



MSM @ ICAAP 9

SPECIAL REPORT - Bali Indonesia: the 9th International Congress on AIDS in Asia and the Pacific (ICAAP) was held here from 9-13 August 2009. APMG attended and followed Congress streams on most at risk populations (MARPs). The theme for this ICAAP was ‘Empowering People, Strengthening Networks’. The organizing committee wanted to highlight the need for sectors to work together to expand treatment and prevention to sustainable levels across the region. ICAAP 9 was attended by almost 3000 people from 65 countries including the Asia Pacific region, but also Africa, Europe and America. Information about the conference is available at www.icaap9.org.

This article covers some, not all, sessions on transgendered peoples (TG), gay men and other men who have sex with men (MSM) at ICAAP 9 and has been developed by APMG Asia Pacific. The Asia Pacific Coalition on Male Sexual Health (APCOM) convened an MSM preconference workshop as well as a range of regional caucus meetings that are not covered in this report but which are presented on the APCOM homepage – read more at www.msmasia.org.

More information about HIV and APMG is available at:

www.hivinasia.blogspot.com (English) | www.thaihivinasia.blogspot.com (Thai) | www.aidsprojects.com

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1. SYMPOSIUM: OVERCOMING LEGAL BARRIERS TO COMPREHENSIVE PREVENTION AMONG MSM

The symposium ‘Overcoming legal barriers to comprehensive prevention among MSM’ was one of the most interesting at the Congress. In particular, the speech by Mr Anand Gover, credited with successfully leading the fight to overturn Indian legislation criminalizing sex between men, was particularly significant. The speeches of The Hon Michael Kirby and Mr Anand Gover were taken verbatim during the session for presentation here.

a. The Hon Michael Kirby

Let me start by reflecting on the speech by the President of Indonesia who got his lips around those words MSM, sex workers and injecting drug user and did so with the First Lady in similar language recognizing the realities of citizens of his country and giving leadership to his country. We're lucky that the President here has done so. I want to pay my respects to UNDP in picking up the baton and recognizing the importance of prisoners, refugees, women, MSM, IDU and sex workers -vulnerable groups all. The initiative of UNDP needs to be praised.

I go back to 1983-4 when Jonathon Mann came to Australia and appointed me to the Global Commission on AIDS. I remember those Commission meetings, the great scientists who were there - how they predicted that within ten years we would have a vaccine and within twenty years we should have a cure. We have to get in to the minds of the people most at risk now to change their behavior and safer sex conduct because there is no cure coming soon. I was a judge for 34 years. Altering peoples' conduct, particularly by law, is not a successful strategy. People will continue to act in given ways. Instead, we need to get in to the minds of people themselves. And that is the challenge we have pending a vaccine and cure. A number of points were made today that remind me of the things being said at the beginning of the epidemic.

- HIV is a human rights issue
- That HIV is a women's issue
- That it's essential to engage vulnerable groups in discussion about strategy and policy

MSM in most countries in this region are highly vulnerable. 20 of the countries here criminalize sex between men and that is a situation I grew up in, in Australia. I grew up in that situation and it makes you feel like you have second class status and it means marginalized groups can exist outside the messages of society and those messages that aim to protect them. So many will not put it [being MSM] out on the table and they will keep it to themselves. And yet by not bringing it out and by not being open about sexuality the reality is that MSM conspire in the attitudes of society toward them. If only every person who was gay identifying or MSM stood up in society – if they all stood up the whole shabby and dishonorable strategy to denigrate and put them outside the family would be over. But that's not going to happen any time soon. We have to think through the strategies to facilitate change - especially to legal sanctions.

How? Legislation. First, engaging politicians, community groups and, let it be said, mostly straight people persuading politicians to change the law. It's [the law criminalizing same sex behavior] not only wrong but in the times of HIV it's a real impediment to getting into the minds of MSM and the prevention strategies they require.

We've been talking about this for a long time and many politicians do nothing and will do nothing about this matter. In India, 60 years after Kinsey, 50 years after reform in Britain, the law remained firmly in place. The second strategy is to engage the Courts – International Tribunals and Courts. In Ireland and Cyprus the Human Rights Committee of the UN. And in respect of Tasmania in my country the Human Rights Committee of the UN again. But also Courts in South Africa and Supreme Courts in the US and the Delhi High Court.

The recent decision in India was in large part due to Anand Gover and his particular strategies. The people involved in that decision are great fighters for human rights. They organized seminars throughout India and just talked about these issues in the presence of judges and lawyers. Often it's a

matter of personifying it. In terms of the White Australia policy, we were able to change it when people began to meet Asian Australians and this is the way to change attitudes toward MSM.

However, in our region we've got bad news. In Singapore, a committee of the Law Society recommended a legal change for that State, introduced it in to parliament. But a Professor of Law had become a member of a Pentecostal group and said it would be the end of civilization and so nothing was done.

In Cambodia, in the case of sex workers, the Government has engaged unfortunate steps in recent times. But we've had Hong Kong upholding the principle of equality of gay people. Nepal's Supreme Court and Delhi High Court rulings. UNDP and UNAIDS in China and Hong Kong and elsewhere also. So it's very important at this phase of the epidemic that we should have this session on overcoming legal sanctions. This session is emblematic of the need to focus on vulnerable groups. The third phase of the epidemic is prevention – the plain fact of the matter is the world won't continue to expend ARV funds to people who are infected. The whole strategy has to be on prevention and that means focusing on vulnerable groups, MSM, reducing stigma, accessing people in the vulnerable groups and giving messages for their own self protection. Infections worldwide continue to increase at 2.7 million people per year. We have to prevent this continuous epidemic.

Finally, what can we do to give a new impetus? I saw in one UNDP booklet a quotation from Dr Neil Blewett. He said, "the best way is not to crash through. The best way is to respect the fact that people are at different stages and endeavor to engage in dialogue with them". I agree but after a decade or two you then have to begin to ask 'what is a new strategy that will get a change?' What new pressure can those who are donors exert on those countries? Do you have to stand by indefinitely?

The Director of UNAIDS, Global Fund, UNDP, the President of Indonesia, many people are saying the right thing - the planets are in alignment specifically on the MSM issue. But people like me are fed up. It's [discrimination] not scientific, not rational. We have to translate words in to action. We need to address how we can do just that.

b. Mr. Anand Gover

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I think the point has been made that criminalization of private practices of groups vulnerable to HIV impedes HIV programs and goals. It has to be addressed. Secondly, it should be appreciated that there is gross injustice in the criminalization of private practices. Even drug users and criminalizing their personal behavior is antithetical to the notion of having freedom in the use of your leisure time and activity. It is an imposition of western culture - I can drink alcohol and smoke cigarettes but not smoke marijuana. In criminalization, customary practices are denied. It breeds corruption and it doesn't address the real issue at all. Sex work criminalization is driving HIV transmission underground. Very few people take these issues head on. If you remove criminality then you can successfully intervene. But people are uncomfortable with them [these groups] or the climate is not right.

In India, we took a decision in 2000 that it is very important to remove the criminal sanction [of same sex behavior] in the Criminal Code. It was British and not Indian at all. In our religion Hijra are part of our culture - we have an attitude toward them but we had not criminalized it. The fact is that one must take a decision that these injustices have to be removed and only then can you progress toward it. Michael [Kirby] was quite correct when he said that when you take a decision there are a number of things you have to do. As lawyers we don't take the time to sensitize all stakeholders – but this is important and

particularly it's important to sensitize Judges, the legal community, the police. They also realize and understand. Police say "Why are we trying to catch men having sex with other men or drug users when we have other issues that are more important?" Over a period of time you are able to have an impact on sensitizing stakeholders who are part of the establishment and also the opening up of situations where gay men could form into groups as HIV service providers. E.g. Humsafar group – they started not as a gay group. But now the first gay group has been officially registered [in India]. But that opened up over a period of time and HIV provided a huge opportunity and an umbrella for these issues: about HIV, injustice and how it affected HIV. Spaces opened up for gay men and other vulnerable groups. It was not an accident. It was in fact a lot of sensitization.

A lot of people said why are you taking up this issue? You need to be determined and focused on change. You have to go in for the long haul. Not short term, fly by night operators. A lot of people want publicity. But follow the principles of the Baghavat Gita - be like a rock, and do not expect any reward or benefits.

In this case [the overturning of Section 377 of the Indian Criminal Code] it was not lawyers who decided how the case would go. We involved the community from day one. HIV in India and other places it is the community who are the deciders. They decided whether we should go to the Supreme Court. Then we had to be ready for the big bats. A lot of people feel that the matter was taken up by a non-gay group - NAZ Foundation. They felt it should have been taken up by the gay groups. But in 2001 who would file a petition? So it was an HIV group. But if it were a gay group working on HIV it would have been much better.

Next we had to decide whether to change the law by an amendment process or by a constitutional process. One of the grounds that we took up was privacy. A lot of the groups don't want to take up the privacy ground because most do not want to take on the sexual issues related to privacy. The other thing was a lot of the groups said it's a gay human rights issue why take up HIV as the matter. Again, you always expose the issue of the opposition and you expose yourself. One argument in that case in privacy was that the State can come and say there is a compelling State interest to criminalize any private behavior e.g. rape. They couldn't precisely make this sort of argument because of HIV. [It was possible for HIV organizations to say] "If this law continues to be on the statute book then HIV intervention will be impeded." There is no State compelling force to keep the status quo.

In terms of the decision of the Delhi High Court - already people in Singapore want a workshop on this issue. Malaysia has expressed an interest. And judges in other jurisdictions are keenly reading this judgment. This should be followed up in other countries.

VARIOUS MSM ORAL PRESENTATIONS AND POSTERS

2. Oral Presentation: APN+ results of the Asia Treatment Survey of PLHIV

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This is an overview of findings in relation to transgendered peoples (TGs) and men who have sex with men (MSM) living with HIV from an APN+ Treatment Survey. Further information about sample size and recruitment of participants etc. is available on the APN+ website www.apnplus.org. The importance of the APN+ survey is that it underlines how significant education is to effective treatment and adherence (the overall survey found large numbers of people were taking ARVs while not knowing exactly what they were taking or the importance of adherence to staying well in the long term). It also underlines

continued health care setting discrimination and human rights violations for some MSM and TGs in the region.

This investigation was undertaken in six countries in the Asia Pacific region and the number of MSM and TG participants was 897. Mean age of participants was 32.5 and 32% resided in urban settings such as capital city while 28.5% resided in rural settings and towns.

HIV information and counseling - 59.3% of the participants received HIV tests in government hospitals. Of these:

- 13% reported HIV screening without consent
- 81.6% received post test counseling
- 81% disclosed their sexuality to the service provider
- 41% did not receive friendly or sensitive service

Access to HIV related services – Barriers to service included:

- Length of travelling times
- cost of services, legal issues
- travel emerged continuously as a barrier
- lack of adequate information about services and treatment
- stigma reported

ARV access - In total nearly half (46.4%) are in need of ART, among those who are in need 71% are taking it. Barriers include: lack of adequate knowledge about ART, fear of side effects, denial of service by doctors, unfriendly HIV service providers, lack of availability of ART services, ART out of stock in government centers, being unable to pay for treatment.

Access to OI treatment – 61% can access treatment for OIs, participants reported a variety of barriers for not accessing OI treatment but these were not reported in the presentation.

Attitude of health care providers (HCP): nearly two thirds of the participants (64.6%) had disclosed their sexuality to HCPs half of the participants reported that their HCPs encouraged them to discuss openly their sexual health issues. Some participants reported that HCPs disclosed their HIV status and sexuality to others without consent. Some reported denial of services (21.1%) and physical assault (9.6%) by HCPs.

Other issues: some fears their partners might find out their HIV status prevented accessing or adhering to treatment. Some said clinic opening hours are not suitable for them if they are involved in sex work.

3. Poster 135: HIV Vaccine Acceptability among High-risk MSM and Transgenders in Thailand

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HIV prevalence among MSM in Bangkok (30%) and Chiang Mai (16.9%) rivals the hardest hit regions of Sub-Saharan Africa. Thailand has enrolled more volunteers in HIV vaccine trials than any other country in the world. Based on Diffusion of Innovation theory, we assessed the acceptability of future HIV vaccines and the impact of vaccine characteristics, socio-cultural and structural factors on vaccine acceptability in order to provide empirical support advancing tailored combination prevention. The authors recommend education and social marketing interventions to increase acceptability of partial efficacy HIV vaccines. Social and community interventions to combat anti-gay and HIV stigma, and

promotion of HIV vaccine uptake as a ‘pro-social’ behavior to support the community and nation (in contrast to individual-level approaches) are recommended.

Authors: Peter A Newman Ph.D.; Surachet Roungrakphon PhD (cand); Suchon Tepjan BA; Suzy Yim MSW. **Institutions:** Faculty of Social Work, University of Toronto; King Mongkut University of Technology North Bangkok Thailand; Chiang Mai University.

Methods included data collection – phase 1: in depth 45 minute semi structured interviews in Thai and English (n=40) – Phase 2: structured 3- minute Thai language survey questionnaire programmed on laptop computers (n=260) Sampling and recruitment included MSM, MSW and M2F transgendered people recruited using venue based sampling from LGBT, MSW and HIV prevention organizations as well as gay sex venues and nightclubs in 3 Thai cities. Data analysis included – phase 1: narrative3 thematic analysis with techniques from grounded theory and phase 2: conjoint analysis with a fractional factorial experimental design to assess acceptability of hypothetical HIV vaccines with different attributes, and the impact of attributes on acceptability.

Table 3: Impact of HIV Vaccine - Quotations from Participants:

“People might think we have HIV”

“If we want something to protect our bodies, it should have 100% effectiveness”

“Everybody would have doubts or be afraid for the long term; you’ll never know what’s going to happen after 5-1- years”

“It’s worth trying. Well, at least I have that 5 years of fun (laughing)... that 5 years of, you know, miraculous fun”

“If it’s 500 baht people will be ok. 1000 [baht] people will not be able to afford it.”

“I don’t want to be involved unless someone else proved it first”

“Not from the government hospital... I think the vaccine won’t be the same as from a rich hospital”

“If they go to a public hospital, then it seems usual, nothing secretive. But if they go to an unknown clinic... people will start thinking and suspecting that person.”

Conclusions and recommendations

Include education and social marketing interventions to increase acceptability of partial efficacy HIV vaccines as this may support initial HIV vaccine uptake.

Social and community interventions to combat anti-gay and HIV stigma, and promotion of HIV vaccine uptake as a pro-social behavior to support the community and nation (in contrast to individual-level approaches) may ensure the effectiveness of future HIV vaccines as a component of combination behavioral and biomedical prevention among vulnerable communities in Thailand.

Structural interventions including government and corporate vaccine cost subsidies, and dissemination of HIV vaccines through a variety of venues – both population-specific (e.g. targeting male sex workers, gay men or Transgendered) and universal (for the general population, i.e. “unmarked”) – may optimize HIV vaccine coverage among populations at highest risk of HIV infection in Thailand.

Funding from this study was provided by the Social Sciences and Humanities Research Council, The Canada Research Chairs Program and Canada Foundation for Innovation. Branding for this research looks like: “Voices Thailand: HIV prevention and healthcare research”.

4. ORAL PRESENTATION: Discussion Groups: an innovative strategy for gay men and Waria in Indonesia

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This presentation underlined the need for ongoing, sustainable community-based support and education. At international level there is a debate about the best single or multiple dose interventions to sustain HIV prevention behaviors at the lowest possible cost. However, authors of this presentation point out that Coca Cola understands they must hit you over and over again for your whole life to get you to remember to drink Coke. Therefore, the challenge, they argue, is to find interventions that can be sustained over the long term, driven by the community and that support community behavior change while also being good value for money. The authors describe discussion groups called *Kelompok diskusi* used in Indonesia. Kelompok Diskusi are a different kind of focus group that they argue can achieve the above aims.

Authors: Tom Boellstorff and Andi Akbar Halim

THE PROBLEM

HIV has been reported in Indonesia since late 1980 but there are still many new infections among gay men other MSM (a problematic term) and Waria (male-to-female transgenders).

In Indonesia, as often in the Asia Pacific, knowledge about HIV is high at individual level but not consistently turned into sustained behavior change at community level. There is a need to integrate HIV/AIDS knowledge with other health and social issues - from STIs to discrimination. Knowledge about HIV among Waria and MSM is generally high, they know about HIV, know what it is, but it's not getting translated in to sustained behavior change and its being done at the individual level and not at the community level. The atomized individualistic approach to HIV prevention programs being pushed by donors and other folks is of concern and that atomization is characterized through the term MSM which is a problematic one.

WHAT'S NEEDED?

What's needed is not new knowledge so much as a new method for sharing knowledge that can build upon and strengthen community gay men and Waria who usually can't learn about their identities from their families. The aim is to change norms at the community level. But also to strengthen community for gay men and Waria – men that call themselves 'gay men' are not all elites; they are often low class but what gay means to them may differ.

THE BACKGROUND

The *Gaya Celebes Foundation* formalized in Makassar city (South Sulawesi province) in 1995. It is a community based organization for gay men, other MSM and Waria. It began with street outreach, but now engages in a range of activities.

THE IDEA OF KELOMPOK DISKUSI

Focus group: the name seems similar but *kelompok diskusi* are very different from traditional focus groups. The idea of focus groups originates in marketing and social science research. Also used for years in HIV research. But there are two limitations with typical focus groups: one, they meet only once. Two: they bring together people who don't know each other ahead of time.

HOW KELOMPOK DISKUSI WORK

Kelompok diskusi is a different kind of focus group that overcomes both limitations mentioned above. One, they meet regularly usually once a month for years. Two, participants come primarily from a shared social network. But *kelompok* discussions do not just build upon community. They create community – these groups are creating and strengthening community not just individual identity.

STEPS TO SETTING UP A DELOMPOK DISKUSI PROGRAM

- Hire and train outreach workers and discussion group leaders – some staff can do both but different skills needed.
- Outreach – get to know the communities first.
- Identify community leaders who can take turns to host monthly meetings.
- Build to hold monthly meetings – early topics HIV101 to more advanced topics stigma, relationships, support skills.
- Evaluation and sustaining the KD.
- KD as foundation for further activities e.g. VCT, entertainment, events, support groups. It can include bringing PLHIV in to the group.

ADVANTAGES AND LIMITATIONS/CHALLENGES OF KELOMPOK DISKUSI

Advantages include

- They are relatively inexpensive,
- Information can be customized, repeated over time and learned in a context of group reinforcement,
- They are an excellent environment for bringing together wide range of topics and turning knowledge into action

Limitations/challenges include

- Requires dedicated staff;
- Organized KD every month can be time consuming (particularly ensuring attendance),
- Requires sustained funding, scalable but not always easily so.

Professor Boellstorff (presenter of this session) points out that Coca Cola understands they must hit you over and over again for your whole life to get you to remember to drink Coke.

WHAT KELOMPOK DISKUSI TEACH US

Turning to community is not enough. In many cases we must build community through HIV prevention. When basic HIV/AIDS information is already well known methods like KD are effective at helping make that knowledge relevant to daily life. A need for more research on the effectiveness of KD in different contexts is indicated.

5. ORAL PRESENTATION: BEACH BOYS IN SRI LANKA ARE THEY AT RISK OF HIV TRANSMISSION

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Concerns about Sri Lanka and sex tourism, poverty, lack of employment opportunities and displacement have resulted in beach boys generally being viewed as a vulnerable group for HIV infection. Poor access to condoms, partners who are unwilling to use condoms and prior research indicate that beach boys had low levels of awareness of STIs and HIV. This research was attempting to answer the question ‘Are beach boys at risk?’ as well as the factors that help identify which men are at risk. Does HIV prevention look feasible with this group of men?

Author: Patrick Rawstorne et al, University of New South Wales, Australia

BACKGROUND

- There has been tsunami damage and conflict internally for many years in Sri Lanka.
- There are lots of internally displaced people and that affected the study in some regards.
- It's a beautiful country.
- Buddhist monks play an important role in contributing to the social norms, setting values and setting laws in the country.
- We were establishing a behavioral research survey and capacity development work.
- Cross sectional behavioral surveillance survey.

Formative mapping: this mapping exercise aimed to determine: where are the beach boys? What number are they? How accessible are they?

BASIC PROFILE OF BEACH BOYS

- 553 men/ 482 men reported which median age 25 (17-56)
- Education: completed Years 0 level
- Literacy: 97.3% able to read and write
- marital status: married 24% and never married 74%
- Monthly income: LKR 10,-20,000 (100-200 USD)

BEACH BOYS DEMOGRAPHICS

- 100% employed and types of work included: 74.5% tour guides; 20.7% retail 8.2% fisherman
- How many of the sample were paid or received goods for sex? 16% received payment from at least one male partner; 5% received payment from at least one female partner

ARE BEACH BOYS AT RISK OF HIV TRANSMISSION?

- Yes.
- Almost 60 % reported unprotected sexual intercourse with at least one casual partner in the previous twelve months.
- Sexual intercourse with both male and female partners
- Sex with both foreigners and locals: 34% had sexual intercourse - 79% both local and foreigners while 17% with local foreign male and female partners.

WHAT FACTORS HELP IDENTIFY WHO IS MOST AT RISK?

- Men who engaged in unprotected anal intercourse in the twelve months prior to the study were **more likely** than those who use condoms all the time to have smoked cannabis in the previous twelve months; they had sexual intercourse with both male and female non-regular partners; had more foreign male partners with anal intercourse; had STI symptoms and were more likely to believe they are hiv risk.
- Men who engaged in unprotected anal intercourse in the twelve months prior to the study were **less likely** to work as tour guides, less likely to have heard about hiv through health services; less likely to believe that a person with HIV can be health looking; less likely to believe that people can protect themselves from hiv using condoms; less likely to have used a condom at first sexual intercourse.

DOES HIV PREVENTION LOOK FEASIBLE?

- Goal to change sexual practice toward one hundred percent condom use with casual partners
- Knowledge gaps around HIV transmission

- Skills to negotiate sex, payments for sex and condom use with foreign partners.

CONCLUSIONS

Beach boys are at risk of HIV. Contrary to the stereotypes, they don't necessarily exchange sex for money. Their jobs often provide a legitimate way of approaching tourists. They often instigate and seek romantic relationship with male and female tourists. These data point clearly to types of health promotion/hiv prevention messages that are needed and are usable for this population.

6. POSTER 126: Hong Kong: Drug using MSM had higher HIV risk behaviors despite more prevention than non-drug using counterparts.

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A territory wide seroprevalence study among MSM was conducted at the end of 2006. The result has caused alarm as it suggests HIV prevalence is about 4.05% which is many times higher than other MARPs such as commercial sex workers. Recent overseas documents demonstrated drug using was positively associated with HIV infection among sexually active MSM, which could be one of the reasons contributing to rising HIV cases. Up until now the situation in HK is still not clear, although drug possession and drug trafficking are prohibited by law.

Authors: KM Mak, WL Mak, HL Ho.

METHODS

A venue based survey was conducted in bars/clubs and saunas by trained MSM interviewers, which was composed of self-administered behavioral questionnaires on the subject of sexual risk, condom usage and testing habits; together with unlinked anonymous HIV antibody (Western Blot) testing by way or urine sample collection. Stratified random sampling method was adopted to enhance representativeness.

RESULTS

- 859 valid samples were collected. Of these 12.3% (n=106) reported drug use - commonly these were poppers, ketamine, ecstasy and Viagra.
- The seroprevalence (non-adjusted) of drug using MSM was 8.5% compared with 2\3.7% of non-drug users.
- More non-Chinese than Chinese MSM (22.4% versus 11.8%) claimed to have drug use practice.
- Drug using MSM tended to have more anal sex partners than non-drug users. They also engaged in more anal intercourse with casual sex partners not to mention a higher proportion of casual sex partners observed in this group (93.5% versus 81.9%).
- In relation to prevention, there was a smaller proportion of consistent condom use with regular sex partners in drug using MSM (30.2% versus 44.9%).
- Despite all this, the overall condom usage rate between any of the groups was not accountable (reporter: not sure what this means).
- The authors of this study conclude that drug users 'fail' [reporters' quotation marks] to perform safe sex consistently (i.e. 100% use of condom) when compared to MSM not taking drugs during sex with their casual partners.
- A double proportion of drug using MSM compared with non drug using ones had sex outside HK as well as drinking alcohol before or during anal or oral sex.
- In view of the health promoting service delivery, it showed that drug using MSM received more HIV prevention information (free condom and HIV prevention message) and a 20% higher

utilization of HIV/STI screening services that non-drug users and there was no dissimilarity regarding the location of having HIV/STI testing service.

CONCLUSIONS

Drug using MSM were covered by preventive activities and received health messages. They were also more proactive in testing behaviors. Their sexual behavior, for example, number of sex partners, multiplied their risk of contracting HIV, in addition to the effect of recreation drugs.

Hence, screening of drug use can be considered to serve as a proxy indicator of high-risk sexual behaviors among MSM. It is important to explore underlying factors of recreational drug use so that targeted interventions can be implemented that reduce the harm of substance abuse.

7. POSTER 318: Stigma and Discrimination towards MSM in the context of HIV in Vietnam

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This poster presentation focused on promoting a new developed training toolkit and curriculum called “Understanding and Reducing Stigma and Discrimination against MSM”. The HIV epidemic in Vietnam is concentrated among key populations at higher risk, including MSM, IDU, and SW. There is high prevalence among MSM in Ho Chi Minh City (5%) and Hanoi (9%) compared to 0.43% estimated prevalence among 15-49 year olds nationally. The authors underline that the report of the Commission on AIDS in Asia projected new infections among MSM in Asia could increase from 2 million in 2009 to 5 million in 2015 and nearly 8 million in 2019 unless HIV interventions for MSM are scaled up.

CHALLENGES IN RESPONDING TO HIV AMONG MSM

- The lack of strategic information including size estimation and social research
- Misunderstanding of the concept of MSM and the confusion between MSM and homosexuality and between behavior and identity
- Significant overlap in high risk behaviors such as drug use and sex work but limited integration of interventions for different groups and
- Insufficient technical resources and lack of MSM friendly services
- A Vietnam specific training toolkit “Understanding and Reducing Stigma and Discrimination against MSM” has been developed to address these challenges and to support emerging HIV interventions for MSM. It provides health and social service providers, media and policy makers with essential knowledge and skills to work effectively with MSM on gender and sexuality issues.

A WELL ADAPTED TOOLKIT TO REDUCE STIGMA AND DISCRIMINATION IN VIETNAM

The toolkit includes three main sections: gender, sexuality and sexual health; stigma and discrimination related to HIV and MSM and action plan and advocacy.

This is the first toolkit for MSM and HIV related stigma developed in Vietnam. It is well adapted to the needs and the contexts of the target groups and has received positive feedback during the adaptation and pre testing proves.

The toolkit can be used for and by difference audiences and target groups including: health and social service providers, NGO and COB staff, media, police, policy makers as well as MSM groups. It was the first opportunity for many participants to learn about forms of stigma, MSM and the relationship between HIV and MSM.

Quote from one participant: “I am very pleased and highly appreciate [for] this toolkit. I think that the toolkit will be very effective for increasing awareness of policy makers which will lead to increasing impact for later interventions”. (A workshop participant who is a staff member of the provincial AIDS Centre, March 2008).

Quote from another participant: “I think that the content is practical and the methodology is good. I enjoyed participating in the workshop. I get a better, a more through and correct understanding about homosexuality. We need to conduct more communication and disseminate information about MSM issues to society which will help to reduce self stigma as well as discrimination toward MSM” (A participant of the workshop for policemen and journalists, March 2009).

THOROUGH AND CONSULTATIVE PROCESS

The Institute for Social Development Studies and UNAIDS Vietnam developed the toolkit. In consultation with key target groups including MSM groups, health service providers, NGOs CBOs, media and policy makers. A part of the toolkit is adapted from the MSM module of the International HIV/AIDS Alliance’s toolkit *Understanding and Challenging HIV Stigma*. The drafting process included a literature review, consultation, meetings, pilot testing and dissemination of the toolkit.

This toolkit is an innovative initiative that breaks the silence on sexuality and MSM in Vietnam. By applying participatory learning processes, the development of the toolkit empowered and equipped people with the skills to openly and confidently discuss sensitive issues. The development process in Viet Nam was unique and instructive as the MSM community was actively involved from the beginning to the end, which was itself a capacity building exercise for future training of trainers. Users need to be creative and flexible in applying the toolkit to difference audiences, durations and contexts.

8. Poster 119: Strategies for Increasing Migrants’ Access to HIV Services in Thailand

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This poster sits outside the theme of this field report but was of interest to the author so is documented here for others who may have an interest in migrant access to HIV services in Thailand. It appears an excellent example of successful HIV prevention and support in a multi-language and multi-cultural target groups. Lessons learned are concrete, practical and have evidence and analysis to back them up. In all, a best practice example of how to undertake HIV prevention and support in a multi-cultural context.

Author: Brahm Press Organization: Raks Thai Foundation, Thailand.

Background – there are over 2 million migrant workers in Thailand, only a quarter are properly registered. Eighty percent come from Myanmar, the rest from Cambodia and Lao PDR. Migrant work in unskilled jobs is commonly described as the 3D jobs – dirty, dangerous and difficult.

Migrants’ Vulnerability to HIV: contributing factors include language barriers, being a hard to reach population and limitations on mobility. Migrants are coming to start work at younger ages. Improper information about HIV or limited access to condoms increases risk. Sub groups have high risk behaviors such as men working on deep sea fishing boats and karaoke women.

The PHAMIT Program

The first phase (2003-2008) of the Prevention of HIV among Migrant Workers in Thailand Program covered 21 provinces and was support by the Global Fund. PHAMIT was a collaborative project of eight

NGOs: Raks Thai Foundation (Principal Recipient), World Vision Foundation of Thailand, Foundation of AIDS Rights, MAP Foundation, Stella Maris Center, Empower Foundation (Chiang Mai), Pattanarak Foundation and PATH (contracted as technical consultant), working partnership with the Ministry of Health's Dept of Health Services Support. The second phase of PHAMIT, which started as of 2009, is being expanded to cover 33 provinces.

Strategies: PHAMIT uses a combination of outreach and in-reach strategies:

- Networks of volunteers provide behavior change information, condoms and referral
- Behavior change materials reflect migrants life styles, cultures and situation in Thailand and are produced in a variety of mediums in migrant languages
- Drop In Centers attract migrants by providing a location that migrants can go to relax and where they can access information and referral to services
- Migrant Health Assistants are trained to assist in hospitals and provide VCCT to migrants in their own language
- The MoPH established a module for Migrant Friendly Services' in ten focus provinces.
- Outputs and Outcomes evaluation

RESULTS

- PHAMIT reached over 442,000 migrants with direct activities and distributed over 6.8 million condoms.
- The final impact assessment for PHAMIT shows that self reported condom use among migrants has increased considerably.
- Migrants are increasingly able to access STI and VCCT services and migrants have been included under Thailand's National AIDS Plan.
- PLHIV migrants are receiving ART through a special program under the MoPH.
- PLHIV migrants are receiving support through PHAMIT volunteers and Migrant Health Assistants, and PLHIV support groups at some sites.

LESSONS LEARNED

- A mixed strategy of outreach combined with DIC is necessary to overcome issues of accessing migrant workers.
- A strategic partnership between NGOs and the health department can lead to systems that increase migrants' access to health and HIV services
- HIV prevention programming for migrants needs to support migrant communities and protect migrants' rights, as well as respect language, culture and dignity through the meaningful participant of migrants in implementation.

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