Changing Gears:

a Guide to Effective HIV Service Programming for gay other men who have sex with men in Asia
Objectives of the Framework

• Introduce the latest science and innovations in HIV service programming for MSM
• A source for advocacy with donors and policy makers
• Provide checklists to see the extent to which HIV service programming for MSM is up-to-date
Definitions

- Men who have Sex with Men includes all biologically-born men who have sex with other biologically-born men regardless of gender identity, motivation for having sex, or identification with any or no identity.

- It is important to realise that while epidemiologists often lump MSM and TG together, they are very different in terms of their identity, social and sexual networks and in their public health needs. TG need to be given due attention and not lumped under a broad male sexual health or MSM-paradigm!*

Where data is available, HIV epidemics in MSM are expanding in all countries around the world, regardless of income.

Around the world, HIV infection in MSM is substantially higher than of general population men.

This disproportionate burden is often wrongly explained in moral terms—but it is largely explainable by looking at the high per-act and per-partner transmission possibility of HIV in receptive anal sex.

HIV prevalence among general population adults (15-49) and MSM, 2010-2014


* Latest estimates for 2014; **2013 data; *** 2012 data
MSM and HIV (2)

• If transmission risk was similar to vaginal sex, 80-90% of HIV incidence in MSM would not occur.
• Many MSM practice both insertive and receptive roles in anal sex, which helps HIV spread faster in this population. If MSM were limited to just one role (‘top’ or ‘bottom’) HIV incidence would be reduced by 19-55% in high-prevalence epidemics.
• Taking both these factors into consideration explains 98% of the surplus of HIV infections among MSM.

The HIV epidemic among Asian MSM is projected to expand further.
National prevalence masks high prevalence in localized geographical areas.
Overview of HIV data in ….

- Latest HIV prevalence among MSM: … [year]
- Latest HIV incidence among MSM: …. [year]
- Latest HIV prevalence among MSM aged 15-21: ….. [year]
- Latest HIV incidence among MSM aged 15-21: ….. [year]
- [add additional data on: condom use, STI rates, HIV testing uptake, estimated # of MSM living with HIV, etc – use more than 1 slide if necessary]
This Framework has 4 components:

Component 1: Knowledge and data

Component 2: Comprehensive innovative and effective HIV services for MSM

Component 3: reaching young MSM

Component 4: Syndemic context
Component One:

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

- Tool for diagnosing, monitoring, evaluating and prioritising HIV responses among MSM
- Seven levels:
  1. Total # of MSM in need of HIV services
  2. Estimated proportion living with HIV (prevalence)
  3. Proportion of (2) who have been diagnosed (tested)
  4. Proportion of (3) who have made contact with HIV services
  5. Proportion of (4) who has initiated ART
  6. Proportion of (5) who is adherent to ART
  7. Proportion of (6) who reached viral suppression
HIV service cascade: a ‘leaking pipe’

1. Identify key populations
2. Reach key populations
3. Test key populations
4. Diagnose PLHIV
5. Enroll in care
6. Initiate ART
7. Sustain on ART
8. Suppress viral loads

Continuous prevention and testing for HIV-negative KPs, timely HIV results

Outreach, HTC promotion/linkages, and HIV literacy

Retained in care; determination of ART eligibility

ART adherence

Timely ART initiation

Example (U.S.A.)

[Bar chart showing percentages of people living with HIV in the U.S. for different stages of intervention: HIV-infected, HIV-diagnosed, linked to HIV care, retained in HIV care, on ART, and suppressed viral load (≤200 copies/mL).]

- HIV-infected: 1,178,350
- HIV-diagnosed: 941,950
- Linked to HIV care: 725,302
- Retained in HIV care: 480,395
- On ART: 426,590
- Suppressed viral load (≤200 copies/mL): 328,475

Common barriers to HIV services for MSM

- Actual or imagined stigma and discrimination
- Fear of disclosure (two levels)
- Fear of actual or imagined treatment costs
- Inconvenient opening hours or location of services
- Fear of test results or of side effects of ARV drugs
- Too much bureaucracy, too many referrals
Who/where unreached MSM?

- Who are we reaching? (often the easiest to reach)
- Need to link to other networks of risk (sex work, drug use, underground party-scene, illegal saunas or clubs, internet-based sex networks)
- ‘Mapping’ needs to be an ongoing exercise, continuously linked in to program operations
The need to ground HIV services in local cultures and societies…

- Peer education, counseling, community based responses: all based on Western gay experience towards individual behavior change
- Not much attention for society/culture/family/religion/other structural factors influencing life of MSM in this country
- Different sense of identity/community/sexual cultures that need to be understood
- Any services and programs have to be grounded in social/ethnographic research
Component 2:

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

• Behavioural interventions (Age- and context-appropriate peer education/outreach, condom and lubricant distribution, awareness campaigns online or via other media, promotion of HIV counselling and testing, case management)

• Biomedical interventions (Treatment as Prevention (TasP), Pre- and Post-Exposure Prophylaxis, (PrEP/PEP)

• Structural interventions (legal reform, efforts to reduce stigma and discrimination, address homophobia / hetero-normativity in schools and workplaces)

• Addressing related (syndemic) conditions (Comp. 4)
Interventions, Efficacy, and Evidence

For the first decade or so of the global HIV epidemic, promoting ‘ABC’ (‘Abstinence, Being faithful and Condoms’) was considered the only viable prevention strategy against HIV.

‘Abstinence’-programmes were vigorously promoted by religious conservatives around the world, but did not show any effect on the incidence of unprotected sex or teenage pregnancy*

Condom and lubricant promotion, either via social marketing or distribution via peer outreach or health facilities, with supporting information/education materials

Does one size fit all???

From 1998 onwards it became clear that putting people living with HIV on antiretrovirals was the most effective measure to prevent onward transmission of HIV, because people with suppressed viral loads are much less likely to be infectious.*

At the same time, it was discovered that men who have sex with men found other ways to reduce their HIV risk that did not involve condom use, especially in settings where high percentages of gay men test for HIV regularly. Negotiated safety, sero-sorting, strategic positioning were somewhat protective, withdrawal was not. **

Biomedical interventions: Pre-exposure Prophylaxis (PrEP)

- Strong evidence that antiretroviral medicines can be effectively used as a prophylactic against HIV (Pre-Exposure Prophylaxis, or PrEP)*
- There is no ‘silver bullet’ for HIV prevention; need for different prevention strategies to be combined**
- Need to discontinue seeing prevention as separate from HIV testing and treatment, care and support.
- Finding undiagnosed MSM and putting them on treatment remains the single best and most cost-effective intervention!

* UNAIDS PrEP Guidance, 2015
PREP works, if taken!


1 26% over two visits, 38% maximum at one visit.
PrEP is for people at substantial risk of HIV infection and not forever

- Small network of sex partners
- Condoms and lube
- Moves to city to look for work
- Recreational drugs, loose network of partners, some transactional sex
- Find user-friendly clinic! Test HIV neg. start PrEP
- Discuss prevention options, stop PrEP
- Finds small jobs, makes a network of friends

Professionalise outreach

• Agree on much higher standards for what outreach workers and facility-based HIV workers should know or be able to do (skills).
• O/W should be rewarded for the professional service they are expected to provide. This should include a standardised draft Terms of Reference with recruitment criteria.
• Remuneration of outreach workers should be good and partly performance-based with agreed performance indicators based on case-finding.
• Evaluate O/W every quarter, using previously-agreed performance goals.
Case Management

- Due to the arrival of biomedical interventions (TasP, PEP, PrEP) it is increasingly irrelevant to separate ‘prevention’ from ‘treatment, care and support’
- Need for integration ➔ case-management approach
- A caseworker is someone who is tasked with helping a client navigate health services, and literally accompanying him between different facilities or, within the same facility, between different counters or departments.
- The caseworker is linked to O/W and is responsible for supporting the MSM in accessing the test and hearing the test result. He is also responsible to ensure newly-diagnosed cases are supported in undergoing a confirmation test, CD4 test (depending on the country) and other baseline tests and that the person gains access to and enrolled in antiretroviral treatment and other services, such as TB screening and treatment for STIs.
Utilise social media and the internet

• Review ongoing HIV services, especially outreach, and assess the extent that they do or do not take online sexual networking and online health seeking into consideration.

• Study how the potential of the internet can be further harnessed for the purpose of promoting HIV testing and enrolment in or adherence to HIV treatment and care.

• Establish written guidelines on how cyber-based outreach should be conducted; organisations using the internet or social media should have protocols in place about safety and security of its personnel.

• Design a ‘code of conduct’ for outreach workers who make use of the internet for their work, clarifying ethical principles and good practices.

• Make sure outreach workers understand and take precautions for the specificities of apps using geo-location data and potential dangers in countries where homosexuality is either illegal or an often-used ploy for blackmail by law enforcement personnel.
Diversify options for HIV testing (1)

- Provide a mix of different options for HCT beyond clinic/facility based services for a wider range of MSM. Examples are:
  - O/W-provided HIV screening-testing
  - Testing at special events
  - Testing for special audiences at facilities, but outside office hours
  - Incentive-based testing using coupons (similar to RDS)
  - Home-testing.

- Ensure that effective systems for accompanied referral are in place for each testing modality to avoid people who test positive from dropping out of the HIV treatment cascade.
Diversify options for HIV testing (2)

• Ideally, HIV testing should only occur when accompanied access to the next level of service (i.e. confirmation test, possibly a CD-4 test) is immediately available.

• The quality and procedures for HIV testing should be similar across all modalities, and be governed by strict guidelines.

• Conduct evaluations of different testing modalities to assess which ones work best.
Proposed basic package of interventions for MSM – ‘One-Stop’

1. Condoms and lubricants
2. (Voluntary) Pre-Exposure Prophylaxis, perhaps initially only for those at highest risk (for example, disconcordant couples, male sex workers who use drugs)
3. HIV counselling and HIV testing (different modalities)
4. Diagnostic tests and treatment for common sexually transmitted infections such as Syphilis, gonorrhea, chlamydia, Herpes
5. Optionally vaccinations against Hepatitis B and C and for virgin adolescent MSM, the HPV vaccine
6. CD-4 and/or other baseline tests required for enrolment in antiretroviral treatment, HIV treatment itself and the treatment of opportunistic infections and other care and support interventions.
Advanced / additional package for high-risk MSM should include

• Include at least 3 different sizes and types of condoms and possibly different types of lubricant

• Clinical services to promote general rectal health, including the diagnosis and treatment of warts, hemorrhoids, fistulae and other common problems that provide discomfort for MSM
Component 3:

Reaching young MSM by ensuring a developmental approach to HIV services
Why is incidence high in young MSM?

- Because there are more uninfected people among them...
- They may be ‘bottom’ more than older age cohorts
- Physiological reasons (not fully grown)
- Psychological reasons → adolescence, risk taking
- Naïveté about love, expectations of lover
- Stigma, discrimination → coming out stress
- Syndemic factors → drugs, alcohol
Why is access to services difficult?

- Age of consent – need for parental consent
- May not be reached by outreach → not see the need to get tested
- Fear of being infected (ignorance)
- Fear of stigma, discrimination, disclosure (of sexuality and HIV status → loss of family support)
- Fear of costs of treatment
- Same insurance as parents → disclosure fear
- Fear of side effects
What works for young MSM?

• We don’t really know…
• More research/assessments needed…
• What is presented here is based on experiences in Asian countries and on ‘common sense’
1. Reduce need for parental consent

- In Indonesia no questions are asked about age of those tested;
- In Thailand the age of consent for HIV testing was reduced from 18 to 15;
- In other countries, outreach workers sometimes provide ‘parental consent’
2. Provide youth-friendly services

- Use language that is understandable/common among young MSM
- Information and education materials should look ‘cool’, attractive
- Make use of the internet and social media for outreach, referral and links to reliable websites with further information
- Involve young MSM in designing and delivering the service
- Ensure staff is sensitized, understanding and accepting of young MSM (also guards, other staff)
3. Set up fail-proof case management

- Ensure that young MSM who test positive are linked (via more than one channel) to a case manager, preferably someone living with HIV
- Ensure support online, via telephone, LINE/WhatsApp or Facebook messenger
- Accompany young people the first few times they are accessing pre-ART and ART services
- Try to make them member of a support group
A proposed Pilot Project

Preventing HIV and linking young MSM to HIV services
Four settings to be mobilised to reach young MSM

- Health services
- Community and Families
- Internet
- Schools

Young MSM
Component 4:
Embedding HIV services in a wider syndemic response
Syndemic factors (1)

- HIV does not occur in isolation, but is often linked to social conditions and other health problems.
- **SYNDEMIC**: a ‘synergistic interaction of two or more coexistent diseases and resultant excess burden of disease’*
- Seeing HIV as a component in a wider set of ‘syndemic conditions’ helps understand why some people have more difficulty changing towards safer sex behaviors than others, and points to the need to consider other pressing social and health problems of the people we are trying to reach rather than focus only on HIV.

Key conditions that decrease the likelihood that a client uses condoms or accesses HIV counselling and testing services might include:

- Binge drinking / alcohol use or addiction
- Drug use (especially crystal meth or ‘ice’)
- Depression, severe loneliness or other mental health issues, often caused by alienation from family, friends and community
- Being sexually compulsive, i.e. ‘addicted to sex’
- Having a history of sexual abuse
- Having a violent boyfriend/intimate partner
- Having considered suicide or having tried to commit suicide
- Having a history or current involvement in sex work
- Poverty and homelessness

Santos, Glenn-Milo, et al. "Syndemic conditions associated with increased HIV risk in a global sample of men who have sex with men." Sexually transmitted infections 90.3 (2014) and T Guadamuz et al, 2015
Psychosocial health conditions are associated with increased HIV incidence in a cohort of 1,292 Bangkok-based MSM.

THANK YOU

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