

Acknowledgements

Many hours of planning and preparation went into the presentation of the “Strategizing Interventions among MSM in the Greater Mekong Sub-region (GMR) CDC-GAP/USAID-RDM/FHI-APD Workshop” and to the development of this Strategy Report. Financial support and technical input were provided by three sponsoring agencies: the US Centers for Disease Control and Prevention Global AIDS Program (CDC-GAP), United States Agency for International Development Regional Development Mission Asia Regional Program (USAID-RDM ARP), and Family Health International Asia Regional Program (FHI-ARP).

First, the planning committee members who crafted the concept and agenda for the workshop, and who continue to provide coordination and support:

1. For CDC-GAP: Dr. Michael O’Reilly, Chief of Asia Regional Program and Martha Scherzer, Associate Chief of Asia Regional Program;
2. For USAID-RDM ARP: Matt Friedman, Deputy Director Regional HIV/AIDS Health Office and Suzanne Ross, Senior Technical Advisor HIV/AIDS;
3. For FHI-ARP: Philippe Girault, Male Sexual Health Technical Officer/Asia Pacific Department and Paul Causey, Technical Consultant/Asia Regional Program (workshop facilitator and author of this report);
4. For UNESCO Bangkok: Jan Wijngaarden, Regional HIV/AIDS Coordinator.

In addition to the planning committee, the following workshop attendees also made presentations: Vu Ngoc Bao, Lauren Beaty, Patrick S. Chong, Donna Flanagan, Dr. Frits Van Griensven, Rapeepun Jommaroeng, Dr. Graham Neilsen, Dr. Kharisma Nugroho, Dr. H. Fisher Raymond, Kha Sovannara, and Chris Ward. As well, the support of and guidance from Clif Cortez, Senior Policy and Technical Advisor, Office of HIV/AIDS-USAID and Billy Pick, HIV/AIDS and STD Advisor-USAID, proved invaluable for the workshop.

Logistical support for the planning and production was provided by staff of all three supporting agencies but special thanks for this support is offered here to the CDC’s Shanidapha Meesa-ard, Chutchawal Petchor and Sutisa Rommaneeyapet and FHI/ADP’s Napat Phisanbut and Chunjira Wichai.

Finally, without the active participation of the invited guests who came with their experience and expertise in the region and in the areas of HIV prevention, care, support and treatment, the success of this workshop would not have been possible. A full list of these experts and their affiliate organizations is listed in Appendix 3.

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EXECUTIVE SUMMARY

Strategizing Interventions among MSM in the Greater Mekong Sub-region (GMR) Workshop, a three-day conference in Bangkok, Thailand was convened on February 28, 2005. The US government/donor agencies, CDC-Global AIDS Program (GAP), USAID-Regional Development Mission Asia Regional Program (RDM-ARP), and Family Health International (FHI) Asia Regional Program (ARP), brought together over 50 regional experts from eight countries to present and discuss the implications of recent research to prevent transmission and treat infection of HIV among men who have sex with men (MSM).

HIV and STI prevalence among MSM in five countries in the GMR (Cambodia, China [Yunnan and Guangxi provinces], Laos, Thailand and Vietnam) are influenced by the following conditions:

- While research in this population to date has been limited, there is evidence of the need for targeted interventions for MSM.
- Stigma and discrimination contribute to a lack of HIV and STI prevention, care, support and treatment, as well as planning and funding for male sexual health programs.
- Limited community cohesion impedes positive role modeling and targeted interventions to promote increased behaviors that safeguard health. Few indigenous community based organizations (CBOs) or non-governmental organizations (NGOs) exist in this region, and most have limited capacities to implement and manage HIV/AIDS interventions.
- Access to services and commodities, including testing, condoms and lubricants, is inconsistent. Although condoms are available in most GMR areas appropriate lubricants often are not.
- There is a need for stronger linkages between prevention, care and treatment services from staff that are sensitive to and knowledgeable of MSM issues.
- More data is needed to help guide strategic programming and better direct resources locally, nationally and regionally in the GMR.
- Additional resources are needed for MSM; however, there needs to be a resource analysis to calculate these needs.

Three priority needs were identified by the participants of the workshop:

- 1) Strengthening of existing or newly created community organizations, MSM and non-MSM, so that they can facilitate access to prevention, care, support and treatment services by MSM;
- 2) Improvement of existing clinical services through the adoption of clinical guidelines and training in the health care sector in the GMR;
- 3) Engagement with regional governments to recognize the need for HIV prevention, care, support and treatment services by MSM and to establish relevant, supportive policies, programs and adequate resources.

In addition, regionally based planning, coordination and methods of funding from CBOs, NGOs, international non-governmental organizations (INGOs) as well as the United Nations (UN) and national governments is needed to demonstrate substantive commitment to reducing HIV transmission among MSM. Workshop participants crafted a document that describes a minimum package of interventions for each of two broad goals for the GMR: to decrease HIV incidence and prevalence among MSM and to mitigate the impact of HIV/AIDS on MSM living with HIV/AIDS (PLWHA) and their families. This package can be used as a model in the first step of a country strategy to achieve the overall results.

INTRODUCTION

The HIV epidemic in Asia is as diverse as the countries and cultures that comprise this region. While the epidemic here has largely been driven by heterosexual sex and injecting drug use, governments are recognizing that men who have sex with men (MSM) and their partners are at high risk of becoming infected with HIV. Discomfort among regional leaders with the occurrence of male-to-male sex in Asia has meant that very few data have been collected among this group. While this situation has begun to improve recently, only a few interventions have been implemented. This is especially true for the GMR¹, where data and interventions among these populations remain limited.

In order to address this disparity, the US Centers for Disease Control and Prevention (CDC) Global AIDS Program, USAID Regional Development Mission Asia Regional Program, and Family Health International (FHI) Asia Regional Program decided to bring together experts from the GMR to discuss best practices and strategize ways to prevent HIV among MSM.

On the 28th of February 2005, a three-day workshop called “Strategizing Interventions among MSM in the Greater Mekong Sub-region (GMR) Workshop” was convened. The two main objectives of the workshop were: 1) to define a minimum package of evidence-based interventions for HIV/AIDS prevention, care (including sexual health) and support targeting MSM, and 2) to develop a comprehensive strategy for effective and successful implementation of these interventions in the Greater Mekong Region. Over 50 representatives from eight countries attended.

THE ISSUES

Terminology

The meeting began with a presentation and discussion of appropriate terminology. As presented by Jan Wijngaarden, Regional HIV/AIDS Coordinator, UNESCO Bangkok, use of the term “MSM” can be problematic because the distinction between self-identifying individuals and specific behaviors is not always clear. However, a definition and understanding of the populations involved is necessary for developing effective interventions.

- Men who have sex with men often have female partners as well and do not necessarily identify themselves as part of an MSM community.
- This lack of identity and definition may present problems for research design, outreach and intervention as well as for donors.
- In most areas, there exist overtly feminine MSM who choose to identify as women and therefore may not include themselves in the category of MSM. The same holds true for their sexual partners, who may believe that they do not have sex with men.
- Behavior rather than identity or orientation is a key to identifying HIV risk.

¹ In this concept paper the Greater Mekong Region refers to the following countries: Cambodia, China (Yunnan and Guangxi provinces), Laos, Thailand and Vietnam.

Fluidity of male-to-male sexuality

- In our region, there is a huge variety and fluidity of male-to-male sexual behavior
- Behavior seems to be less linked to identity – ‘indigenous’ identity labels are in short supply
- Because seen as a behavior, male to male sex seems less linked to guilt / sin than in other areas of the world – easier to interpret it as a game or as release, like drinking alcohol or gambling
- This makes the number of ‘MSM’ potentially huge

Masculinity, Sexuality and Male-to-Male Sex in the GMR

For purposes of this meeting, the term MSM will be used to refer to biological men who have sex with other biological men, recognizing that reduction of male-to-male transmission of HIV and sexually transmitted infections (STIs) is the principal intention of the strategy.

Social and Legal Situation

Male-to-male sex is generally a well-hidden behavior and is often not acknowledged. In many cases, men are expected to marry, have children, and support their family regardless of sexual preference or practice. Stigma and discrimination are common and cause reluctance in disclosing male-to-male sexual behavior.

- In three studies (two in Cambodia and one in China), 13 – 14% of MSM were reported to be married.
- The natural visibility of overtly feminine MSM puts them at greater risk of harassment.

Key findings from Focus Group Discussions

- Stigma and discrimination limit the ability of MSM to maintain social networks
- MSM long hair are more likely to experience discrimination because of their greater visibility
- Consequences can include poverty through unemployment, and police harassment including sexual assault

*Men Who Have Sex with Men in Cambodia:
HIV/AIDS Vulnerability, Stigma and Discrimination
("long hair" refers to overtly feminine MSM)*

Little is known about the legal situation of MSM in the GMR.² No laws have been found that prohibit male-to-male sex, although anecdotal evidence suggests there is harassment and detainment of MSM – particularly those who are also sex workers. For overtly feminine MSM, legal environments do not allow for change in gender status.

² See also: *Legal Situation for MSM in the GMR* (Appendix 4).

Sexual Health Issues of MSM

Dr. Graham Neilsen from FHI/ Asia Pacific Department (APD) began this session by sharing the World Health Organization's (WHO) definition of sexual health, first published in 1975:³

- Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love.
- Fundamental to this concept are the right to sexual information and the right to pleasure.

Applying this to the situation of MSM in the GMR, he addressed language barriers in talking about risk behaviors with MSM and with the health care workers (HCW) who might serve them. Dr. Neilsen also stressed the need for clinical guidelines for MSM.

Without training and guidelines, HCW may not be sensitive to:

- Specific lifestyle concerns such as intimate relationships, sex work, aging, stigma and discrimination.
- Clinical diagnosis and management of conditions such as anorectal disorders, STI, HIV and depression.
- For overtly feminine MSM, these same health issues are compounded by issues such as hormone treatment and surgery.

There exist challenges for the delivery of health services at the community, clinical and structural levels. For instance, the lack of a clearly defined "community" makes targeted interventions difficult, as do stigma and discrimination and the complexity of relationships in and between MSM sub-groups and their sexual partners. Structural barriers include:

- access to condoms and lubricants
- public health system reforms and catchment area registration requirements
- payment mechanisms for services, especially for the poor
- mobility of the target populations.

Research was recommended as a core component of a strategy for improving sexual health. This could help define the target populations, provide evidence for effective interventions, and baseline information for monitoring and evaluation.

Capacity building, particularly in the areas of clinical and community services, was identified as a key step in mitigating HIV and AIDS in the region.

Epidemiology of HIV/STI in MSM in the GMR

Dr. Frits van Griensven, PhD, MPH, Associate Director for Research, HIV/AIDS Program, Thailand MOPH - U.S. CDC Collaboration, reviewed existing research in the GMR related to men who have sex with men.

- Limited but significant studies have been undertaken in the GMR.
- 3 - 9% of men surveyed in the GMR have engaged in male-to-male sexual behavior.

³ WHO Technical Report Series Number 572, *Education and treatment in human sexuality: the training of health professionals*. Geneva, 1975.

Population data on male same-sex experience in the GMR			
Country	Year	%	MSM definition
Thailand - national survey	1990	3.4%	Self-described homo -bisexual or bisexual (Sittitrai et al 1994)
Thailand - conscript survey	1993	6.5%	>= 1 male partner in lifetime (Beyrer et al 1995)
Thailand - Northern youth survey	2002	9.1%	Self-described orientation (van Griensven et al 2004)
Hong Kong - phone survey	2000	4.1%	Ever sex with man (Lau et al 2002)
Singapore - medical students	1990	6.6%	Report being homosexual or bisexual (Singh et al 1992)

Epidemiology of HIV and STI in MSM in the Greater Mekong Region

- The prevalence of HIV among MSM is 3 – 17%, which is 5 – 15 times higher than the prevalence of HIV found in the general population. STI prevalence among MSM is 5 – 27% in the GMR. (Over 59% of MSM in Indonesia at the Aski Stop AIDS clinic presented with gonorrhoea on their first visit, as reported later in the workshop.)
- Condom utilization is consistently low among MSM involved in risk behaviors.

HIV and STI prevalence among MSM in the GMR					
Country	Year	Sample	% HIV	% STI	Reference
Vietnam - HCMC	2002	Convenience 208 MSM	5.8%	HBsAg 27% Syphilis 7%	Cao et al, 2002
	2004	Snowball 600 MSM	8%		NIHE, 2004
Cambodia - PP	2000	TLS 206 MSM / MSW	14%	Syphilis 5.5% Urethral NG 5% Urethral CT 7%	Girault et al, 2004
Thailand - BKK MOPH Surveillance Thai Red Cross VCT	2003	VDTS 1121 MSM	17%	N.A.	van Griensven, et al, 2005
	2004	STI clinics MSW	~10%		MOPH, 2004
	2003	Anonymous clinic 317 MSM	17%		Phanuphak, 2004
Laos			N.A.	N.A.	
China - Beijing	2001-3	Snowball 482 MSM	3.1%	N.A.	Choi et al, 2003

Epidemiology of HIV and STI in MSM in the Greater Mekong Region

Risk behavior data among MSM in the GMR				
Country	Year	Sample	% Behavior	Reference
Vietnam - HCMC	2001 2004	Outreach 219 MSM Snowball 600 MSM	78% unprotected sex with casual male past year 49%-57% unprotected sex with casual male past 6 mo	Colby et al, 2003 NIHE, 2004
Cambodia - PP PP, BTBG, SRP	2000 2002	TLS 206 MSM/MSW Snowball 370 MSM	67% unprotected sex with casual male past mo 83%-100% unprotected sex with casual male past mo	Girault et al, 2004 Catalla et al, 2002
Thailand - BKK	2003	VDTS 1121 MSM	36% unprotected sex with casual/steady male past 6 mo	van Griensven, et al, 2005
Laos - Vientiane, L Prabang & S'ket	2004	TLS 281 OF and 401 male partner	61% unprotected sex with casual male past 3 mo	PSI, 2004
China - Beijing	2001-3	Snowball 482 MSM	49% unprotected sex with male past 6 mo	Choi et al, 2003
China - online	2001	Internet 353 MSM	46%-57% unprotected sex with male ever	Wang et al, 2002

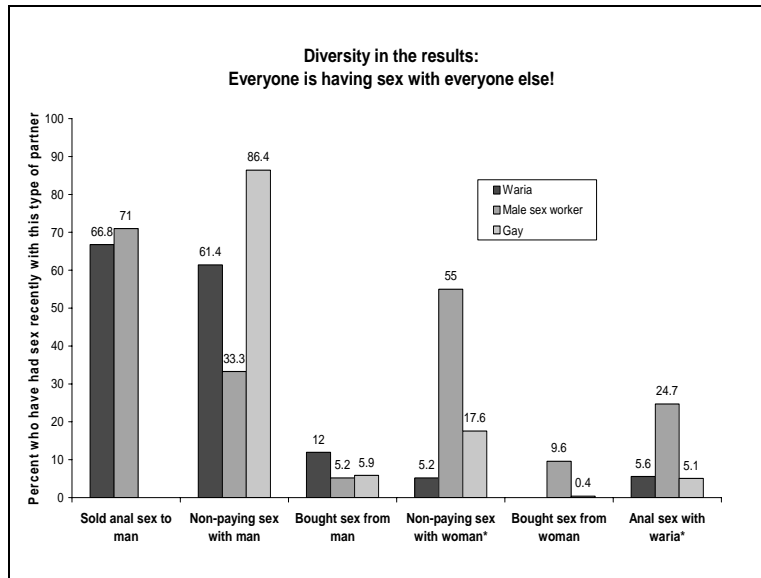
Epidemiology of HIV and STI in MSM in the Greater Mekong Region

- MSM risk behavior may provide a bridge for HIV with women, as was also indicated in a 2004 UNAIDS *AIDS in Asia* report.⁴ High percentages of MSM reported also having sex with a woman in four countries reported by Dr. van Griensven:

Cambodia (two studies)	43% and 70%
China (in Beijing)	22%
Thailand (Bangkok)	25%
Vietnam (Ho Chi Minh City)	22%

The data presented from Indonesia describes a similar incidence of shared risk behaviors:

⁴ Monitoring the AIDS Pandemic Network, *AIDS In Asia: Face the Facts*, UNAIDS 2004. Page 55.



Interventions for MSM in Indonesia
("Waria" refers to overtly feminine MSM)

Evidence of MSM behavioral risks and HIV prevalence has been documented in various settings in the GMR. More sophisticated research would add greatly to our basis of knowledge, but interventions should not be postponed until such data is available. Increased STI surveillance and reporting and MSM population size estimation studies could be conducted as more program implementation begins.

Dr. van Griensven concluded with the following recommended next steps:

- Implement, monitor and evaluate targeted interventions for MSM
- Build and engage MSM communities to take ownership and respond to their epidemic
- Research and link prevention with regional HIV epidemics
- Build partnerships between MSM communities, national programs, NGOs, INGOs and the business sector.

Interventions for MSM in the GMR

FHI/ARP recently conducted a survey of interventions for MSM in the GMR. Philippe Girault, Male Sexual Health Technical Officer with FHI/ APD, reported the findings at the workshop. A questionnaire was developed and distributed to 76 agencies beginning in November 2004. As of February 2005, 26 had completed the questionnaire, 21 replied that they do not support MSM interventions and 5 replied by giving suggestions; 24 have yet to respond. The results from the 26 respondents were summarized as follows:

- Interventions for MSM are relatively new with the oldest project having started in 2001.
- In general, few CBOs were identified. Vietnam reported government organization (GO) involvement; Thailand reported a multi-sector coalition of CBO, NGO, INGO and GO; and Laos reported only INGO involvement.
- Funding for MSM interventions mostly comes from the UN, INGOs, private foundations, and European, Canadian and US governments.

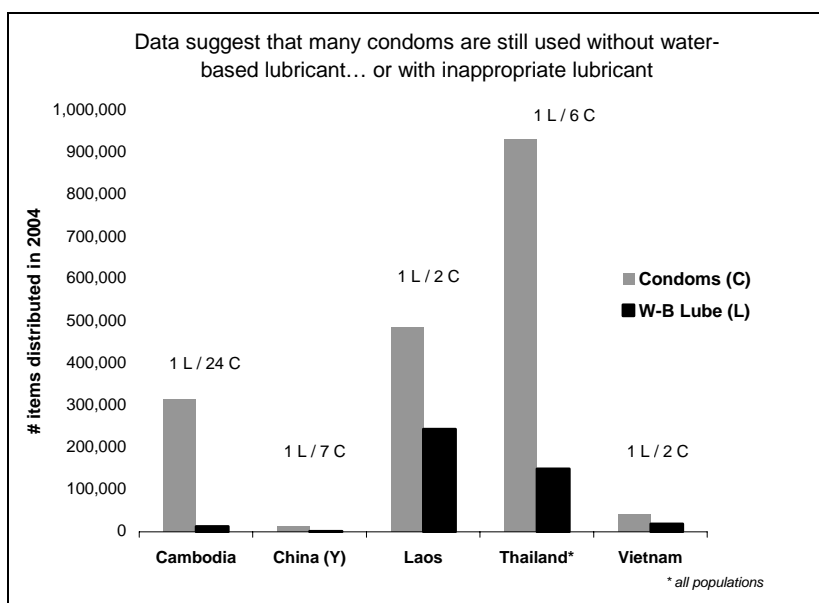
Level of Funding Reported for MSM Interventions in 2004

- Thailand: \$365,000 - 600,000
- Myanmar: \$250,000 - 500,000
- Vietnam: \$145,000 - 295,000
- Cambodia: \$120,000 - 260,000
- China: \$100,000 - 180,000
- Laos: \$20,000 - 60,000

Overview of Interventions for MSM in the GMR

Some basic components such as outreach, peer education, behavior change communication, and service centers are in place in most of the projects. In all countries, there is limited access to voluntary counseling and testing (VCT), STI treatment and antiretroviral (ARV) services but these services are generally not tailored to MSM. In a few areas, linkages of services do exist but are tenuous. Even where services are available, stigma and discrimination may deter MSM from using these services.

Sustained and consistent access to condoms and lubricant is essential to HIV prevention as well as the reduction of STI incidence. More than half of condoms are distributed through social marketing campaigns as part of community prevention interventions, which better assures sustainability; however, in China, condoms are available only through free distribution programs. Water-based lubricant significantly reduces all types of condom failure⁵ but access to it remains an unmet need in the GMR.



Overview of Interventions for MSM in the GMR

Few countries in the GMR reported social-cultural interventions such as those aimed to mobilize the community or provide access to legal and human rights services. Advocacy is limited mainly to the local level.

⁵ Gabbay Dr Mark B, NHS Executive North West/National Health Service (UK), *A randomised controlled trial of the effect of additional lubricant on condom failure*, July 2002.

In concluding, Mr. Girault observed that the number of interventions targeting MSM in the region is increasing but there is little long-term strategy, coordination or adequate resources. Areas where high levels of HIV prevalence among MSM have been identified are currently covered by some services but little is known about the quality and/or effectiveness of the interventions. There needs to be a rapid implementation of interventions where other “hotspots” have been identified. Further research will help guide strategy development, support monitoring and also provide evidence to evaluate and strengthen current and new interventions.

LESSONS LEARNED IN THE REGION

Several presentations on lessons that have been learned by implementing agencies and partners in Asia were made on the second day of the workshop.

1. Thailand: Rainbow Sky Thailand started in 2001 with street outreach in Bangkok’s main public park and now implements a large variety of activities and services in three parts of the country. A significant lesson is the success of involvement of the community including training volunteers to conduct services; however, the ability to sustain services by volunteers was cited as a problem.
2. Vietnam: Since January 2004, MSM interventions have been underway in three cities, Ho Chi Minh City, Hai Phong and Khanh Hoa, including recruitment and training of peer educators/outreach workers, and referrals to VCT services. Lessons include the importance of advocacy work with local authorities as learned in Khanh Hoa.
3. Indonesia: While not in the GMR, Indonesia has been involved in a significant number of MSM interventions. In the area of program development, they learned that use of operational research and involvement of MSM in research and program design were essential to successful interventions. Increased availability of services by use of mobile clinics is needed in order to reach the many sub-populations of MSM as well.
4. Cambodia: A recent survey of the MSM situation in Cambodia included interviews of key informants, reviewed literature, and conducted focus groups. A first-ever national meeting on the issue was held with over 125 participants, most of whom were MSM. They identified the pressing need to help MSM build personal/individual identities through increased social networks and human rights advocacy and education campaigns.

THE MINIMUM PACKAGE

As planned in the objectives for the workshop, the participants defined a minimum package of evidence-based interventions for HIV/AIDS prevention, care (including sexual health) and support targeting MSM. Two broad goals were crafted with five objectives, suggested implementation activities, and dynamics in the areas of policy and advocacy, capacity building and knowledge management that are also needed to realize the objectives.

Goal One: Decrease HIV transmission among MSM in the GMR

1. Increase correct and consistent condom use among MSM
2. Increase use of appropriate STI services by MSM
3. Increase coverage of prevention services for MSM

Goal Two: Mitigate the Impact of HIV/AIDS on MSM PLWHA and their families in the GMR

1. (Care and Support) Increase use and coverage of HIV care and support services by MSM PLWHA and their families, including HIV testing
2. (Treatment) Increase access to appropriate ARV for MSM PLWHA

The package is a dynamic document to be modified as needed throughout the region. CBOs, community representatives, HIV service providers, NGOs, INGOs, government agencies and other donors involved or interested in MSM interventions in the GMR will be asked for input, including discussion at the next strategy meeting planned for later in 2005. See Appendix 5 for the final draft document.

CHALLENGES

Throughout the workshop, people shared challenges in implementing services for MSM in the GMR. In a formal session, the group discussed specific challenges that the activities in the minimum package would present in each country (see also Appendix 6). Those challenges, broken down into broad categories, are listed below:

- Data and research
 - HIV/STI incidence and prevalence
 - Qualitative research
 - Need for population size estimates
- Access to programs with staff sensitivity to MSM (STI services, VCT and ARV)
- Condoms and lubricants (need sustainable distribution methods and increased access to lubricants)
- Governmental regulations and policies
 - CBO/NGO restrictions
 - Meeting spaces
 - Conflicts between public health and law enforcement agendas
 - Apprehension about MSM services
 - Lack of inclusion in national planning
- Lack of adequate resources
- Organizational capacity (staffing, funding, program coordination)
- Social issues (stigma and discrimination, societal misunderstanding of MSM)
- Access to information (mass media, written communication, internet availability and access)

GAPS IN INTERVENTIONS AND KNOWLEDGE

Participants broke out into country groups and were asked to map the existence of MSM activities, social dynamics, mobility patterns, current or planned interventions and linkages. The exercise helped reveal gaps in interventions and knowledge. Each country then identified three such gaps, as follows:

Cambodia:

1. Involvement of and cooperation between MSM sub-groups
2. Low coverage particularly in non-urbanized areas
3. Staff capacity (training and development; low staffing levels)

China:

1. Policy development/all levels of government

2. Evidence-based programming
3. Community mobilization (limited financial and human resources)

Laos:

1. Knowledge (formative/qualitative research)
2. Capacity building and scale up for outreach, education, advocacy
3. Quality health care services including VCT, STI and ART

Thailand:

2. Time and resources for capacity building
3. MSM-friendly STI/VCT services
4. Coverage outside of Bangkok and Chiang Mai

Vietnam:

1. Advocacy and policy development
2. Socio-cultural interventions
3. MSM-friendly services (clinical)

PRIORITIZING THE IMPLEMENTATION ACTIVITIES

Using the list from the *Minimum Package of MSM Interventions for the GMR*, the participants prioritized activities. Concern was expressed by some participants that ranking activities hierarchically might give a wrong impression of actual importance, since many activities should be implemented simultaneously. However, participants agreed that these lists should be viewed as guidelines and that their application would differ according to local needs.

Here are the first five activities as they were ranked by the participants within each category (1 = highest priority).

#	PREVENTION	CARE AND SUPPORT	TREATMENT
1	Targeted communication strategies	Home/Community-based care (MSM access)	Policy/ Advocacy
2	Community mobilization	Policy/ Advocacy	Training
3	Policy/ Advocacy	Training	Sensitization of health care providers to enable MSM access
4	Distribute condoms and lubricants (free and/or CSM)	OI prophylaxis and treatment	Treatment advocacy
5	Peer Education/ Outreach/internet	Support group	Adherence support (incl. MSM access to ARV)

TWO-YEAR VISION AND ACTION PLAN

As the workshop approached the end of the third and final day, the group proposed specific commitments for immediate and future action. A 20-point list of items for action over the next two-years was agreed upon by the participants.

Regionally based planning, coordination and methods of funding from CBOs, NGOs, INGOs as well as the UN and national governments were key recommendations from the workshop. Responsibilities must also be divided among the many parties who are invested in mitigating HIV in the region along with ways to identify and allocate the resources needed for implementation of the interventions. (See also Appendix 7.)

CONCLUSION

Research shows that there are large numbers of men who have sex with men (MSM) in the Greater Mekong countries of Cambodia, China (Yunnan and Guangxi provinces), Laos, Thailand, and Vietnam, with extensive risk behavior. Data shows, as well, a real HIV epidemic along with high rates of STI among these MSM. Governments are recognizing that MSM and their partners are at high risk of becoming infected with HIV.

After three days of discussing these issues, participants set two objectives: 1) decrease the transmission of HIV, and 2) mitigate the impact of HIV and AIDS among MSM in the GMR. The workshop described a *Minimum Package of MSM Interventions of the GMR* as a first step toward fulfilling these objectives.

Three priority needs were identified:

- 1) Strengthening of existing or newly created community organizations, MSM and non-MSM, so that they can facilitate access to prevention, care, support and treatments services by MSM;
- 2) Improvement of existing clinical services through the adoption of clinical guidelines and trainings in the health care sector in the GMR;
- 3) Engagement with regional governments to recognize the need for HIV prevention, care, support and treatment services for MSM and to establish relevant and supportive policies and programs with adequate resources.

The workshop participants ended with a commitment to helping achieve the 20-point vision and action plan, to take the findings of the workshop back to their communities for discussion and input, and to support the next meeting planned for wider participation later in 2005.

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Abbreviations

AFAO	Australian Federation of AIDS Organizations
AIDS	Acquired Immune Deficiency Syndrome
ART	antiretroviral therapy or treatment
ARV	antiretroviral drugs
BKK	Bangkok, Thailand
BTBG	Batdambang, Cambodia
CBO	community-based organization(s)
CDC-GAP	US Centers for Disease Control and Prevention Global AIDS Program
CSM	condom (and water-based lubricant) social marketing
DIFD	Department for International Development (UK)
FHI-APD	Family Health International, Inc. Asia Pacific Department
FHI-ARP	Family Health International, Inc. Asia Regional Program
GMR	Greater Mekong Region
GO	government organization(s)
HBsAg	Hepatitis B surface antigen
HCMC	Ho Chi Minh City, Vietnam
HCW	healthcare worker
HIV	Human Immunodeficiency Virus
INGO	international nongovernmental organization(s)
IFRC	International Federation of Red Cross and Red Crescent Societies
MARP	most at risk populations
MOPH	Ministry of Public Health
MSM	men who have sex with men
MSW	male sex worker
NGO	nongovernmental organization(s)
PLWHA	person or people living with HIV/AIDS
PP	Phnom Penh, Cambodia
SRP	Siem Reap, Cambodia
STI	sexually transmitted infection(s)
TLS	Time Location Sampling
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
US	United States (of America)
USAID-RDM ARP	US Agency for International Development Regional Development Mission Asia Regional Program
VCT	voluntary counseling and testing
VDTS	Venue Day-Time Sampling
WHO	World Health Organization

**Strategizing interventions among MSM
in Greater Mekong Region
CDC-GAP/USAID-RDM/FHI-APD workshop
28 February – 2 March 2005**

Background

The general discomfort among the Government and National AIDS Program leadership with the existence of men having sex with men (MSM) and occurrence of male-to-male sex in Asia has meant that very little data has been collected among this group. As a result, following the logic of a vicious circle (no data, no problem, no intervention, no data), few interventions have been implemented.

This is especially true for the Greater Mekong Region⁶ (GMR), where data and interventions among these populations remain limited. A good example is Thailand, which a decade ago took a pragmatic and non-judgmental approach to tackle the HIV epidemic among certain groups in the country (especially sex workers and their clients), but has swept MSM under the carpet. In this sub-region, MSM are not included in any of the HIV/AIDS national strategic plans – at best, they are mentioned under a broad and vague umbrella of high-risk populations. The main reasons for this are poor understanding by policy makers and stakeholders of the different expressions and variety of masculinity and sexuality in general, and of male-to-male sexuality in particular. Second, in most countries there is an unfavorable social and political climate to discuss issues related to MSM, let alone to enable them to organize or to form communities to fight against the epidemic. Third, partly as a result of the first two reasons, there is inappropriate allocation of resources for HIV prevention, care and support for MSM.

However in the past years some countries in the GMR have started to collect information on male-to-male sex. After years of programming neglect, this has yielded some unpleasant surprises: high levels of unprotected anal sex (commercial and non-commercial), low use of water-based lubricants, and, as a result, high levels of HIV prevalence: infection rates of 15% were found among MSM in Phnom Penh (Cambodia, 2000); 17% of MSM in Bangkok (Thailand, 2003); 8% of MSM in Ho Chi Minh City (Vietnam, 2004); 3% of MSM in Beijing (China, 2004). These findings have led to the implementation of pilot interventions in the cities where the research was conducted, but at the same time other possible “hotspots” with significant male-to-male sexual vulnerability to HIV/AIDS have been left unidentified, thus uncovered by appropriate interventions.

In none of the GMR countries, strategies and guidelines to scale-up these initial interventions among MSM exist. As a result, access to HIV prevention and care/treatment for these specific populations is still limited. This poor coverage challenges the short and long-term impact of current pilot interventions on the

⁶) In this concept paper the Greater Mekong Region refers to the following countries; Thailand, Cambodia, Laos, Vietnam and China (Yunnan and Guangxi provinces)

dynamic and growth of the HIV epidemic in this sub-region – not only among MSM, but since many of them, often under societal pressure, get married or have girlfriends, also among women and their children.

Despite some progress in designing and implementing prevention and care programs in the region, there is no agreement or clear guidance about the type and methodology of interventions or services that should be provided to MSM. In fact, no study or evaluation has so far clearly proven any short-term impacts of the current interventions, or has started to derive a model for interventions targeting MSM in this region. Therefore, a minimum comprehensive package of interventions for MSM should be discussed and defined and recommended, in order to strengthen current interventions and implement new ones in the identified hotspots in the GMR. It might also serve as a framework for policymaking and for monitoring and evaluating these programs.

Developing a way forward on these issues by sharing information about current approaches and interventions, sharing research findings and designing a 'minimum comprehensive package' for interventions targeting MSM, as well as a strategy to implement it, would benefit these vulnerable populations and would contribute to a decrease of the epidemic in this sub-region. This workshop is a first step for the USG agencies to join efforts to address these issues and strategize appropriate interventions for MSM in the sub-region.

Objective of the workshop

The three-day workshop aims 1) to define a minimum package of evidence-based interventions for HIV/AIDS prevention, care (including sexual health) and support targeting MSM, and 2) to develop a comprehensive strategy for effective and successful implementation of targeted interventions among MSM in the Greater Mekong Region.

Preparation work

The following tasks need to be conducted before the workshop. These will be implemented by FHI/APD prior to the organization of the workshop, with inputs from Ministries of Health, National AIDS Programs, CDC, UNESCO, UNAIDS, and other key partners:

- ◆ Mapping of existing interventions among MSM in the GMR
- ◆ Overview of the epidemiological situation of MSM in the GMR

Outlines of the agenda

During this three-day workshop, the facilitators and the participants will answer to the following questions through presentations and working groups:

1. What do we know about different forms of masculinity and related sexuality in the GMR?
2. What are the main sexual health issues related to MSM to be addressed?

3. What is the epidemiologic situation (size estimation, behavior and HIV and STIs prevalence) of MSM in this sub-region?
4. What are the existing interventions targeting MSM in this sub-region?
5. What would a minimum comprehensive package of interventions to implement for MSM look like?
6. What would be the main challenges in implementing this comprehensive package for MSM?
7. What are the strengths and weakness of interventions targeting MSM in Asia?
8. What are the gaps in terms of knowledge and interventions related to MSM in this sub-region?
9. What should be the main priorities for research, for advocacy and policy, and for programmatic action in this sub-region? Who would be the main actors in these fields and how can we move ahead?
10. What are the next steps?

Human resources

Focal points

CDC/GAP: Michael O'Reilly

FHI/APD: Philippe Girault (Deborah Murray – back-up)

USAID: Matt Friedman / Suzanne Ross

UNESCO: Jan W de Lind van Wijngaarden

Logistics

FHI/APD and CDC/GAP will coordinate to ensure the logistic of the workshop. The focal points for the logistic of this workshop are:

Khun Shanidapha Meesa-ard, CDC/GAP

Khun Chunjira Wichai, Program Officer, FHI/APD

Facilitators and co-facilitators

A consultant, Paul Causey, hired through FHI/APD, is the facilitator for this workshop. He will be assisted by six co-facilitators selected from USG agencies and key partners.

Date and venue

Bangkok, 28 February- 02 March 2005

Venue: A Raffles International Na Park Nai Lert, Bangkok

Participants

A maximum of 35+ participants will attend this workshop. The participants are mainly coming from USG agencies and their key partners in the GMR. Facilitators, co-facilitators and agency staff do not need to register as participants.

Workshop Agenda

Strategizing Interventions among MSM in the Greater Mekong Subregion (GMR)* CDC-GAP/USAID-RDM/FHI-APD Workshop

28 February – 2 March 2005

Bangkok, Thailand

Monday 28 February 2005			
8:00	Registration		
8:30	Opening statements	CDC-GAP Director USAID/RDM Director FHI/APD Director	5 minutes each
8:45	Introduction	Facilitator	
9:00	Masculinity, sexuality and male to male sex in the social and cultural context of the GMR	Jan W. de Lind van Wijngaarden, UNESCO	15 minutes PowerPoint and 15 minutes of discussion
9:30	The social and legal situation of MSM in the GMR using Cambodia as an example.	Chris Ward, Policy Project	15 minutes PowerPoint and 5 minutes of discussion
9:50	Break		
10:05	Sexual health issues of MSM	Graham Neilsen, FHI	15 minutes PowerPoint and 15 minutes of discussion
10:35	Epidemiology (size estimation, behavior and prevalence) of HIV and STI in MSM in the GMR	Dr. Frits Van Griensven, CDC	15 minutes PowerPoint and 15 minutes of discussion
11:05	Overview of interventions for MSM in the GMR	Philippe Girault, FHI	25 minutes PowerPoint and 15 minutes of discussion
11:45	Questions and answers	Facilitator	
12:00	Lunch break		
13:15	Plenary presentation and discussion of a minimum comprehensive package of interventions for MSM. Introduction of a sample worksheet.	Dr. Michael O'Reilly, CDC and Matt Friedman, USAID/RDM	Presentations and Plenary discussion
13:30	What would a minimum comprehensive package of interventions for MSM look like?	Country groups with 1 co-facilitator each	Group work and discussions using the sample worksheet.
15:00	Break		
15:15	What would be the main challenges in implementing this model in our countries?	Country groups with 1 co-facilitator each	Group work and discussions
16:00	Report back of main challenges in each country	Group reporters & Facilitator	Plenary presentations (10 minutes each) and plenary discussion
17:00	Wrap-up	Facilitator	

Tuesday 1 March 2005			
8:30	Summary of Day 1	Facilitator	Plenary discussion
8:45	Lessons learned from interventions for MSM from the region: Thailand	Rapeepun Jommaroeng, Rainbow Sky Bangkok	15 minute PowerPoint and 15 minutes of discussion
9:15	Lessons learned from interventions for MSM from the region: Vietnam	Patrick Chong, GAP Vietnam, (Haiphong and HCMC projects)	15 minute PowerPoint and 15 minutes of discussion
9:45	Lessons learned from interventions for MSM from the region: Indonesia	Kharisma Priyo FHI/Indonesia	15 minute PowerPoint and 15 minutes of discussion
10:15	Break		
10:30	Lessons learned from interventions for MSM from the region: RDS in South China	Henry Raymond, GHI/UCSF	15 minute PowerPoint and 15 minutes of discussion
11:00	Lessons learned from interventions for MSM from the region: Cambodian MSM and Prevention	Thaiy Theo (Kha Sovanara), Policy Project	15 minute PowerPoint and 15 minutes of discussion
11:30	Summary: lessons learned for the region of these interventions	Facilitator	
12:00	Lunch break		
13:15	Mapping exercise: What currently exists in terms of knowledge and interventions related to MSM in this sub-region?	Matt Friedman, USAID/RDM	15 minute PowerPoint and 15 minutes of discussion
13:45	Mapping of each country to help identify challenges, gaps and linkages.	Group discussion facilitated by a co-facilitator using the mapping exercise	Group discussions by country
14:45	Report back of what currently exists in terms of knowledge and interventions related to MSM in this sub-region	Group reporters & Facilitator	Plenary presentations (5 minutes each)
15:15	Break		
15:30	What are the gaps in terms of knowledge and interventions related to MSM in this sub-region? Areas of concern include: <ul style="list-style-type: none"> • advocacy/policy/discrimination • prevention, care, support and treatment (ARV) • Socio-cultural interventions/transformations • STI and sexual health • Surveillance, research and M&E 	Group discussion facilitated by a co-facilitator using the map	Group discussions by country
17:00	Wrap-up	Facilitator	

Wednesday 2 March 2005			
8:30	Summary of Day 2	Facilitator	
8:45	Plenary presentation of gaps in knowledge and interventions by country	Group reporters	Plenary presentations, 10 minutes each
9:45	Summary: overview of gaps	Facilitator	
10:00	Break		
10:15	Main priorities for research, advocacy, policy and programmatic action	Country groups with 1 co-facilitator each	Group discussions by country
12:00	Lunch break		
13:15	Plenary presentations of main priorities	Group reporters	Plenary presentations, 10 minutes each, and 25 minutes plenary discussion
14:30	Summary: Overview of priorities	Facilitator	
14:45	Break		
15:00	Discussion and comparing main priorities with the Model developed during Day 1	Facilitator	Plenary discussion
15:30	Moving forward - Next steps	CDC/USAID/FHI	Plenary Discussion
16:30	Summary of the workshop and closing remarks	Facilitator CDC Director USAID Director FHI Director	Plenary Discussion
17:30	End of workshop		

***GMR COUNTRIES:**

1. Cambodia
2. China/Guangxi and Yunnan provinces
3. Laos
4. Thailand
5. Vietnam

Workshop venue:

Karaket Room off the Gallery
 Nai Lert Park Bangkok – A Raffles International Hotel
 (formerly the Bangkok Hilton Hotel)
 2 Wireless Road (between Sukhumvit and Petchaburi Roads)
 Bangkok, Thailand

List of Workshop Participants

Participants:

	Name	Title	Agency	E-mail contact
1	Mr. Clif Cortez	Senior Policy and Technical Advisor Office of HIV/AIDS	USAID	ccortez@usaid.gov
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3	Mrs. Prachara Rumakom	Program Specialist	USAID/RDM	prumakom@usaid.gov
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5	Mr. Habib Urahman	Program Manager	PSI/Myanmar	habibpsi@myanmar.com.mm
6	Ms. Lauren Beaty	Project Assistant	PSI/Laos	lbeatypsi@yahoo.com
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18	Dr. Patchara Sirivongranson	Chief STI Cluster, BATS	Thailand MoPH	pasirivong@yahoo.com
19	Ms. Chomnad Manopai boon (1 st day)	Chief of Special Population Section	CDC	Chomnadm@tuc.or.th
20	Mr. Prin Visavakum	Project Coordinator	CDC	Prinv@tuc.or.th
21	Dr. Lies J.M. Bollen	Medical Research Scientist	CDC	Lbollen@tuc.or.th
22	Dr. Michael Qualls	Cambodia Rep	CDC	MUQ1@cdc.gov
23	Dr. Hor Bun Leng	Deputy Chief/GAP	CDC	Lhor@state.gov

	Name	Title	Agency	E-mail contact
24	Dr. Stuart Koe	Chief Executive Officer	CDC	Stuart.koe@fridae.com
25	Ms. Serena Lam	Fridae.com Rep.	CDC	
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29	Dr. Graham Neilsen	Associate Director of Technical Division	FHI/ APD	gneilsen@fhibkk.org
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38	Mr. Vu Ngoc Bao	Program Manager	FHI/Vietnam	bao@fhi.org.vn
39	Dr. Tran Thinh	Program Coordinator Provincial AIDS Committee	PAC/HCMC, Vietnam	
40	Mr. Liang Jun	Program Field Coordinator	FHI/China	liangjun@fhichina.org
41	Mr. Jiang Hua	Vice Director	Chendu Gay Community Care Organization , China	Retro120@163.com

Facilitator and Co-facilitators:

	Name	Title	Agency	E-mail contact
1	Mr. Paul Causey	Technical Consultant	FHI/ APD	paul@revisionasia.com
2	Mr. Matt Friedman	Deputy Director Regional HIV/ AIDS Health Office	USAID/RDM	mfriedman@usaid.gov
3	Ms. Suzanne Ross	Senior Technical Advisor HIV/ AIDS	USAID/RDM	sross@usaid.gov
4	Dr. Michael O'Reilly	Chief of Asia Regional Program/GAP	CDC	Oreilly@tuc.or.th
5	Ms. Martha Scherzer	Associate Chief of Asia Regional Program/ GAP	CDC	marthas@tuc.or.th
6	Mr. Jan W. de Lin van Wijngaarden	MSM Project Coordinator	UNESCO	j.wijngaarden@unesco.org
7	Mr. Philippe Girault	MSH Technical Officer	FHI/ APD	pgirault@fhibkk.org

Supporting Staff:

	Name	Title	Agency	E-mail contact
1	Ms. Shanidapha Meesa-ard	Program Management Assistant of Asia Regional Program	CDC	ShanidaphaM@tuc.or.th
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3	Ms. Sutisa Rommaneeyapet	Secretary of Asia Regional Program	CDC	sutisar@tuc.or.th
4	Ms. Napat Phisanbut	Program Management Unit	FHI/ APD	napat@fhibkk.org
5	Ms. Chunjira Wichai	Program Officer of Asia Regional Program	FHI/ APD	chunjira@fhibkk.org

Observers:

	Name	Title	Agency	E-mail contact
1	Dr. Gordon Mansergh	Representative from CDC/Atlanta	CDC	
2	Mr. Thomas Guademaz	Student from Hopkins University	CDC	

Legal Situation for MSM in the GMR

LEGAL SITUATION FOR MSM IN THE GREATER MEKONG REGION

Sources: *International Lesbian Gay Association* (last updated 1998); <http://www.sodomylaws.org>; <http://www.utopio-asia.org>; *Bangkok Post*; *The Nation* (Thailand).

	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
General Situation	<p>“The concept of homosexuality does not exist in Khmer culture. Sex acts between same-sex partners is usually accepted, and is not defined as homosexuality. It is expected that people get married to produce children as an important expectation from society and culture.”</p>	<p>Changing</p>		<p>“Dr. Peter Jackson found that Thai academia and areas of the public sector support rabidly anti-gay, anti-lesbian and anti-kathoeay attitudes and practices that are often out of step with the more tolerant attitudes of the general population....While an overgeneralization, homosexual people in most situations are free to lead private lives as gay men and lesbians without interference, provided they do not come out. However, when someone openly identifies as being gay or lesbian, then intense indirect pressures can be applied from bosses, colleagues, friends and family to make life very difficult or even intolerable.”</p>	<p>Changing</p>

	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
Laws covering sexual activity	None apparent	None apparent	No laws against same-sex encounters although may be "an offence against the local manners and customs" and (therefore) "punishable according to the Penal Code".	None known although may violate cultural norms ("Thai ways") that can bring police action.	None although same-sex acts may be seen as "undermining public morality" (similar to "public indecency" or "soliciting" in certain other jurisdictions) and can be used to prosecute homosexual conduct.
Age of consent laws:					
MSM	16	21		15	
FSF	16	21		15	
Heterosexual	16	16		15	
Sex work				18	
Freedom of Association				Very open with many GLBT organizations	
Freedom of Expression/Censorship		Often discouraged or prohibited in media		Censorship of media including TV/movies occurs randomly.	
Anti-discrimination laws/cases					
Anti-vilification laws/cases					
Employment					
Access to military				Not open to MTF.	

	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
Partnership Recognition (other than parenting)	Apparently allowed	Same sex cohabitation not expressly illegal		No legal status although some temples will perform "ceremonies".	Gay marriage banned in 1998
Other Rights				Sex reassignment not recognized by law.	
Street Violence, "Social Cleansing", Police Harassment, etc	Yes especially for sex work	Yes; with fabricated (unrelated) charges		Street violence very rare. Police harassment occurs randomly under "New Social Order" campaign; police often ban condom use in sex establishments (used condoms prove sex is occurring onsite, which is illegal).	
HIV/AIDS Human Rights Issues	Changing for the better	Changing for the better			Changing
HIV+ travel restriction (inbound)	None			None now	

MINIMUM PACKAGE FOR MSM INTERVENTIONS IN GMR -- Draft Version 1.2

Goals	Objectives	Implementation Activities	Policy and Advocacy	Capacity Building	Knowledge Management
<p align="center">Decrease HIV prevalence among MSM in the GMR</p>	<p align="center">Prevention</p> <p>Increase correct and consistent condom use among MSM</p> <p>Increase use of appropriate STI services by MSM</p> <p>Increase coverage of prevention services for MSM</p>	<ul style="list-style-type: none"> • Peer education/ outreach/internet • Establish VCT or strengthen linkages to existing VCT • Service center • STI Treatment services • Distribute condoms and lubricant (free and/or CSM) • Targeted communication strategies • Community mobilization • Policy/advocacy • Other trainings • Sero and behavioral Surveillance • STI Surveillance • Prevention for positives • Linkages 	<ul style="list-style-type: none"> • Stigma and discrimination reduction • Apply GIPA principles whenever appropriate • Mobilize MSM community/opinion leaders • Policy/advocacy (regional, national and local leaders) 	<ul style="list-style-type: none"> • Development of peer outreach/education and social networks • Clinical issues of male sexual health for clinicians • Program and business mgmt. trainings (program development, M&E, finance, HR policy, etc.) 	<ul style="list-style-type: none"> • Monitoring and evaluation systems • Size estimation • Surveillance at the provincial/local level • On-going targeted program mapping • Qualitative research (social/political situation, etc.)
<p align="center">Mitigate the Impact of HIV/AIDS on MSM PLWHA and their families in the GMR</p>	<p align="center">Care and Support</p> <p>Increase use and coverage of HIV care and support services by MSM PLWHA and their families</p>	<ul style="list-style-type: none"> • Sensitization of home/community- based health care providers to enable MSM access • Policy/advocacy • Support groups • Counseling services • Information and referral • OI prophylaxis and treatment providers to enable MSM access • Psycho-social support • Training • Linkages 	<ul style="list-style-type: none"> • Media training and education • Link to legal services and human rights organizations • Incorporate MSM in national surveillance 	<ul style="list-style-type: none"> • Desensitization/ culture appropriateness training • Regional information exchange (study tours, etc.) • Sustainability 	<ul style="list-style-type: none"> • Evaluate local program effectiveness • Analysis of violence, empowerment and impediments to access
	<p align="center">(HIV) Treatment</p> <p>Increase access to appropriate ART for MSM PLWHA</p>	<ul style="list-style-type: none"> • Sensitization of health care providers to enable MSM access • Treatment literacy • Policy/advocacy • Adherence support • Training • Linkages 	<ul style="list-style-type: none"> • Resource allocation • Donor mobilization and coordination 	<ul style="list-style-type: none"> • Planning and costing 	

Challenges to MSM Interventions in the GMR

By Topic and Country

TOPIC	CHALLENGE	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
Program access -general		◆	◆	◆	◆	◆
	Lack of capacity of health care services	■		■		
	Lack of clinical guidelines on all MSM issues	■	■	■	■	■
	Lack of MSM friendly medical providers					
	Lack of resources for overtly feminine MSM		■			■
	Lack of services for poor, rural, mobile populations	■	■	■	■	■
	Lack of technical capacity for intervention implementation					■
	Mixing DU with non-DU MSM	■				■
	Peer education for mobile populations					■
Program access -prevention		◆	◆	◆	◆	◆
	Outreach limitations (disclosure by sex workers/protect clients)					■
	Inability to reach MSM youth				■	
	Lack of prevention supplies (condoms, lubricant, rapid test kits)		■		■	
	Lack of STI services access	■	■	■	■	
Program access -care and support; treatment			◆		◆	
	Access to ARV (MSM friendly)		■		■	
	Lack of CD4 testing, equipment		■			
	No linkages to VCT, psycho-social		■			
Program coordination			◆	◆		◆
	Creating interventions to address a variety of targets			■		
	No coordination of HIV programming		■	■		
	No linkages		■			
	Scale up needed			■		

TOPIC	CHALLENGE	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
Staff capacity		◆	◆		◆	◆
	Misunderstanding by police of function of peer educators				■	■
	Street crime due to night work	■				
	Training of personnel	■	■	■	■	■
	Volunteer capacity not sustainable/unable to hire paid staff				■	
	Workload	■	■			
Inadequate funding		◆		◆	◆	
Governmental issues – regulations			◆	◆	◆	◆
	Catchment area restraints		■		■	
	Censorship about explicit language in public meetings					
	Limits on information access including internet					
	NGO/CBO restrictions		■	■		
	No support/conflicting regulations for social marketing		■		■	
	Police agenda conflicts with public health		■	■	■	■
	Policy conflicts (inter-ministerial)				■	
Unregulated STI clinics		■				
Governmental issues – planning and coordination			◆	◆		◆
	MSM not included in National HIV Plan		■			■
	No/little commitment to VCT		■			
	No national HIV strategy		■	■		
Governmental issues – service delivery		◆	◆	◆		◆
	No/little support for MSM/male sexual health issues/services	■	■	■		■
Access to information		◆	◆		◆	◆
	Internet access		■			
	Lack of alternative communication channels/outdated methodologies				■	
	No STI in MSM guidelines		■			
	No/little basic MSM information					■

TOPIC	CHALLENGE	CAMBODIA	CHINA	LAOS	THAILAND	VIETNAM
Lack of data		◆	◆	◆	◆	◆
	Lack of analysis of cultural impediments			■		
	Lack of data on MSM			■		
	Size estimation/MSM/MARP	■	■	■	■	■
	STI/HIV prevalence	■	■	■	■	■
Social issues		◆		◆		◆
	Lack of societal recognition of MSM	■	■	■	■	■
	Lack of social networks	■				
	No/very limited social spaces					■
	Restrictions from family/pressure to marry			■		■
Stigma and discrimination		◆			◆	◆
	Disclosure issue (MSM)	■				■
	Hidden MSM identity/behaviors (no visibility)	■			■	
	Neighborhood resistance (NIMBY)					■

Two-Year Vision (2005–2007) for MSM Interventions in the GMR

Strategizing Interventions among MSM in the Greater Mekong Sub-region (GMR)
CDC-GAP/USAID-RDM/FHI-APD Workshop, Bangkok, Thailand, March 2005

1. Follow up meeting with other players including:⁷
 - a. Implementers (on the ground)
 - b. Government sector (e.g., Ministries of Health, etc.)
 - c. Non-USG donors, UN and INGOs (UN, AFAO, AusAID, Canada, DFID, IFRC, private foundations, etc.)
2. Identify the location and number of hotspots (mapping)
3. Regional Most-at-Risk Populations (MARPs) estimations for MSM made (baseline)
4. Increase the number of MARPs receiving any HIV/AIDS services
5. Increase the number of MARPs being reached with peer education/outreach by xx (*number to be set after baseline is established*)
6. Through qualitative research, analyze and describe the MSM population (including sexual/social culture, gender/sexual identities, behaviors, barriers to interventions, etc.) in at least four countries.
7. National meetings in at least three countries with MSM and/or MSM peer educators
8. Collaborative MSM Regional Strategy in place (multi-partner/donor, government buy-in, etc.)
9. Regional Program Costing completed
10. At least three of the countries will have national surveillance among MSM, both sero- and behavioral surveillance.
11. At least 150 clinicians trained in clinical aspects of male sexual health
12. Three times increase in:
 - a. Number of male sexual health clinics
 - b. MSM prevention services (community-based when appropriate)
13. Internet-based network providing:
 - a. State of the art HIV/STI transmission and treatment information
 - b. Links to local VCT and ARV treatment centers and providers
 - c. Access to regional BCC materials, media campaigns, etc.
14. MSM prevention and/or care included in most national strategies and Global Fund applications (for advocacy and policy)
15. Establish relationships with all existing human rights commissions around issues of MSM.
16. Double the number of CBOs working with MSM
17. 75% of NGO, CBO, GO MSM programs are trained on:
 - a. Program management (e.g., implementation, M&E, sustainability, etc.)
 - b. Technical skills
 - c. Advocacy skills
18. National targeted communication strategies in at least three countries
19. 100% of existing programs will establish methods of distribution of condom and water-based lube.
 - a. 50% of existing programs will establish a social marketing campaign strategy for distribution sustainability.
20. 100% of existing programs will establish written links with appropriate local service providers.

⁷ The next meeting is planned for later in 2005.