



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!*

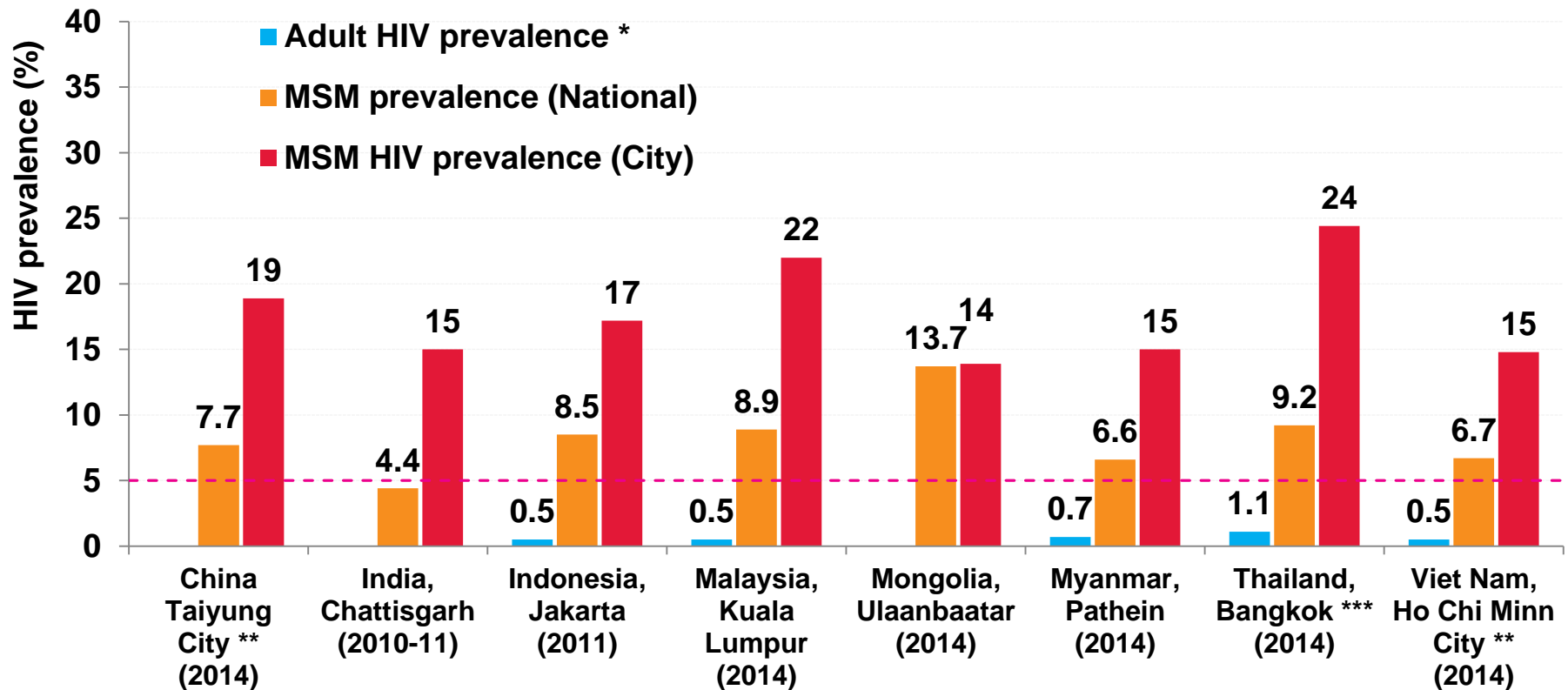
*van Griensven, Frits, Prempreeda Pramoj Na Ayutthaya, and Erin Wilson. "HIV surveillance and prevention in transgender women." *The Lancet Infectious Diseases* 13.3 (2013): 185-186.

MSM and HIV (1)

- 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.

Source: Beyrer, Chris, et al. "Global epidemiology of HIV infection in men who have sex with men." *The Lancet* 380.9839 (2012): 367-377.

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



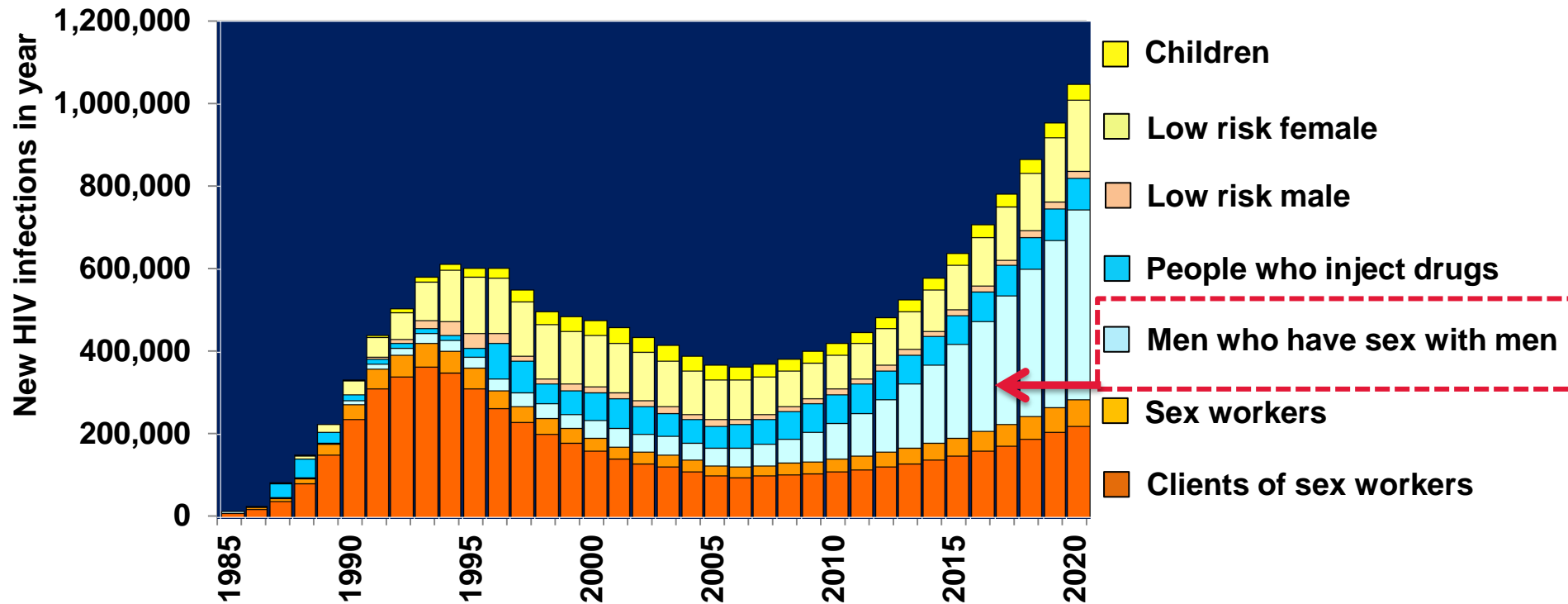
* Latest estimates for 2014; **2013 data; *** 2012 data

MSM and HIV (2)

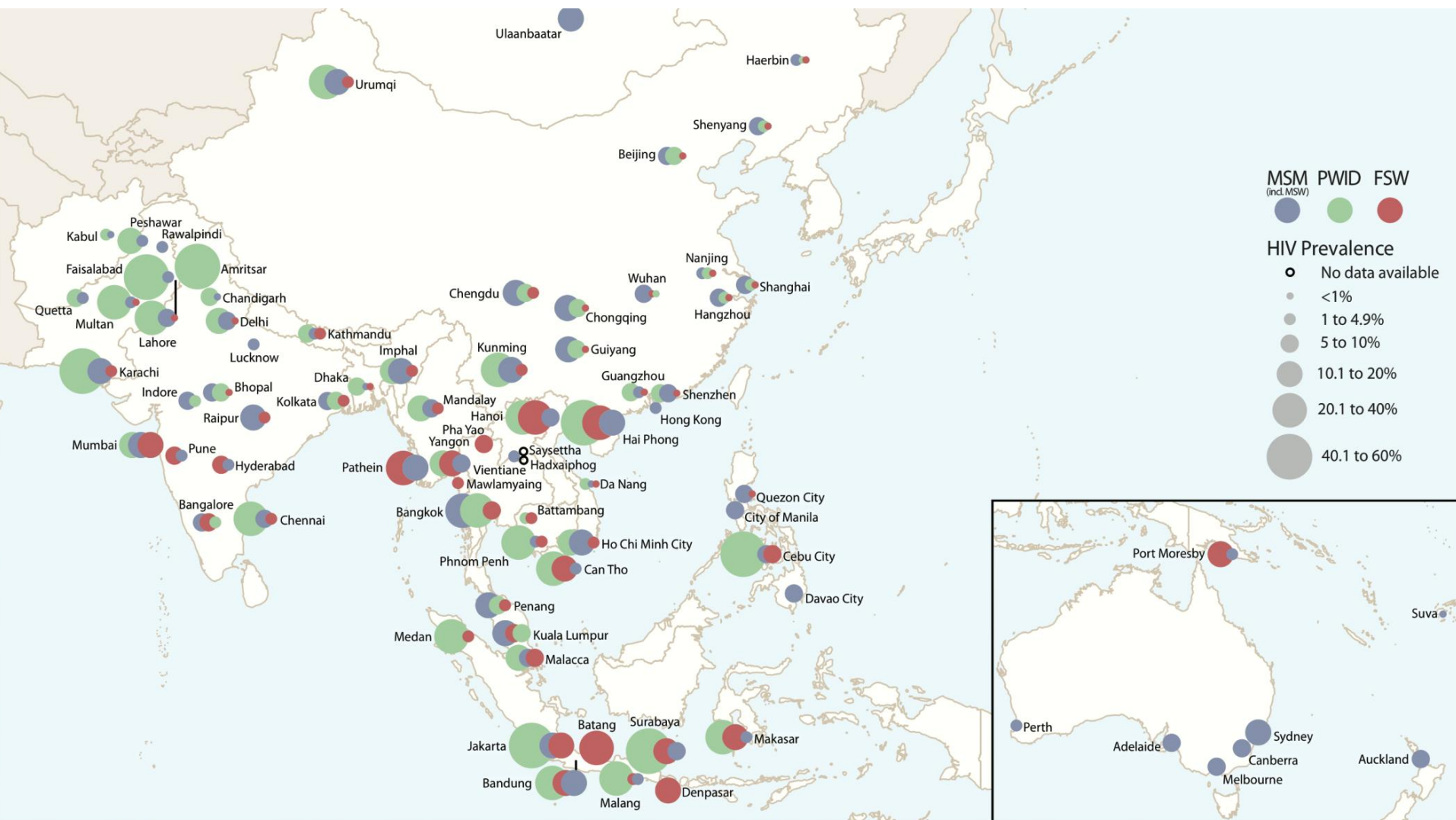
- If transmission risk was similar to vaginal sex, 80-90% of HIV incidence in MSM would not occur.
- Many MSM practice both insertive and receptive roles in anal sex, which helps HIV spread faster in this population. If MSM were limited to just one role ('top' or 'bottom') HIV incidence would be reduced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

Source: Beyrer, Chris, et al. "Global epidemiology of HIV infection in men who have sex with men." *The Lancet* 380.9839 (2012): 367-377.

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

Equity. Dignity. Social Justice.

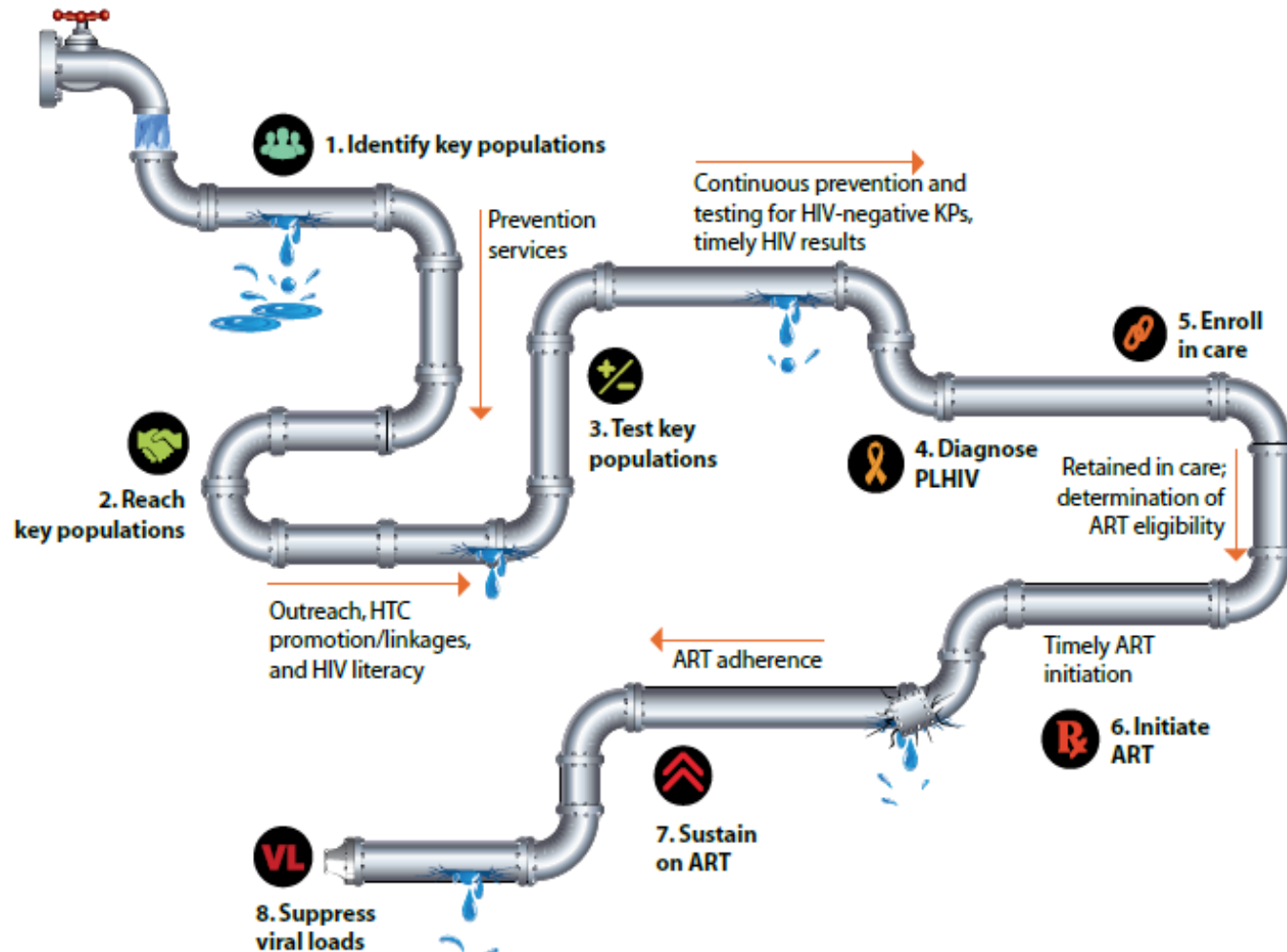
Component One:

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

Cascade of HIV Services

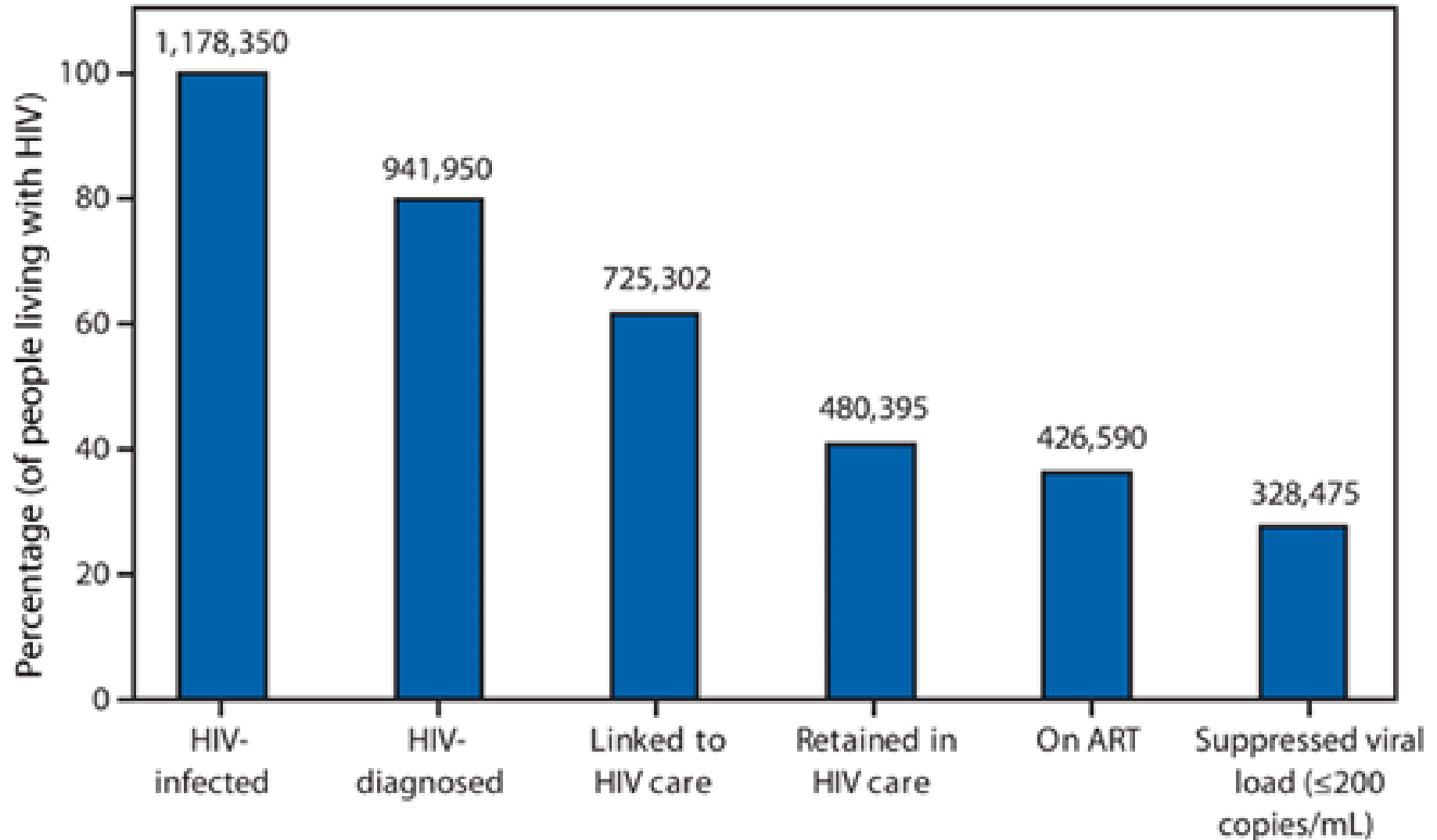
- Tool for diagnosing, monitoring, evaluating and prioritising HIV responses among MSM
- Seven levels:
 1. Total # of MSM in need of HIV services
 2. Estimated proportion living with HIV (prevalence)
 3. Proportion of (2) who have been diagnosed (tested)
 4. Proportion of (3) who have made contact with 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



Note: KPs = Key Populations, HTC = HIV Testing and Counseling, ART = Antiretroviral Therapy, PLHIV = persons living with HIV. Source: USAID/FHI 360, PEPFAR and Linkages, HIV Cascade Framework for Key Populations. Washington DC, FHI 360, 2015.

Example (U.S.A.)



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

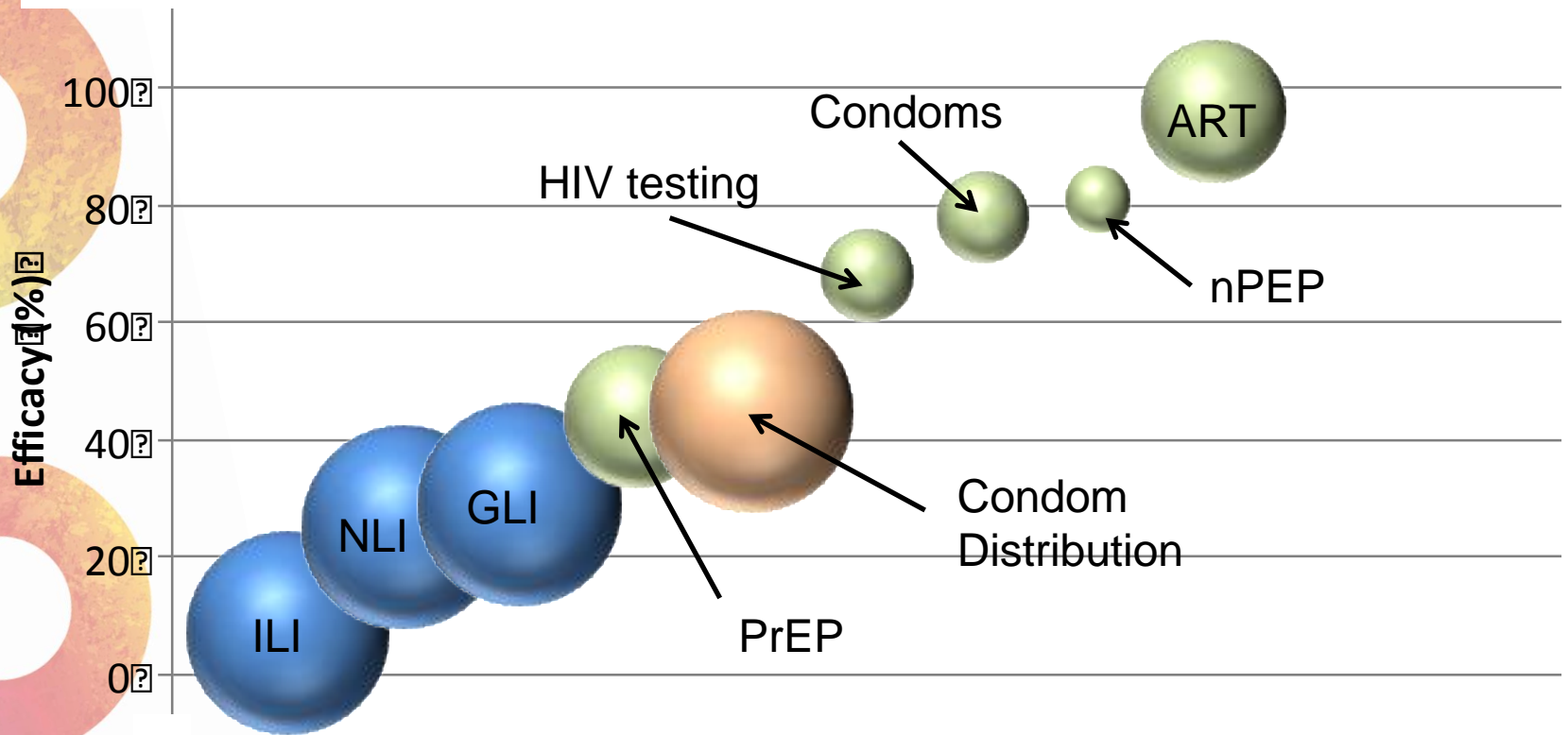
Component 2:

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



ILI: Individual-level behavior change intervention; NLI: Network-level behavior change Intervention; GLI: Group level Behavior change intervention. Size of bubble is proportional to strength of evidence. Blue: Behavior change; Green: Biomedical; Orange: Structural. (Sullivan P, et al, Lancet 2012)

Behavioural interventions

- 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???

*Underhill, Kristen, Paul Montgomery, and Don Operario. "Sexual abstinence only programmes to prevent HIV infection in high income countries: systematic review." *Bmj* (2007), Santelli, John, et al. "Abstinence and abstinence-only education: a review of US policies and programs." *Journal of Adolescent Health* 38.1 (2006): 72-81 and Kirby, Douglas B. "The impact of abstinence and comprehensive sex and STD/HIV education programs on adolescent sexual behavior." *Sexuality Research & Social Policy* 5.3 (2008): 18-27.

Treatment as Prevention (TasP)

- 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.**

* Dieffenbach, Carl W., and Anthony S. Fauci. "Universal voluntary testing and treatment for prevention of HIV transmission." *Jama* 301.22 (2009): 2380-2382.

** Jin, Fengyi, et al. "HIV risk reduction behaviours in gay men: unprotected anal intercourse, risk reduction behaviours, and subsequent HIV infection in a cohort of homosexual men." *AIDS (London, England)* 23.2 (2009): 243.

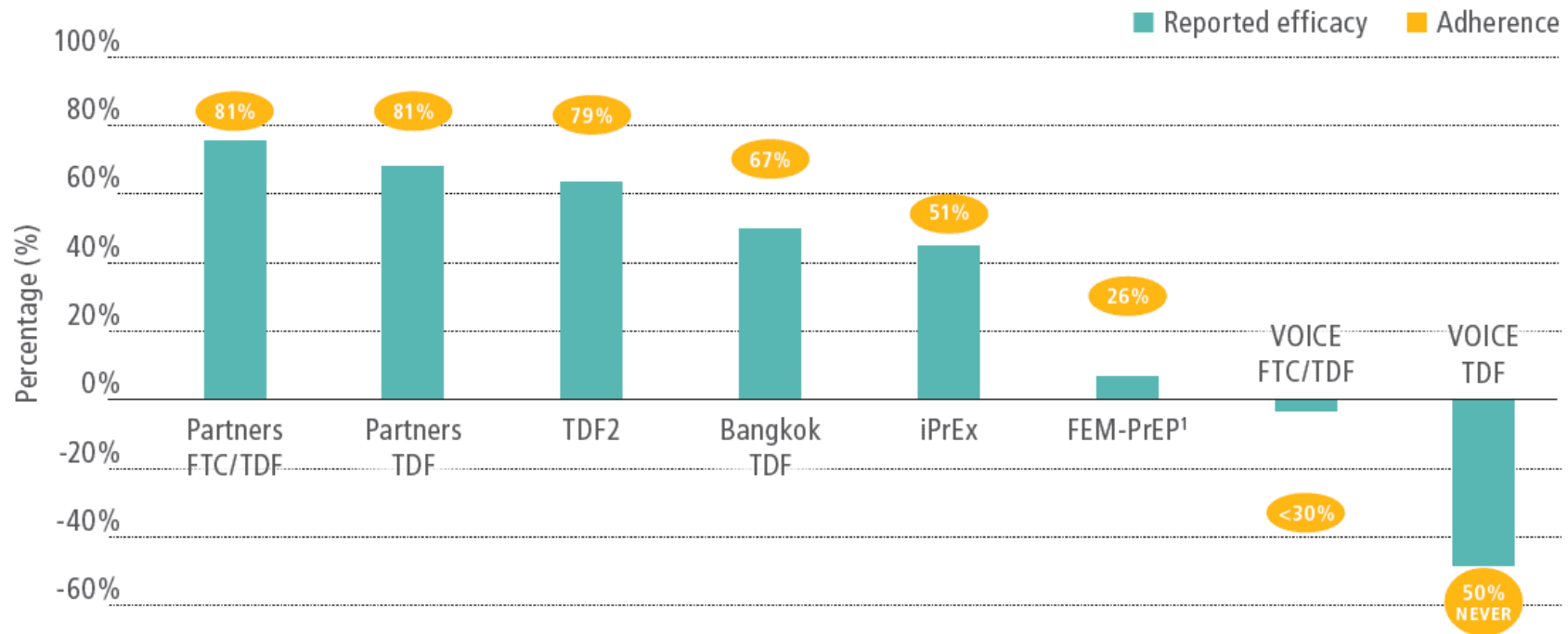
Biomedical interventions: Pre-exposure Prophylaxis (PrEP)

- 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

** Varghese, Beena, et al. "Reducing the risk of sexual HIV transmission: quantifying the per-act risk for HIV on the basis of choice of partner, sex act, and condom use." *Sexually transmitted diseases* 29.1 (2002): 38-43 and Kurth, Ann E., et al. "Combination HIV prevention: significance, challenges, and opportunities." *Current HIV/AIDS Reports* 8.1 (2011): 62-72.

PREP works, if taken!

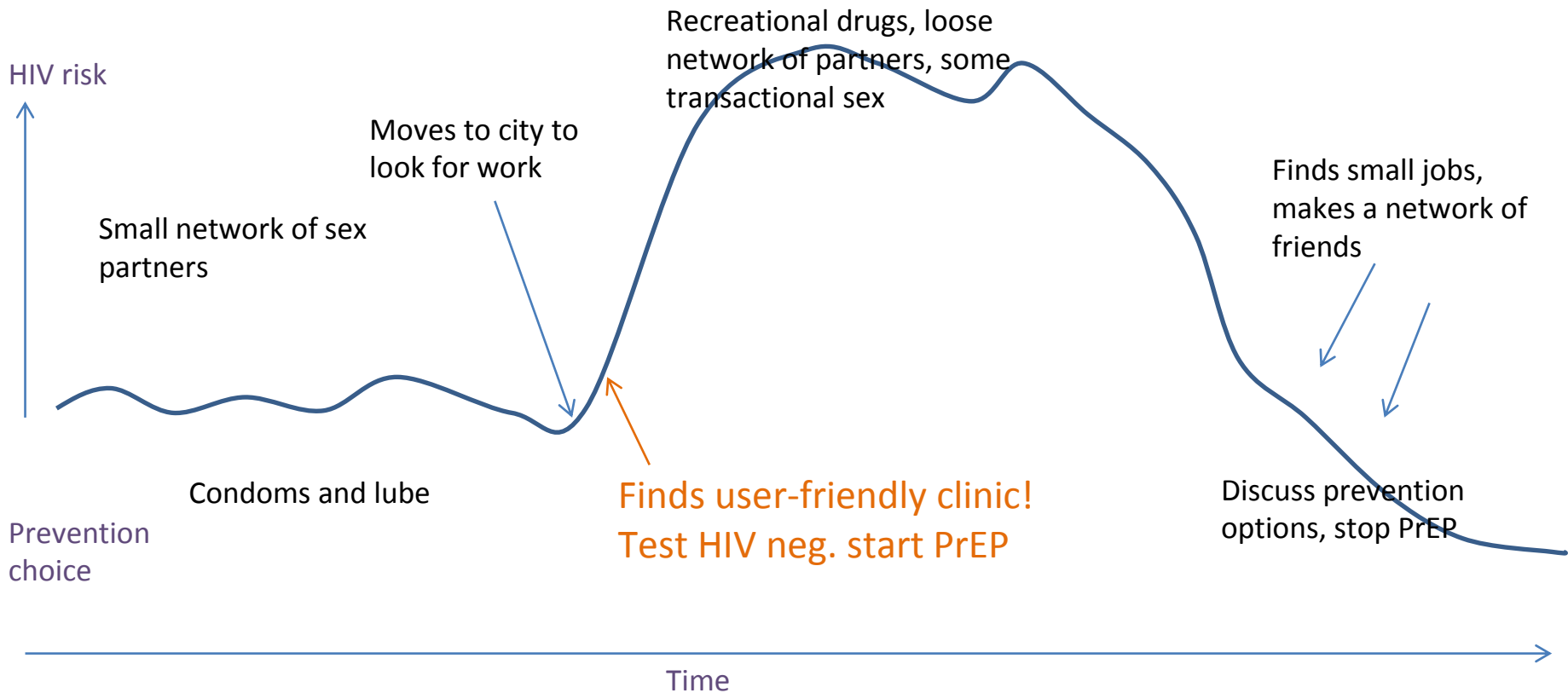


¹ 26% over two visits, 38% maximum at one visit.

Peter Godfrey-Faussett, Science Advisor, UNAIDS, presentation to PrEP consultation in Bangkok, 2015

Equity. Dignity. Social Justice.

PrEP is for people at substantial risk of HIV infection and not forever



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, discordant 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, gonorrhoea, 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
- Naiveté 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



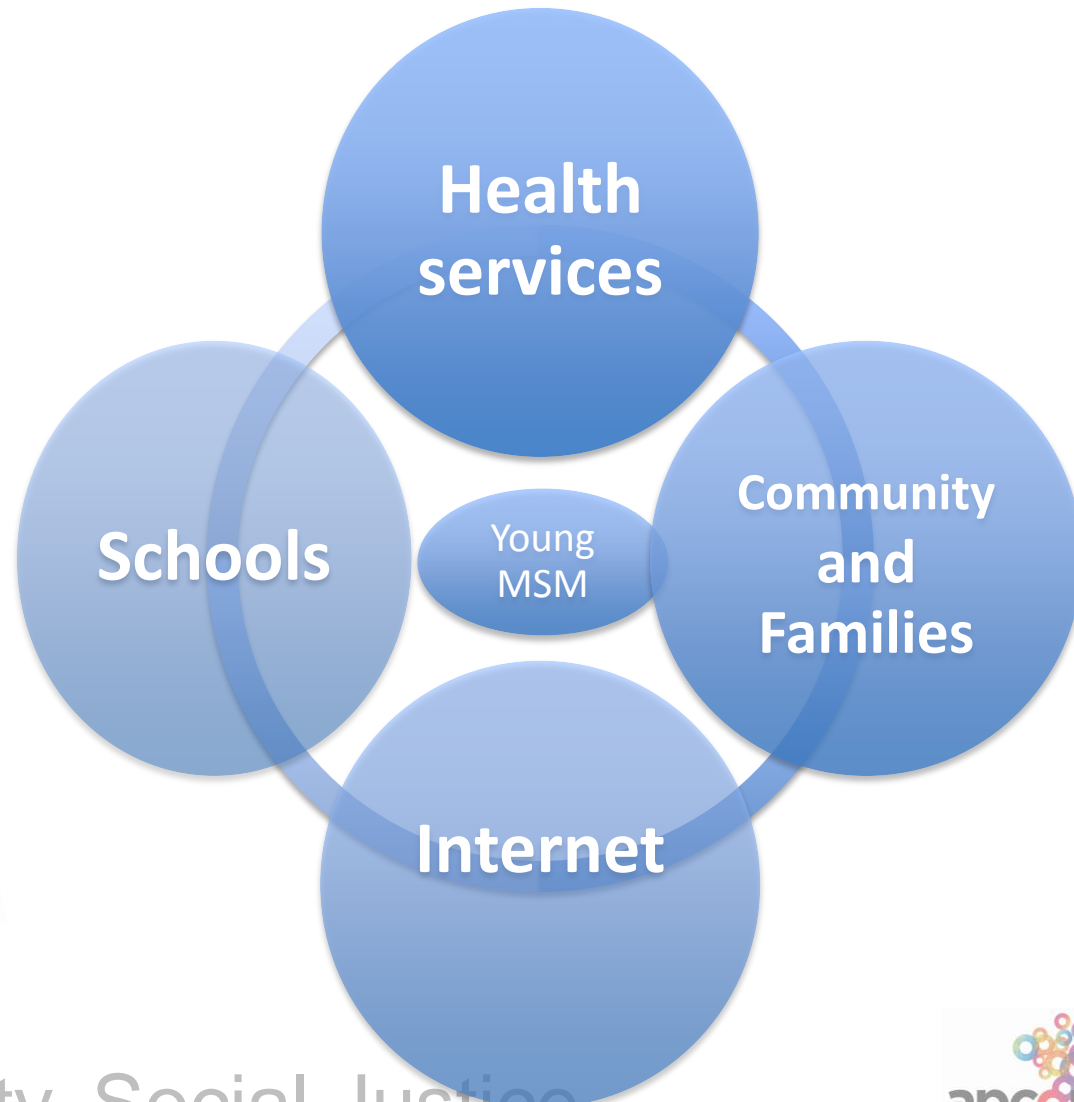
A proposed Pilot Project

Preventing HIV and linking young
MSM to HIV services

Equity. Dignity. Social Justice.



Four settings to be mobilised to reach young MSM



Equity. Dignity. Social Justice.



Component 4:

Embedding HIV services in a
wider syndemic response

Equity. Dignity. Social Justice.



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.

* Singer, Merrill, and Scott Clair. "Syndemics and public health: reconceptualizing disease in bio-social context." *Medical anthropology quarterly* (2003): 423-441.

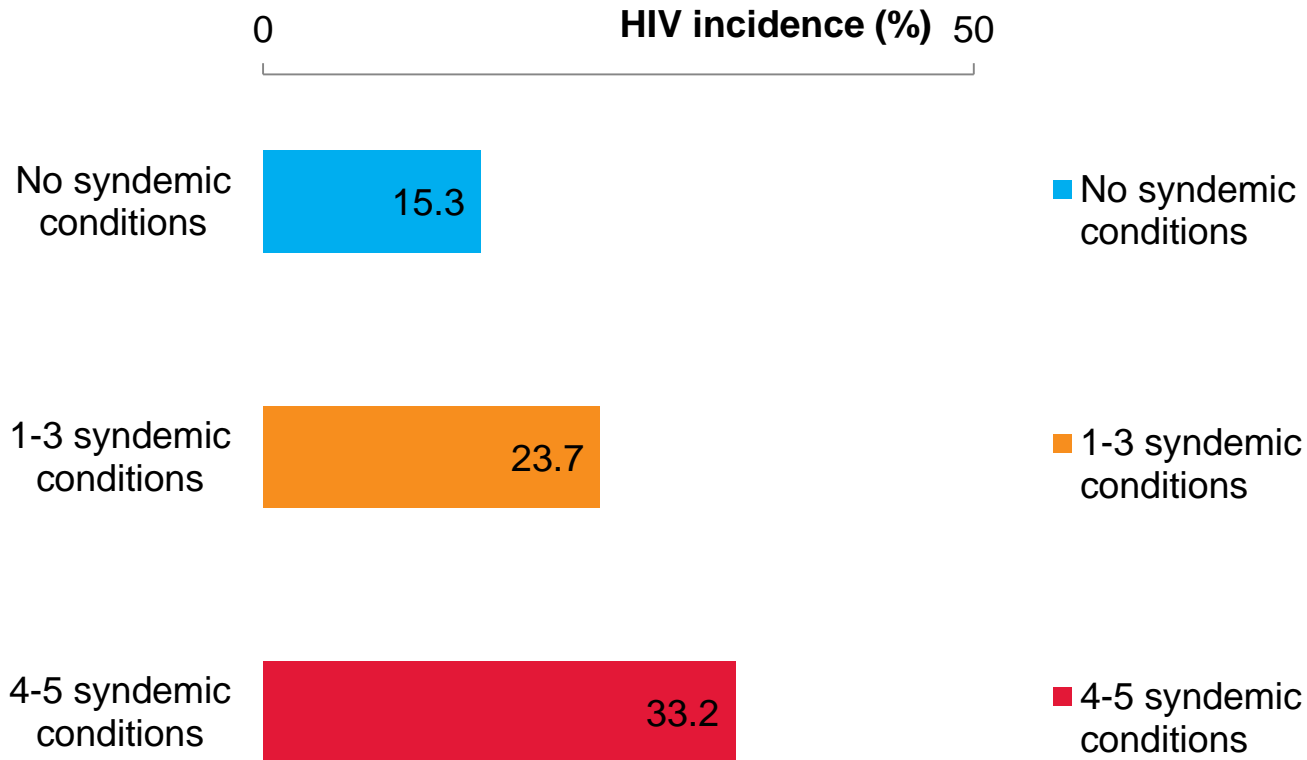
Syndemic factors (2)

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



Source: Guadamuz, T. E., et al. "Psychosocial health conditions and HIV prevalence and incidence in a cohort of men who have sex with men in Bangkok, Thailand: Evidence of a syndemic effect." *AIDS and Behavior* 18.11 (2014): 2089-2096.

THANK YOU

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Component 2:
**Comprehensive
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