



Ensuring Universal Access to Comprehensive HIV Services for MSM in Asia and the Pacific

Determining Operations Research Priorities to Improve
HIV Prevention, Treatment, Care, and Support Among
Men Who Have Sex With Men

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Executive Summary

This report summarizes an assessment that was carried out in early 2009 to identify priorities for operations research to better understand effective models for HIV prevention, treatment, care, and support among men who have sex with men (MSM) in Asia and the Pacific.

What We Know

Significant HIV epidemics now exist among populations of MSM in many parts of Asia and the Pacific. In China, it is estimated that MSM are up to *45 times more likely to be HIV-positive* than the general population.¹ In Thailand, MSM are *20 times more likely*, and surveillance figures estimate that more than 28% of the MSM population has HIV.² A recent study in Lao PDR suggests that MSM could account for up to 75% of all new infections.³

Current statistics likely describe only a fraction of MSM at risk for HIV. There are many more MSM than those who identify as gay or transgender. In Asia, as in many other places in the world, there are men who have sex with both men and women but do not identify as gay or do not associate any particular identity with their sexual behavior.⁴ The Asian Epidemic Model estimates that there are 10 million MSM in Asia, some of whom have sex with women or are married.⁵ It also predicts that if HIV prevention does not improve from 2007 levels, MSM will soon account for the largest proportion of people living with HIV in Asia.⁶

Despite these alarming estimates, rates of HIV infection among MSM in Asia and the Pacific have largely been hidden. MSM have not been a focus of sentinel surveillance programs; indeed a recent UNAIDS study of 20 countries in Asia reported that 60% of national surveillance mechanisms did not include MSM in their data collection and 15% did not collect behavioral and HIV infection data among MSM.⁷

Hundreds of small and medium-sized programs in Asia and the Pacific are now trying to reach MSM with HIV interventions. Most are nongovernmental and focus on raising awareness about HIV and conducting outreach to men assumed to be most at risk, such as those found at public venues for sex or social gathering. Very few of these HIV programs provide a full range of social and clinical

If HIV prevention does not improve, MSM will soon account for the largest proportion of people living with HIV in Asia.

services including sexually transmitted infection (STI) and HIV treatment and care. Some programs provide voluntary HIV testing and counseling, while others refer clients to MSM-friendly testing and counseling services. Some are linked to public or private hospitals and clinics, where they are able to help reduce the stigma and discrimination that MSM experience and can help health workers establish policies, procedures, and attitudes that encourage the use of these services by MSM.

However, most MSM are also not being reached by HIV programming. The rates of HIV prevention program coverage for MSM across Asia and the Pacific are staggeringly low—estimated at an average of 2% across 11 South and Southeast Asian countries in 2005.⁸ More research is needed to apply existing knowledge: that effective HIV prevention, treatment, care, and support programs can allow people at risk of HIV infection and those with HIV to gain the knowledge, means, and individual and social capacity to avoid acquiring or transmitting HIV and to access appropriate health and community services.

What We Need to Know

Nongovernmental organizations (NGOs) support MSM programs in several countries in Asia but there is little information about how to assist them in scaling up their operations and services to reach larger numbers of MSM in different geographical areas. There is also little information about the most appropriate package of interventions to offer in each setting and to each sub-population, or about the tipping point of frequency and scale that would bring about a significant long-term decline in new infections.

Long-term progress against HIV across the diverse populations of MSM can only be achieved if there is a clear understanding about *how* to reach MSM who are most at risk for HIV and AIDS, what sort of information they would respond to, and the kinds of services they would need and use.

Initial Recommendations for Establishing an Operations Research Agenda

Develop Alternate Intervention Models: Two distinct service models emerged from this assessment. The first involves supporting MSM NGOs in their efforts to integrate STI and HIV clinical services into their overall HIV prevention and care programs. This model is in place in several MSM NGOs across the region. The second model involves increasing access for MSM to existing mainstream STI and HIV prevention and care services. This usually involves hiring MSM staff, training all staff in MSM sensitivity, training medical and nursing staff in STI prevention and treatment for MSM, and adjusting opening hours to increase access. A third possible model is a hybrid of these two and involves setting

up MSM clinics run by mainstream health or community NGOs that provide clinical services and a safe space for MSM to gather and support one another.

Map Currently Available Services: This assessment was aimed at identifying the range of models in current use and examining how they might be expanded or tested. An important next step would be to carry out a more comprehensive mapping exercise that would examine in detail the characteristics of each of the models being used and compile what is known about access levels, reach into sub-populations, quality of care, and longitudinal engagement with MSM.

Conduct Regional Consultations With Key Stakeholders:

The operations research agenda needs a high level of local relevance and ownership. This requires regional, national, and local input from individual and group consultations to identify local needs and concerns, special considerations, potential obstacles, opportunities for collaboration, and so on.

Assess Logistical Factors: For this operations research to provide relevant information for the field in the most expeditious manner, it will need to build on existing work. That means identifying sites where interventions for MSM HIV prevention, treatment, and care are in place, and helping the organizations and groups working in those settings to formalize and strengthen the approaches they are using, expand their reach and range of services, and put in place an operations research framework to provide answers to a set of measurable questions. The sites will require assistance in choosing which models to adopt or expand, resources to carry out this expansion, technical guidance on establishing the operations research framework, and assistance in conducting, analyzing, and reporting on the research.

Determine Potential Opportunities for International and Regional Collaboration:

Strengthening high-quality, evidence-based MSM HIV prevention and care interventions across Asia and the Pacific requires establishing a set of foundation documents to provide policy guidance, regionally relevant best practices, and evidence for action. The global documents developed to support HIV prevention and care among injecting drug users (IDUs) are a good example of this foundation and were used extensively to build more consistent, high-quality practice in that area. Several of these key foundation elements exist already in the Asia-Pacific region but these will need to be compiled, further developed, and promoted. This will require broad collaboration by regional groups such as the Asia Pacific Coalition on Male Sexual Health (APCOM), the Asia Pacific Council of AIDS Service Organisations (APCASO), and the Asia Pacific Network of People Living with HIV/AIDS (APN+); UN organizations such as UNAIDS, UNDP, UNESCO, and the World Health Organization (WHO); key regional donors such as USAID, the U.S. Centers for Disease Control and Prevention's Global AIDS Program (CDC GAP), and AusAID; and other key regional players such as Family Health International (FHI), Pact, the International HIV/AIDS Alliance, amfAR, and the Gates Foundation.

Develop Standards and Guidelines: It is essential that the expansion of MSM HIV prevention and care services across Asia be driven by an agreed set of quality standards and guidelines. Most of the elements of these standards already exist or can be adapted from standards and guidelines being used in other places.

Address Funding Considerations: MSM HIV prevention and care programs and services are funded in several countries in the region through a range of mechanisms. USAID-funded agencies such as FHI and others support programs in several countries. Some MSM groups receive, or are about to receive, funds from principal recipients of Global Fund grants. Others are funded as part of donor country allocations to recipient countries under national AIDS strategies. Although all of these programs have their own monitoring and evaluation frameworks and performance/impact indicators, it would be desirable for this operations research to work alongside services and programs that are receiving their core operational funding from other sources. The operations research resources could then be used to maximum effect by focusing on issues of model clarification and strengthening, and service consistency and quality.

Key Questions That Need to Be Addressed

1. What is the optimal spectrum of services that support HIV prevention and care among MSM?
2. What are the best strategies to engage diverse populations of MSM?
3. What are the best ways to track service delivery, utilization of services by MSM, and the effects of services?
4. What is required to establish and disseminate an MSM-specific standard of care?

Operations Research to Obtain Answers to These Questions

amfAR believes that operations research can provide policymakers and national program managers with new options, generating compelling evidence about program models that engage heavily affected populations with an appropriate spectrum of services in a manner that reduces HIV transmission and minimizes the impact of HIV infection. A key focus of this operations research should be the identification of program models that have significant reach into MSM populations, that are replicable across many settings, and that produce sustained HIV prevention and care outcomes.

This operations research could also generate evidence required by national governments to embed an effective range of MSM HIV prevention and care services into their national AIDS strategies, national AIDS programs, and donor initiatives such as those funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Introduction

This report summarizes an assessment that was carried out in early 2009 to identify priorities for operations research to better understand effective models for HIV prevention, treatment, care, and support among MSM in Asia and the Pacific.

It is critical that a clear understanding of the forces that drive the HIV epidemic among MSM be developed, country by country and setting by setting, so that programs and interventions can be tailored more precisely. This understanding needs to focus on exactly how to reach different sub-populations of MSM with the right mix of messages and services, and with the necessary frequency, to help ensure sustained, safer behavior and long-term use of health and community support services. This will involve long-term partnerships with MSM organizations and the populations they serve, but it also demands significant efforts to reach those MSM who do not gather in communities and do not derive an identity from the sex they have with other men.

The challenge is to reach MSM with proper information, support, and care, through sources they find trustworthy, safe, credible, and that they will return to again and again.

This report recognizes that the term “men who have sex with men” (and its shorthand, “MSM”), while problematic, was constructed to take the discussion beyond Western gay-identified men and to open up the possibility of targeting all men who may be at risk for or are living with HIV as a result of their sexual activity with other men (See Appendix B).

For MSM, as for most people, there is a significant gap between knowing the risks of HIV or knowing one’s HIV status on the one hand, and being able to take actions to minimize risk or maintain one’s health on the other. The challenge for the response to HIV among MSM is to reach MSM with proper information, support, and care, through sources they find trustworthy, safe, credible, and that they will return to again and again. The ultimate goal is to understand these broad constructs well enough to promote health-seeking behavior among MSM in Asia and the Pacific with a view to sustaining HIV prevention among MSM and adequately supporting those living with the virus.

Key Messages

This report aims to provide:

- A summary of recent history leading to the current focus on MSM in Asia and the Pacific;
- An analysis of community, identity, space, and sexual desire and behavior among MSM and transgendered people for the purposes of developing policy, strategy, and service programming (see Appendix B);
- Examples of current successful community and facility-based services targeting MSM and transgendered people in Asia and the Pacific (see Appendix C);
- Key recommendations for operations research to improve the quality and reach of HIV prevention, treatment, care, and support services and programs for MSM and transgendered people in Asia and the Pacific.

Methodology

This assessment involved a desk review of the formal and informal literature describing the response to HIV among MSM in Asia and the Pacific, along with visits to selected services and NGOs in Malaysia, Cambodia, Thailand, Vietnam, India, and Nepal. It was not intended as a formal evaluation of the services and programs that were visited. The intention of this assessment was to examine the models that are being used to reach MSM with HIV prevention and care information, as well as voluntary counseling and testing (VCT), and STI and HIV clinical services.

What Is Known About MSM and HIV Risk in Asia and the Pacific

How Did It Get to This?

Despite the vulnerability of MSM to HIV/AIDS, until recently little attention has been focused on these communities in Asia. Stigma and discrimination have marginalized MSM and rendered them invisible, and the result is that the unique prevention and treatment needs of these populations have largely been ignored.⁹

The rising rates of HIV among MSM in Asia and the Pacific remained hidden for many years as governments, international NGOs (INGOs), and multilateral agencies focused on preventing and responding to HIV among the general population and in other most-at-risk populations. Behavioral and other studies demonstrate the damaging results of this focus—MSM may have interpreted the fact that organizations focused on the general population (and remained relatively silent on MSM risk) to mean that sex between men presents a low risk for HIV. In some cases, men have been choosing sex (including unprotected sex) with other men because they believe sex with women, including female sex workers, poses the real risk for HIV transmission.^{10,11}

This is not to say that there have not been MSM initiatives in Asia during this time. Donors have provided funding to MSM organizations in several countries, primarily to support HIV awareness, drop-in centers, and outreach to MSM at sites of sex. Some donors have provided community VCT, mobile STI clinics, and clinical services within NGOs and community-based organizations (CBOs). While these programs and services have had some impact on the individuals and communities they have reached, the scale of their reach into communities and their duration have typically been limited, and they have generally been disconnected from the mainstream HIV response in the country. Because these programs have been primarily project-based, they have also not usually provided MSM community organizations with the stability of funding they require to mature and grow, forcing them to move frequently between donors to shore up their core budgets.

A number of researchers and NGOs have been sounding the alarm on MSM and HIV in Asia for some time. As early as 1992, some questioned the focus on the general population and other most-at-risk populations to the exclusion of MSM, but these voices were in the minority and largely ignored.¹² Almost a decade later, sex between men was still receiving very little attention. Some have attributed this to local,

national, and regional homophobia, and, internationally, to “a backlash against gay men’s involvement in HIV and a backlash against focusing on MSM and gay men in HIV work.”¹³ Gay community leaders working in INGOs along with multilateral and donor agencies were “trying hard not to be seen as working on too many gay issues.”¹⁴ There are now many reports that criticize national governments for a lack of action and recommend that governments adjust their national strategies to add a scaled-up focus on HIV prevention and care among MSM. There are few reports, however, urging INGOs, multilaterals, and donor agencies to reflect on their own history of ignoring MSM and calling upon them to institute the policy and technical guidance framework that has driven the scale-up of response among other most-at-risk populations. A question remains unanswered: When so many resources are devoted to HIV, how could the entire

When so many resources are devoted to HIV, how could the entire international community have overlooked or simply ignored the rapidly rising rates of HIV infection among MSM?

international community have overlooked or simply ignored the rapidly rising rates of HIV infection among MSM? In order for all stakeholders to move forward confidently in responding to MSM, it is important to examine the questions of whether, and how, a culture within the international multilateral system (UNAIDS, UNDP, WHO, etc.) subtly or even overtly fueled homophobia.

This is not to negate the challenges that exist at the government level across the globe and that represent a real obstacle to the international multilateral system’s ability to achieve traction in the fight against HIV among MSM. For instance, no fewer than 80 countries criminalize consensual homosexual sex. In Asia and the Pacific, Bangladesh, Bhutan, Brunei, India,¹⁵ Malaysia, Maldives, Myanmar, Nepal, Pakistan, Singapore, and Sri Lanka (a total of 11 countries) have laws that criminalize consensual sexual activity among persons of the same sex. Institutional promotion of “a culture of hatred” results in covert and overt discrimination and a denial that sex between men actually occurs.¹⁶ In these contexts, collecting data on male-male sex or services for MSM is not easy and often not possible. (See Appendix A: The Hidden HIV Epidemic Among MSM in Asia and the Pacific for more information on the history of the epidemic among MSM in the region.)

What Is Happening Now in Relation to HIV Among MSM?

There are now alarming HIV prevalence rates among MSM in Asia and the Pacific. A quick scan of the available evidence shows just how serious the situation really is. Cross-sectional surveys in a number of cities in China have demonstrated that MSM may be up to *45 times more likely to have HIV* than the general population.¹⁷ In Thailand, MSM are *20 times more likely*.¹⁸ A recent study in Lao PDR suggests that MSM could account for up to 75% of all new infections.¹⁹ Overall, *MSM are as much as 25 times more likely to be living with HIV than the general population of Asia and the Pacific*.²⁰ Data from 2008 show that MSM in urban areas of Thailand, Cambodia, and Myanmar are experiencing severe HIV epidemics, with prevalence greater than 10%. MSM in cities in Vietnam, Lao PDR, Indonesia, China, Nepal, and India face intermediate-level epidemics with prevalence of 2% to 10%. Emerging MSM epidemics are now evident in Pakistan, Bangladesh, East Timor, and the Philippines.²¹

Figure 1 shows the percentage of adult HIV prevalence attributable to MSM across seven capitals in Asia. This research demonstrates increasing infection rates among MSM in Bangkok, rising from 17.3% in 2003 to 28.3% in 2005. In a presentation to the 8th International Congress on AIDS in Asia and the Pacific, Bangkok was highlighted as an example of what can happen when HIV among MSM is not combated early, resulting in an epidemic that quickly outpaces prevention efforts. Bangkok is now “the epicenter for HIV infection within the Greater Mekong Sub-region.”²² HIV prevalence among MSM in China rose from 1% to more than 5% between 2004 and 2006. In Karachi, Pakistan, HIV prevalence rose from 4% to almost 8% for the same period. In Singapore, HIV prevalence in the patient caseload of MSM in Action for AIDS (Singapore’s anonymous testing center) rose from 3.5% in 2003 to 6.4% in 2006.²³

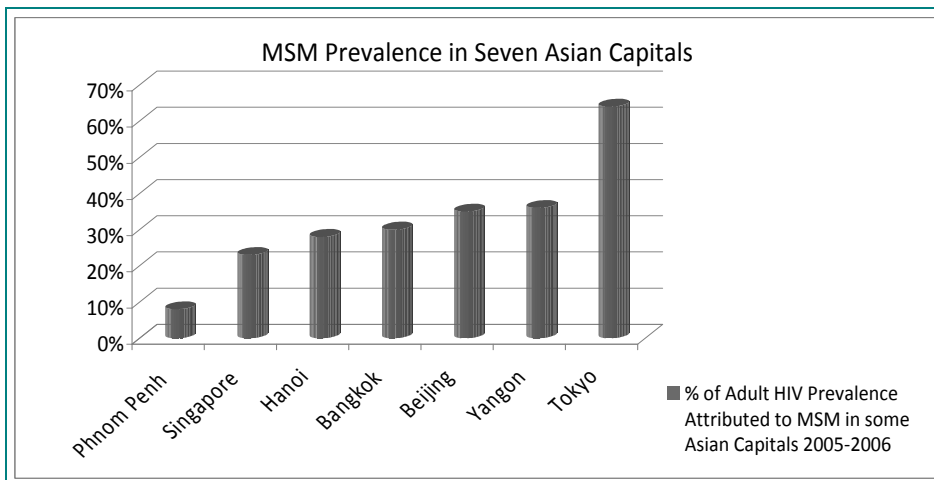


Figure 1: MSM Prevalence in Seven Asian Capitals

Levels of sexual risk behavior in MSM have been estimated at between 40% and 60% in East Asia and Southeast Asia and 70% to 90% in South Asia.²⁴ This study, which analyzed a range of other studies, defined sexual risk behavior for MSM as unprotected sex or commercial sex with a man in the past 12 months. It found that over 50% of MSM reported unprotected anal sex within the last six months before each survey period.²⁵ It is still unclear if these varying epidemiological patterns of HIV among MSM are resurgent spreads, ongoing spreads undocumented over time, newly emerging HIV epidemics, or combinations of these.²⁶

Most countries in Asia spend less than 1% of their HIV budgets on MSM, despite 5% to 20% of new infections occurring among them.

There is little information about what drives the decisions and assumptions MSM are making about sex and HIV risk, and this makes it difficult to be sure which targeted prevention messages and services would work most effectively for MSM in particular settings. All of this is not surprising when you consider that most countries in Asia spend less than 1% of their HIV budgets on MSM, despite 5% to 20% of new infections occurring among them. amfAR has demonstrated the lack of attention to MSM in government strategy, policy, and overall responses in a report that found almost half of 128 countries surveyed did not report on MSM to the UN as part of sentinel surveillance and monitoring.²⁷ Only ten of the 128 countries were able to report that at least 60% of MSM had access to prevention services. And 91 countries (a staggering 71%) did not report at all on MSM. When countries adequately measure MSM, they find greater than anticipated rates of HIV and risk behavior.²⁸

A UNAIDS study of 20 countries in Asia reported that 60% of national surveillance mechanisms did not include MSM in their data collection and 15% did not collect behavioral and HIV infection data on MSM. Only 8% provided MSM with the means of preventing HIV transmission, while 75% did not provide any targeted funding for MSM. At the level of strategy, the report found that 40% did not mention MSM in their national AIDS plans.²⁹

The Asian Epidemic Model estimates that there are 10 million MSM in Asia, some of whom have sex with women or are married.³⁰ The model predicts that if HIV prevention does not improve over 2007 levels, MSM will soon account for the largest proportion of people living with HIV in Asia. The number will double every two years until, by 2020, MSM will contribute to half of all new infections in the region.

What Else Needs to Be Known?

While it appears that the information provided by surveillance systems in Asia and the Pacific about HIV among MSM is improving, designing appropriate programs and services requires much more information, particularly from social and operations research and from groups working successfully among MSM in Asia and the Pacific.

In addition to the epidemiological and behavioral studies that have taken place, quite a bit of attention has been paid to describing the sub-populations of MSM in different parts of Asia. However, this has still left gaps in knowledge about how to reach these sub-populations, with what range of services and messages, and with what frequency.

Where MSM NGOs have received support, there is little information about how to help them scale up their operations and services so they can reach larger numbers of MSM and different geographical areas. There is also little information about the most appropriate package of interventions to offer in each setting and to each sub-population, and about the tipping point of frequency and scale that would bring about a significant long-term decline in new infections.

There have been several smaller-scale attempts to reach those MSM who are not likely to attend drop-in centers or receive services aimed at those who identify as MSM. But it is not clear whether it is possible to reach these men through their sexual partners, who may identify as MSM and may gather at MSM CBOs and NGOs, or through direct outreach to the site of sex, or through general men's health services. It is also not clear which sub-populations benefit from the initiatives that have been used to decrease stigma and increase the MSM-friendliness of general health services, and which sub-populations remain isolated, either by fear of discrimination or actual experiences of prejudice. These knowledge and data gaps make evidence-based service planning almost impossible.

MSM and MSM Populations

There now seems to be international consensus that MSM community-based and community-led groups and organizations are essential to any effort to scale up HIV services. But can the concepts "gay," "MSM," and "transgender" (and their derivations across Asia and the Pacific) improve community mobilization? From the first introduction of the term "men who have sex with men," there has been heated debate in

both developed and developing contexts about its use. Strong concern remains about who is included and excluded by the term but there is little agreement about what might replace it.

Especially in Asia, the discourse about MSM can be heavily focused on identity because the way men and transgendered people identify varies so widely, both within borders and across them. But a singular focus on identity can miss the point: identity is important, but it is not the only issue that needs consideration. In reality, the themes of identity, community, space, sexual desire, and behavior have been at the heart of informed thinking about men who have sex with men and HIV services since the beginning of the epidemic.

What is most important is that the ways men appear or identify may not align with the ways they behave sexually or with their desires and fantasies about sex with other men.

It is not just an academic exercise to take into account such issues as space, desire, community, and identity—these considerations provide service planners, policymakers, and implementing agencies with a framework for understanding the way in which men get together for sex, and the possibilities of communicating with them about HIV risk and the availability of health and community services. The goal of slowing HIV transmission and expanding treatment can only be achieved across diverse populations of MSM if there is a clear understanding about how to reach them, what sort of information they would respond to, and what kinds of services they would need and use. It is clear that much more needs to be known in order to be confident that the national strategies and services that are in place across Asia and the Pacific can achieve this goal. (See Appendix B: Defining MSM and MSM Populations for a more detailed discussion of this topic.)

Operations Research Into HIV Prevention and Care Among MSM

While it is clear that the epidemiological information available to planners, policymakers and implementers is improving, there is still little information available to guide the development of effective models to respond to the specific HIV prevention, treatment, care, and support needs of MSM. This section summarizes what is being done to develop models and approaches for MSM prevention and care in Asia and what operations research is needed to take this effort forward.

In September 2005, 191 UN member states endorsed the goal of universal access to HIV prevention, treatment, and care for all who need it. This universal access agenda provides a useful framework for advocating and measuring progress in the response to HIV among MSM. Countries describe their

It is clear that a range of connected services is required to meet the HIV prevention and care needs of MSM.

progress against this goal in reports to UNGASS (United National General Assembly Special Session on HIV/AIDS) and include universal access targets in their national AIDS strategies, Global Fund proposals, President's Emergency Plan for AIDS Relief (PEPFAR) plans, and other donor-funded programs. This is a better framework for inspiring a response among most-at-risk populations, for it places value on preventing HIV transmission and providing HIV treatment, care, and support for people from marginalized populations as a legitimate and worthy end in itself. This is more useful than previous "bridging population" arguments, which sometimes suggested that HIV should be addressed among marginalized populations as a way to prevent the epidemic from reaching general populations, which must somehow be more deserving.

Several tools and frameworks have been developed to help countries in putting the universal access agenda into practice. These have built on the model of a continuum of HIV prevention, treatment, care, and support services. The WHO has developed a set of priority interventions for the health sector and these have been adapted for use with particular populations.³¹

The prevention-to-care continuum refers to a range of services and interventions that aim to keep people healthy by preventing disease, promoting health, and treating and managing illness. Prevention-to-care incorporates approaches including health promotion, behavior change communication,

emotional and social support, and clinical care. It aims to encompass the broad bio-psychosocial needs of individuals and populations. In fighting HIV, the prevention-to-care continuum is considered essential to reaching universal access to HIV prevention, treatment, and care across the globe. For MSM, a conceptual model for the HIV prevention-to-care continuum includes:

- **Improving knowledge** through community education, outreach services, and promoting the effective use of condoms and other prevention tools;
- **Promoting behavior change** through community mobilization, health education workshops, seminars, support groups, cultural change, and other activities that build a population-level commitment to safer sexual behavior;
- **Providing STI diagnosis and treatment** through accessible clinical services that help to reduce population-level rates of sexually transmitted infections, individual susceptibility to HIV infection, and general health;
- **Enabling people to know their HIV status** through effective VCT services that provide pathways to ongoing prevention support for all, and HIV treatment, care, and support for people diagnosed with HIV;
- **HIV treatment, care, and support** that provides for the social and emotional needs of people with HIV, including peer support and education as well as clinical and community care and antiretroviral therapy (ART) and opportunistic infection (OI) treatment and prophylaxis;
- **Access to other health promoting services** such as harm reduction; drug substitution and drug and alcohol treatment services for alcohol and drug users; mental health services; and tuberculosis (TB) diagnosis and treatment services; and
- **Access to other social, legal, and welfare services** that affect the other drivers of the epidemic: poverty, unemployment, poor mental health, marginalization, and lack of education.

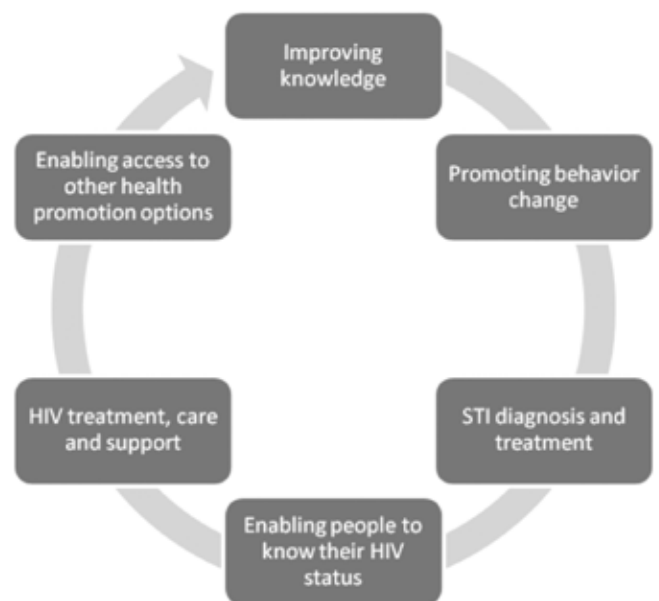


Figure 2: Prevention-to-Care Continuum

Many MSM community organizations operate in a sophisticated manner to deliver an increasingly complex array of services to their members and communities.

What is particularly important in this continuum is the connection between all of these strategies. Universal access aims to put in place a set of approaches and services that are designed around the full range of community and individual needs. It focuses on the person as a whole and places great importance on ensuring that people do not fall through the cracks between services.

Along with the identification of the types of services and interventions necessary to reach populations affected by HIV, there have been significant developments on issues of reach and coverage—determining what sort of services at what frequency and to what proportion of the affected population will bring about the behavior change and impact mitigation necessary to have a long-term effect. Some are referring to this as the “intervention dose.” This debate is somewhat more developed in the response to HIV among IDUs, supported by an organized harm reduction movement with its own international journals, associations, and conferences. This has led to the development of a range of policies, evidence for action documents, and service models.^{32,33,34} But this process is underdeveloped in the response to HIV among MSM.

Universal Access for MSM

The mechanics that drive the development of HIV-related services for MSM comprise a complex set of relationships between national governments, INGOs, donors, research institutions, health services, and MSM community organizations. They govern, manage, and fund the delivery of services to people at risk of and living with HIV. INGOs, donors, and research institutions assist countries by providing technical assistance, funding, and implementation support. Some fund and/or deliver MSM prevention-to-care programs in various settings. MSM community organizations (where they exist and have funding) deliver outreach, advocacy, and community care programs. In very limited cases, they deliver clinical services to MSM that span the HIV prevention-to-care continuum.

In many cases, national governments, donors, and international organizations have been late in recognizing the driving forces that have been fuelling an epidemic among MSM—marginalization, criminalization, poverty, and a lack of resources for anything beyond small-scale, boutique, or



Figure 3: Mechanisms that Drive the MSM Prevention-to-Care Continuum in Asia and the Pacific

demonstration projects. Discrimination and a tendency to favor simplistic general population strategies in concentrated epidemic settings have resulted in a silence that has prevented funding of MSM prevention-to-care services at the level required to make a significant impact.

INGOs and research institutions have funded or delivered some high-quality services to MSM that can provide important strategic information about HIV. These services provide good examples of better engagement with affected communities and of best practices, especially in relation to VCT. HIV clinics and services, their models, and the knowledge that comes from them provide vital information to help achieve wider service coverage for MSM. In some cases, however, these services sit outside the national or provincial government health infrastructure and this can limit the strategic influence that such services have on government systems. And scale is a major issue. In some cases, boutique services provided outside the government system may have the opposite effect of scaling up, allowing governments to feel satisfied that they are responding adequately to HIV among MSM without challenging them about issues of reach and coverage.

MSM community organizations, where they exist, generally operate in difficult circumstances—resistant governments, legal impediments, and high levels of stigma and discrimination—with relatively low levels of funding, annual contracts, and funding cycles that limit their ability to plan. Nevertheless, many of them operate in a sophisticated manner to deliver an increasingly complex array of services to their members and communities. Some have had significant success in mobilizing MSM communities and reaching MSM who do not identify with community. They have developed enduring relationships with government services that have resulted in breaking down barriers to access,

MSM community-based and community-led groups must receive expanded funding and substantial technical assistance to scale up HIV services among MSM.

especially for MSM sub-populations that have been heavily disadvantaged in service access—particularly feminized MSM and transgendered people who suffer pronounced alienation and discrimination.

Findings From This Assessment

Systems and Infrastructure

Overall, the systems of national, international, and community-based interventions are not reaching across the MSM HIV prevention-to-care continuum and fail to counter key elements that are having a detrimental impact on MSM at individual and population levels. While some governments have increased their focus on the populations most affected by HIV, the response targeting MSM has been slower to receive adequate levels of funding than some other populations, e.g., sex workers and IDUs.

There are some specialized government VCT approaches for MSM that could be scaled up to provide MSM with greater access to HIV prevention-to-care services inside the public health infrastructure.

Specialist clinics for MSM are examples of good practice and contribute to the strategic information available to planners and policymakers. But because they are usually funded by international organizations and positioned outside government health infrastructure, it may be difficult for them to create lasting change.

MSM community-based and community-led groups are essential to scaling up HIV services among MSM. They are capable of leading a sophisticated approach to prevention-to-care across MSM networks and communities and sustaining links across health infrastructure, but those links must be strong. In addition, the MSM groups must receive expanded funding and substantial technical assistance.

Operational and Clinical

Many MSM do not see how knowing their HIV status will benefit them. Often they are diagnosed in isolated VCT services and most are lost to follow-up until they develop

HIV illness. HIV clinical services tend to play no role in HIV prevention beyond providing knowledge of HIV status, on the assumption that ongoing MSM HIV prevention is being done in the community.

MSM community workers report that many MSM are reluctant to use public STI clinics because of fear of stigma, discrimination, and being treated poorly by staff. That fear leads MSM to pursue self-treatment for STIs and to seek out community pharmacies and private providers for HIV testing and treatment.

Some MSM sub-populations (particularly transgendered people, migrants, and the homeless) cannot access ART because of lack of identity papers or fixed abode, or because they are deemed unreliable and therefore a compliance risk by health workers.

Lack of coordination between VCT, STI, HIV, TB, and drug treatment services forces individual MSM to find and access the services they need. This means that effective HIV prevention-to-care hinges on the ability of individual MSM to have the knowledge, courage, and money required to move from one service to another for information, prevention, treatment, care, and support. Many fall through the cracks of these uncoordinated services and are lost to referral and follow-up.

Policy and Guidance

There is little information available to guide the choice of intervention models for MSM HIV prevention, treatment, care, and support, and little guidance available to assist governments, donors, and implementers to set and maintain service standards. There is also insufficient social and operations research available to ensure evidenced-based service and program design for MSM.

MSM Service Models Currently in Use

A wide range of service models are available to reach MSM in Asia. These can be categorized in several ways. Some clinics focus primarily on VCT and refer newly diagnosed MSM with HIV to community services. It is clear that this limited focus on knowledge of status alone is insufficient to ensure long-term behavior change and HIV health-seeking behavior. Some had serious gaps in their service models, such as diagnosing STIs but not offering treatment or referring people to other services for treatment. In many cases there seems to be insufficient attention to the prevention-to-care continuum, or a resignation to the limits of the services that are provided without time and resources allocated to connecting services together to make referral more effective.

Some of the more mature MSM groups in the region have been providing a range of VCT, STI, and other clinical services in an attempt to bring isolated MSM sub-populations into HIV prevention, treatment, and care. The models that they are using warrant close examination as they provide essential

information about reaching more isolated groups of MSM. (See Appendix C: Case Studies of MSM Service Models in Asia and the Pacific for an overview of models currently in use.)

In terms of clinical services, some models aim to increase the receptiveness of mainstream government clinical services by encouraging a more MSM-friendly environment. amfAR's assessment of the response to HIV among MSM in Asia found several INGOs working with local services to create MSM-friendly clinics. Confidentiality is carefully observed and some provide testing as well as treatment and ongoing support

In several countries including Thailand, Myanmar, and China, some specialized government-run VCT services for MSM and other most-at-risk populations are housed within mainstream hospitals and clinics. These services are taking important steps toward increasing access to and use of services by MSM. They employ MSM to assist in service delivery to other MSM. Some are paid while others are recruited from local MSM networks to act as volunteers or "expert patients."

Because these services are based in hospitals or within the health infrastructure, they have the advantage of being able to diagnose and treat HIV and STIs often in the same session in which rapid tests and syndromic STI treatment are available. The hospital setting may attract MSM who are more comfortable talking with mainstream doctors and nurses. At the same time, MSM-allied health professionals, volunteers, or "expert patients" in these clinics offer peer connections, as well as links to community services.

In some places, INGOs and international research institutions provide VCT programs that operate alongside epidemiological, behavioral, or clinical research programs. The services provided are usually of high quality, confidentiality is carefully observed, and they may have the resources for rapid testing. They may also engage local MSM as volunteers and "expert patients" or in the evaluation of service quality

Current Models

1) Increase MSM-friendliness of mainstream clinics (private and/or public)

- + Can be more anonymous
- + Usually employ MSM as staff or 'expert patients,' creating a stronger community connection
- + Often diagnose and treat HIV/STIs in the same session
- Requires substantial resources; often limited to urban centers
- Continued attitudinal barriers among staff can exist; at times lack of linkage between different functions
- Can leave out clients who lack official paperwork (e.g. migrants)

services. Some also engage local MSM as volunteers, "expert patients," or to evaluate service quality on an ongoing basis. They often develop strong ties to MSM CBOs where they exist. However, there have been limits in scaling up these INGO services and they see only a small number of HIV-positive MSM.

Other models aim to take clinical services directly to harder-to-reach MSM through mobile clinics or clinics within MSM NGOs. To generate and maintain a steady flow of clients, all of these rely on social marketing and outreach through MSM community CBOs and NGOs, which provide safe spaces like drop-in centers. They generally provide their clients with a minimum set of services. For cases requiring more specialized care, they advocate for access to mainstream government HIV services.

Current Models

3) Government-Run VCT Services for MSM

- + high quality; confidentiality observed
- + resources to provide quality care (e.g. rapid testing)
- + often hire MSM as staff or 'expert patients'
- + good linkages to community-based MSM NGOs
- See small numbers of clients
- Some programs tend to recruit patients of higher education or social status
- Clinics often positioned outside local health infrastructure

on an ongoing basis. They often develop strong ties to MSM CBOs where they exist and provide some of their funding. However, limits to scale-up remain a theme in INGO and research-led VCT clinics. They see a relatively small number of MSM. Some report caseloads that appear to be overrepresented by MSM with university educations and it is unclear what provision is being made for providing services for MSM with less education or more limited financial resources. These clinics can suffer from being positioned outside the local health infrastructure and may therefore be limited in their capacity to integrate into long-term national or provincial health service plans. In fact, there are examples of active resistance from national and provincial governments to embracing these models, even where they demonstrate success. This is generally

Current Models

2) Take clinical services to MSM communities (mobile clinics; mini-clinics within community-based NGOs)

- + Greater access to clients; greater trust
- + Better success in empowering clients to get tested or seek treatment
- + Greater linkages to additional prevention and support services
- Rely on social marketing or demand creation strategies
- Suffer from loss to follow-up, especially when external treatment services are needed
- Confidentiality and quality of care concerns are increased

Scaling up services to MSM in Asia and the Pacific will not be possible through clinic and hospital settings alone. MSM community-based and community-led groups are essential if programs are to reach all of the MSM requiring information and services.

due to the perception that these services give an advantage to the MSM community over other communities competing for scant healthcare resources and that they are unsustainable in the long term.

Although few in number, the MSM-friendly “one-stop-shop” prevention-to-care service model certainly provides an effective approach for reaching MSM in their geographical area and beyond. They seem to work best in urban environments that have an emerging MSM community as well as outreach services that can draw new clients into the program and dispel fears among MSM about discrimination, disclosure, and poor treatment. Some of these are true “one-stop-shops” including VCT, HIV treatment and care, STI and TB treatment, and opioid substitution services. These were usually established as demonstration models to show governments how MSM can be effectively reached. Difficulties arise when governments do not have the resources to reproduce these models or mechanisms to bring them into national or provincial health budgets.

Some models take a general most-at-risk populations approach, acknowledging that there are efficiencies to be gained by trying to reach a range of marginalized populations. These models also take account of the fact that people belong to more than one population—some MSM are also sex workers or drug users, or both.

Scaling up services to MSM in Asia and the Pacific will not be possible through clinic and hospital settings alone. MSM community-based and community-led groups are essential if programs are to reach all of the MSM requiring information and services.

Current Models — Key Findings

- ✓ **Many models exist; need to be analyzed and tested to identify best practices for scale-up**
- ✓ **Effective models likely to include a combination of approaches that allow for:**
 - ✦ Prevention-based outreach
 - ✦ VCT / treatment / palliative care / other clinical services
 - ✦ Community support
 - ✦ Advocacy
- ✓ **Community-based advocates and groups must be engaged to have *ownership* of programs**
- ✓ **Working closely with local or state health infrastructure(s) seems to lead to greater success**

Key Issues for Future Operations Research

There are still many questions to be answered if the obstacles to universal access to HIV prevention and care are to be overcome for MSM in Asia and the Pacific. The key issues that have emerged from this assessment are:

Getting the Spectrum of Services Right

It is clear that a range of connected services is required to meet the HIV prevention and care needs of MSM. What is not clear is how decisions are to be made about what services to provide and who should provide them. Access to data on population size, STI and HIV burden, and differential risk among sub-populations is essential to this planning, as is information on the obstacles faced by each sub-population in accessing services and information. A clearer understanding of the other drivers of the epidemic among sub-populations—poverty, extreme marginalization, drug and alcohol use, lack of power in negotiating safer sex, and so on—is also important.

In order to determine who is to deliver these services in each setting, it is essential to answer these questions:

- What mix of government and community services is most appropriate to the setting?
- To what extent will working on the MSM-friendliness of government services overcome access barriers? How enduring is this approach?
- What contribution can community-directed clinical services make in each setting?
- Which sub-populations will remain without access and what can be done for these groups?
- How can services be better connected so that people move easily between them and are not lost to follow-up?
- How can other services like drug and alcohol and mental health services be incorporated?
- How can quality standards be developed and used?

Case Management and Measurement Issues

This is an emerging area in the MSM response that needs a lot of attention. Many programs still focus on measuring activity and individual service interventions yet lack the ability to effectively show how far they are reaching into MSM sub-populations. Service providers record information about clients who present to them, but not many programs try to track the pattern of use as people move from service to service. The use of unique identifier codes in some IDU programs in Central Asia has demonstrated that it is possible to employ these service tracking strategies with marginalized populations.³⁵

Here, operations research will need to start providing answers to questions like:

- How can an individual's or population's pattern of service use be better measured?
- What is the appropriate intervention dose for effective prevention and care in each setting and for each sub-population? What services delivered to which populations with what frequency produce a significant impact on an HIV epidemic?
- How can the focus be shifted from individual service provision to case management, so that people and populations achieve long-term improvements in health outcomes?

The Contributions of MSM Community-Based Organizations and Nongovernmental Organizations

There are striking examples in the region of MSM CBOs and NGOs playing very sophisticated and effective roles in prevention and care service planning and delivery. Some of these organizations are now more than 10 years old and took considerable time to reach this level of stability and competence.

- Under what conditions or in which settings is it desirable or essential to have strong MSM CBOs and NGOs contributing to the response?
- How is the development of emerging MSM CBOs and NGOs best supported?
- What other models of community engagement with health services are possible and effective?

Embedding MSM HIV Prevention and Care in National and Local HIV Responses

When it comes to this goal, there is some catching up to do in comparison with other responses aimed at most-at-risk populations.³⁶ Where there have been some successes in scaling up the response to HIV among IDUs (expansion of opioid-substitution services, expansion of primary healthcare for IDUs with HIV, and wider availability of needle/syringe services), these have come about partly because of a concerted effort on the part of international agencies, donors, and practitioners to provide a foundation of standards, guidance, evidence, and policy materials. Even though these have not yet reached the scale and coverage required across the region, they are, in many cases, more centrally represented in national strategies, Global Fund projects, and other donor initiatives than programs for MSM.

While there are some guidelines available to pilot clinical practice for MSM STI services, few exist to drive program design and service development.^{37,38} An urgent investment in standards, guidance, evidence, and policy materials is required.

Initial Recommendations for Establishing an Operations Research Agenda

1. Develop Alternate Intervention Models

Two distinct service models emerged from this assessment. The first involves increasing access for MSM to existing mainstream STI and HIV prevention and care services. This usually involves hiring MSM staff, training all staff in MSM sensitivity, training medical and nursing staff in STI prevention and treatment for MSM, and adjusting opening hours to increase access.

The second model involves supporting MSM NGOs in their efforts to integrate STI and HIV clinical services into their overall HIV prevention and care programs. This model is in place in several MSM NGOs across the region. It has some distinct access advantages, but only appears to operate well when the NGO has had time to develop a level of stability, usually gained from several years of HIV prevention work involving drop-in and outreach services. It requires a significant identifiable MSM population that is willing to gather relatively openly.

A third possible model, which is a hybrid of the first two, is currently being used in less populated areas or in areas where MSM NGOs have not yet emerged—for instance in Myanmar and Southern India. This model involves setting up MSM clinics (run by mainstream health or community NGOs) that provide clinical services and a safe space for MSM to gather and support one another. The model being proposed

An important next step would be to carry out a more comprehensive mapping exercise that would examine in detail the characteristics of each of the models and compile what is known about access levels, outreach to sub-populations, quality of care, and longitudinal engagement with MSM.

in Malaysia—setting up MSM clinics in urban public health clinics after normal operating hours—is also a hybrid of these models and relies on backup prevention services provided by an MSM NGO.

2. Map Currently Available Services

This assessment was aimed at identifying the range of models in current use and examining how they might be expanded or tested. An important next step would be to carry out a more comprehensive mapping exercise that would examine in detail the characteristics of each of the models and compile what is known about access levels, outreach to sub-populations, quality of care, and longitudinal engagement with MSM. This would assist in the process of drawing up a comprehensive menu of approaches for countries, funders, and organizations to employ and test.

3. Conduct Regional Consultations with Key Stakeholders

The operations research agenda that is developed and implemented needs a high level of local relevance and ownership. This requires regional, national, and local input from individual and group consultations to identify local needs and concerns, special considerations, potential obstacles, opportunities for collaboration, and so on. These consultations would involve collaborating with program implementers and researchers working on MSM issues in the region to formulate an operations research protocol that would help guide the development and implementation of demonstration projects. Such consultations would also inform the logistical assessment discussed below.

4. Assess Logistical Factors

For this operations research to provide relevant information for the field in the most expeditious manner, it will need to build on existing work. That means identifying sites where interventions for MSM HIV prevention, treatment, care, and support are in place, and helping the organizations and groups working in those settings to formalize and strengthen the approaches they are using, expand their reach and range of services, and put in place an operations research framework to provide answers to a set of measurable questions. This will be more efficient and effective if it is building on existing practice and expertise rather than starting new programs from scratch. Ideally, the sites chosen should reflect the range of models set out in recommendation 1 above and should contain the basic elements required for the development of a comprehensive approach.

The sites will require assistance in choosing which models to adopt or expand, resources to carry out this expansion,

technical guidance on establishing the operations research framework, and assistance in conducting, analyzing, and reporting on the research. This will require the identification and resourcing of a central coordinating agency for the research at the regional level.

5. Determine Potential Opportunities for International and Regional Collaboration

The environment for high-quality, evidence-based MSM HIV prevention and care interventions across Asia is relatively weak, and strengthening it will require creating a set of foundation documents to provide policy guidance, regionally relevant best practice, and evidence for action. The global documents developed to support HIV prevention and care among IDUs are a good example of this foundation and were used extensively to build more consistent high-quality practice in that area. Several of these key foundation elements exist already in Asia but these will need to be compiled, further developed, and promoted. This will require broad collaboration by regional groups such as APCOM, APCASO and APN+; UN organizations like UNAIDS, UNDP, UNESCO, and WHO; key regional donors like USAID, CDC GAP, and AusAID; and other key regional players such as FHI, PACT, the International HIV/AIDS Alliance, amfAR and the Gates Foundation.

6. Develop Standards and Guidelines

It is essential that the expansion of MSM HIV prevention and care services across Asia be driven by an agreed-upon set of quality standards and guidelines. Most of the elements of these standards already exist or can be adapted from standards and guidelines being used in other places.

7. Address Funding Considerations

MSM HIV prevention and care programs and services are funded in several countries in the region through a range of mechanisms. USAID-funded agencies like FHI and others support programs in several countries. Some MSM groups receive, or are about to receive, funds from principal recipients of Global Fund grants. Others are funded as part of donor-country allocations to recipient countries under their national AIDS strategies. Although all of these programs have their own monitoring and evaluation frameworks and performance/impact indicators, it would be desirable for operations research efforts to work alongside services and programs that are receiving their core operational funding from other sources. The operations research resources could then be used to maximum effect by focusing on issues of model clarification and strengthening, and service consistency and quality.

8. Identify a Set of Testable Questions

There is still a significant amount of operations research required to guide governments, international organizations, and donors in their efforts to advance HIV prevention and care among MSM in Asia and the Pacific. To spark discussion and encourage timely initiation of practice-based research, amfAR proposes four initial operations research questions that need testing:

1. What is the optimal spectrum of services?

Providing an interconnected spectrum of services will be the best approach to addressing the HIV prevention, treatment, care, and support needs of MSM. But these services will need to differ across settings, varying according to the MSM populations to be reached, the capacity and readiness of governmental and nongovernmental providers (including health providers, law enforcement, MSM social venues, etc.), and the contributing factors of HIV vulnerability (such as poverty, drug or alcohol use, mobility and migration, incarceration, institutionalized criminalization, persecution and/or violence, social marginalization, etc.). In each setting, unique solutions will need to be found to address challenges in reaching more vulnerable networks of MSM, lowering thresholds for accessibility to services, linking interventions and providers, and developing and achieving consistent indicators of accessibility and quality. However, in all cases, the best approach to addressing the health and human rights needs of MSM will be an approach that addresses multiple needs from multiple providers and multiple access points, linking all of this with consistent messaging, accessibility, and quality over time.

2. What are the best approaches to engaging MSM?

Multiple pathways and models of engagement with MSM and health intervention providers will be possible and effective in HIV prevention and care service planning and delivery. In some cases, the best approach will be to reinforce and work through established MSM-led organizations that have, over years or decades, developed access to and the trust of MSM networks and

The best approach to addressing the health and human rights needs of MSM will be an approach that addresses multiple needs from multiple providers and multiple access points, linking all of this with consistent messaging, accessibility, and quality over time.

have a level of stability, competence, and financial and programmatic integrity that compares favorably with other possible providers. In other settings, HIV programming may be more feasibly implemented in partnership with emerging MSM organizations or other health or human rights organizations working with MSM networks.

3. What are the best ways of tracking service delivery, utilization among MSM, and the effects?

Service tracking strategies can be effectively used by programs working with MSM, even MSM who are highly marginalized and/or who do not self-identify according to sexual behavior, sexual orientation, or non-normative gender roles. In the same way that MSM throughout the world innovate in finding each other (such as through the Internet or public venues), HIV intervention programs can innovate in tracking who is being reached, by which interventions, and to what effect. Methods, including use of unique identifier codes or network-based tracking, can measure how deeply HIV interventions are reaching into defined social and sexual networks of MSM, the patterns and frequency of individual and network exposure to HIV interventions, the intensity and “dose” of those interventions as experienced by individuals and networks, and changes over time in health and human rights indicators.

4. What is the best way to establish and disseminate an MSM-specific standard of care?

An investment in on-site, practice-based training for MSM-focused programs to share, implement, and document high international standards and effective practices and policies—coupled with targeted advocacy activities that include documented successful outcomes resulting from this approach—will dramatically increase the likelihood that these standards, practices and policies will become embedded in national strategies, Global Fund projects, and other donor initiatives, thus contributing to potential achievements of scale-up.

Intensified social and operations research to test the four questions above can help ensure:

- Evidence-based service and program designs;
- Demonstrable improvements in the range of interventions, quality, use, and effect; and
- A move in many countries from small-scale, disconnected demonstration projects to larger-scale and higher-quality efforts sufficient for significant reduction in rates of HIV transmission among MSM and significant improvements in health outcomes for MSM with HIV.

Appendices

Appendix A: The Hidden HIV Epidemic Among MSM in Asia and the Pacific

Worldwide, infection of MSM dominated the early story of HIV/AIDS. Male-male sex efficiently transmits HIV because anal sex causes small tears in the mucous membranes that allow HIV to infect the receptive partner. Yet in Asia the risks facing MSM have been neglected, as reflected in the high prevalence of HIV previously documented. How has this come about?

Governments have concentrated on HIV prevention campaigns that are aimed at either the general public or more easily identifiable vulnerable groups such as female sex workers and IDUs. This has left NGOs—often small, local organizations with little capacity—to run prevention campaigns aimed at MSM. Although these NGOs have connections to the community, they often lack the resources or manpower to conduct broad campaigns.

At the end of the 1990s the international system finally began grappling with the concept of HIV risk in MSM, but the policy debate remained inconsistent and often contradictory. In 1997, the Monitoring the AIDS Pandemic (MAP) report assessed the status and trends of the epidemic in Asia and the Pacific.³⁹ This report placed the focus squarely on sex workers and drug users, not on MSM. The report referred to MSM as an affected community in Indonesia, Hong Kong, Singapore, Sri Lanka, Australia, and New Zealand. However, the report noted that infection rates among MSM in Hong Kong, Indonesia, Malaysia, Myanmar, Nepal, and Singapore were relatively low or reaching a plateau, and did not track rates among MSM in other countries. At the same time, UNAIDS estimated that between 5% and 10% of HIV infections worldwide were a result of sex between men and that the extent of male-male sex was “probably underestimated.”⁴⁰ It called for governments to include MSM in their national programs and, in particular, to deliver STI testing and treatment services and the means to prevent HIV to MSM.

Four years later, the MAP assessment of the epidemic in Asia dramatically changed. Its 2001 report referred to MSM as “a neglected population” and acknowledged that they had been ignored as an at-risk group in many nations.⁴¹ The 2001 MAP report emphasized the role of MSM as a “bridging population,” potentially transmitting HIV to the general population by having sex with women as well as men. In 2003, some important HIV social research emerged from Bangladesh, India, Thailand, and Indonesia in studies of HIV transmission, sexual identities, and sexual practices among MSM.⁴² In 2004, a new MAP report stressed that while Asian countries ignored MSM, HIV was spreading rapidly among them.⁴³ The

report presented “shocking findings” from nine countries, describing high HIV prevalence among MSM in Bangkok, Mumbai, and Phnom Penh, extraordinarily high levels among transgendered people, and significant risks related to MSM and sex work. In 2005, MAP used the findings of its 2004 report to produce a resource directed specifically at MSM in Asia. The 2005 report urged Asian countries to target MSM in their HIV outreach programs, paying particular attention to issues of condom use, sex work, drug use, and MSM who routinely have sex with both men and women.⁴⁴

It was not until 2005 that international policy advice on MSM and HIV risk for Asia and the Pacific reached a point of consistency. Since then, attention to the issue has been steadily increasing:

- amfAR released a special report at the International AIDS Conference in Toronto, Canada, in 2006 entitled *MSM and HIV/AIDS Risk in Asia: What Is Fueling the Epidemic Among MSM and How Can it Be Stopped?*⁴⁵ This report used the most recent research available to highlight HIV infection rates among MSM populations in Asia and the Pacific, identified key factors fueling the spread of these epidemics, and identified prevention and treatment solutions to halt the spread of HIV among MSM and their sexual partners in the region.
- The Purple Sky Network was formally established in July 2006 to provide advocacy and a communication forum for key focal points on MSM across the Greater Mekong Sub-region.⁴⁶
- The Global Forum on MSM and HIV was established at the Toronto AIDS Conference in 2006.
- In 2007, amfAR launched the MSM Initiative to support community-based efforts aimed at addressing HIV among MSM throughout the developing world.⁴⁷
- The Asia Pacific Coalition on Male Sexual Health (APCOM)—a regional coalition of MSM and HIV community-based organizations, the government sector, donors, technical experts, and the UN system—gathered momentum in 2007.
- amfAR released another special report in 2008 entitled *MSM, HIV and the Road to Universal Access – How Far Have We Come?*, which presented the latest epidemiology on HIV among MSM and analyzed their access to prevention, care, treatment, and support.⁴⁸
- The Global Forum on MSM & HIV organized a major forum for the Mexico City International AIDS Conference in 2008,⁴⁹ and the issue of MSM and HIV in the developing world was also highlighted throughout the conference.
- In 2008, the Commission on AIDS in Asia released a report recognizing the need to focus on risk behaviors in female sex workers, IDUs, and MSM.⁵⁰
- Today, MSM strategies and position papers are being developed by the Global Fund and within the UN system. UNDP has been appointed the lead agency on MSM and HIV under the UNAIDS global division of labor.

Appendix B: Defining MSM and MSM Populations

There now seems to be international consensus that including community-based and community-led MSM groups and organizations is essential to any effort to scale up HIV services for this population. But can the terms “gay,” “MSM,” and “transgender” (and their derivations across Asia and the Pacific) improve community mobilization? There is a great deal of discussion about identity and the role it plays in forming and sustaining networks and communities. From the first introduction of the term “men who have sex with men,” there has been heated debate in both developed and developing contexts about its use. Strong concern remains about who is included and excluded by the term but little agreement about what might replace it.

Especially in Asia, the discourse on MSM can be heavily focused on identity because the ways men and transgendered people identify varies and resonates so widely both within borders and across them. But a singular focus on identity can miss the point: identity is important, but it’s not the only issue that needs consideration. In reality, the themes of identity, community, space, sexual desire, and behavior have been at the heart of informed thinking about MSM and HIV prevention-to-care since the beginning of the epidemic.

There are many more men who have sex with men than those who identify as MSM, gay, or transgender. In Asia, as in many other places of the world, there are men who have sex with men and with women, but who do not identify as gay or attribute any particular identity to their sexual behavior.⁵¹ They can’t be easily identified or reached with services, but they need to have access to sexual health education and HIV prevention, treatment, care, and support.⁵² In India, one group of men is described as “see(ing) their sexual practices with other males as another expression of penetrative masculinity, or *masti* (play), and (they) do not perceive themselves as a distinct sub-population apart from the general ‘normative’ male population.”⁵³ There are situations that appear to encourage male-male sex as a temporary behavior—including imprisonment, military service, and migrant work. HIV prevention and care programming for MSM needs to take these environmental factors into account and not be based on false notions that these men will eventually change how they self-identify and/or feel comfortable using services overtly targeted to MSM.

Identity, community, space, sexual desire, and behavior, when brought together, are part of the conceptual framework for thinking about MSM that will help to better mobilize MSM networks, communities, and organizations. They represent the points of connection between MSM. No matter how men identify, sex between them brings them together. Men find ways to have sex that appropriate the public spaces

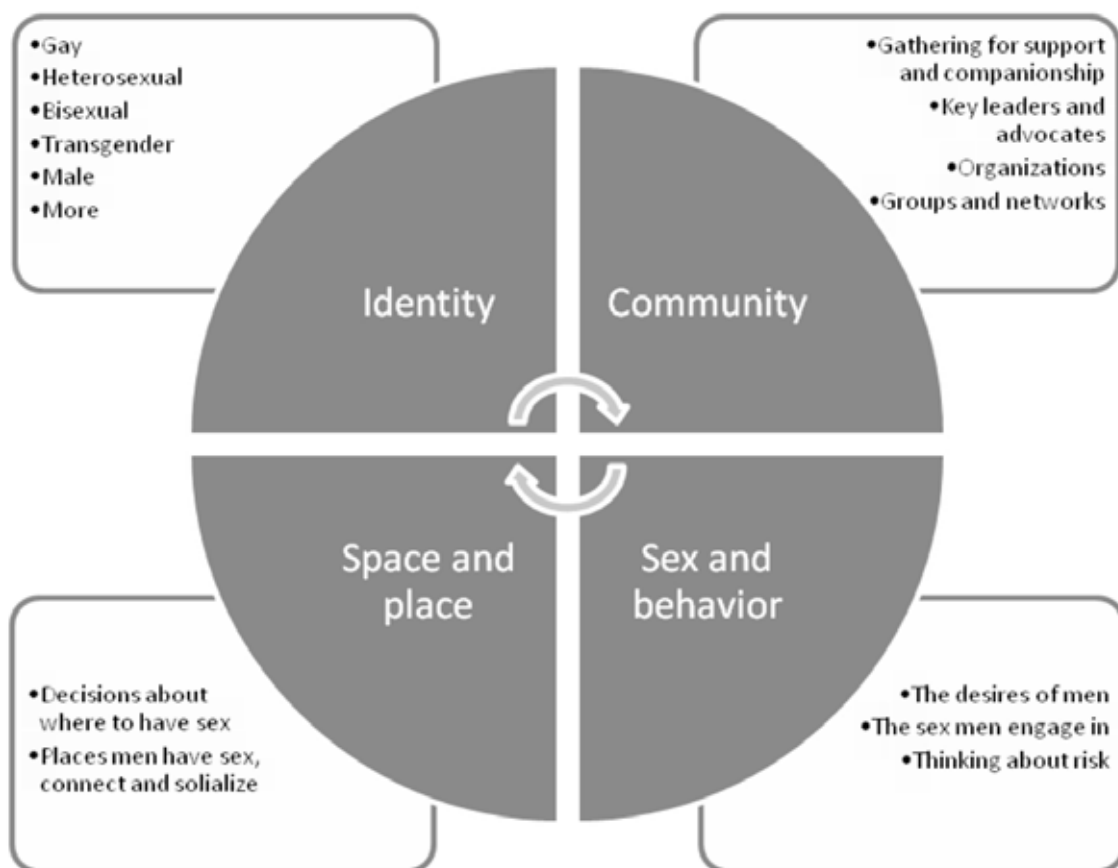


Figure 4: Men Who Have Sex With Men—A Conceptual Framework

Grouping all MSM into one category promotes the false notion that any man who has sex with a man is on some sort of developmental pathway towards incorporating his sexual behavior into some kind of homosexual identity.

around them and maintain their anonymity—they decide on these spaces together, sometimes through language and sometimes through a complex array of unspoken behavioral, sexual, and collective signals. Community means men gathering and communicating with each other, not only about where and how to have sex, but also about their social needs and desires, beyond sex. The men who came together to form the Humsafar Trust, an MSM NGO in Mumbai, gathered because they recognized that they needed a new form of family if they were not going to marry women in India.

MSM speak the language of sexual behavior and desire between men and understand those desires and the dynamics that underpin them. Identity, community, space, desire and behavior are key points of connection between gay men, transgendered people, and men who have sex with men but who do not identify as gay. This is the “lived experience” that adds the essential ingredient to effective MSM scale-up.

These points of connection demonstrate why MSM community leadership and involvement is absolutely vital to scaling up the response across Asia and the Pacific. The MSM community, expressed differently in each country and place, will provide ongoing knowledge and information about the dynamics of the other categories described here: identity, space and place, sex, and behavior. Shifting and changing dynamics will require continuous rather than one-off engagement to ensure that messages and services keep pace with changing needs and contexts.

Community

MSM and transgendered people experience a range of social disparities that remained largely invisible in Asia and the Pacific until high rates of HIV and STIs revealed them. Within many societies in Asia and the Pacific, there are individual MSM and transgendered people who have come together to actively resist their circumstances, respond to HIV, build community, and provide support to each other. They have developed small groups, networks, and organizations to provide companionship and to advocate for social change that can lead to better health for all MSM and transgendered people.⁵⁴ The principles of community development embodied

in the health promotion model remain the best way of understanding the power of these individuals, their groups, and networks, as well as sustaining and supporting them. In community development theory, these leaders and advocates are referred to as *key social change agents* who operate within societies to influence and change them.⁵⁵ The groups themselves support other groups, create new leaders, and build healthier communities. They enable active community players to do the same. These groups and individuals have an impact well beyond the MSM who feel comfortable joining these communities and represent the best chance to sustain an impact that spans the HIV continuum of care for MSM and transgendered people.

Space

One key characteristic of the collective activity of MSM is the appropriation of space, often public space, for covert use as meeting points and places for sex that will protect, as far as possible, the anonymity of the users.^{56,57} The signifiers that signal ‘public space as sex space’ vary from society to society as do the choices about what spaces are most commonly utilized for sex. Signals might include looks between men as they pass each other, men alone in public (which in some cultures is unusual), men entering and exiting a particular venue, or messages or diagrams on walls or trees. It is usual for public cinemas, parks, public toilets, truck stops, rest areas on highways, trains, buses, and train and bus stations to be appropriated for sex. These spaces change, depending on a number of variables, such as an increase in police presence, arrests, violence, or others who are not MSM moving in and occupying the spaces. Changes in location will not always be signaled between men. A place change may only become obvious when a man attempts to use that space—for example, if a man turns up to a cinema or park to find that it no longer operates as a covert sex space. He needs to turn his attention to other spaces he knows of, or he may have to search the city or province to find new sex spaces that are emerging. MSM of all kinds generally understand the appropriation of space in their particular locality. MSM remain the experts on the spatial dynamics involved in sex between men and therefore know how best to communicate with men who use these spaces.⁵⁸ This knowledge makes it possible for MSM CBO and NGO outreach workers to reach non-identified MSM, even if the men being targeted may never attend a drop-in center or MSM service.

Sexual Desire and Behavior

Men desire each other and have sexual fantasies about each other. They communicate and enact these fantasies. This is MSM sexual engagement at its root and it occurs between all groups of MSM, even groups who might not communicate in other spaces of society. Men desire sex with other men in various ways, places, positions, and combinations. When having sex, men communicate their sexual fantasies and desires in different ways. If the sex space is public, then communicating about these desires may be without words using only looks and gestures. If the sex space is dark (in a cinema or park, a public toilet, or a truck stop at night),

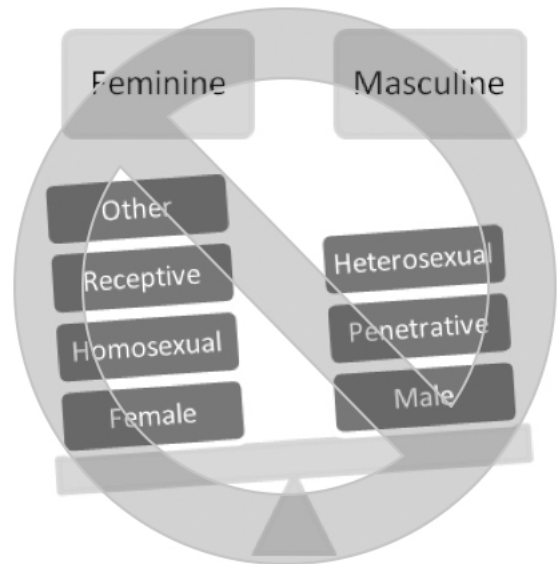
then gesturing might simply include moving one's body into positions that demonstrate what is desired but might also allow for physical resistance, which signals "I'm not interested in that." Sex in these covert ways may be desirable in and of itself for many MSM. There is a great deal of gay men's literature which describes how intimate and sexually fulfilling these moments can be.⁵⁹ Regardless of how MSM identify, they are engaged in these acts of desire with each other. It is this desire, the communication of the desire, and the behavior in enacting it that provide the opportunity for effective HIV prevention education that can be achieved and sustained by MSM themselves.

Identity

The term "men who have sex with men" was coined as a way to describe behavior and practice (biological men who have sex with other biological men) rather than to establish a sexual identity in addition to "gay" or "bisexual." However, MSM is now often used as a shorthand, catch-all term to describe both behavior and identity,⁶⁰ which has led to several problems. The use of MSM as an identity does not suit transgendered people, many of whom do not identify as men. It also ignores self-identified gay men and emerging urban gay communities in the region.⁶¹ Moreover, it has been used in ways that are too simplistic to recognize the varied forms of male-male sexual transmission of HIV⁶² and it groups all MSM into one category, promoting the false notion that any man who has sex with a man is on some sort of developmental pathway towards incorporating his sexual behavior into some kind of homosexual identity.

Two strategies have been suggested to resolve some of these problems: 1) focusing on sex between men, using the term "male-male sexual practice" rather than the acronym MSM, and 2) using local terms in each setting that have been derived to describe the different expressions of male-male sexual behavior and identity.⁶³ These include terms like *long hairs* and *short-hairs* in Cambodia, and *kothis*, *panthis*, and *double deckers* in India.

In India, *panthis* are masculine MSM whose sexual orientation is predominantly focused on sex with women. *Double deckers* are men who are sexually inclined toward masculine men. *Danga* are men with distinct feminine characteristics who have sex with men, and *ali* are said to be the third gender, neither men nor women.⁶⁴ *Kathoey* in Thailand are men who live as women and can be found in almost every town and city in the kingdom. The term *kathoey* is also used in Cambodia and Lao PDR, reflecting the historically shared aspects of culture and language of these three countries. *Kathoey* will at times use different polite participles and pronouns when addressing heterosexuals and MSM, further distinguishing themselves from others in their communities. Across Thailand, Lao PDR, and Cambodia, more and more literature exploring sexual identity includes terms such as *lady-boys* as well as *MSM long and short haired*. In



Indonesia, the *waria* are transgendered people who live openly as women.⁶⁵ In Viet Nam, *bong kin* are MSM who live as men without any outward identifying features that distinguish them as men who have sex with other men. *Bong lo* are men who wear female clothes and present themselves as women. In a study of 600 MSM in Viet Nam, 76% identified as *bong kin* while 12% identified as *bong lo*, and an additional 12% as men who have sex with both men and women.

This is not an exercise in linguistic correctness. Becoming familiar with these terms and the different sub-populations they describe is one way of paying attention to the diversity of behavior, identity, risk, and vulnerability across the spectrum of male-male sexual behavior and should lead to the development of responses that are better tailored to the needs of particular sub-populations.

Although these identities may appear to be binaries of "feminine" and "masculine," there is a duality and fluidity to them that also needs to be considered. When describing men, feminine can be female, homosexual, receptive, or passive. Masculine can be seen as male, penetrative, and heterosexual. Often though, seemingly contradictory combinations of these "binaries" can appear together in both individuals and sub-populations. What is most important here is that the ways men appear or identify may not align with the ways they behave sexually or with their desires and fantasies about sex with other men. Masculine men are sometimes receptive in anal sex and feminine or transgendered men may be insertive in anal sex. So assumptions about identity and role are not necessary predictors of sexual practice or risk in ways that seem obvious and sexual practice of course might change from day to day as the desire or setting changes. This is important for targeting prevention messages and communication, and for STI and HIV risk assessment in particular.

Appendix C: Case Studies of MSM Service Models in Asia and the Pacific

As noted earlier, there is a wide range of service models in use to reach MSM in Asia and the Pacific. The following are case studies of the MSM programs and organizations that were visited and interviewed as part of this assessment.

Thailand's MSM Clinic Program

In Thailand, six MSM clinics operate in and beyond Bangkok. Mainstream doctors and nurses undertake medical consultations, examination, and treatment, delivering a VCT-style service while MSM allied health professionals are employed to provide pre- and post-test counseling. In many cases these clinics, while specializing in MSM, also target other most-at-risk populations. Rainbow Sky is the national gay and lesbian CBO in Thailand and actively works with MSM to prevent HIV through outreach programs, workshops, retreats, and advocacy across the kingdom. Rainbow Sky convenes a health services network made up of MSM employees from these centers. The network helps to sustain cooperation across the medical and community sectors, as well as the active involvement of MSM as an at-risk population.

Limited resources are a problem: if significant numbers of MSM were to attend, these clinics would be overwhelmed and unable to deliver services within current resources.

There remain some difficulties with these models. In some of the sites, loss-to-follow-up rates are high and connection to community MSM groups remains low. Continued attitudinal difficulties among some medical and allied health staff pose a barrier to quality service delivery to MSM. One limitation is that in medical settings there may be fewer incentives for clinic staff to link with the other services that might educate and support MSM. However, there was some success in building alliances across sectors. These services, where they exist, are not at scale and are not reaching large numbers of MSM in their areas. Limited resources are a problem: if significant numbers of MSM were to attend, these clinics would be overwhelmed and unable to deliver services within current resources. In some places this fear has resulted in a restriction in services. Staff at one clinic stated that they could diagnose but not treat syphilis, because if it became known in the MSM community that they were treating

syphilis, more people would come forward for treatment and the clinic would be overwhelmed.

China's Shenzhen MSM Clinic

In China, an MSM clinic operates in Shenzhen through a unique initiative of the local and national governments and the WHO. The clinic embraces a broader HIV public health approach through collaboration with local MSM organizations and businesses; training of healthcare workers on MSM issues; deploying mobile clinics; initiating an innovative outreach program using the Internet, telephone, and mobile services; using volunteers; and actively involving community members in directing and evaluating the service.

Ho Chi Minh City: MSM-friendly Community Clinic

In Vietnam, the Ho Chi Minh City Provincial AIDS Committee delivers its HIV community services through a one-stop-shop model for HIV prevention and care, incorporating VCT, HIV clinical care, TB and drug substitution services, mental health, and STI services. The complex also houses an MSM community organization (Blue Sky) that provides outreach and drop-in services and is responsible for generating client demand for the community clinical services through its outreach and behavior change communications. The long relationship between the MSM group and these district HIV services works to ensure that district-level HIV services are MSM friendly and accessible.

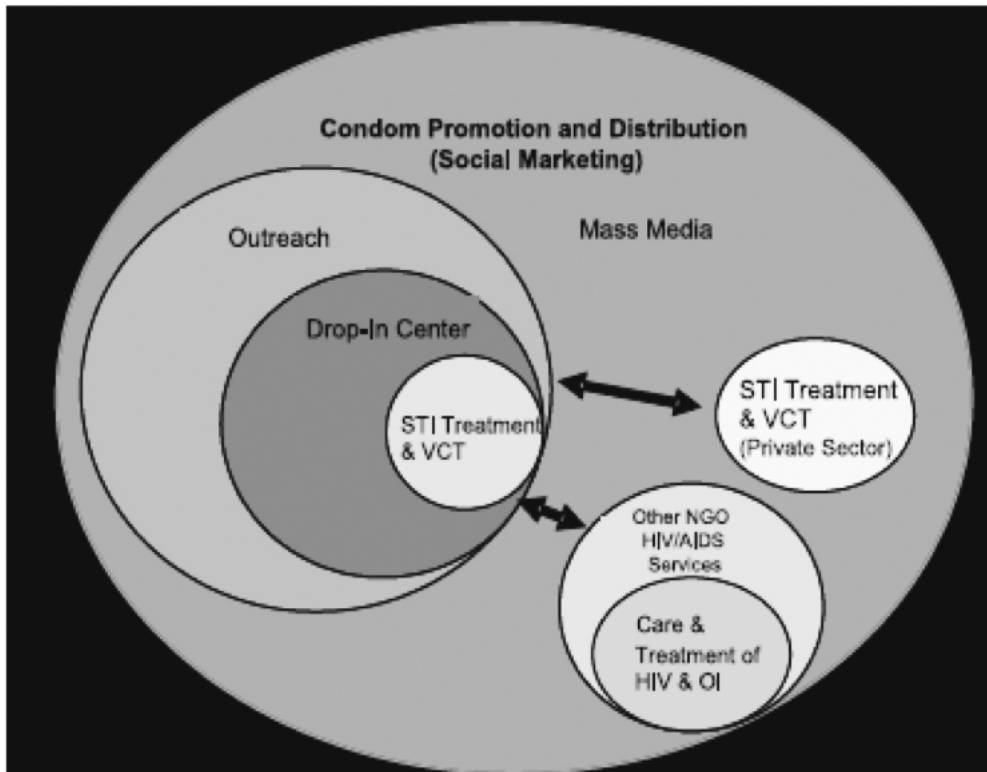
Thailand's Silom Community Clinic

In Thailand, an MSM community clinic has been providing HIV VCT to MSM in Bangkok, supported through a collaboration between the Thailand Ministry of Public Health and the U.S. CDC. The service is located in Bangkok Christian Hospital on Silom Road, which is a major center for gay and MSM commercial and social activity in the city. The clinic is housed within the hospital and a confidential card system allows clients to register at the clinic itself without revealing their personal details through the hospital's mainstream admission system. Some of the clients are part of a cohort bio-behavioral study; they complete computer generated questionnaires every four months about their sexual behavior and are tested for HIV and STIs on site. The clinic also provides general HIV VCT services to MSM beyond the research cohort. It delivers rapid testing for HIV and syphilis and tests for other STIs. It also provides vaccination for hepatitis B. It refers to government services for HIV treatment and care; STIs are treated on-site. The team at the Silom Community Clinic is currently expanding their program to provide increased support to MSM and research promising interventions for MSM.

The CDC is working in collaboration with the Ministry of Health in Thailand to assist it in identifying and rolling out an effective model that will help MSM to access the services they need.

Minimum Package Concept—PSI Myanmar⁶⁶

In Myanmar, Population Services International (PSI) is taking a most-at-risk population approach to its intervention design, and focusing on delivering a minimum package of services to populations. The package includes VCT and STI clinical services delivered directly to MSM through community drop-in centers. The model is summarized in the following diagram:



This model pays particular attention to issues of scope and coverage and reports contact with 66% of MSM through outreach services. The focus is on outreach to sites where MSM gather socially or where they have sex, providing access to drop-in centers and to community-provided STI and VCT services.

Behavior change among the target populations has been found to be correlated with exposure to the program activities.

Cambodia's Chhouk Sar II Clinic

In Cambodia, the Chhouk Sar II Clinic was established in Phnom Penh to provide treatment, care, and support to HIV-positive MSM in 2007 with funding and collaboration from FHI. Unlike a number of other clinics of this sort, Chhouk Sar II is able to diagnose and treat at one center. Medical personnel provide HIV VCT, CD4 tests, HIV viral load tests, ART, and OI prophylaxis. Condoms are available and all services are free to the patient. The service is located close to the CBO Men's Health Cambodia in order to ensure a close alliance and efficient cross-referrals. There are monthly support groups, individual counseling, and health education on HIV knowledge, healthcare, adherence, and prevention.

Malaysia's PT Foundation

PT Foundation started in 1987 as Pink Triangle in Kuala Lumpur. It provided HIV prevention and sex advice to MSM through telephone counseling. It later expanded to respond to various appeals by communities experiencing discrimination because of HIV and their sexuality. PT now provides services to a range of at-risk communities through a complex model that includes prevention-based outreach,

VCT and other clinical referral services, community drop-in centers, telephone counseling, and advocacy. It provides VCT to most-at-risk-populations in Penang and Kuala Lumpur, including sex workers, transgendered people, IDUs, and MSM. It also provides a follow-up service for clients who test HIV-positive at local hospitals and clinics. The latest evaluation shows that around 90% of these newly diagnosed people access follow-up services.

PT Foundation supports HIV treatment, care, and support through close relationships between its peer workers and the staff of government HIV treatment services. This allows it to assist in treatment adherence and support for MSM. PT Foundation does this in the midst of a relatively hostile policing environment, in which carrying condoms is seen as a sign of sex

work or immorality. The Foundation wants to expand its reach into East Malaysia and Johore. It has developed effective local models, but wants assistance in packaging these for expansion to reach scale. PT plans to expand into a hub of training, mentoring, and generating new knowledge for HIV clinical prevention and care that would incorporate training healthcare workers and physicians, working alongside nurses in clinics, and accompanying patients to hospital services.

PT is also planning to establish MSM-friendly clinics in collaboration with state health departments by bringing in

The PT model shows the kind of innovation that can lead to a rapid increase in coverage of populations once isolated from HIV prevention and care.

MSM-friendly visiting doctors and other health workers to make use of government clinics after hours and linking this to its outreach and drop-in work.

The PT model shows the kind of innovation that can lead to a rapid increase in coverage of populations once isolated from HIV prevention and care. A focus on state rather than national-level health service planners helps clients access direct health services. Bringing in visiting health staff to a separate clinic for most-at-risk populations avoids the fear of some health workers that increasing their client load of these populations in their own clinics might somehow alienate their other clients.

Mumbai's Humsafar Trust

Humsafar was set up in 1989 by a small group of friends who had chosen to live as gay men and not to marry women, but were concerned about isolation and loneliness as they grew older. Out of that group came *Bombay Dost*, a gay magazine that later became a successful community communication tool for MSM. The founding board decided early in Humsafar's life that it would be an organization committed to dialogue and negotiation with authorities rather than confrontation. They decided that they would not duplicate or substitute services provided by the state, but would work on getting access to these services for their constituents.

They began with an HIV information service for MSM, provided via phone and mail, along with a drop-in center, and conducted outreach at sites where MSM gathered socially or where they had sex. They developed a good relationship with a Mumbai government hospital (Sion) and developed a unique referral system that minimized the discrimination and poor treatment that MSM had been experiencing when they tried to access STI services. This involved giving out cards at outreach sites that qualified MSM for quick and MSM-friendly services at the hospital and having outreach staff accompany people to clinics. Gradually, with the assistance of Sion hospital doctors, they introduced their own clinical services at the drop-in center and now have three centers across Mumbai with drop-in and clinical services for MSM sub-populations. Humsafar also provides legal advice and other welfare services at these centers.

Humsafar now has 206 staff and 198 of these are MSM. It acts as a mentoring agency for emerging MSM CBOs, helping them to build the capacity they need to serve their communities.

While Humsafar works with a variety of sub-populations—male sex workers, transgendered people, homeless MSM—it does not make assumptions about HIV risk based on an individual's perceived membership of a particular MSM sub-population, but bases risk assessment and service development on the individual's actual risk behaviors.

Humsafar found that male sex workers were not using its drop-in and clinical services as much as other MSM, so it set up a separate service for this group, linking this sub-population into its wider network.

As clinical services developed, Humsafar recognized the need for particular support for MSM with HIV and now operate a peer volunteer support system for MSM with HIV and a support group called Safe Sailors.

In keeping with its non-substitution philosophy, Humsafar does not provide ART, but helps its clients to participate in the government's HIV treatment program. It does, however, provide an ART start-up program for people who may find it difficult to qualify for the government system—transgendered people without the correct identity papers for example—and then assists them in accessing government services.

Humsafar is now funded from a range of sources, but primary among them are the Maharashtra State and Mumbai District AIDS Control Societies. This recognition by government AIDS response groups is essential to Humsafar's sustainability.

Humsafar's success contains some important lessons on MSM NGO involvement:

- It started with drop-in and outreach, and expanded gradually into providing on-site clinical services as it became more stable and confident;
- It is firmly established as part of the state and local government response;
- It avoids duplication of government services whenever possible; and
- It contributes to achieving scale by mentoring other local MSM CBOs and NGOs.

Bandhu Social Welfare Society (BSWS), Bangladesh⁶⁷

Bandhu Social Welfare Society was formed in 1996 to address concerns of human rights abuse and denial of sexual health rights, and provide a rights-based approach to health and social services for one of the most stigmatized and vulnerable populations in Bangladesh, *kothis/hijras* and their partners. The organization was born in response to surveillance studies and a needs assessment that identified MSM as a population in need of services in Bangladesh. BSWS has been officially registered since 1997. It started with a staff of two and a small program in Central Dhaka. Over the years it has emerged as a national MSM NGO with more than 200 employees who currently provide social and health services to a broad range of MSM in 14 districts.

A core objective of BSWS' work is to advocate and provide an environment that assures the respect and dignity of all MSM and transgendered people—irrespective of their specific gender and/or sexual identity. It also works to create a supportive social, policy, and legal environment to ensure the basic human rights of MSM in Bangladesh, including their right to sexual health.

The BSWS model is based on field offices that provide drop-in centers. The centers provide safe space for the MSM community, HIV prevention services, and referrals for STI treatment and care.

The current services that BSWs provides to MSM (including *hijras* and other transgendered people) reflect the key objective of community strengthening and mobilizing to engage more effectively in governance, policy development, and sexual health and rights service delivery. Services focus on three key areas:

1. Community development and response: Provision of safe spaces for community development and mobilization; outreach and community-building services; health education; distribution of sexual health products; knowledge generation; capacity building; and networking, information dissemination, policy development and advocacy.
2. Social welfare and support services: Social support services; psychosexual and psychosocial counseling; and a livelihood skills program.
3. Health services: STI management and general health treatment services; HIV VCT; care and support services; and referrals for ART and other health services.

Clinical services include STI and general health treatment, HIV VCT, and psychosexual counseling. BSWs hires doctors on a part-time basis to provide these services, but would eventually like to develop its own clinical team rather than procure services from others. There is a low prevalence rate among the clients of BSWs and it does not provide extensive services to HIV-positive MSM.

Field services include outreach and friendship building, community development and mobilization, social meetings, education and awareness, behavior change communications, condom distribution, and referrals to clinics. Center-based activities include socializing and support groups, vocational training and skills building, drop-in services, and community-building activities. BSWs is developing VCT services for MSM, and also provides subsidized STI treatment, counseling and support at some of its sites.

BSWS also uses a case management model in which clients move from receiving field services to becoming regular members. This is possible for the *kothi* (feminized MSM) who identify as part of a community, but not for *panthi* (masculine MSM) who come from all walks of life. Therefore, most services are aimed at *kothi*, while *panthi* and other non-*kothi* access clinical services. Transgendered people have their own group, Shustha Jiban (Happy Life), which was established in October 2000 as a part of BSWs, and then became independent in May 2005. BSWs provides them with support and capacity building. The organization was recognized as a best practice model by UNAIDS in 2001 and, in coordination with a national AIDS/STD program in Bangladesh, it is in the process of forming a national taskforce on HIV and human rights for MSM and transgendered populations.

Again, the Bandhu model is a sophisticated one that has developed gradually over time and shows that MSM NGOs can, with support, take ownership of clinical services and embed them into a community-based prevention-to-care continuum.

Poro Sapot, Papua New Guinea

Another group working in a difficult environment is the Poro Sapot Project, part of Save the Children Papua New Guinea.

Poro Sapot is an STI/HIV intervention working with sex workers and MSM in three provinces—the capital Port Moresby, Lae (Papua New Guinea's second largest city), and in Goroka and Kainantu, two towns in the highlands. Poro Sapot runs the only sexual health clinic in the Pacific that specifically targets MSM.

The project trains and supports MSM who provide outreach in the community, bringing other MSM into contact with the project's STI and HIV prevention and care services. Discrimination against identifiable MSM who seek clinical services from mainstream clinics in Papua New Guinea is extremely high. In towns where there is no dedicated clinic, peer educators accompany MSM to mainstream clinics to ensure that they receive the care they need. The project works closely with these clinics to ensure non-discriminatory care. It also works closely with the police to reduce harassment and violence.

The project works under the three values of "Recognition, Respect, and Reliance" and hosts drop-in centers where MSM can gather and support each other.

The Blue Diamond Society, Nepal⁶⁸

The Blue Diamond Society (BDS) started informally with outreach to MSM in parks in Kathmandu at the end of 2000, and was formally established in September 2001. Formed to focus on LGBT issues, including MSM, it also took on HIV, handing out condoms and addressing the issue of human rights. Its work on human rights expanded in 2003 in response to increasing violence towards transgendered people. BDS started to address treatment, care, and support in 2004. It recently obtained funding to build a care center, as well as a hospice in Kathmandu for HIV-positive MSM. BDS centers offer both HIV prevention and treatment services and referrals, and BDS refers MSM and transgendered people to government hospitals for ART.

BDS established a drop-in center in 2002, while continuing to do outreach work. BDS has responded to identified needs, rather than planning its strategies and growth. Its chosen models of intervention have grown out of these needs and available funding. It was able to expand its work in 2004 to other districts and began to address treatment, care, and support. In 2005, with more funding, it began work in five other cities, and in 2006 expanded to working in 20 cities across 15 districts (with funding from FHI and the UK's Department for International Development). In 2006, BDS established a national federation with nine founding partners—which now includes 16 organizations, four of them focused on lesbians. BDS maintains more than 60 staff members, with 23 in Kathmandu, and is now in 24 districts, with six care and treatment centers and 25 HIV prevention centers. Additional funding for an HIV prevention program

for MSM and transgendered people has been provided since April 2009 by the Global Fund.

The BDS model began with outreach and expanded to drop-in-centers. The MSM it has reached are regularly in contact with the network. BDS centers offer well-integrated HIV prevention and treatment services. They refer clients to government hospitals for ART. The drop-in centers have a mixed clientele, though few partners of transgendered people attend.

The two major challenges for BDS have been scale-up and discrimination. While BDS has grown significantly in size, it needs to grow further. Thirty districts have requested HIV prevention, care, and support for MSM. However, the national government focus remains primarily on HIV among IDUs and migrants.

MSM and transgendered people have faced high levels of violence, discrimination, and oppression. BDS has focused on both advocacy and solidarity. Its advocacy work includes documenting violence against MSM since 2003, and advocating for greater awareness within government, leading to the recognition of MSM as a vulnerable group in the national HIV strategic plan at the end of 2003. To address the high levels of stigma and discrimination against transgendered people in the workplace, BDS has maintained a constant campaign to prevent abuses, publicize problems, and educate policy makers and the general public. It has publicized police abuse through international e-mail campaigns and has organized forums with international experts to discuss legal and constitutional issues. This has paid off, as abuse has declined and Nepal's Supreme Court approved of same-sex marriages in November 2008. BDS's leader, Sunil Pant, is now a member of Parliament in the new government. MSM responses now appear in the national budget for the first time ever, and it is now legal to be gay in Nepal. BDS has also used other innovative campaigns to address stigma and discrimination against transgendered people, such as its transgender beauty salon and transgender "Beauty and Brains Contest."

BDS has grown and developed in a fragile and difficult political environment and is now a mature and stable organization that makes a key contribution to Nepal's response to HIV.

The MSM Initiative

The MSM Initiative's mission is to significantly improve HIV prevention, treatment, care, and support among MSM populations in resource-limited countries across Africa, Asia and the Pacific, the Caribbean, Eastern Europe and Central Asia, and Latin America. The Initiative addresses the HIV/AIDS burden among MSM through the following strategies:

- Supporting and empowering grassroots MSM organizations by providing direct financial support and capacity-building in the form of community awards;
- Promoting research on MSM and HIV and building understanding and awareness about HIV epidemics among MSM and other groups; and
- Advocating for effective policies and increased funding for programs and initiatives addressing MSM at risk of HIV/AIDS.

Since the launch of The MSM Initiative at the International AIDS Society Conference in 2007, these objectives are being met through the program's community award grant-making process. Approximately \$1.25 million has been committed as of May 2009, with 39 community award grants totaling nearly \$900,000 distributed in the first year alone. These grants support MSM organizations in developing countries and other resource-limited settings to provide HIV/AIDS prevention, treatment, care, and support. Additionally, the funds help build local capacity, fight stigma, inform research, and catalyze political action. The Initiative's grant-making and support systems are community-driven, with regional consultations held directly with affected MSM communities and funding proposals evaluated by peer reviewers in each region.

The MSM Initiative has also formed a variety of partnerships with global health and HIV/AIDS organizations to further international advocacy and awareness efforts. These organizations include UNAIDS, UNDP, the Global Forum on MSM & HIV, and the International HIV/AIDS Alliance.

Stopping the Epidemic Among MSM

At its core, The MSM Initiative, like amfAR's other programs, is committed to saving lives, reducing the spread and impact of HIV, and helping to stop the global epidemic. However, this cannot be accomplished without a comprehensive response—a response that must include MSM and other vulnerable groups. Since its inception in 2007, amfAR's MSM community awards program has been extremely successful, with demand for grants from frontline organizations far exceeding the limited funding available. In Africa alone, a second-year request for proposals generated 67 applications from 19 countries seeking more than U.S. \$1.3 million. However, because of resource constraints, amfAR was able to fund only eight groups working in six

countries at a total cost of \$100,000. To put these numbers in perspective, the remaining \$1.2 million funding gap equals countless lives lost, a spiraling number of new HIV infections among MSM, and a mounting tragedy that could be averted with increased funding and concerted support from bilateral government donors, multilateral agencies and private foundations and corporate giving programs.

amfAR will continue to provide leadership to ensure that governments and other key agencies recognize and support the needs of MSM globally.

amfAR's Historic Role in the AIDS Epidemic

amfAR, The Foundation for AIDS Research, is dedicated to ending the global AIDS epidemic through innovative research. Funded by voluntary contributions from individuals, foundations, and corporations, amfAR has invested nearly \$290 million in support of its programs and since its establishment in 1985 has awarded grants to more than 2,000 research teams worldwide. Aside from its TREAT Asia network, amfAR has invested more than \$10 million in international grants alone, and has supported prevention and education activities in 39 countries, such as Argentina, Ethiopia, Gambia, India, Indonesia, Nigeria, and Tanzania.

Since its inception, amfAR has increased understanding of HIV and helped lay the groundwork for major advances in HIV/AIDS treatment and prevention. Previous grants have supported:

- early studies critical to the development of protease inhibitors;
- pioneering work that led to the use of AZT to block mother-to-infant HIV transmission;
- the first studies demonstrating the potential of DNA vaccines;
- identification of CCR5 as a critical co-receptor for HIV; and
- the identification of the anti-HIV properties of the T-20 compound, the first fusion inhibitor to be approved for use by the FDA.

In the late 1980s, amfAR pioneered the concept of community-based clinical trials on AIDS. Between 1989 and 1996, amfAR invested more than \$30 million in its Community-Based Clinical Trials Network and helped expand access to experimental therapeutics to tens of thousands of patients, facilitated the "real-world" testing of the safety and efficacy of new drugs, and, by actively engaging the community in the process, helped revolutionize the conduct of clinical trials in the U.S.

One of the first advocates for people affected by HIV/AIDS, amfAR galvanized national leadership on the epidemic. The Foundation was instrumental in securing passage of key federal legislation shaping the U.S. response to the HIV/AIDS epidemic, including the Hope Act of 1988, the Ryan White Care Act of 1990, the Americans with Disabilities Act of 1990, and the NIH Revitalization Act of 1993.

Today, the Foundation's activities continue to focus on:

- the identification and funding of promising, innovative research projects that have not yet attained sufficient preliminary data to secure grants from traditional funding sources, such as the U.S. National Institutes of Health and the pharmaceutical industry;
- HIV/AIDS prevention and treatment education programs for the public and healthcare providers;
- public policy activities to protect the human rights of all people affected by the epidemic and to advocate the allocation of increased federal resources for HIV/AIDS programs based on scientific fact and solid public health principles; and
- global initiatives, such as TREAT Asia and The MSM Initiative, that help healthcare workers and AIDS organizations in developing countries to maximize local resources and facilitate the development and implementation of effective international research, treatment, prevention, and education strategies.

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