the Pacific
UNDP Regional Centre for Asia Pacific, Colombo
23, Independence Avenue,
Colombo 07, Sri Lanka

Telephone: +94 11 4526 400
Fax: +94 11 4526 400
Email: rcc@undp.org
Web: www.undprcc.lk