



Scaling up HIV programming for men who have sex with men - the experience in Asia and the Pacific

**A report to the Global Forum on MSM & HIV
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Prepared by Paul Causey on behalf of APCOM - the Asia Pacific Coalition on Male Sexual Health

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“Scaling up focused HIV prevention strategies for populations most at risk represents an urgent public health necessity.”

From Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS to the 62nd session of the United Nations (2008)



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MSM HIV programming in the Asia and Pacific region has advanced more rapidly over the last three to five years compared with other regions with predominantly low and middle income countries. This paper is the result of a regional meeting of technical experts held in May 2008 in Bangkok, Thailand. Each of these individuals has unique direct professional experience and involvement in one or all aspects of the processes that are believed to have aided these advances in HIV programming for MSM in Asia and the Pacific.

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1. **Aditya Bondyopadhyay**, Coordinator, APCOM; RR/APCOM + MSM-GF
2. **Asia Nguyen**, Programme Officer - Coordination, UNAIDS Viet Nam; GMS
3. **Clifford Cortez JD**, Senior Technical Advisor HIV/AIDS, USAID Asia; GMS & RR/APCOM
4. **Don Baxter**, Executive Director, AFAO; GMS & RR/APCOM + MSM-GF
5. **Edmund Settle**, HIV/AIDS Programme Manager, UNDP China; GMS & RR/APCOM
6. **Indrajit Pandey**, Programme Officer, UNAIDS RST AP; RR/APCOM
7. **Philippe Girault**, Senior Technical Officer, Male Sexual Health Program, FHI/APRO, GMS & RR/APCOM
8. **Rob Sutherland**, Capacity Development Officer – MSM; UNAIDS RST AP,
9. **Dr. Ruben del Prado**, Country Coordinator for Guyana and Suriname, UNAIDS; RR/APCOM + MSM-GF
10. **Shivananda Khan OBE**, Chief Executive, NFI; GMS & RR/APCOM + MSM-GF
11. **Paul Causey**, Consultant, APCOM (MSM-GF/AFAO); GMS & RR/APCOM
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The paper was principally authored by Paul Causey, who also helped coordinate, for FHI-APRO, both the early work in the Greater Mekong Sub-region and the International Coalition on Male Sexual Health and HIV/AIDS in Asia and the Pacific, (Risk and Responsibilities). He is currently a consultant to the Asia Pacific Coalition on Male Sexual Health (APCOM) and participated in the start up of the Secretariat operations and the APCOM website at www.msmasia.org.

For additional information about the Asia Pacific Experience, including copies of reports mentioned in this paper, contact either of the Secretariat offices below:

Purple Sky Network

Siam Arayawongchai, Coordinator, MSM Program
TREAT Asia
Exchange Tower
21st floor, suite 2104
388 Sukhumvit Road, Klong Toey
Bangkok 10110 Thailand
Telephone: +66 (0) 2663 7561
Fax: +66 (0) 2663 7562
Email: jack.arayawongchai@treatasia.org

Asia Pacific Coalition on Male Sexual Health

Aditya Bondyopadhyay, Secretariat Coordinator
11/4 A 1st Floor, Double Story Area
Prem Nagar, Janakpuri
New Delhi-110075 India
Telephone: +91-11-6510-7911
Email: adityab@msmasia.org

Commonly used abbreviations and acronyms

| | |
|--------------------|--|
| ADB | Asian Development Bank |
| AFAO | Australian Federation of AIDS Organizations |
| AIDS | Acquired Immune Deficiency Syndrome |
| amfAR..... | American Foundation for AIDS Research |
| APCOM | Asia Pacific Coalition on Male Sexual Health |
| APN+..... | Asia Pacific Network of People Living with HIV/AIDS |
| APNSW | Asia Pacific Network of Sex Workers |
| ART/ARV | antiretroviral therapy or treatment/antiretroviral drugs |
| ASEAN | Association of Southeast Asian Nations |
| CBO | community-based organization(s) |
| CDC | China Centre for Disease Control and Prevention |
| CSO | civil society organization(s) |
| DFID | Department for International Development (UK) |
| FHI-ARPO..... | Family Health International - Asia Regional Program Office |
| FSW..... | female sex workers |
| GMS | Greater Mekong Sub-region |
| HIV | Human Immunodeficiency Virus |
| Hivos..... | Humanist Institute for Cooperation with Developing Countries |
| HPI/RTI..... | Health Policy Initiatives/Research Triangle Institute |
| ICAAP..... | International Congress on AIDS in Asia Pacific |
| IDU | injection drug user |
| ILO..... | International Labour Organisation |
| INGO | international nongovernmental organization(s) |
| MARP..... | most at risk populations |
| MSM | men who have sex with men |
| MSM-GF..... | Global Forum on MSM & HIV |
| NFI | Naz Foundation International (UK) |
| NGO | nongovernmental organization(s) |
| PLHIV | person or people living with HIV include those with AIDS |
| PSN | Purple Sky Network |
| RR | Risks and Responsibilities – International Consultation on Male Sexual Health and HIV/AIDS in Asia and the Pacific |
| RTI..... | Research Triangle Institute |
| STI | sexually transmitted infection(s) |
| TAF..... | Technical Support Facility |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNAIDS RST AP..... | UNAIDS Regional Support Team - Asia and the Pacific |
| UNDP..... | United Nations Development Programme |
| UNDP RBAP | UNDP Regional Bureau Asia and the Pacific |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Populations Fund |
| USAID | United States Agency for International Development |
| US-CDC..... | The Centers for Disease Control and Prevention (USA) |
| WHO | World Health Organization |

...“it’s the epidemiology.” ... in low and concentrated HIV epidemics ... MSM is a critical part of transmission dynamics ... many in this region, including government representatives, are committed to the reduction of HIV in MSM because MSM are an important epidemiological factor relative to HIV/AIDS, as experience has shown in other parts of the world.

From Report from HIV Prevention and Care Interventions for MSM in the Greater Mekong Sub-region Regional Consultative Forum (2006)

Introduction

Increased attention to HIV epidemics among men who have sex with men (MSM)¹ in middle and low income countries can be seen in the publication of new studies and research. These epidemics are now documented to be underway in Asia, Africa, the Caribbean, Latin America, and the former Soviet Union states of Eastern Europe. Many of these HIV/ MSM epidemics share common traits in addition to mere mode of transmission. These commonalities exacerbate or indirectly contribute to the problem, and include criminalization of male to male sexual activity (MMSA), social exclusion from mainstream healthcare systems including infection control planning and services, societal stigma and discrimination against same sex ‘orientations’ which are regarded as non-mainstream, exclusion from human rights initiatives and protections, and lack of comprehensive HIV surveillance.^{i ii}

In Asia and the Pacific, response to HIV infection among MSM was nearly non-existent until after the year 2000. General discomfort with the fact of sex among men in Asia meant government and national AIDS programme priorities usually did not include data for this group prior to the year 2000. As a result, the logic of a vicious circle was followed - no data meant there must be no problem; therefore, no interventions including research or surveillance were undertaken, which assured there would be no document of need or risk behaviours, and so forth.

There is now, though, data available for most countries along with increases in programmatic responses in some areas. Inclusion of MSM as a ‘most at risk population’ (MARP) now exists and MSM and HIV programming in the region has advanced more rapidly over the last three to five years when compared to regions with similar low and middle income countries. As well, the recently released report of the independent Commission on AIDS in Asia in March 2008 stated clearly that efforts to halt the Asia HIV epidemic must now focus on high risk behaviours occurring chiefly among three sub-populations – female sex workers (FSW), injection drug users (IDU) and men who have sex with men.ⁱⁱⁱ

This paper intends to help understand what made the difference in Asia and the Pacific for increased attention to MSM and HIV. There is wide agreement in the region that two processes, one sub-regional and one region-wide, have provided a framework and context which both strengthened MSM advocacy for improving the response to HIV and allowed most national governments in the region to support – or

¹ “Men who have sex with men” (MSM)) is an inclusive public health term used to define the sexual behaviours of males having sex with other males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular ‘community’. The words ‘man’ and ‘sex’ are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male to male sex takes place. (APCOM 2008)

at least not to oppose or suppress – the development of HIV programmes for MSM. The two processes culminated in the creation of, respectively, the Purple Sky Network, a coordination effort for MSM and HIV interventions in the Greater Mekong Sub-region (GMS), and the Asia Pacific Coalition on Male Sexual Health (APCOM). The contributions by these two processes to the scale up of HIV interventions and the work needed to achieve it are referred to in this paper as “the Asia Pacific Experience”.

The Global Forum on MSM & HIV (MSM-GF) convened a meeting of 12 technical experts in April 2008 in Bangkok, Thailand to discuss and document the two processes. Most of these participants had been involved in the start up and implementation of either or both of the processes and many continue to support both of them in their work. As well, all continue to be directly involved in work to improve and increase universal access to HIV services for MSM and transgenders, among others.

The Bangkok meeting set two critical objectives:

1. To provide a space for the critical reflection, clarification and documentation of effective advocacy strategies and techniques contributing to improved MSM programming in the Asia Pacific region.
2. To provide MSM programme activists and supporters, particularly from Africa, Central Asia and Eastern Europe, with a range of well-considered and potentially useful strategies and techniques to build momentum for MSM programming and to help overcome resistance from authorities and gatekeepers.

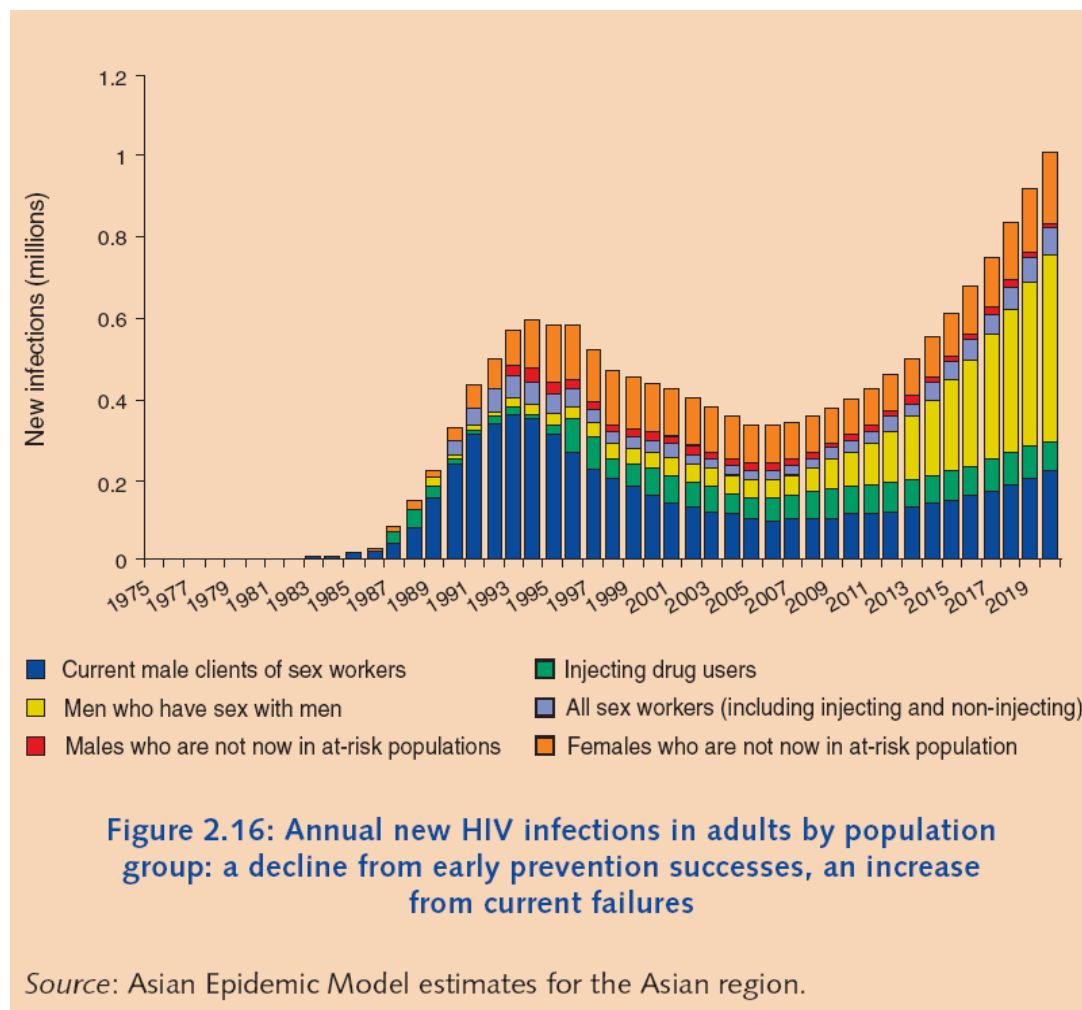
This paper is intended to be taken to MSM activists, programme planners and, hopefully, government officials in other regions, to learn from, adopt and adapt the lessons of the Asia Pacific Experience. It is hoped that this work will inspire community leaders, government policy makers and international donors alike to consider how best to assist in the scale up of timely and evidenced-based interventions in the accelerating global HIV epidemics among MSM.

Situation of MSM and HIV in Asia and the Pacific

The incidence of male to male sex is known to happen in every country of the Asia Pacific region yet in most countries it is largely denounced, ignored or disregarded by mainstream society. In some countries, same sex activity is criminalised by laws held over mostly from the time of colonial rule. This situation has led to a lack of public health attention to the needs of this sub-population, including HIV interventions which strategically focus on prevention, treatment, care and support for MSM.

The 2008 report from the Commission on AIDS in Asia estimates that at least 75% of HIV infections in the region can be linked directly to high risk behaviours occurring during sex between men, female sex work and injecting drugs. Moreover, the Commission used a well-proven projection model to calculate what might happen if current epidemiological trends continue in this atmosphere of neglect. It revealed that

50% of all new infections in the region will be among MSM by 2020, outnumbering HIV infections caused by the other two sub-population groups.^{iv}



From *Redefining AIDS in Asia - Crafting an Effective Response*, Commission on AIDS in Asia (2008)

A 2006 survey of the coverage of HIV interventions in 15 Asia Pacific countries estimated that targeted prevention programmes reached less than 8% of the estimated number of MSM,^v whereas 80% coverage is needed to effectively reduce the incidence of HIV infections.^{vi} Substantial HIV epidemics among MSM are now well documented in urban areas across Asia, with HIV prevalence rates of 30.7% in Bangkok (2007)^{vii}; 15.6% in Maharashtra State (2007)^v; 12.3% in New Delhi (2007)^{viii}; 8.7% in Phnom Penh (2005)^{ix}; and 5.8 % in Beijing (2007)^x. Despite these findings indicating that HIV prevalence among MSM is up to 50 times higher than prevalence among general population adults and contributes to between 10 and 25% of the total number of HIV cases in several countries, investment in HIV programming for MSM remains very low (0%-4% of the total spending for HIV programming region-wide^{xi}).^{xii}

Although coverage of HIV services for MSM in Asia and the Pacific continues to be very low, it has been dramatically increased from the almost zero attention in 2000 to

now. Largely responsible for this increase are the two processes, the Asia Pacific Experience, supporting and leading advocacy and scale up in Asia Pacific. The Purple Sky Network serves as a focal point for advocacy, support and coordination in the Greater Mekong Sub-region. The Asia Pacific Coalition on Male Sexual Health (APCOM) is a collective comprised of representatives from MSM communities and groups involved in HIV work, the government sector, donor and development agencies, INGO technical experts and the UN system. Both initiatives have provided a framework and context to HIV among MSM, which strengthened MSM advocacy for improving the response to HIV and allowed many national and local governments in the region to better understand and support – or at least not directly oppose or suppress – the development of HIV programming for men who have sex with men.

History – Conception to Inception

Not until 2006 were MSM included in any national AIDS control plans in Asia and the Pacific – at best, they had been mentioned under broad categories with other high-risk populations. There had been, however, some information on male-to-male sex collected in countries in the GMS, South Asia and Indonesia that provided some unpleasant surprises: high levels of unprotected anal sex, very low use of or access to water-based lubricants, and high levels of HIV infection rates.^{xiii}

These findings had led to some progress in designing and implementing pilot programmes for prevention and care programmes for MSM in most of the urban areas where the research was conducted, but other possible “hotspots” with significant male-to-male sexual vulnerability to HIV (and sexually transmitted infections (STI)) were highly suspected but remained undocumented. As a result, of course, these hotspots also lacked targeted interventions.

There also was no agreement or research to guide the type and methodology of interventions or services that would best be provided to MSM in the region. In Vietnam, an MSM sub-group of the Technical Working Group on HIV/AIDS had started meeting in 2004, which led to a discussion of HIV among MSM in the GMS at an HIV and drug use meeting in Cambodia at which government officials and civil society were both present. It was felt by those at the meeting, in discussing the early reports, that the few data available should be used to “wake people up about MSM and HIV in the GMS.”

A meeting was undertaken and the GMS HIV and MSM process (referred to here as the GMS process) began with two United States government donor agencies, the US Centers for Disease Control and Prevention Global AIDS Program (CDC-GAP) and United States Agency for International Development Regional Development Mission (USAID-RDMA), and the international non-government organisation (INGO) Family Health International Asia Regional Program (FHI-ARP). The process was to start with a workshop to assess the extent of HIV and MSM in the six Greater Mekong countries (Cambodia, China (Yunnan and Guangxi provinces), Laos, Thailand, Vietnam and Myanmar/Burma), and to decide on a minimum comprehensive package, or conceptual framework, of interventions for MSM, which could also be used as a framework for policymaking and monitoring and evaluating programmes.

In South Asia, and particularly in India, there is a long history of civil society, including community organising among lesbian, gay, bisexual and transgender (LGBT) people. In 1994, an historic national conference for gay men was held in Mumbai and key leaders were empowered to begin addressing many of the issues facing gay men at that time, including HIV among MSM. Humsafar Trust and Naz Foundation International (NFI) began developing and supporting HIV programming for gay men and MSM, together with transgenders (hijras and kothis), in India and Bangladesh, and soon afterwards in Nepal and Sri Lanka. Several sub-regional and provincial meetings were held in the late 1990s and early in the new century, which were by and for MSM civil society but always included members from both the donor and government sectors, although most often only as observers rather than “official” representatives.

At a meeting in 2004 during the International AIDS Conference in Bangkok, Thailand, the idea for a pan-regional consultation on MSM and HIV was first conceived. The INGO Naz Foundation International (NFI) solicited support from UNAIDS, both the Regional Support Team (RST) for Asia Pacific and the India office, and WHO India to for its sponsorship of what was to become the International Consultation on Male Sexual Health and AIDS in Asia and the Pacific, Risks and Responsibilities (referred to here as the RR process). Significant encouragement and enthusiasm was also given by key donors, particularly DFID and USAID, early on (over 20 international donor agencies and INGO supported the RR meeting).

These earlier meetings, mostly informal and amongst friends and colleagues, helped to stimulate local communities and leaders alike to begin initiatives intended to drive the scale up of HIV programming for MSM using international pressure. Both processes, the GMS coordination and the RR international consultation, were designed from the beginning to include government partners. And both took the approach to focus on the facts as they was known at that time. In response to the question as to why donors and INGO were beginning to take notice and support HIV interventions among MSM in the GMS, one donor participant in one of the GMS workshops stated, “It’s the right thing to do... after all, it’s the epidemiology [of HIV].” He elaborated that in low and concentrated HIV epidemics as in the GMS, MSM is a critical part of transmission dynamics and that the reduction of HIV in is an important epidemiological factor relative to HIV/AIDS, as experience has shown in other parts of the world.^{xiv}

“...although nearly all countries have national strategic frameworks addressing populations most at risk, fewer than half have implemented HIV prevention services focused on injecting drug users, men who have sex with men or sex workers in all or most districts in need.”

From Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS to the 62nd session of the United Nations (2008)

Planning and preparation

The beginning of the GMS coordination process was largely donor driven because there were so few civil society organisations (CSO) involved in the work at the time. The sponsoring agencies created a technical advisory committee that included other

INGO, mostly those receiving US government support for community HIV programming, and UNESCO (later expanded to include UNAIDS RST). Likewise, NFI, the sponsor of RR, created a similar committee with the addition of local MSM community leaders and opened a secretariat office in New Delhi to handle all logistics for the meeting, planned to be up to 400 people from all parts of Asia and the Pacific.

The first workshop of the GMS coordination process invited over 50 regional experts from INGO and community-based organisations (CBO) but also from governments, to present and discuss the implications of the recent research. The participants were charged with creating a plan of action to effectively respond to the HIV epidemics among MSM in the sub-region, to propose a minimum set of HIV interventions, and prioritise scale up for known and suspected hotspots. There was recognition that this effort could not be driven only by donors, that civil society organisations had to be developed or strengthened in order to take the lead. The workshop ended with agreement that a consensus was needed from a larger group of people, especially additional community and government representatives from each country, where possible. A second larger meeting was planned for six months later.

In contrast, the beginning of the RR process was led by community leaders, specifically from NFI as described before, but broadened to include other key leaders from all parts of the Asia Pacific region and particularly from India and South Asia, where friction between community groups and individuals is fairly commonplace. One donor has stated that it was this broad alliance of community groups and their leaders, joining together for the RR planning and implementation, which allowed continuing and additional support for the RR process.

An RR steering committee was assembled to guide content and programme design. The committee met only twice before the consultation meeting began but worked electronically via emails, including intense editing of documents during programme development. The overarching principle of RR, similar to the GMS, was that the meeting should be community-led but at all levels be tripartite, bringing together three diverse parts of the HIV response that do not often regard one another as equals – community/civil society including activists (those involved or invested in MSM and HIV work and issues), government officials (national AIDS and HIV control specialists and epidemiologists), and researchers, technical experts and academics (including representatives from the UN system) with direct experience in MSM and HIV issues. Further, unlike most international meetings, the steering committee set the very high standard of insisting that everyone attending, other than the technical experts, would be fully supported to attend – travel and accommodations were to be fully paid by the meeting itself – and the meeting would be conducted for free to all invited, including lunch, dinner and tea breaks. The thinking behind this idea was simple: “Make it more difficult to say ‘no’.”

The need for data

The most current research available in each country or area was recognised as the first place to start, programmatically, in both of the processes. Therefore, both collected and reviewed data on these key categories:

- HIV prevalence among MSM
- Estimation of the size of the population of MSM

- Identification of HIV interventions for MSM underway
- Level of access to clinical treatment services for HIV and STI sensitive to MSM
- Availability of prevention commodities (including condoms and appropriate lubricants)
- Inclusion of MSM in regard to national AIDS planning
- Amount of investment in HIV and MSM programmes
- Legal environment of MSM and male-to-male sex

For the GMS process, the technical advisory committee undertook an inventory of all known INGO and governments supporting HIV interventions in each of the six countries. Researchers were asked to compile currently known data on prevalence and/or incidence of HIV among MSM. Technical experts were asked to review what was known about the “communities” of MSM including patterns and methods of self identity, diversity of populations (commonalities and differences), the legal situation facing MSM, typical treatment by public and private health systems, and general societal attitudes towards same sex-oriented males including transgenders (male to female).

For the RR process, some significantly different and highly effective activities were undertaken. With the agreement for technical support from UNAIDS RST, the vast network of the UN system was seen as available to the process of data development. First, an in-country process was undertaken in each country of the region, under the guidance of a UN HIV focal point – the UNAIDS country coordinator (UCC) where one existed, or others to be identified by WHO or UNFPA. A total of 21 countries completed the in-country process, which sought to:

- Conduct an in-country meeting or consultation with the government health/HIV officials, researchers and local MSM/HIV community groups, with the intention of seeking consensus on the situation of MSM and HIV;
- Prepare a country situation analysis of MSM and HIV following a set of indicators developed by UNAIDS with the input of the RR technical committee;
- Decide upon a group of community people to join a working group to attend and participate in the consultation itself. Working groups were planned to include national AIDS government planners and researchers from each country, with formal invitations issued by the UN focal point.

The success of this approach was notable on many levels. In many if not most of these countries, it was the first time that MSM civil society and community leaders had sat in the same room and talked openly about sex between men and HIV risk with national government representatives and researchers. The in-country meetings chose and prepared the working groups that were to attend the consultation, and provided the basis for what most agree is the first community-developed and most accurate data collection on MSM and HIV in Asia and the Pacific. In several countries it was reported that the government participants in the process had never realised the extent of the problem or the large number of their citizens at high risk due to a lack of prevention and treatment services. They also reported surprise at the breadth of community organising, formal and informal, within MSM communities. In one Pacific island country, the process led to a pledge from the national AIDS planning board representative to add MSM to its list of targets for the following year. The

process also led to UNAIDS support for the formation of the Pacific Sexual Diversity Network (PSDN), strengthened UN system commitments in China and more concentrated attention to the need for MSM and HIV community development in India (UNAIDS India conducted a total of five pre-RR meetings in different areas throughout India).

Key research papers were commissioned by Risks and Responsibilities, coordinated by NFI and supported by UNAIDS and USAID, for distribution as background information for the delegates. A range of topics specific to MSM in Asia Pacific were covered such as epidemiology of HIV infection and risk behaviours, an overview of human rights related to health and male-to-male sex, HIV programme spending, same sex male sexuality and HIV, prevention best practices and a summary paper of the pre-RR in-country responses. The groundbreaking 2006 TREAT Asia/amfAR advocacy paper, “MSM and HIV/AIDS Risk in Asia”, was also distributed at the meeting.^{xv}

For the second meeting of the Greater Mekong process, the technical advisory committee was expanded to include country and regional directors for key INGO programmes and representation from UNAIDS RST. All work was coordinated by an outside consultant² with logistical support from FHI. The previous data collection and review were continued and updated. In fact, the second GMS forum meeting began with announcement of the startling increase in HIV prevalence among sexually-active MSM in Bangkok, Thailand (a 64% increase from two years previous – 28.3% up from 17.3% in 2003³).

The main challenge for the GMS forum was the need to develop what next steps were needed to help bring HIV among MSM in the GMS under control, in view of limited interventions, studies and the cultural reluctance to deal with the sex between men directly. To achieve this, “best practice” HIV intervention projects from five countries were presented, after which participants were asked to work in country groups in breakout sessions to review and update the work of the first meeting. A total of 150 people were invited, using informal networks to identify the most appropriate civil society representatives as well as concerned or willing people from the government sector in each country⁴.^{xvi} Established relationships of the donors and INGO working in the GMS were the key factor in identifying the best people, as well. Recognizing that some participants may have limited English language skills, two-way translation was planned for four languages at significant additional expense. The meeting was also seen as an opportunity to broaden donor support for MSM and HIV interventions in the sub-region and 15 donors from non-US government agencies were invited; however, few actually attended.

Involvement of the United Nations system

In the early part of the development of these processes, it was felt that while there was rhetoric within UNAIDS regarding MSM there was no real activity or support

² The independent consultant, Paul Causey, was also the principal author of this paper.

³ As cited earlier, the rate of HIV prevalence among MSM in Bangkok had increased to 30.7% in 2007.

⁴ Government officials from Myanmar/Burma had to be excluded from this meeting due to restrictions from funders; however, CSO representatives were invited.

happening. This changed dramatically once the GMS process was underway and increased to strategic planning and participation in the lead-up, execution and after effects of the RR consultation. Throughout both processes (and continuing today), UNAIDS helped in data collection and documentation often commissioning papers for the process that generated a much-needed knowledge base for the enrichment of both processes.

It was difficult, at first, to fully engage UNAIDS sponsor agencies; however, there were exceptions. UNESCO Asia Pacific had long supported MSM and HIV work, principally in the Greater Mekong, and this support accelerated with UNESCO providing high level leadership in working directly with governments and donors. The work of UNDP China in conducting national meetings, as part of the UN Technical Working Group on MSM and HIV (UNTWG-MSM), included participation of other UN agencies in China such as WHO, UNFPA and UNAIDS. The UNTWG-MSM included the RR in-country process in its mandate and helped to secure support for many participants to attend the consultation, as did UNAIDS Pacific.

UNAIDS RST joined the RR process as the principal technical support agency and lent its technical expertise, name and funding support to the RR process. Utilising its member state relationships with key government officials, involvement by governments was facilitated and assured. The coordination of the in-country processes was pivotal in preparing the country teams and providing the consultation with much needed information on the state of the HIV epidemic among MSM in the region. UNAIDS India facilitated the co-hosting of RR by the National AIDS Control Organisation of India, with NFI. High level India government support was instrumental in opening the doors for other governments to participate. UNAIDS also assisted in financial management, support and training for locally-recruited rapporteurs, in contracting a venue appropriate for government officials, taking into account security and protocol requirements, and in inviting and assisting with the travel arrangements for government officials.

Implementation phase

For the most part, both meetings, the GMS second and larger meeting and the RR international consultation, concluded with intended results – to attain increased attention including national governmental support that could lead to increased funding and subsequent scale up of HIV interventions for MSM in the Greater Mekong and throughout Asia and the Pacific, respectively. Both meetings are documented in final reports, which are available on the internet or from the Secretariat offices for each of the initiatives (please see Acknowledgements).

The GMS second consultation meeting was attended by 147 people as planned although, regrettably, with attendance by only a few donor representatives beyond the meeting sponsors. Each person joined one of the seven working groups in breakout sessions, one for each country plus one for the sub-region as a whole. After hearing the fully translated presentations, working groups met individually to process the information, discuss the implications and application to the unique needs and concerns for their situation, and to review, comment on or correct the data that had been collected.

The two-year vision for HIV interventions in the Greater Mekong was reviewed and each country group named specific interventions which were most urgently needed, set a timeframe (within two years) for the completion of each item as connected to the two-year vision, and named output indicators that could be used in evaluation of the success of the plan. By the end of the meeting, each working group had agreed to a two-year vision for its country and for the sub-region, and had committed to continuing working together as a country working group on their return home as well as to expand the group to inform and include others not able to attend the meeting. The sub-regional working group ended with a recommendation to establish a secretariat to help coordinate the work between countries including support, training and access to funding, to coordinate data collection with a particular emphasis on reliable estimations of the number of most at risk MSM, and to complete and update a sub-regional strategy with additional input from others. The idea for a coordinating focal point with a secretariat was unanimously accepted by all of the participants and the US government sponsoring agencies committed to financial support for the first two years of operation.

The RR consultation brought together 380 people from all areas of the AIDS response in Asia Pacific and other regions with over 30 different countries represented. The meeting received significant support from leading international human rights activists with opening statements read or delivered by a wide range of people including the Most Reverend Archbishop Desmond Tutu, Dr. Nafis Sadik, the UN Secretary-General's Special Envoy for HIV and AIDS in Asia and the Pacific, and JVR Prasada Rao, Regional Director for UNAIDS RST Asia Pacific. Mr. Rao named the following five key measures that “should be regarded as non-negotiable actions for the national governments” in addressing MSM related AIDS responses:^{xvii}

1. Accord MSM and transgender interventions a priority in the national strategic plans;
2. Earmark resources directly to the MSM and transgender networks for capacity;
3. Change laws that criminalize male-to-male sex by creating a groundswell public opinion;
4. Undertake public education for halting harassment of MSM, transgender and community workers who provide services for these groups;
5. Ensure full involvement of MSM and transgendered people in the national planning process.

The RR consultation followed a tight programme which consisted of expert presentations on three daily themes: data assessment and review (what is known and what is needed to be known); obstacles and challenges; and next steps to be taken (“the way forward”). Country working groups, which included community, technical expert and government delegates, joined with others from their sub-region or area⁵ to collectively discuss, document and report back at the end of each day on the findings from the pre-RR in-country process, on how the presentations and ideas presented in morning sessions might best be applied or adapted to each sub-region, and finally the identification of actions that should be taken in the near future.^{xviii} The last part of the

⁵ The RR technical committee choose to establish seven different sub-regions or areas to which each country was assigned: Developed Asia, Greater Mekong (but not the southern provinces of China), the Pacific, South Asia (but not India), Southeast Asia (but not the GMS) and, due to the size of populations, two country ‘sub-regions’ - China and India.

RR consultation was an open discussion and feedback that ended with general delegate support for three documents that had been developed with the Steering Committee and distributed at the beginning of the meeting: the Delhi Declaration on Collaboration, Principles of Good Practise, and Ways Forward: Task Force/Coalition.⁶

Results of the processes

The early processes for both the Greater Mekong Sub-region and the region-wide advocacy effort undertaken by the Risks and Responsibilities consultation culminated in meetings that led to many positive results as reported above. The ongoing work has also been successful in moving forward the agenda of the scale up of HIV interventions for MSM in Asia and the Pacific, at least in certain key areas, and in the Greater Mekong Sub-region.

The planning and development of a Greater Mekong Sub-region strategy for MSM and HIV led directly to, among other things, the establishment of the Purple Sky Network. Immediately following the second GMS meeting and with the commitment of the funders, an appropriate entity to host the secretariat was sought. The American Foundation for AIDS Research (amfAR) had long established a presence in Asia and the Pacific with its Treat Asia programme, principally supporting access to treatment for the increasing number of people living with HIV through a cooperative network of clinics, hospitals, and research institutions working together with civil society.^{xix} TREAT Asia was chosen to serve as the host for the Regional Coordination Secretariat for the new network of HIV programmes for MSM in the Greater Mekong Sub-region, which later adopted the name of Purple Sky Network.

Since its beginning, PSN has been successful in assisting community groups, some existing and some new, and government agencies in each of the six countries it supports. As well, initiatives have been launched that have aided programme development and design in several locations and shared at GMS sub-regional meetings held annually since 2005. In 2007, the Purple Sky Network underwent an assessment of progress using the indicators and goals from the first two-year vision for the sub-region after hearing from each country Working Group on the progress of the Work Plans that were written in the 2005 meeting and updated at subsequent PSN meetings.

Encouraging findings were reported and illustrated the commitment and efforts of the different government agencies, donors, MSM national working groups and NGOs/CBOs/INGOs to increase HIV interventions among MSM in their country, particularly during the two previous years.^{xx} In five of the six GMS countries, MSM are now featured in the national AIDS plan, and in Cambodia, China and Thailand, separate MSM national strategic frameworks have been developed. Four GMS countries now include MSM in national HIV surveillance with two countries undertaking a first formal baseline assessment of HIV among MSM (Laos in 2007 and China in 2008). The overall number of MSM projects increased since the first

⁶ All three documents are available from www.nfi.net with additional background material also on the APCOM website at www.msmasia.org.

inventory as reported in the 2005 meetings in the GMS as well in all but one country (Myanmar/Burma).

The planning and presentation of the Risks and Responsibilities consultation led to the formation of the Asia Pacific Coalition on Male Sexual Health (APCOM) in 2007, as called for by the delegates to the consultation, after preliminary work was performed (in the absence of funding) by NFI, UNAIDS RST AP and two key consultants involved with the original consultation. The Humanist Institute for Cooperation with Developing Countries (Hivos), a major supporter of RR and a long-time supporter of lesbian, gay, bisexual and transgender civil society in developing countries, including MSM and HIV, was the first independent funder, providing a three-year operational grant, thus joining the support of UNAIDS RST and NFI. APCOM was officially launched at the ICAAP 8 meeting in Colombo, Sri Lanka, after formally establishing itself with a meeting of a board of trustees at which a governing constitution was adopted. APCOM, at this time, does not function as a legal entity on its own but maintains charitable status through NFI as fiscal agent.

Opened to regional, sub-regional and national networks, and all individual MSM and HIV organizations or programmes, APCOM is governed by a 19-member Board comprised of community representatives from the same seven Asia Pacific sub-regions as developed for the RR consultation (and mentioned above). In addition, the board includes representatives from transgender communities, the people living with HIV (PLHIV) community, the government sector, donor and development agencies, a communications advisor and technical advisors from INGO and the UN system, (UNAIDS, UNDP and UNESCO, at present).

Additional accomplishments since the end of the RR consultation include:

1. Website development, supported by UNAIDS, to include a sub-regional communication focal point for members, sub-regional and country information, news stories and resource material on MSM and HIV in Asia and the Pacific not readily found elsewhere.
2. Scorecard indicators development for the continuing monitoring and reporting on the progress of the HIV response for MSM, by country.
3. Policy briefs, research papers and communication documents to keep MSM and HIV issues in the forefront and provide advocacy work with needed documentation and guidance, including:
 - a. A World AIDS Day 2007 press release
 - b. Co-release, with USAID, and distribution of a brief on Investment in HIV interventions for MSM in Asia and the Pacific, from the RR background paper developed by Constella Futures Health Policy Initiatives (March 2008)
 - c. Updating and release of the RR background paper on epidemiology of HIV among MSM in Asia and the Pacific (for co-release with UNAIDS RST AP in August 2008)
 - d. Funding priorities, investment analysis and identification of gaps in a peer-reviewed paper (for co-release with ADB, UNAIDS and HPI/RTI in August 2008)
 - e. Policy brief on the knowledge gaps and why basic research is necessary (for release in August 2008)

- f. Transgender community mapping in South Asia and Southeast Asia (for release in August 2008) and other sub-regions (for co-release with APNSW in 2009)
 - g. Commentary paper on the Role of Research and MSM community involvement (for release in August 2008)
 - h. Policy brief on media coverage and its impact on MSM (for co-release with UNDP in 2009)
 - i. Reference Guide for Policy Makers on MSM and HIV (for co-release with UNDP in 2009)
4. Donor and INGO briefings in Bangkok, Thailand on MSM and HIV aspects in the report from the Commission on AIDS in Asia (April 2008)
 5. Convening of a region-wide meeting of community leaders and technical experts for development of a strategic framework or roadmap for immediate needs of MSM in Asia Pacific, under a cooperative grant from UNESCO and UNDP and others (planned for October 2008)
 6. Participation and support to SE Asia and Indonesia network development under a cooperative grant from UNESCO and UNDP (ongoing)
 7. Participation in the MSM-GF Steering Committee and in the International AIDS Conference 2008 satellite meeting in Mexico City
 8. Asia Global Fund Round 9 proposal development for South Asia, with the objective to use the experience in other sub-regions (2008)

Recommendations on starting a process – expert advice

The technical experts who participated in the Global Forum on MSM & HIV (MSM-GF) meeting on the processes which culminated in the Purple Sky Network and the Asia Pacific Coalition on Male Sexual Health offered many specific recommendations for anyone or any organisation seeking to duplicate and adapt the work as described in this paper. First and foremost, they recommend a careful examination of both donor-driven and community-driven processes in order to assess which might best apply to local situations, keeping in mind that for large and diverse regions such as Africa, a combination of processes may be desired or needed.

To achieve the desired tripartite involvement along with community acceptance of any new initiative, it is important to learn when and how to compromise. Communities must speak with a unified voice to help overcome the desire of some official gatekeepers to deny or disregard the issue. There is need to learn how to use language, too, so that all groups will remain involved and believe that their issues are included. Governments, donors and communities within the broader “community of MSM” use terminology to describe themselves, their work and their issues differently. The wordsmithing of documents will be needed after receiving input from all partners. For example, the first name chosen for the RR consultation during the early stages of planning was found to be offensive to some donors and community groups as well as implied endorsement of male to male sex, still an illegal act in the home country of India. In the GMS, references to transgenders and to one particular country were modified to be acceptable to donor agencies as well as some key government officials. There is an ongoing international debate on sexual diversity and sexual minorities. The debate will arise and should be handled straightforwardly with open discussion with all involved and consensus resolution adopted.

Recommendations on initiating a planning process

Here is a list of things to consider during start-up phases of a process to address MSM and HIV in a particular region, and is based upon the Asia Pacific Experience:

- 1. Analyze the local and regional situation carefully.**
 - a. Look for parallel processes that may be similar in effort but not necessarily targeted to HIV or MSM.
 - b. Create a baseline mapping to determine the status of issues including HIV and STI epidemiology, MSM population size estimates, sociological data, and so forth.
 - c. Review outside influences and plan how to neutralise resistance such as discriminatory laws, and legal, cultural and religious practices which are opposed to openly addressing sex between men.
 - d. Document places where key data elements are missing and decide on a process to obtain it, such as the GMS inventory of MSM and HIV services and the pre-RR UN led in-country process.
 - e. Research donors but do not limit it to only those that may provide direct cash support. Some donors and the projects they support will be able to participate in ways that do not involve direct funding but which will offset expenses, such as underwriting travel expenses, paying meeting room rentals or assigning staff committed to the project.

- 2. Identify key individuals who might serve as ‘champions’ for the process from a variety of sectors - civil society, of course, but government, donors and technical experts from INGO, as well.**
 - a. Start with known friends and allies - strong personal relationships greatly benefited the Asia Pacific Experience.
 - b. Gain the support and participation of the UN system from the beginning, starting with the UNAIDS Regional Support Team and the UN-designated lead agency on HIV and MSM.
 - c. Equals should invite equals (donor – donor, government – government, and so forth) to increase success in diversity of participation.
 - d. Attempt to find young people from communities who can be developed, through the process, to assume leadership in the near future.
 - e. From this group, establish a core team of those most capable of moving the process forward.
 - f. Establish a technical expert committee to provide ongoing advice and assistance.
 - i. Apply for outside technical assistance, e.g., from the UNAIDS-supported technical assistance facilities in Southeast Asia, South Asia and Africa.
 - g. Plan committee meetings to take place at major events at which all or most of the members will also attend, such as regional AIDS conferences, to save costs and help assure involvement of more members.

3. Establish a time-based work plan with divisions of labour and responsibilities clearly defined.

- a. Start early enough and be realistic about the amount of time that will be needed (recommended to be at least one year from inception).
- b. Consider establishing a secretariat or at least sufficient staffing (recommended to be 2 – 3 people capable of committing to the process full-time).
- c. Coordinate the work plan with planning and work cycles of involved organisations so the work can be included in existing and future work cycles.
- d. Determine realistic costs and create a funding plan.
- e. Include a media strategy tailored to the local situation but that will serve the objectives of the process.

4. Production of the meeting itself is crucial for the success and must be carefully planned.

- a. Use of skilled facilitators is important for productivity, particularly those assigned to working groups during breakout sessions.
 - ii. Consider recruiting technical experts from the UN system as they are accomplished facilitators.
 - iii. Train and prepare facilitators well in advance of the meeting including development of preparatory materials.
 - iv. Facilitators need to be open and independent; avoid assigning anyone to a group for which they may have direct professional responsibility.
- b. Like facilitators, if volunteers are used they need to be recruited early on and provided training and onsite support.
- c. Travel support for meeting participants must be planned as far in advance as possible so that lower airfares can be obtained as well as outside support can be found (see below).

Recommendations on working with donors

There are many issues and potential problems related to funding and donor support that were discussed during the MSM-GF meeting on the Asia Pacific experience. Some issues are unique to community-led processes but most will apply to all processes including donor-driven ones. All initiatives should develop a diverse funding base, including private foundations, international (governmental) development agencies, INGO, established CSO, UN system agencies including UNAIDS, as well as national governments and private corporations, where possible. And any initiative must speak with one unified voice, as mentioned above, so donors and governments both will be assured that there is wide acceptance of the effort among a variety of communities and stakeholders. Additional recommendations include:

1. **During research on donors in the start up phase, include an analysis of donor mandates, funding priorities and grantmaking cycles so you do not miss opportunities.** They are all different and each message must be correctly targeted. Do not isolate MSM as the single issue; look for entry points that may not be directly related to MSM or HIV (e.g., human rights issues,

women's programmes that may encompass transgender male to female services, poverty alleviation, and so forth). Understanding a donor's funding strategy, including past and recent fund recipients, will save both you and the donor time and money.

2. **Plan necessary accommodations and travel far in advance, including that which may be needed by secretariat staff and planning committee members for meetings.** Often, a donor will approve grant funds to be used for travel for programme and management staff, as happened extensively with US government-funded INGO for both the GMS meetings and the RR consultation. Other sources for internationally-sponsored travel for CSO are also available, such as from UN system agencies.
3. **Particularly for community-led processes, cash flow may quickly become an obstacle, as venue costs, salaries and printing are all costs which require immediate and advance payment.** Try to negotiate with funders so that these costs can be paid directly or advanced to the fiscal agent. There are advantages to using an INGO as a single payer source, such as happened in the Greater Mekong, but you must also meet often stringent international accounting procedures that may not be cost effective or have the flexibility that might be needed for last minute changes.
4. **Consider asking donors to coordinate their support for both the process and the greater issue of funding scale up of MSM interventions in the region.** This is a need even now in the Greater Mekong and Asia Pacific, which would greatly help both CSO and donors alike. The UN agency, ILO, is well-equipped, experienced and may well carry the mandate to help in such coordination.

Conclusion: joining together works

The Greater Mekong Sub-regional coordination and the pre-RR and post-RR Asia Pacific processes had one very significant impact – both brought the attention of many national governments to the issue of HIV epidemics among MSM and the need to address them directly. This resulted in positive changes in national AIDS plans and strategic planning to reduce the incidence of HIV and increase services for MSM. Having government representatives sit down and talk with civil society leaders and activists, together with collaborative partners from the donor and development sector and with support from UNAIDS and sponsoring UN agencies, produced this success.

Governments as a whole will listen more when approached by a large number of many different constituents, such as those assembled for all of the consultations mentioned in this paper. There is advantage, too, of bringing government officials out of their offices and out of their home country; it gives them latitude to both listen and actively participate in problem solving well beyond what may be otherwise possible.

There may be times when communities must be vocal and visible advocates for their constituencies. But throughout the scale up processes in Asia and the Pacific the single most important idea to emerge was very simple: working together results in reduction of HIV. As learned in the GMS when it was stated so eloquently by one donor representative, and adopted and quoted during the RR consultation – we must maintain the focus on the epidemiology of HIV, the growing body of evidence of HIV epidemics among MSM, and on the fact that it is high risk behaviours, unwittingly

engaged in by MSM unreached by HIV interventions, that will drive HIV epidemics in the world today. This focus makes the need for increased attention including funding for the scale up responses to HIV among MSM, an undeniable and inarguable fact.

Why we should work with male-to-male sex and HIV prevention, treatment, care and support:

- It is the right thing to do on humanitarian grounds.
- It is the right thing to do epidemiologically.
- It is the right thing to do from a public health perspective.

Males who have sex with males (MSM) whether their self-identity is linked to their same sex behaviour or not, have:

- The right to be free from violence and harassment;
- The right to be treated with dignity and respect;
- The right to be treated as full citizens in their country;
- The right to be free from HIV/AIDS;

MSM who are already infected with HIV have the right to access appropriate care and treatment equally with everyone else, regardless of how the virus was transmitted to them.

Naz Foundation International

From a poster at the RR International Consultation on Male Sexual Health

ⁱ Beyrer C., *HIV/AIDS epidemics among men who have sex with men (MSM) in Africa, Asia, Latin America and the Caribbean, and the CIS*, PowerPoint® presentation, Full Enjoyment of Human Rights by All meeting (2008), available at www.msm&hiv.org

ⁱⁱ Cáceres C, KondaK, Pecheny M, Chatterjee A, Lyerla R, Estimating the number of men who have sex with men in low and middle income countries, *Sexually Transmitted Infections* 2006;82(Supplement 3):iii3-iii9; doi:10.1136/sti.2005.019489 (BMJ Publishing Group Ltd.)

ⁱⁱⁱ Executive Summary - *Redefining AIDS in Asia - Crafting an Effective Response* (2008). Commission on AIDS in Asia. Oxford University Press, New Delhi, India (2008):4

^{iv} See Figure 2.16 in *Redefining AIDS in Asia - Crafting an Effective Response* (2008). Commission on AIDS in Asia. Oxford University Press, New Delhi, India (2008); p 57

^v *Men who have sex with men: the missing piece in national responses to AIDS in Asia and the Pacific*. Geneva: UNAIDS (2007).

^{vi} Executive Summary- *Redefining AIDS in Asia - Crafting an Effective Response* (2008). Commission on AIDS in Asia. Oxford University Press, New Delhi, India (2008):4

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- viii National Institute of Health & Family Welfare (NIHFW) and National AIDS Control Organization (NACO). *Annual HIV Sentinel Surveillance 2006*. Country Report, New Delhi, India, 2007
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- xiii *Strategy Report - Strategizing Interventions among MSM in the Greater Mekong Sub-region (GMR) CDC-GAP/USAID-RDM/FHI-APD Workshop*, Family Health International (2005)
- xiv *HIV Prevention and Care Interventions for MSM in the Greater Mekong Sub-region (GMS) Regional Consultative Forum*, Family Health International (2005), available at www.ahrn.net
- xv RR report citation; available at www.nfi.net/
- xvi *Report from HIV Prevention and Care Interventions for MSM in the Greater Mekong Sub-region (GMS) Regional Consultative Forum*, Family Health International (2005)
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- xix *Global Initiatives – About Treat Asia* (website article), amfAR (2008), available at www.amfar.org
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