



**REGIONAL  
REPORT**

***MSM and HIV Counselling and Testing  
in Asia and the Pacific***







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APCOM is committed to increasing investment in, and scaling up coverage of, HIV prevention, treatment, care and support for MSM in Asia and the Pacific. This report is another step in that direction.



## Background

HIV counselling and testing (HCT<sup>1</sup>) is the key entry point for MSM to link themselves to health services, and if necessary, to care and treatment<sup>3,4,5</sup>. However, according to UN-AIDS<sup>6</sup>, present efforts to stop the continued rise of HIV infection rates among MSM are insufficient. HCT services aimed at MSM are blocked by various factors<sup>7,8,9</sup> in Asia and the Pacific<sup>10</sup>. Punitive laws prevent MSM from seeking such services and any necessary medical attention<sup>11,12,13</sup>. The cultural, ethical and religious values in various countries in Asia and the Pacific, as well as clauses in the 2011 Political Declaration on HIV AIDS, impede access to HCT for MSM<sup>14</sup>. Criminalization of same-sex activity is still outlawed in 19 of 48 countries in Asia and the Pacific. This makes offering, accessing, and expanding HCT and its accompanying care and treatment difficult<sup>15</sup>. Responses to rising HIV trends among MSM are limited, and knowledge of HIV serostatus among MSM is low. There is inadequate programme coverage, a failure to meet the changing needs of the community, and low levels of community involvement that hinder progress in reducing the number of HIV infections among MSM<sup>16</sup>. In East Asia, it has been reported that less than one in ten MSM receive basic intervention packages due to inadequate resources and funding<sup>17</sup>.

This signals the need for more HCT services in Asia and the Pacific<sup>18,19</sup> to achieve the goals in the 2011 United Nations Political Declaration on HIV and AIDS of reducing sexual transmission of HIV by 50%, and reaching 15 million people living with HIV with antiretroviral treatment by 2015<sup>20</sup>.

This report focuses on the HCT services offered to MSM by NGOs<sup>21</sup> or CBOs<sup>22</sup> in countries across Asia and the Pacific<sup>23,24</sup>, in the period September 2013 to February 2014. The objectives of this report are to:

1. Identify and analyse the HCT services offered;
2. Identify and analyse how MSM are encouraged to utilize HCT services;
3. Identify and analyse how MSM are linked to HCT services;
4. To identify and analyse how loss to follow-up in HCT services is avoided;
5. Identify and analyse how MSM are referred to confirmatory testing;
6. Identify and analyse how MSM are linked to treatment and care;
7. Identify and analyse challenges to comprehensive service provision;
8. Advocate for the improvement of access to and quality of HCT services for MSM;
9. Increase the uptake of HCT by MSM in Asia and the Pacific.

HIV counselling and testing (HCT) in China.



## Methodology

A first draft of questions on HCT models shared with MSM in Asia and the Pacific was refined through responses gained in a pilot study. The pilot study used an email questionnaire that was sent to leaders of various MSM-aligned organizations in the region<sup>26</sup>. This list of questions was further expanded via a workshop conducted during the Pre-Conference of the 11th International Congress on AIDS in Asia and the Pacific in Bangkok, Thailand<sup>27</sup>. The finalized list of questions on HCT models formed a qualitative questionnaire<sup>28</sup>. This qualitative questionnaire was emailed to leading NGOs and CBOs that offer HCT to MSM in Australia, Bangladesh, Cambodia, China, Fiji, Hong Kong, India, Indonesia, Lao PDR, Malaysia, Mongolia, New Zealand, Pakistan, Papua New Guinea, the Philippines, Singapore, Thailand, Timor Leste, Tonga and Vietnam<sup>29, 30</sup>.

A qualitative content analysis matrix<sup>31</sup> was used for data analysis where recurring themes, similarities, differences, and outstanding successes or outstanding challenges, were identified.

Group discussion during MSM and TG Community Forum  
ICAAP11, Bangkok Thailand





## Findings

### HCT SERVICES OFFERED<sup>32</sup>

Responses indicated that HCT services offered by NGOs and CBOs generally covered pre-test counselling, post-test counselling and blood testing. The procedure that HCT followed as indicated by the responses were: 1) Self-risk assessment; 2) Enhance client understanding of risk factors; 3) Assess client's risk of infection; 4) Gain consent from client; 5) Blood is drawn<sup>33</sup>; 6) Client is asked to wait for results through Rapid Test, or to return for results if the blood is sent to a pathology lab for testing; 7) Post-test counselling<sup>34</sup>.

Easy access to HCT sites increased the attractiveness of HCT services. HCT became less attractive when sites were difficult to find or if MSM were difficult to reach out to. HCT sites were experienced as less hostile when staff and volunteers were MSM, and three different models of staffing were reported<sup>35</sup>.

The success of HCT services in catering to the HCT needs of MSM was shown to be highly dependent on staff and volunteers who were well trained. Training for staff and volunteers was scheduled either quarterly or annually. Training and training materials<sup>36</sup> were provided by international partners<sup>37</sup>. HCT training covered clinical issues, medical and support systems for adherence, basic care of patients with HIV, and management of emergency situations. The effectiveness of the training was evaluated through an annual performance review of the technical competencies of staff and volunteers. Apart from technical competencies, it was reported that the success of HCT services also depended on the ability of staff to display professionalism<sup>38</sup> and empathy<sup>39</sup>.

### ENCOURAGING AND LINKING MSM TO HCT SERVICES

Targeted outreach was used to encourage MSM to access HCT services. Targeted outreach fell into two distinct models: i) direct targeted outreach and ii) indirect targeted outreach. Direct targeted outreach included face-to-face communication<sup>40</sup>, referral to anonymous clinic services, discrete test sites that do not draw hostile attention, and mobile testing services. Indirect means of communication included the internet, advertising<sup>41</sup> and collaterals<sup>42</sup>, awareness campaigns, and networking<sup>43</sup>. The use of financial incentives to encourage MSM to use HCT services was rare due to the financial constraints under which the NGOs and CBOs function<sup>44</sup>. At one site, incentives given in kind were directed at encouraging further use of HCT<sup>45</sup>.

The qualitative questionnaire identified four strategies used by respondents to link MSM to HCT services once the targeted outreach was successful in establishing contact:

1. HCT was conducted in full by the trained volunteers of the NGO or CBO and further case management was referred to medical institutions;
2. HCT was conducted by trained volunteers, with the exception of the blood test, which was done by medical personnel;
3. MSM were referred directly to a partner organization that conducted HCT<sup>46</sup>;
4. A combination of 1 and 3.

## Findings

### AVOIDING LOSS TO FOLLOW-UP AND REFERRAL TO CONFIRMATORY TESTING

It was reported that despite all efforts, clients were sometimes lost to follow-up. The lead causes of this were the waiting period between the actual blood test and disclosure of results, and false seropositive test results that lead to clients not trusting HCT services. These factors signalled the need to minimize the waiting period for results, and for more accurate tests. When blood testing was outsourced, client contact information was gathered so that clients may be contacted. This reduced loss to follow-up<sup>47</sup>. Client coding and use of international or national standards of tracking clients were also utilized to manage loss of clients<sup>48</sup>. Where necessary, clients were referred to confirmatory testing<sup>49</sup>.

### LINKING MSM TO TREATMENT AND CARE

Seropositive MSM were urged to seek treatment through national health systems. This effort was supported by partner organizations<sup>50</sup>, and in some cases, small incentives from the NGO/CBO were used to further encourage seropositive MSM to seek treatment<sup>51</sup>. Health systems provided seropositive MSM with antiretroviral therapy (ART)<sup>52</sup>, group counselling, HIV case management, government-funded medical assistance, and clinical psychological services<sup>53</sup>. Links to services supporting adherence to ART in the form of support groups<sup>54</sup> and facilities<sup>55</sup> were viewed as essential by all NGOs and CBOs<sup>56</sup>. However, due to financial and cultural constraints, support for ART adherence was not always available<sup>57</sup>. In general, client experience of HCT services and linkage to care and treatment were reported to be encouraging. Clients reported better quality of life, and involvement in the NGO/CBO as volunteers, following their use of HCT services.

### COMPREHENSIVE SERVICE PROVISION

Comprehensive service provision is defined as services which encompass pre-test counselling, post-test counselling, blood test for HIV antibodies, referral to counselling should the client be HIV+, referral to care should the client be HIV+ (e.g. to HIV+ MSM support groups, psychological assistance), access and referral to anti-retroviral treatment, and access and referral to support to adherence to anti-retroviral therapy (ART). NGOs and CBOs reported the need for, willingness to provide, and demand for comprehensive services. However, NGOs and CBOs also reported barriers to offering comprehensive services. These barriers were: a lack of funding; resources for technical training were not always available; lack of experience of members of NGOs and CBOs to manage such an undertaking; unavailability of a location that could support such services; and high dependence on volunteers who lacked the time and experience to execute comprehensive service provision. As a result of these barriers, NGOs and CBOs could not be confident of providing comprehensive services that were sustainable. NGOs and CBOs who have thus far provided comprehensive services also voiced concerns with regard to sustainability.



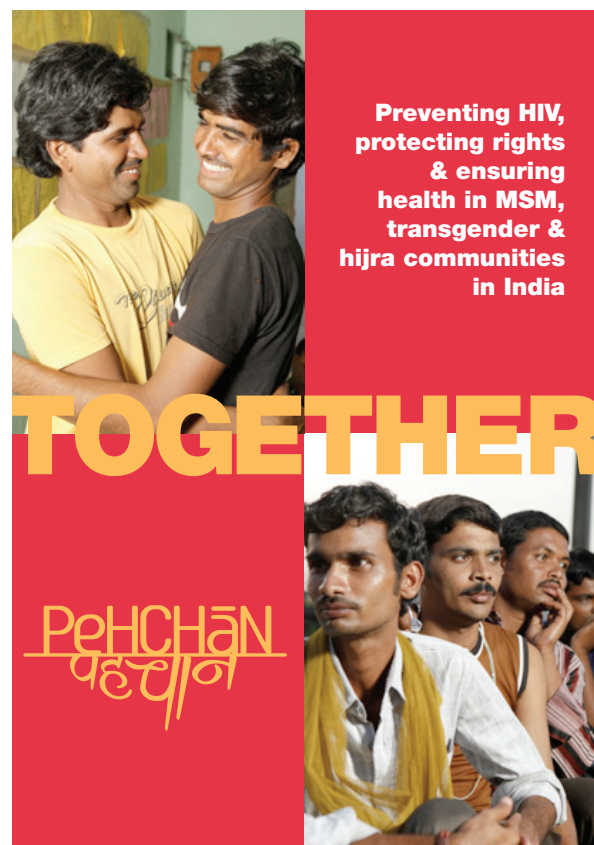
## DISCUSSION

Despite challenges, the availability of HCT for MSM in Asia and the Pacific plays a significant role in HIV prevention and treatment, and assists in meeting the Millennium Development Goals of combatting HIV and AIDS, and reducing HIV transmissions through VCT<sup>58</sup>. Stakeholders cannot remain complacent with present levels of HCT service uptake, and the level of skills and resources in NGOs and CBOs must be raised in order to achieve higher rates of HCT. Respondents identified comprehensive service provision as an effective means to that end.

Creativity and innovation in targeted outreach messages are needed to attract MSM to HCT services. Messages need to be supported by the continuous upgrading of skills among NGO/CBO staff/volunteers in professionalism and empathy, as well as technical skills. The success of HCT is dependent on the visibility, availability, accessibility, confidentiality and affordability of services. Dependable partnerships and collaborations with public and private organizations that effectively offer services for treatment, care, and adherence to ART, also add to the success of HCT services.

Various factors detract from the effectiveness of HCT services. Loss of clients due to a long waiting period for test results and inaccurate test results bring the HCT provider's reputation into question by MSM. The lack of sustained funding negatively affects efforts to increase HCT uptake among MSM. Poor coordination between local, national and regional efforts in offering HCT services to MSM is another detracting factor to HCT service success. The findings also indicate that for comprehensive service provision to be effectively offered, the availability of funding must be prioritized. These detracting factors need to be addressed to achieve an increase in HCT utilization by MSM.

Testing Poster in India



## RECOMMENDATIONS

- Messages aimed at increasing the uptake of HCT by MSM must be targeted specifically at the MSM population. The appeal of these messages must be understood by MSM at a personal level.
- NGOs and CBOs should adopt more innovative and creative incentives to lead MSM to HCT services.
- NGOs and CBOs that offer HCT to MSM must be recognized as professionals. Proper funding from government bodies for the training of staff and the building of capacity should be prioritized.
- More accurate and reliable on-site HIV tests are needed.
- Policy change is needed at the government level to actively combat the stigma and discrimination surrounding HCT and sex between men.
- Standard operating procedures at clinics must respect the rights and dignity of MSM.
- The present capacity and resource gap in creating, implementing, and sustaining comprehensive service provision must be bridged. To that end funding, technical training, and experiential learning, must be made available to NGOs and CBOs to provide HCT to MSM.
- Funding from international sources as well as from national Ministries of Health for comprehensive service provision must be dependable for the foreseeable future. This will improve the sustainability of these services.

Preparing condoms  
HTC in Pakistan





## APPENDIX A



### JOINT STATEMENT ON SCALING UP VOLUNTARY COMMUNITY-BASED HIV TESTING AND COUNSELLING FOR KEY POPULATIONS IN ASIA AND THE PACIFIC

**BANGKOK, Thailand, 21 November 2013**—United Nations entities, civil society networks and development partners in Asia and the Pacific are joining to urge for a rapid increase of voluntary confidential community-based HIV testing and counselling for key populations at higher risk—including men who have sex with men, transgender people, sex workers and people who use drugs— in the region, to help ensure more people in need are able to access life-saving antiretroviral treatment.

Low levels of access to HIV testing and counselling for key populations at higher risk remains a serious cause for concern in Asia and the Pacific. Across the region, less than half of the key populations know their HIV status, which can lead to late diagnosis, late initiation to care and treatment services, and can result in unnecessarily high morbidity and mortality for people living with HIV. This also means the benefits of the prevention impact of antiretroviral treatment are not being fully maximized in the region.

Although countries in Asia and the Pacific have made significant strides to expand coverage of antiretroviral therapy in recent years, in 2012 only 51% (43%-63%)<sup>59</sup> of people eligible for antiretroviral treatment were receiving it.

If access to antiretroviral treatment is to be increased (to levels committed by nations through the 2011 United Nations General Assembly Political Declaration on HIV/AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS), there is an urgent need to change current approaches to HIV testing and counselling in the region.

Ensuring key populations at higher risk have access to testing, prevention, care and treatment services is fundamental to progress on HIV in Asia and the Pacific. Current facility-based HIV testing needs to be augmented by and respectful of community approaches to reach key populations who are currently under-served. This can only be achieved by ministries of health partnering with community organizations who are trusted by their peers to provide life-saving HIV prevention, care and support, and who understand how to deliver services that are ethical, convenient, acceptable and effective.

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Voluntary and confidential HIV testing and counselling using rapid testing should be provided in both facility-based and community venues at times and locations that support greater access and uptake. For community organizations to offer HIV testing and counselling, ministries of health must acknowledge, legitimize and actively support their role in providing these services and offer training on use of rapid test devices safely and accurately. Sufficient allocation of funds for these services and adequate test kit supply must be ensured as part of national programmes. Where necessary, national HIV testing policies and protocols need to be modified to include community-based testing and counselling.

Across Asia and the Pacific, evidence shows that many people do not undergo HIV testing for fear of stigma and discrimination, and disclosure that can affect their livelihoods. In some settings in the region, testing practices such as coerced or mandatory testing of key populations, including sex workers and migrants continue to be reported. Through a number of community-based testing and counselling programmes already conducted in the region, evidence shows that community-based testing helps reduce stigma and discrimination, encourages greater up-take of services and ensures greater protection of human rights. In the drive to increase community-based testing, ministers of health and community groups need to work together to monitor the quality of services, ensure that they conform to ethical standards, including confidentiality and consent and safeguard the human rights of communities and key populations against all forms of coercive testing.

*We (United Nations entities, civil society networks and development partners in Asia and the Pacific) are committed to work with countries and communities to support community-based confidential and voluntary testing and counselling through:*

- Review of existing national testing strategies and approaches, and revise where needed to expedite progress
- Strengthening of partnership between ministries of health and communities
- Support of community-led efforts to promote, and increase demand for HIV testing
- Advocate for communities as equal partners in delivery of HIV testing services at national level

Supporting as many people living with HIV to be aware of their HIV status as early in their infection as possible, and linking them successfully to HIV prevention, care and treatment services will enable more people to access antiretroviral treatment and to maximize the preventative benefits of treatment.

Such decisive action can lead Asia and the Pacific towards realisation of the bold targets from the 2011 UN Political Declaration as well as the ultimate vision of an Asia and the Pacific with zero new HIV infections, zero discrimination and zero AIDS-related deaths.





## APPENDIX B

### LIST OF CONTRIBUTING ORGANIZATIONS FOR ROUND 3 QUALITATIVE QUESTIONNAIRE

#### AUSTRALIA

The M Clinic is auspiced and managed by the Western Australian AIDS Council and is part of the Clinical Services team of the Council. It is a unique, discrete, confidential peer-based service in Western Australia, catering solely for men who have sex with men (MSM).

M Clinic service combines integrated health promotion with clinical service provision with the aim of reducing acquisition of Human Immunodeficiency Virus (HIV) and other sexually transmissible infections (STI's) at a population health level. The clinic provides a full range of STI and HIV testing and also provides vaccination for hepatitis A and B and human papillomavirus (HPV), the main cause of genital warts. It also gives guys a chance to engage with other health and related services that are on offer to them in Perth by carrying out appropriate referrals

PRONTO! is a new, fast, free and confidential rapid HIV testing service. Pronto! has been designed to specifically cater for gay men and men who have sex with men and is staffed by those who know them best. You can have a rapid HIV test and get your results within half an hour. PRONTO! is an express service which means your entire appointment will take no more than 30 minutes, including the time it takes to get the result of the Rapid HIV Test.

PRONTO! is a partnership between the Victorian AIDS Council/Gay Men's Health Centre and the Burnet Institute.

#### BANGLADESH

Bandhu Social Welfare Society (BSWS) was formed in 1996 to address concerns of human rights abuse and denial of sexual health rights, and provide a rights-based approach to health and social services for the most stigmatized and vulnerable populations in Bangladesh, MSM in particular kothis/hijras and their partners. BSWS has been officially registered since 1997. It started with a staff of two and a small programme in Central Dhaka which was supported by the Royal Norwegian Embassy. Over the years it has emerged as a national community led organization currently providing social and health services to a broad range of 'Sexual Minority Populations' in 21 districts in Bangladesh. A core objective of BSWS' work with MSM and Hijras/transgender people is to advocate and provide for an environment where the respect and dignity of all Sexual Minority Populations is assured, irrespective of their specific gender and/or sexual identity, or the lack thereof, along with the creation of a supportive social, policy and legal environment to enable Sexual Minority Populations to more effectively claim sexual health rights and basic human rights in Bangladesh.

#### CAMBODIA

Men's Health Cambodia (MHC) is a non-profit non-governmental organization based in Phnom Penh. There are four sub-offices in Siem Reap, Kampong Cham, Poi Pet City and Koh Kong province. It has been actively operating in Cambodia since 2002 in the sectors of health, and training and capacity building of health services at all levels. MHC was registered on 25th April 2002. It is recognised by the Ministry of Interior as a dynamic motivated working group of MSM and Transgender people, People Who Use Drugs

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(PWUD), Entertainment workers (EW) and other vulnerable people, working to identify and address the health needs of these groups, and creating a supportive environment for improving their health.

### CHINA

Shanxi Landian Working Group was established in 2006. It is an unregistered grass-roots working group aimed at serving the LGBT community comprehensively. The organization advocates for equality between homosexual people and heterosexual people and to develop the culture of homosexual community, in the hope of contributing to civil society in China. At the same time, the organization actively cooperates with government and other organizations to prevent HIV infection and promote both the mental and physiological health of the MSM community.

### HONG KONG

Hong Kong AIDS Foundation was established in 1991. Prompted by the general public's poor understanding of AIDS and popular misconceptions about those living with HIV/AIDS, a group of people who came from different walks of life and cared for the betterment of the community, joined together to form a non-governmental charitable AIDS service organisation to help curb the spread of HIV/AIDS in Hong Kong.

### India

The India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organisations and communities to support sustained responses to HIV in India. Complementing the Indian national programme, Alliance India works through capacity building, knowledge sharing, technical support and advocacy. Through a network of partners, Alliance India supports the delivery of effective, innovative, community-based HIV programmes to key populations affected by the epidemic.

### INDONESIA

The network of gay, transgender and men who have sex with other men in Indonesia (GWL-INA Network), was established on February 4, 2007 in Surabaya. GWL-INA inspires members of the LGBT community to promote prevention, care, support and treatment of sexually transmitted infections, HIV, and AIDS, and promotes sexual and reproductive rights as well as human rights.

### Lao PDR

The Lao Positive Health Association (LaoPHA)'s main program is in the integration of care and prevention for HIV, AIDS and tuberculosis, and other related diseases. The program focuses on self-support groups and network strengthening, including peer-counselling in ARV centres, home-based care services by trained home-care teams from the self-supporting groups of people living with HIV, orphans and vulnerable children, MSM, transgender people, and their families.

### MALAYSIA

The Penang Family Planning Association (FPA) was registered on 16 January 1962. Since 1989, the association has concentrated on HIV and AIDS work and from 1994, youth camps with HIV and AIDS components were funded by the then State Women's Consultative Council (HAWA) with occasional assistance by the Malaysian AIDS Council (MAC). In 1999, FPA together with Community AIDS Service Penang co-organized the Red Ribbon Carnival, the national level commemoration of World AIDS Day for MAC. Volunteers also presented papers at the 5th International Congress on AIDS in Asia



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Pacific and youths have attended the International AIDS Conference's in Durban (2000) and Mexico (2008). Another innovative project is BATS (Bringing Awareness of Sexual Reproductive Health to Sex Workers).

PT Foundation Malaysia works with gay men and other MSM (Men who have sex with Men) in Malaysia to provide information, support and care service related to HIV and sexuality. WPT Foundation offers the facilities and services to enable gay men and MSM to make informed and responsible decisions in their own lives. PT Foundation is non-discriminatory, non-judgmental and non-confrontational. PT Foundation was established in 1987. Their first service was an HIV/AIDS and sexuality counselling hotline. They have since expanded their services to offer a fully integrated HIV/AIDS programme for gay men and other MSM in Malaysia. Their programme is tailored to suit the challenging environment for MSM in Malaysia and also deals with sexual orientation and identity issues.

### MONGOLIA

Youth for Health Centre is the first established organization for MSM in Mongolia. It was established in 2003 to improve knowledge, attitude and practice on sexual health and prevention of HIV and STI among the MSM community, in order to reduce stigma and discrimination and increase the understanding of sexual orientation in Mongolia.

### NEW ZEALAND

The New Zealand AIDS Foundation (NZAF)'s mission is to achieve a world without HIV and AIDS by preventing the transmission of HIV, and providing support for people living with HIV and their whanau and families. The work of the NZAF is spread over five major functions - HIV Prevention; Communications and Fundraising; Administration and Finance, Research, Analysis and Information; and NZAF Health Services. The Executive Director oversees the operation of these four programmes, while the NZAF Board of Trustees oversees the overall governance of the Foundation.

### PAKISTAN

Naz Male Health Alliance (NMHA) is the first and only MSM and transgender community based organization in Pakistan, and is providing technical, financial and institutional support for improving the sexual health, welfare and human rights of the MSM and transgender community throughout the country. They do this by providing technical support and capacity building to various stakeholders, networks, groups and organizations. Naz Male Health Alliance envisions a society where all people can live with dignity, self-respect and social equality. They strive for the advancement of the social and health needs of the marginalized MSM and transgender population across Pakistan by developing and supporting community-led health and social interventions along with advocating for social justice, equity, health and well-being.

### PHILIPPINES

Founded in July 2011, Love Yourself Inc. (for the Youth & LGBT-MSM) is a community of volunteers that aim to reach out to others to propagate ideas, attitudes, and practices that encourage loving oneself -- to DARE to be oneself, to CARE for oneself, and to SHARE oneself as a means of multiplying joy. The Love Yourself Project is the on-going pioneer project of Loveyourself Inc. It aims to prevent the spread of HIV/AIDS among the youth and key affected population through awareness, counselling and education.

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### SINGAPORE

Formed in 1988, Action for AIDS (AfA) is a voluntary community based organization and a registered charity since 7 October 1994. AfA is also registered under the Ministry of Health from 15 December 2004. AfA's objectives are to provide support and assistance to persons living with HIV and AIDS (PWAs); to increase awareness, education and understanding of AIDS and HIV infection; to combat discrimination and stigmatisation of (PWAs) and their loved ones; and to encourage AIDS-related research activities in Singapore. The organization is run for the most part by volunteers. Various support and welfare programmes are run for people living with HIV/AIDS and their loved ones.

### THAILAND

The Rainbow Sky Association of Thailand is the country's first gay organisation and coordinates the largest network of MSM peer educators in Thailand. Apart from establishing local community centres for men who have sex with men across the country where MSM can meet and socialize, the Rainbow Sky Association trains mentors who provide prevention programmes targeted at other MSM in their communities.

### TONGA

The Pacific Sexual Diversity Network (PSDN) is a network representing the interests of MSM in the Pacific region since 2007. The PSDN is a region-wide network of MSM and Transgender (TG) community organisations and projects and is the first of its kind in the Pacific. It formed in recognition of the need to develop an effective regional response to the actual and potential threat that HIV and AIDS poses to MSM and TG across the Pacific. Currently the Pacific includes representation from Samoa, Papua New Guinea, Fiji, Tonga, Vanuatu and the Cook Islands. The PSDN hopes to expand its representation to include other Pacific countries in the near future.

### VIETNAM

Niem Tin Xanh is part of the larger group Green Faith Forum. It operates in Hanoi, Vietnam and performs outreach to MSM.

AfA Anonymous Mobile Testing Service postcard, Singapore







## APPENDIX C

### QUALITATIVE QUESTIONNAIRE

- 1) How does your organization identify and contact high risk populations?
  - a. Do you utilize targeted outreach and if yes, how do you carry this out (especially if the MSM community is hidden)?
  - b. How do you generate demand for HCT among MSM (e.g. campaigns, spokes persons, and media)?
  - c. Do you utilize online resources (e.g. Facebook pages, webpages, smartphone apps) to reach the MSM community to inform them of your HCT services?
- 2) How do you link individuals to testing?
  - a. Do you refer MSM to testing services offered in other organizations or do you offer these services yourself?
  - b. If you refer MSM to testing in other sites, how do you do so? Do you offer a referral letter or does a representative/volunteer from your organization accompany them to the site?
  - c. What are the user-friendly services you offer?
  - d. Do you offer incentives for consistent testing, e.g. a monetary incentive for coming in every 3 months to be tested?
- 3) What are the effective testing services you offer?
  - a. Is your location easily accessible to MSM?
  - b. Is there community involvement in your organization (meaning is your organization run by members of the MSM community), or are there members of the MSM community on hand to deal specifically with MSM when they come in for HCT?
  - c. Do you train your lay staff? What is the duration of this training and how often is the training done? Is there follow-up training?
  - d. Could you please share a detailed account of your testing procedures? Please share how you perform pre-test counselling, post-test counselling, how you allay anxieties prior to the testing, how do you break the news if the client is HIV+ and how do you manage the situation if the client does not handle the news well?
- 4) How do you avoid loss to follow-up of testing?
  - a. If the client has to return at a later date/time for their test results how do you ensure that they return for their results?
  - b. How do you keep track of your clients and contact them to deliver their test results, especially if they test HIV+? Please share the methods/processes that you use.
  - c. How do you refer your clients who test positive for CD4 testing and where? Please describe if you give them a referral or if you accompany them to the site where CD4 testing is done.

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- 5) What are your links to treatment?
  - a. Do you utilize the peer-system to get HIV+ MSM clients to treatment (ARV)?
  - b. What are your referral networks? Could you please share the names of these organizations and the role they play in providing treatment to HIV+ MSM?
  - c. Do you offer incentives to HIV+ clients to seek treatment?
- 6) What are your links to care?
  - a. Does your organization have links to community (MSM) based care and support?
  - b. What are the links you offer to health systems (referrals, partnerships, MoU)?
  - c. What are the links you offer to community support systems (e.g. MSM positive support groups)?
  - d. If a client begins ARV, does your organization offer support and adherence to ARV regimen adherence (e.g. in the form of training or counselling)?
- 7) What has been the experience of your clients?
  - a. Could you please share some feedback from your clients? These may be anecdotal or results from a survey taken by your clients.
  - b. Has there been any outstanding experience, e.g. a client who has tested positive and has come back to the organization to volunteer, or a client who has tested negative who has since become an advocate for HCT?
- 8) Have you considered comprehensive service provision (counselling, testing, treatment, adherence to treatment, support groups) to your clients?
  - a. If your organization presently offers comprehensive service provision, could you please detail how this service is run?
  - b. If comprehensive service provision is being offered now at your organization, could you please share how you came to the decision to offer it and what have been the benefits/challenges in setting up and running this service?
  - c. If you do not offer comprehensive service provision, could you please share the barriers/challenges that prevent you from doing so?
  - d. If you plan to offer comprehensive service provision in the future but are facing challenges in doing so could you please share these challenges?



## REFERENCES

1. HIV Counselling and Testing. For the purpose of this report, HCT will cover pre-test counselling, post-test counselling and the blood test for HIV antibodies.
2. Within this report, MSM strictly refers to men who engage in sexual acts with other men. Transgender individuals were not part of this categorization.
3. MSMGF ([www.msmsgf.org](http://www.msmsgf.org)) identified HCT as a crucial and necessary step in enabling care and support of Key Populations, as well as reducing the risk of HIV infection through behaviour change and risk reduction.
4. WHO (2011). HIV/AIDS in the Southeast Asia region progress report 2011. Geneva.
5. WHO, UNAIDS & UNICEF (2011). Global HIV/AIDS response: Epidemic update and health sector progress towards universal access. Geneva.
6. UNAIDS (2013). Global Report UNAIDS Report on the Global AIDS epidemic 2013. Geneva, Switzerland.
7. UNAIDS (2011). HIV/AIDS in Asia and the Pacific: Getting to zero. Geneva.
8. Serpookiaw, T. (2013). HIV Australia special ICAAP 11 edition on MSM and transgender people in Asia and the Pacific. Vol 11 no. 4 p. 26. AFAO, Australia.
9. TreatAsia, (2006). MSM and HIV/AIDS risk in Asia what is fuelling the epidemic among MSM and how can it be stopped special report. AMFAR AIDS Research.
10. Punitive laws against sex between men exist in Afghanistan, Bangladesh, Bhutan, Brunei, Malaysia, Maldives, Myanmar, Singapore, Pakistan, Sri Lanka, Cook Islands, Kiribati, Nauru, Papua New Guinea, Palau, Samoa, Solomon Islands, Tonga and Tuvalu (Godwin, 2013).
11. Godwin, J. (2013). HIV Australia Special ICAAP 11 Edition on MSM and transgender people in Asia and the Pacific. Vol 11 no. 4 p. 8. AFAO, Australia.
12. UNAIDS (2013). Global report UNAIDS report on the global AIDS epidemic 2013. Geneva.
13. WHO, UNAIDS, GIF, MSMGF & UNDP (2011). Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people recommendations for a public health approach. Geneva.
14. inFOCUS (2012). Men who have sex with men & the 2011 political declaration on HIV/AIDS. Vol 5 May 2012.
15. UNAIDS (2013). UNAIDS report 2013 HIV in Asia and the Pacific. Bangkok, Thailand.
16. UNAIDS (2013). UNAIDS report 2013 HIV in Asia and the Pacific. Bangkok, Thailand.
17. UNAIDS (2011). HIV in Asia and the Pacific: Getting to zero. Geneva, Switzerland.
18. Draft of UNAIDS Report "Scaling up HIV Testing and Counselling Among Key Populations In the Asia-Pacific Region: Challenges and Opportunities". Please refer to the Joint statement on scaling up voluntary community-based HIV testing and counselling for key populations in Asia and the Pacific in Appendix A.
19. United Nations General Assembly Resolution 65/277, 8 July 2011. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. [http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610\\_UN\\_A-RES-65-277\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf)
20. Non-governmental organizations.
21. Community-based organizations.
22. APCOM's reach covers Australasia, China, Developed Asia, Greater Mekong, India, Insular Southeast Asia, the Pacific region and South Asia.
23. The full list of these NGOs and CBOs may be found in Appendix B.
24. In line with the 6th Millennium Development Goal of combating HIV/AIDS and the reduction of transmission through HCT. For more specificity, please see target 6A of Goal 6 at <http://www.undp.org/content/undp/en/home/librarypage/mdg/the-millennium-development-goals-report-2013.html>.
25. These organizations were Bandhu Social Welfare Society (Bangladesh), Hong Kong AIDS Foundation (Hong Kong), Youth For Health Centre (Mongolia), PT Foundation (Malaysia), New Zealand AIDS Foundation (New Zealand), Naz Male Health Alliance (Pakistan), Love Yourself Inc. (the Philippines), Action for AIDS (Singapore) and Rainbow Sky Association of Thailand.
26. A total of 50 participants from the following countries attended the workshop: Australia, Bangladesh, Belgium, Bhutan, Brunei, Cambodia, Canada, China, Fiji, France, Hong Kong, India, Indonesia, Kenya, Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Netherlands, New Zealand, Nigeria, Pakistan, Papua New Guinea, the Philippines, Samoa, Singapore, Sri Lanka, Switzerland, Thailand, Tonga, the UK, the USA and Vietnam.
27. Please refer to Appendix C for the qualitative questionnaire emailed to the NGOs and CBOs.
28. Please refer to Appendix B.
29. Responses were not received from Fiji, Papua New Guinea and Timor Leste.
30. A qualitative analysis matrix allows for comparison of qualitative data from a thematic perspective.
31. The full range of services offered by each participating NGO/CO can be found in Appendix D.
32. The exception to this model occurred when blood tests were performed by a partner organization.
33. Post-test counselling is dependent on the HIV serostatus of the client. If the client is tests seronegative, then behaviours that prevent infection are reinforced. If the client tests seropositive then the client is referred to a medical facility for confirmatory testing, commencement of ART, support groups and psychological counselling.
34. Model 1: Fully staffed and volunteered by MSM; Model 2: Fully staffed and volunteered by members of the LGBT community; Model 3: Staffed by MSM but LGBT allies were encouraged to be part of the HCT service.
35. Examples include the Minimum Standard Module and Asia-Pacific Counselling Module.
36. International partners reported were PSI, KHANA and FHI360.
37. Professionalism was described as the ability to refer MSM to medical services, counselling services, legal services, provide or subsidize transportation services, psychological counselling, support groups and spiritual guidance. Professionalism also encapsulated the provision of shelter facilities, a confidential space, operating hours that met the needs of MSM, helplines, effective information dissemination, condom and lubricant distribution, organization of health camps and safer sex workshops, as well as providing drop-in centres that met the needs of MSM.
38. Empathy was reported to be non-judgement of MSM clients, offering emotional support and maintaining the confidentiality of the MSM's identities. Strong rapport built with MSM was also identified as part of empathy.
39. Trained counsellors approached MSM in venues where MSM were known to gather. The venues identified by the participating NGOs and CBOs were mainly public parks and malls. Other sites where MSM were approached by the trained counsellors included public events organized for MSM, dorms/ hostels where MSM sought accommodation, massage parlours, beauty salons and clubs. Other forms of face-to-face communication included educational sessions and counselling sessions.
40. Advertising was done in electronic and print media that cater to MSM.
41. Pamphlets and flyers distributed at events organized for the LGBT community.
42. Networking here referred to good-word-of-mouth of the benefits of HCT and the quality of HCT services offered to MSM.
43. These incentives were limited to small amounts of cash to defray the travel expenses of the MSM between their accommodation and the HCT venue.
44. MSM clients were given a voucher for complimentary HIV testing which is redeemable by them or an acquaintance.
45. Referral systems included: 1) MSM make own appointments; 2) The NGO/CBO makes the appointment; 3) A formal referral system, e.g. referral letter or a numbered card system; 4) MSM is accompanied to the referral partner by staff or volunteers of the NGO/CBO.
46. In some cases, if the client tested seropositive, the case was referred to the appropriate medical authorities who were then responsible for informing the client of the need for confirmatory testing.
47. Examples of this are the GP Client Management Suite and the Red Cross Log Book.
48. Five routes were found utilized by NGOs and CBOs for this process. The first was a specific process where the client was given a choice of medical institution referral; the second was where the referral for confirmatory testing was made by the partner organization that conducted the blood test; the third was where the client was accompanied by a member of the NGO/CBO to a medical facility for confirmatory testing; the fourth was where a client was given a written referral to a medical institution that would conduct the confirmatory testing; and the fifth was where clients were given information on how they may seek confirmatory testing at a medical institution on their own.
49. Fremantle Hospital, B2 Clinic, Ainslie House, General Practitioners (Perth, Australia); The Centre Clinic (Melbourne, Australia); General Hospital in Shanxi Province, the Number 4 People's Hospital in Taiyuan, Green Harbor Hospital of Linfen (China); ART Centres (India); Champasak Hospital, Savanakheth Hospital, Khammoun Hospital, Setthathirath Hospital and Mahasot Hospital (Lao PDR); Government Hospitals (Malaysia); Infectious Disease Wards (New Zealand); Pal Plus Society, Bridges and Marhana Welfare Trust (Pakistan); Research Institute for Tropical Medicine, Philippine General Hospital, San Lazaro and Makati Medical Center (the Philippines); CDC of Tan Hock Seng Hospital, Infectious Diseases of National University Hospital System (Singapore); The POZ Home Center (Thailand); Tonga Family Health Association (TFHA) and Ministry of Health (Tonga); and Bach Mai Hospital, Viet Duc Hospital, District Health Centres and Hanoi Association of HIV/AIDS Prevention (Vietnam) are the partners named by the respondents as their referral points for clients who test seropositive to receive and begin treatment.
50. This incentive is different from that noted in footnote 49. Incentives come in the form of transportation to seek treatment or cash for transportation to refill ART prescription. It was also reported that in some cases no incentives were given.
51. Antiretroviral Therapy.
52. In most cases reported in Asia and the Pacific, the Ministry of Health was depended upon for information as well as the continued development of health systems that met the needs of seropositive MSM.
53. Linkage to support groups by the NGO/CBO may take the form of a support group formed by the NGO/CBO itself; and linkage to a partner organization that offered support for ART adherence to seropositive MSM. Support was also offered to seropositive MSM through annual educational activities organized by the NGO/CBO.
54. Support systems for MSM were formed by seropositive MSM, seropositive MSM and their family members and MSM-based care and support centres. In cases where no formal networks existed, seropositive MSM formed their own support system.
55. NGOs/CBOs either provided the support services themselves or offered these support services through a partner organization.
56. Financial constraints were due to lack of funding. Cultural constraints were due to conservative views in society regarding HIV/AIDS, and/or religious views regarding same-sex sexual activity.
57. Please see footnote 27.
58. Under the 2010 WHO guidelines
- 59.

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advocacy issues that affect the lives  
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