Addressing HIV prevention, care, and research priorities among MSM in Asia

amfAR - The Foundation for AIDS Research
Kevin Robert Frost
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Overview

✓ The Who - Definitions
✓ The What – HIV sero-prevalence/incidence data
✓ The Why - Key factors in the epidemic
✓ The How - What is needed
✓ The amfAR MSM Initiative
✓ Developing an operations research agenda for MSM in Asia
Who are MSM??

✓ Any man who has sex with a man regardless of self-identification related to homosexual behavior

✓ Based on behavior, encompasses all identities

✓ Can include
  • Men who identify as gay, bisexual, or otherwise same-gender oriented in sexuality and sexual practice
  • Men who do not identify as same-gender oriented, but who have sex with other men because of economics (sex workers), environments (prisoners) or societal constraints (gender separation, gender norms).
  • Transgender individuals who self-identify as female.

✓ Not much data/information about Young MSM
HIV/AIDS among MSM

✓ **UNAIDS: Some progress in general populations**
  
  • Global HIV prevalence leveling off as prevention takes hold
  • Fewer AIDS-related deaths due to availability of ARVs
  • HIV epidemics remain concentrated among MSM, IDUs and sex workers in most of the world, including in countries with concurrent generalized epidemics.

✓ **Growing recognition that HIV/AIDS resources don’t follow greatest need**

✓ **Increased awareness of linkages between HIV/AIDS prevalence, gender roles, and sexual/human rights**
HIV prevalence among MSM in Selected settings

HIV Prevalence Among MSM in Selected Settings

- MSM Prevalence
- Adult Prevalence (2006 UNAIDS Estimate)

Sources: Wade et al. 2005; Girault et al. 2004; van Griensven et al. 2005; Action for AIDS Singapore, 2006; Go et al. 2004; Pando et al. 2006; UNAIDS, 2006; Caceres et al., 2005; Strathdee et al., 2006; CENSIDA, CA State Office of AIDS; Patterson et al, IAS, 2006; Strathdee et al, pers. comm. Viani et al, 2006.
APPROXIMATE HIV PREVALENCE RATES AMONG MSM IN SELECT COUNTRIES

UNITED STATES
25% in a study of MSM in five U.S. cities.
HIV infections among MSM in the U.S. increased 13% between 2001 and 2006.

LATIN AMERICA
21% in Uruguay
15% in Mexico

EASTERN EUROPE
27% in Ukraine

AFRICA
40% in Kenya
22% in Senegal

ASIA
28% in Bangkok in 2005–up from 17% in 2003.
17% percent in Maharashtra, India.
HIV/AIDS among MSM

- On average, MSM in developing countries are 19 times more likely to be HIV positive than general public
  - Georgia: 24 times more likely
  - Senegal: 27 times more likely
  - China: 45 times more likely
  - Bolivia: 179 times more likely

- Globally, fewer than 1 in 20 MSM have access to HIV/AIDS services

- Most countries do not track HIV among MSM; nor include MSM in National AIDS Plans

- Majority of Global Fund, bilateral aid flows through local governments, excluding MSM
HIV prevalence among MSM
Bangkok Thailand 2003 – 2007

- 2003: 17.3%
- 2005: 28.3%
- 2007: 30.7%
HIV among Young MSM

- Very few studies; few with disaggregation by age analysis

- **Brazil Horizons Study** (Campinas – 2005-07; 800 MSM)
  - Sixty-two percent of sexually active MSM aged 14–19 years had never been tested for HIV, and 46 percent of these individuals had unprotected receptive anal intercourse in the past two months
  - A high proportion of MSM reported having suffered homophobic violence at least once in their lifetime (85 percent), as well as in the past 12 months (70 percent).

- **Senegal Population Council Study** (Dakar – 2003-06; 290 MSM)
  - The first sexual experience often occurs with an adult during adolescence. Survey respondents first sexual encounter with a man occurred on average at 15 years. This experience was often with an adult, someone they knew or had recently met. A third of the sample reported that the adult was part of the respondent’s extended family.

Sources:
Why – Global

✓ Lack of Recognition/Existence

✓ Stigma and Discrimination
  ➢ Violence/Sexual Abuse
  ➢ Lack of family/community acceptance/social support
  ➢ Higher rates of substance use (IDU)
  ➢ Lack of access to health care/hostile environment
  ➢ Access to affordable water-based lubricants
  ➢ Heterosexism in prevention programs (abstinence-until marriage only)

✓ Criminalization (85 countries criminalize same sex behavior)
  ➢ Extortion/Lack of protection from abuse
  ➢ Easy target for conservative politicians/leaders
Why – Global

✓ Biological Factors
  - Sexual Abuse
  - Sexual transmission (anal sex 5-10 times more efficient)
  - STIs often go untreated

✓ Poverty
  - Lack of family support can lead to poverty/transactional sex
  - Power dynamics of gender/age in relationships

✓ “Hidden” Populations
  - Gender norms limit expression/identities
  - Reaching MSM vs. gay men
  - Environmental issues (e.g. prison; military, etc.)

✓ Treatment Messaging / Fatigue/ Generational
What is needed?

✓ **Research/Increased understanding of unique needs:**

- Emerging sexual/gender identities and expressions (culturally specific) which can involve experimentation
- Unique prevention, treatment, care and support needs (Homo/Trans-phobia within youth focused programming)
- Social support needs (e.g. peers; family; community)
- Cogitative and physical developments
- New technologies (e.g. internet; cell phone) as means to reach Y/MSM
How - What is needed?

✓ Evidence-based interventions for MSM in Global South

✓ Increased funding from Global Fund, PEPFAR (USAID/CDC), and other government and institutional donors for:
  - Direct program support; targeted research; capacity building; global advocacy

✓ Political support for MSM/HIV issues
  - Integration into National AIDS Plans / HIV/AIDS Programs
  - End criminalization/discrimination of male-male sex
amfAR’s MSM Initiative

To significantly improve HIV prevention, treatment, and care among MSM in resource-limited countries
What is the Goal?

Improved health and well-being for gay men, MSM and transgenders

☼ Universal access to HIV services: prevention, treatment and care
☼ Decline in the number of MSM acquiring HIV through sex and drug use
☼ Reduced burden of STIs
☼ Prolonged health and quality of life for MSM with HIV
amfAR’s MSM Initiative

Strategies:

- **Community Awards**: Support and empower grassroots MSM organizations

- **Research**: Build understanding and awareness about HIV epidemics among MSM

- **Advocacy**: Advocate for effective policies, increased funding
Program Update

✓ Provided over $1.6 million in small grant awards ($15,000-$40,000) to 64 organizations in 46 countries in 5 regions

- Securing funding to frontline groups in need (seen success – replication; scale-up; greater networking)
- Building capacity of those groups to receive/spend funds strategically
- Utilizing streamlined grant making mechanisms
- Utilizing peer review process/regional networking
Community Awards
Asia-Pacific Round 1&2

- **Focus on comprehensive services**
  - Developing HIV protocols to include MSM (Thai Red Cross)
  - Reaching positive MSM in Myanmar (withheld) and Nepal (Blue Diamond Society)

- **Focus on behavior change**
  - Social support and personal identities (China, APLA)
  - Sexual Health Diaries (Thailand, SWING)

- **Focus on capacity-building of CBOs**
  - Skills development on Research Methods and Strategic Planning for CBOs (Samoa, Pacific Sexual Diversity Network)
  - Participatory Governance Structures; Advocacy Skills with local governments (scale-up through UNDP Funding), (Philippines, TLF-SHARE Collective)
Community Awards
Asia-Pacific Round 3

- Latest Asia-Pacific Round (awarded October 09)
  - 112 Applications from 22 countries for single or joint awards of $15,000 - $30,000 each
  - Over $2.2 million in total requests
  - Total amount awarded for rounds 1-3 US$470,000.00 (projected)
  - 20 Organizations have received awards
Forging a Response
What We Know

• Hundreds of small and medium-sized programs in Asia and the Pacific are now trying to reach MSM with HIV interventions.

• However, most MSM are not being reached by HIV programming.
What We Need to Know

• Nongovernmental organizations (NGOs) support MSM programs in several countries in Asia but there is little information about how to assist them in scaling up.

• There is also little information about the most appropriate package of interventions to offer in each setting and to each sub-population.

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

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

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

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

3) Link VCT programs to operations research

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

- take into account clients belonging to multiple populations (e.g. MSM + CSW; MSM + IDU)
- offer ‘one-stop shop’ approach
- high quality services; confidentiality observed
- can face discrimination because of social stigma of MARPs, risking alienation of clients
- clinics often positioned outside local health infrastructure
Key Findings

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

- Map currently available services
- Develop alternate intervention models
- Conduct regional consultations with key stakeholders
- Assess logistical factors for implementing programs and bring them to scale
- Determine potential opportunities for international and regional collaboration
- Develop standards and guidelines
- Address funding considerations
Key Questions That Need to Be Addressed

• What is the optimal spectrum of services that support HIV prevention and care among MSM?

• What are the best strategies to engage diverse populations of MSM?

• What are the best ways to track service delivery, utilization of services by MSM, and the effects of services?

• What is required to establish and disseminate an MSM-specific standard(s) of care?
Thank You!!

www.amfar.org/msm