



Health Resource Facility

Scoping exercise:

Options for AusAID support for comprehensive approaches to address HIV infection among men who have sex with men in the Asia Pacific Region

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3 June 2009

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Acronyms

AAA	Accra Agenda for Action
ACON	AIDS Council of NSW
ADB	Asian Development Bank
ADRA	Australian Development Research Awards
AFAO	Australian Federation of AIDS Organisations
AHAPI	AusAID HIV/AIDS Partnership Initiative
AHRF	AusAID Health Resource Facility
AIDS	Acquired Immunodeficiency Syndrome
AIPH	Australia-Indonesia Partnership for HIV
AMTP	AIDS Medium Term Plan
APCASO	Asia Pacific Council of AIDS Service Organisations
APCOM	Asia Pacific Coalition on Male Sexual Health
APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Antiretroviral Therapy
ATS	Amphetamine Type Stimulants
AusAID	Australian Agency for International Development
BCC	Behaviour Change Communication
BSS	Behavioural Sentinel Surveillance
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CFP	Country Flexible Program
CSO	Civil Society Organisation
DFID	Department for International Development
DIC	Drop-in-Centre
DoH	Department of Health
EC	European Commission
FBO	Faith Based Organisation
FHI	Family Health International
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMS	Greater Mekong Sub-region
GWL-INA	Indonesia Gay, Transgender and MSM Network
HAARP	HIV and AIDS Asia Regional Program
HAI	Highly Active Intervention Package
HCMC	Ho Chi Minh City
HCPI	HIV Cooperation Program for Indonesia
HCW	Health Care Workers
HHTG	Health and HIV Thematic Group
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
HSS	HIV Sentinel Surveillance
HSSP2	Health Sector Support Program
IAC	International AIDS Conference
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting Drug User
INGO	International Non Government Organisation
IPF	Indonesia Partnership Fund for HIV/AIDS
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MDM	Medicines du Monde
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NAP	National AIDS Program
NDoH	National Department of Health
NGO	Non Government Organisation
NSP	National Strategic Plan
PAC	Provincial AIDS Committee

PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counselling and Testing
PLHIV	People Living with HIV
PNAC	Philippines National AIDS Council
PNG	Papua New Guinea
PR	Principal Recipient
PSDN	Pacific Sexual Diversity Network
PSI	Population Services International
PSN	Purple Sky Network
RTCU	Regional Technical Coordination Unit
SOGI	Global Fund Strategy on Sexual Orientation and Gender Identity
SSS	STI Sentinel Surveillance
STI	Sexually Transmitted Infection
SW	Sex Worker
TA	Technical Assistance
3DF	Three Diseases Fund
TDF	Tropical Diseases Foundation
TG	Transgender
TGSW	Transgender Sex Worker
The Alliance	International HIV/AIDS Alliance
The Consortium	AusAID's HIV Consortium for Partnerships in Asia and the Pacific
ToT	Training of Trainers
TRP	Technical Review Panel
TSF SEAP	HIV/AIDS Technical Support Facility South East Asia & Pacific
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
RSTAP	UNAIDS Regional Support Team Asia Pacific
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
US CDC GAP	United States Centres for Disease Control & Prevention Global AIDS Program
USG	United States Government
VAAC	Vietnam Administration of HIV/AIDS Control
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WPRO	Western Pacific Regional Office (WHO)

Glossary

- Men who have sex with men** Men who have sex with men is used as a behavioural term to refer to biological males who have sex with other biological males. As men who have sex with men is used as a behavioural term it also includes biological males with a transgender identity, who usually do not self-identify as men. The term does not imply that men who have sex with men necessarily have a sense of identity or community based on male-to-male sex, although an increasing number of men in Asia and the Pacific do have such an identity. The term includes men who identify as gay, homosexual or with terminology specific to the local language that has culturally specific meaning, and also includes bisexual and heterosexual men who at times have sex with other men. For example, there are significant numbers of men in Asia and the Pacific who have sex with other men who see themselves as normative males and who do not identify with labels or terminology which imply an identity around male-to-male sex. Many men who have sex with men, including those with varying levels of identity around this sexual practice, also have sex with females.
- Structural interventions** Structural interventions are public health measures designed to implement or change laws, policies, physical structures, social or organisational structures or standard operating procedures to effect beneficial environmental or social change that will improve health status at a population level. Structural interventions include programs or policies that change the environments in which risk behaviour occurs. Examples include laws requiring seat belts or interventions to make condoms available in all entertainment establishments and sex on premises venues.

Executive summary

An expanded area of work under Australia's new international development strategy for HIV, *Intensifying the response: Halting the spread* is a focus on HIV prevention among men who have sex with men. The first objective of this scoping exercise was to map, review and analyse current and planned interventions addressing the rapid rise of new HIV infections among MSM in the Asia Pacific Region. The second objective was to provide AusAID with recommendations for maximising the impact of its contribution to comprehensive approaches to address HIV infection among MSM.

The focus countries for the scoping exercise were Burma, Cambodia, Indonesia, Papua New Guinea, the Philippines and Vietnam. Potential AusAID support for regional level work was also explored. The scoping exercise was conducted by document review, mapping, key informant interviews and analysis of all data collected.

Key findings

1. HIV and STI epidemics among MSM in Asia are being driven by high numbers of concurrent male and female sex partners and low rates of consistent condom use. Cross-sectional studies repeated over time have shown the potential for HIV epidemics among MSM to increase rapidly and in some places to hyper epidemic levels. Unless effective prevention measures are intensified it is estimated that by 2020 around 46 percent of new infections in Asia will be among MSM, up from 13 percent in 2008.
2. A comprehensive approach to HIV and sexual health among MSM includes foundational activities to create an enabling environment, supportive interventions needed for the effective operation of the prevention and care package (e.g. capacity building), and a complete prevention and care package. Current MSM programming in Asia and the Pacific place a greater emphasis on delivering prevention services and a lesser emphasis on creating an enabling environment, some supportive interventions, and treatment and care.
3. MSM have now been included as one of the key populations at higher risk of HIV in the prevention strategy of NSPs in each of the six focus countries, although the level of prioritisation varies significantly between countries. Commitments to MSM programming in NSPs have generally not resulted in a significant level of scaling-up. MSM are generally accorded a lower priority than the other key populations at higher risk of HIV (IDUs, FSWs and their clients). National responses to HIV need to effectively respond to all key populations to bring HIV epidemics under control.
4. The limited HIV and MSM response by NAPs appears to be primarily related to the overall capacity of NAPs and their sub-national structures to provide effective coordination (although this is variable), donor coordination of programs in parallel to government, and the level of priority accorded to MSM programming in relation to other priorities.
5. Funding and coverage levels for MSM prevention programs are low and insufficient to halt HIV epidemics in this population.
6. Reviews and evaluations of MSM programs are uncommon. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement.
7. Technical assistance to NGOs/CBOs has primarily been oriented around delivery of a package of behaviour change interventions, with generally no or limited support for community development and mobilisation approaches.

8. Regional activities have contributed significantly to raising awareness of the need for a scaled-up response and in providing leadership and strategic direction.
9. The key priority needs for more effective national responses to HIV epidemics among MSM are:
 - the development of nationally owned, MSM specific National Strategic Frameworks and costed Operational Plans on HIV, AIDS and Sexual Health;
 - effective, nationally led, partnership coordination mechanisms;
 - improved strategic information in relation to population size estimation and social and behavioural research to guide priorities and program development;
 - concrete actions to reduce stigma and discrimination;
 - agreement between key partners on a comprehensive approach;
 - increasing the coverage and intensity of prevention programs and broadening the range of prevention interventions;
 - strengthening the contribution of community development and mobilisation to prevention programs;
 - developing new strategies for increasing MSM utilisation of STI and VCT clinics;
 - ensuring MSM have good access to stigma-free HIV care and treatment services; and
 - addressing capacity development and organisational development needs, especially in relation to the Global Fund.

1. Introduction

1.1 Australia's new international development strategy for HIV

In April 2009 the Australian Government launched its new international development strategy for HIV, *Intensifying the response, halting the spread*. The goal of the strategy is to make a significant and sustained effort to achieve the Millennium Development Goal target of halting and beginning to reverse the spread of HIV and AIDS by 2015 by assisting partner countries to achieve universal access to HIV prevention, treatment, care and support.

Australia's development assistance will support partner countries to focus on six priorities: intensifying HIV prevention, optimising the role of health services within HIV responses, strengthening coordination and capacity to scale up HIV responses, reviewing legal and policy frameworks to enable effective responses to HIV, building the evidence base for an effective HIV response, and demonstrating and fostering leadership on HIV.

Australia will support partner countries to intensify HIV prevention through increased and better targeted HIV prevention activities. Australia has chosen to be selective in the areas it will support within its six priority areas. In Asia, for prevention, populations at higher risk will be the centre of attention, with a specific focus on the needs of two key populations – injecting drug users and men who have sex with men (MSM).¹ In Papua New Guinea (PNG), Pacific island countries and the Indonesian provinces of Papua and West Papua, the populations at higher risk are less defined than in the rest of the Asia Pacific region. This requires a broader approach and Australia's prevention focus will target behaviours and settings where HIV transmission is most likely to occur, addressing factors such as concurrent sex partners, sex work, men who have sex with men, mobility and gender inequalities.

The significantly increased focus on MSM in the new strategy is in response to the understanding that MSM are emerging as the key population group where new HIV infections are accelerating most rapidly in Asia.² (See Section 2 for additional information on epidemiology.) Australia's new strategy endorses the conclusion of UNAIDS that success in addressing HIV transmission in this population will have a direct and significant impact on the size of national epidemics and the cost of responses.³ The strategy indicates the need for comprehensive, user-friendly and accessible prevention services for MSM.

Consistent with the overall orientation of Australia's aid program, the new Strategy underlines the importance of supporting inclusive country led and managed responses and of donors prioritising support within an agreed division of labour to ensure a harmonised approach, in line with the Accra Agenda for Action (AAA).

The primary focus on MSM in *Intensifying the response* is within the area of HIV prevention. Each of the other five priorities also have direct relevance to possible AusAID support for MSM programs, as illustrated in Table 1 below.

¹ AusAID, *Intensifying the response: Halting the spread of HIV*. 2009. p.2.

² *Ibid.*, p. 7 and *Redefining AIDS in Asia: Creating an Effective Response*. Report of the Commission on AIDS in Asia. 2008.

³ AusAID, *Intensifying the response: Halting the spread of HIV*. 2009. p.2 and UNAIDS, *Men who have Sex with Men. The Missing Piece in National Responses to AIDS in Asia and the Pacific*. 2007.

Table 1: Examples of the relevance other *Intensifying the response* priority areas to MSM

Intensifying the response: priority areas	Examples of relevance to MSM programs
Optimising the role of health services within HIV responses	<ul style="list-style-type: none"> - High STI prevalence among men who have sex with men with low utilisation of STI services - Low uptake of VCT – most MSM with HIV do not their status
Strengthening coordination and capacity to scale up HIV responses	<ul style="list-style-type: none"> - Strengthening the commitment and capacity of governments to effectively manage and coordinate an effective response for MSM - Mobilising funds, including through the Global Fund, to enable a scaled-up response - Effective coordination with a wide range of stakeholders to achieve harmonisation
Reviewing legal and policy frameworks to enable effective responses to HIV	<ul style="list-style-type: none"> - Anti-sodomy laws still exist in some countries - No legal protections against discrimination
Building the evidence base for an effective HIV response	<ul style="list-style-type: none"> - Insufficient strategic information available to guide program development
Demonstrating and fostering leadership on HIV	<ul style="list-style-type: none"> - Increased leadership from National AIDS Programs - Advocating for intensifying prevention for key populations at higher risk - Supporting communities to take a leadership role

1.2 Terms of reference

In response to the Australian Government’s commitment to expand its support for work addressing HIV among MSM, AusAID’s Health and HIV Thematic Group (HHTG) commissioned this scoping exercise to:

1. Review and analyse national strategic plans and other policy documents against a comprehensive approach to MSM.
2. Map and review current activities by AusAID and key partners, including coverage, quality and resourcing.
3. Identify gaps in current and planned interventions (geographic, programmatic and efficacy).
4. Identify opportunities for AusAID to maximise its support for HIV programs for MSM through multilateral, bilateral and non-government channels.

The focus countries for the scoping exercise were Burma, Cambodia, Indonesia, PNG, the Philippines and Vietnam. Potential AusAID support for regional level work was also within scope.

Key considerations that have guided the scoping exercise have been:

- The need to build on and complement current and planned interventions.
- For AusAID’s support to be informed by emerging international best practice.
- To work through partner government systems where possible, in partnership with the United Nations and harmonised with other development partners, in line with the Paris Declaration and the AAA.
- To maximise the involvement of men who have sex with men in program design and delivery.

This scoping exercise will be used by AusAID to inform decisions on how it will support programs for MSM. AusAID is also undertaking similar scoping exercises in the areas of greater involvement of people living with HIV, and legal and policy enabling environments. While these other scoping exercises have a broader focus, both have relevance to programming for MSM. The complete terms of reference for this scoping exercise are in Annex 5.

1.3 Methodology

A full description of the methodology is in Annex 6. The key steps in undertaking the scoping exercise were:

1.3.1 Document review

Documents reviewed included national strategic plans, other national policy and programmatic documents, epidemiological data, project and program data and documentation (including coverage, descriptions of existing activities, evaluations and reviews), regional mappings and reviews, and peer review literature. The key focus of the document review was to identify information on the epidemiology of HIV and STIs, existing strategic and policy frameworks, existing and planned HIV and MSM services, including types of services, coverage, quality, lessons learned and financing, information on the efficacy of services, and the range of services that constitute a comprehensive approach. A reference list is at Annex 7.

1.3.2 Mapping

Information for mapping was obtained from the document review and key informant interviews. The purpose of the mapping was to identify current activities of AusAID and others in addressing HIV epidemics among MSM in order to identify gaps (geographic, programmatic and efficacy) in existing work when compared to a comprehensive approach.

1.3.3 Key informant interviews

Interviews were conducted with partner governments, AusAID staff, multilateral and bilateral organisations, regional networks, technical assistance agencies, implementing agencies, including community based organisations (CBOs) formed by MSM, and Australian experts. Interviews were conducted with stakeholders in the six focus countries and at the regional level. A list of key informants is in Annex 8. Interviews had a strong focus on addressing the analytical aspects of this work in areas such as the extent of government commitment, the enabling environment, the role of government in coordinating MSM programs, quality, efficacy, key gaps, and strategic priorities.

1.3.4 Analysis

Following completion of the document review and key informant interviews an analysis of all information was undertaken to develop key findings and recommendations.

1.4 Terminology

The term ‘men who have sex with men’ is used only as a behavioural term, recognising that there is a great deal of diversity among this population and that many men who engage in male-to-male sex have no level of identity around this sexual practice, seeing themselves as normative males. It is recognised that some men in Asia and the Pacific have started to use the term MSM to describe a personal identity with male-to-male sex. This means that the term MSM has taken on a dual and conflicting meaning: on the one hand behavioural and on the other hand a term to describe sexual identity. For ease of reference the acronym MSM has been used in this report but is used only as a behavioural term which does not assume an identity. A description of the meaning of the term ‘MSM’, as used in this report, is in the glossary on page iii.

2. The epidemiological context

2.1 Surveillance systems

MSM have been included in national HIV surveillance systems in most countries. This usually takes the form of integrated biological and behavioural surveillance (IBBS) surveys (Burma, Cambodia, Indonesia, Philippines and Vietnam). In Vietnam, MSM have not been included in the national annual sentinel surveillance. USAID, through FHI, or in some countries CDC GAP, have provided funding and technical assistance for IBBS surveys. IBBS is supplemented with passive case surveillance in some countries. PNG has not conducted any IBBS surveys but includes MSM in passive case surveillance.

2.2 Regional overview

In recent years a picture of significant HIV epidemics among MSM have emerged from cross-sectional surveillance studies in a number of countries. Data on HIV prevalence rates in the six countries within the scope of this work is presented in Table 2. HIV prevalence rates among MSM identified by these studies include: Yangon 28.8 percent (2008), Phnom Penh 8.7 percent (2005), Hanoi 9.4 percent (2006), Ho Chi Minh City 5.3 percent (2006), and Jakarta 8.1 percent (2007).⁴ In the Philippines, HIV prevalence among MSM is very low at 0.3 percent, however, there has been a significant increase in reported cases of HIV and AIDS among MSM from 2005 to 2008, albeit from a low base. This may indicate the start of a significant HIV epidemic among MSM. Meaningful epidemiological data for MSM is not available in PNG. An IBBS has not been conducted and mode of transmission is not reported in 87 percent of case reports.⁵ Annex 1 provides a summary of HIV and STI epidemiological and behavioural data for MSM in each of the six countries.

Table 2: HIV prevalence among MSM in the six focus countries⁶

Country	HIV prevalence All MSM (%)	HIV prevalence male identified MSM (%)	HIV prevalence transgenders (%)
Burma - 2008	28.8	-	-
Cambodia - 2005	-	2.6	9.8
Indonesia - 2007*	-	2 – 8	14 - 34
PNG	Not available	-	-
Philippines - 2007	0.3	-	-
Vietnam - 2006*	5 - 9	-	-

* HIV prevalence varied by site and aggregated data is not available

STI prevalence rates are generally significantly above HIV prevalence rates, ranging from 7 to 55 percent in Burma, Cambodia, Indonesia and Vietnam. There is solid evidence of high rates of risk behaviours in all six focus countries. The behavioural data shows high numbers of casual male sex partners. For example, in Cambodia the number of MSM with two or more male partners in the last month ranged between survey sites from 63 to 74 percent. Consistent condom use with casual male partners in the last month is variable but generally low, ranging from 23 to 55 percent in Cambodia, 29 to 37 percent in Vietnam, 13 to 26 percent for receptive anal intercourse in Indonesia and 45 percent for last sexual intercourse in the Philippines. A common finding of all IBBS surveys is that many MSM have a high number of casual female sex partners, but below the number of male partners. In Vietnam 40 percent of MSM had a female partner in the last year and in Cambodia 80 to 87 percent of MSM had more than 2 female partners in the past year. Consistent condom use with female partners is

⁴ van Griensven F, Epidemiology of HIV Infection among Men who have Sex with Men in Asia and the Pacific: the Gathering Storm. Presentation to the Regional Consultation on Health Sector Response to HIV/AIDS among MSM, Hong Kong, 2009.

⁵ National Department of Health, The 2007 HIV, STI and AIDS Annual Surveillance Report.

⁶ Drawn from IBBS surveys in each country. References are provided in Annex 1: Epidemiology – country summaries

comparable to rates for male partners, with a high potential for HIV transmission. Behavioural data is not currently available for Burma or PNG. (See Annex 1 for additional data.)

Where cross-sectional studies are conducted infrequently or change their sampling methodology, it is difficult to keep a track on trends and make comparisons between surveys. However, where cross-sectional studies have been repeated using the same methodology they have shown the potential for HIV epidemics among MSM to increase rapidly, sometimes to hyper epidemic levels. For example, in Indonesia, HIV prevalence among male identified MSM in Jakarta increased four-fold from 2 to 8 percent between 2003 and 2007.⁷ HIV prevalence among MSM in Bangkok increased from 17 percent in 2003, to 28 percent in 2005, and then to 31 percent in 2007.⁸ It is estimated that in 2005, MSM accounted for 30.3 percent of the total adult HIV prevalence in Bangkok (which was 1.4%).⁹

There is a paucity of HIV incidence studies among MSM in the region. Incidence data is particularly valuable for guiding prevention programs as it can indicate those sub-populations of MSM most at risk. For example, cumulative HIV incidence over 960 days in a cohort of 1,002 Bangkok MSM was 20.8% for MSM aged 15-22 compared to 16.3% for those aged 23-29 and 9.3% for those aged 29-56.¹⁰ This clearly indicates that, at least in Bangkok, young MSM are at particularly high risk. Unpublished data from a CARE Myanmar survey of MSM in project townships found that condom use at first sex ranged between 5-15%.¹¹

HIV prevalence among transgenders is usually higher than among male identified MSM, although this is not always the case. While this should inform prevention priorities, the size of transgender populations is considerably smaller than the number of male identified MSM.

Among MSM, elevated risk for HIV infection is due to network effects.¹² Any sexual network, in which people have multiple and concurrent sex partners, is especially conducive to the spread of HIV. In Asia, the odds of MSM having HIV infection is 18.7 times that of someone in the general population.¹³ The Asian Epidemic Model projects that unless effective prevention measures are intensified, by 2020 around 46 percent of new infections in Asia will be among MSM, up from 13 percent in 2008.¹⁴

Key finding

1. HIV and STI epidemics among MSM in Asia are being driven by high numbers of concurrent male and female sex partners and low rates of consistent condom use. Cross-sectional studies repeated over time have shown the potential for HIV epidemics among MSM to increase rapidly and in some places to hyper epidemic levels. Unless effective prevention measures are intensified it is estimated that by 2020 around 46 percent of new infections in Asia will be among MSM, up from 13 percent in 2008.

⁷ Indonesia National AIDS Commission, Integrated Biological and Behavioural Surveillance among Most at Risk Group in Indonesia, 2003 and 2007.

⁸ van Griensven, *ibid*.

⁹ Tim Brown, personal communication, 2007.

¹⁰ van Griensven F, HIV VCT and Bangkok MSM Cohort Study at the Silom Community Clinic.

¹¹ Sally Moore, personal communication, April 2009.

¹² Garnett GP, Ghani AC; The use of simulation models in exploring the influence of network structures on the epidemiology of sexually transmitted diseases. Washington, 2002.

¹³ Beral, S et al, PLOS 2007; 4:e339.

¹⁴ Redefining AIDS in Asia. Crafting an Effective Response. Report of the Commission on AIDS in Asia. 2008.

3. What constitutes a comprehensive approach?

This section defines a comprehensive approach in addressing the HIV and sexual health needs of MSM. Defining a comprehensive approach makes it possible to identify gaps in current responses to HIV and STI epidemics among MSM and provides a basis for AusAID to determine opportunities to address these gaps.

Figure 1 provides a diagrammatic representation of a comprehensive package of HIV and sexual health interventions and services for MSM in the context of a national strategic framework.¹⁵ Two broad categories of interventions and services are outlined:

- **Enabling environment and supportive interventions:** are the foundational activities which either create an enabling environment to facilitate the implementation of the prevention and care package, or supportive interventions needed for the effective operation of the prevention and care package. Enabling environment interventions are stigma and discrimination programs, policy and legal frameworks, advocacy, community development and mobilisation, relations with gatekeepers and structural interventions. (A definition of structural interventions is provided in the Glossary). Supportive interventions are strategic information, capacity building and organisational development.
- **Prevention and care package:** a comprehensive prevention and care package consists of peer and outreach education, providing the means of prevention (condoms, lubricant and sterile needles and syringes), social marketing (mass and targeted media, internet, social networking), HIV counselling and testing, STI treatment, male sexual health programs, drop-in-centres, and effective linkages with HIV care, support and treatment services.

A comprehensive approach is needed to maximise the effectiveness of the prevention and care package. For example, if no effort is made to minimise stigma and discrimination, this will provide a significant hurdle for the effective implementation of the prevention and care package. Current MSM programming in Asia and the Pacific places a greater emphasis on delivering prevention services and a lesser emphasis on creating an enabling environment, some supportive interventions (e.g. capacity building and organisational development) and care and treatment services. (See Sections 4 and 5 for more details).

While the elements of Figure 1 have many similarities to USAID's comprehensive package of services targeting MSM, it places a stronger emphasis on the enabling environment and supportive interventions. Additional components in Figure 1 compared to the USAID package are advocacy, the legal framework, relations with gatekeepers, structural interventions and organisational development. Additional elements in the prevention and care package are male sexual health programs, a stronger emphasis on social marketing, and needles and syringes.

Annex 4, Evidence for effective HIV prevention programming, provides a summary of the key elements of effective prevention programs that have informed the development of Figure 1.

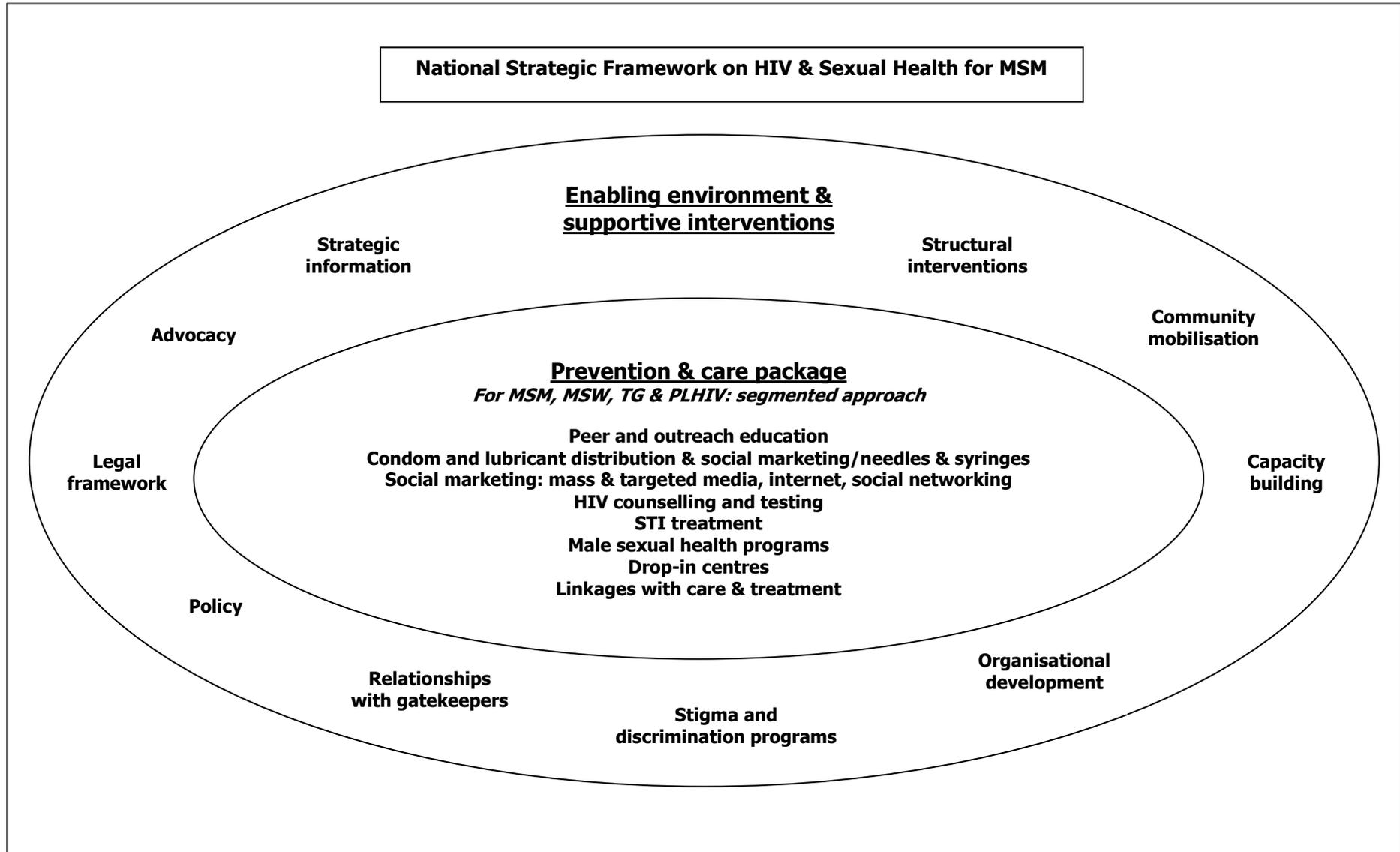
Key finding

2. A comprehensive approach to HIV and sexual health among MSM includes foundational activities to create an enabling environment, supportive interventions needed for the effective operation of

¹⁵ This diagram was developed for this scoping exercise with input from Felicity Young from the Research Triangle Institute and Paul Causey from Asia Pacific Coalition on Male Sexual Health (APCOM).

the prevention and care package (e.g. capacity building), and a complete prevention and care package. Current MSM programming in Asia and the Pacific place a greater emphasis on delivering prevention services and a lesser emphasis on creating an enabling environment, some supportive interventions, and treatment and care.

Figure 1: Comprehensive package of HIV & sexual health interventions and services for MSM in the context of a National Strategic Framework



4. Overview of the current response in Asia and the Pacific

This section provides an overview of the current response to HIV epidemics among MSM in the six focus countries and at the regional level. Mapping of the response in each country and at the regional level is in Annex 2.

4.1 Strategic and policy frameworks

MSM have now been included as one of the key populations at higher risk of HIV in the prevention components of the HIV National Strategic Plans (NSPs) in each of the six focus countries.¹⁶ The NSPs are broad statements of strategic intent and do not explicitly rank key populations in priority order. MSM are also included in NSP Operational Plans or Action Plans. With the exception of Burma, which has a more detailed plan, these plans provide a broad level overview of how to operationalise NSPs through indicative key activities. None of these plans, including the Burma Operational Plan, provide a high level of operational detail nor a delineation of the roles of different partners to facilitate scale-up of the MSM response.

The Cambodian National AIDS Authority (NAA) is the only National AIDS Program (NAP) that has developed a MSM-specific National Strategic Framework and Operational Plan on HIV, AIDS and STI for MSM (2008-2011). The Framework contains five strategies, key objectives, expected results, and coordination mechanisms. The costed Operational Plan details activities for each of the five strategies, including outputs, targets, implementing agencies and timeframes. The plan is aligned with the NSP, the Global Fund grant and other donor funded activities. Indonesia is planning to develop a MSM specific National Strategic Framework and costed Operational Plan in the latter half of 2009.

4.2 NAP leadership and coordination

Effective NAP leadership and coordination of the response to HIV and MSM needs considerable strengthening. However, in Cambodia the Secretary General of the NAA has showed strong personal leadership and a NAA MSM TWG has been established which brings all partners together for the purposes of strategic leadership and coordination. However, the effectiveness of the TWG's and NAA's coordination efforts needs considerable strengthening. Similarly, in Indonesia the Secretary of the National AIDS Commission (NAC) has demonstrated strong personal leadership on MSM and the NAC has established a MSM working group. Efforts are needed to strengthen the functioning of the working group and the NAC's coordination. A MSM TWG has been established in Vietnam with UNAIDS support. While the government participates, the TWG appears to be development partner driven. NAP involvement in leading and coordinating MSM programming in Burma, the Philippines and Vietnam is at a low level and is largely non-existent in PNG. The view of key informants was that the effectiveness of provincial level HIV coordination mechanisms in all countries is variable but generally weak in respect to MSM programming.

The generally low level of NAP leadership and coordination reflects the fact that historically the MSM response has been donor driven, primarily by USAID. Coordination has largely bypassed government systems, with USAID funded technical assistance agencies managing a program of activities with civil society implementing partners. In some cases this occurred because NAPs denied the existence of male-to-male sexual activity or accorded a low priority to MSM. The level of engagement by USAID funded agencies with governments appears to have increased somewhat in recent years because of the emphasis on the 'Three Ones' and as NAPs have started to give at least some level of priority to MSM.

¹⁶ MSM are not included in the Vietnam NSP but have been included in a number of more recent Action Plans.

The limited effective coordination of an HIV and MSM response by NAPs appears to be primarily related to the overall capacity of NAPs to provide effective coordination, donor coordination of programs in parallel to government, and the level of priority accorded to MSM programming in relation to other priorities.

4.3 Priority accorded to MSM by NAPs

Although MSM are now accorded higher priority in NSPs than was previously the case, in light of epidemiological data and the projections of the Commission on AIDS in Asia, the priority accorded to MSM in national HIV responses is generally insufficient. An assessment of the level of priority currently accorded to HIV and MSM in the six focus countries has been developed, based on the views of key informants, document review and the extent of MSM program implementation. The assessment is related only to the response of NAPs and does not take account of donor programs.

Burma: MSM are now attracting higher priority from the NAP in response to epidemiological data. MSM are ranked in the NAP Operational Plan as the second highest priority population after sex workers and their clients. Burma is the only country which has a clear priority ranking for key populations. However, more active engagement by the NAP in leadership and coordination is needed.

Cambodia: While there is no clear differentiation of the priority accorded to MSM relative to other key populations, operationally sex workers and their clients are the highest priority, with MSM being accorded a high priority. The NAA has taken on a leadership role, although its capacity in coordination needs to be significantly strengthened.

Indonesia: Implementation of the NSP clearly indicates injecting drug users (IDU) are the number one priority, followed by sex workers and their clients. MSM appear to be the third priority for prevention work. MSM have started to attract a higher level of priority from government, including a commitment to develop a National MSM Strategic Framework and costed Operational Plan. The capacity of the NAP in coordinating a scaled-up response to HIV and MSM needs strengthening.

PNG: There is a lack of recognition that male-to-male sex occurs in PNG and this has been reflected in a lack of real commitment by the National AIDS Council Secretariat (NACS) to MSM programming and coordination.

The Philippines: The NSP Mid-Term Review and interviews indicate that MSM are now regarded as the highest priority group for prevention work. However, this has not as yet been reflected in an enhanced response. This may reflect funding and capacity limitations for the Philippines National AIDS Council.

Vietnam: Current implementation of the NSP clearly indicates IDUs are the number one priority, followed by female sex workers (FSW) and their clients. MSM appear to be the third priority for prevention work. However, the NAP has not been active in addressing MSM.

4.4 Strategic information

Systems for HIV & STI biological and behavioural surveillance for MSM in each country are briefly outlined in Section 2 on epidemiology and Annex 2 on mapping. The situation for other areas of strategic information is as follows:

- **MSM population size estimations** have been developed in Cambodia, Burma, Indonesia and the Philippines, based on between 2-4 percent of adult males having sex with another male in the last year. Estimates were informed by south east Asian data in an international meta-analysis of studies on lifetime prevalence of sex among males.¹⁷ External technical assistance has largely driven development of these estimates and the level of NAP ownership appears to be low or at best variable, with estimates often perceived by governments as being too high. The estimates are set out in Annex 2: Mapping.
- **Social and behavioural research** on MSM related to HIV and sexual health is limited to very limited in all of the six countries. This is particularly the case in Burma, PNG, the Philippines and Vietnam.
- **M & E:** MSM-specific indicators have been included in national monitoring and evaluation frameworks in all countries, with the exceptions of PNG and Vietnam. It was not possible within the limitations of a broad-ranging scoping exercise to make an assessment of the utility of these frameworks in providing useful data.

4.5 Legal frameworks

Sodomy remains a criminal offence in Burma and PNG. This contributes directly to the stigma associated with male-to-male sex, drives MSM underground making it more difficult for prevention programs to reach them, and provides a legal basis for police harassment of MSM. Repeal of these laws is central to creation of an enabling environment. Despite high levels of stigma and discrimination, none of the countries provides any legal protection for the human rights of MSM. Some HIV-specific legislation, where it exists, provides PLHIV with protection against discrimination.

4.6 Funding

No NAP has budgeted MSM-specific funding, although NAP general budgets support coordination, surveillance and monitoring evaluation of MSM programs, to the extent that these functions are carried out.

It was not possible to meaningfully estimate the amount of funding being spent on MSM programs by country as grants are often allocated as part of larger blocks without an MSM specific component and a number of projects are targeting multiple groups, not just MSM. Funding estimates, where available, are included in the mapping in Annex 2, but do not give a complete picture. However, sufficient information is available to identify which donors contribute the most funds for MSM programs in each country and this information is presented in Table 3.

Table 3: Significant donors for HIV & MSM by country

Country	USAID	Global Fund	3DF	AusAID	ADB
Burma	X		X	X (3DF)	
Cambodia	X	X		X	
Indonesia	X	X		X	
Philippines		X		X	
PNG	X			X	X
Vietnam	X				

X = the donor who is contributing most funding to MSM programs in a particular country. There is insufficient information to identify who is the major donor in Burma.

- **USAID:** is the major donor for MSM programming in Cambodia, Indonesia and Vietnam and funds one small MSM project in PNG.

¹⁷ Caceres, C, et. al. Estimating the number of men who have sex with men in low and middle income countries. *Sex. Transm. Inf.*2006;82;3-9.

- **Global Fund:** Although the Global Fund has made specific calls to include MSM interventions in proposals, to date the amount of Global Fund monies allocated to MSM programming in the six focus countries is generally either small or non-existent. Cambodia is the primary exception with its round 7 US\$6 million grant for MSM. MSM are a reasonably small component of the Philippines rounds 3 and 5 grants, which will end in 2009 and 2010. MSM make up a fairly small component of the Indonesian round 8 grant and will also be included at a similar level in the round 9 proposal. There is no MSM component in existing Global Fund grants for PNG and Vietnam. MSM activities make up 6 percent of the budget in Burma's Global Fund round 9 proposal. MSM may be included in Vietnam's and PNG's round 9 proposals but only as small components.
- **Three Diseases Fund (3DF):** as it is not possible to disaggregate the MSM component of 3DF funding, it is not possible to make a definitive finding on whether USAID or the 3DF contributes most money to MSM programs.
- **AusAID:** In PNG, AusAID provides the greatest level of funding for MSM work, but at quite low levels. AusAID is also the major donor for the ADB PNG economic enclaves and condom social marketing projects which have some reach to MSM within a broad male sexual health approach. AusAID is one of the donors supporting the 3DF in Burma. In Indonesia, the bilateral program is funding one small MSM project in Bali and AFAO, with AusAID Consortium funding, is helping with capacity development of GWL-INA, the national MSM and transgender network. AusAID is funding technical assistance for the development of the NAC MSM Strategic Framework and Operational Plan. In the Philippines, AusAID funded UNICEF and UNFPA programs reach some MSM as part of broader target groups. In Cambodia, the HAARP program will have an MSM component.

Additional information on funding of MSM programs is set out in Annex 2: Mapping.

USAID expects the level of regional funding for MSM work, which supports programs in Burma and PNG, to be maintained. If additional United States Government (USG) regional HIV funds become available, MSM will be a priority. In Indonesia and Vietnam country level USG funds for MSM were seen as flat-lined, with a possible minor reduction in Indonesia. No information was available on future USG MSM funding levels in Cambodia.

4.7 Types of interventions

The core package of prevention services provided in each country consists of behaviour change oriented peer and outreach education, IEC materials, condom & lubricant distribution and social marketing, drop-in-centres (DIC), and referral to STI, VCT and HIV care and treatment services. Mobile STI and VCT services are provided in some DICs in some countries. In Burma, PSI provides STI clinics as a core service component in most of its DICs, with VCT and care and support in a smaller number of centres. Prevention services are focussed on HIV, but also includes STIs and to a lesser and variable extent a broader, non-disease focussed, male sexual health approach. A broader male sexual health approach to reach MSM who have no identity related to their sexual practice is implemented by Burnet in Burma and the ADB enclaves project in PNG as part of broadly targeted non-MSM specific programs. The emphasis of most projects is on sexual transmission, with little integration of injecting and other drug-related risks. In recent years, Family Health International (FHI) programs in Cambodia, Indonesia and Vietnam have developed social marketing approaches using targeted media and HIV/sexual health MSM internet sites, linked to branded DICs and social events, incorporating messaging around community identity.

The role of MSM CBOs in promoting a more open attitude to male-to-male sex has largely gone unrecognised. In many countries these CBOs were the first MSM organisations to be established and in all countries they have significantly expanded MSM-self organisation and visibility. They have demonstrated that some level of openness regarding sexuality/sexual practice is possible. This has occurred in parallel with cultural and economic globalisation and economic growth which has contributed to often rapid growth of communities of men who have some type of identity around their sexual preferences, especially in urban areas.

While the nature of community for MSM in Asia and the Pacific is different to western countries, especially as many men have no or limited identity related to male-to-male sex, many MSM CBOs have successfully adapted community development and mobilisation approaches. With changing social attitudes this approach is becoming easier. Community engagement with HIV and sexual health enables the establishment of norms around safe sex behaviour. To the extent that sexual networks between MSM with some level of sexuality identity overlap with MSM with a normative male identity, the reach of community norms through informal peer education is extended. (There is, however, currently insufficient information available on the nature of sexual networks.) While many CBOs have taken the opportunity to develop a community development and mobilisation approach, this has usually been without technical support from funding agencies, which have seen the role of CBOs as delivering a package of behaviour change interventions from a service delivery perspective.

Structural interventions such as access to entertainment establishments and sex on premises venues for education and ensuring condom availability have been implemented in some countries, but not others. Advocacy appears to be mainly confined to building relations with local level gatekeepers to enable program delivery.

There is a remarkable absence of activities that are specifically devoted to reducing stigma and discrimination against MSM. Stigma and discrimination undermines the enabling environment for the operation of HIV and MSM programs in multifaceted ways. These include making it difficult to reach hidden MSM, the effect of self-stigma on health protective behaviour, an unwillingness by most MSM to access STI, VCT and HIV treatment services for fear of discrimination, embarrassment with purchasing condoms, hostility towards MSM programs from officials such as police, and the belief by NAPs that the number of MSM is small, based on visibility and cultural norms.

The predominant focus of HIV and MSM work is on prevention for negative MSM, with insufficient emphasis on positive prevention. Also, expenditure on care, treatment and support is low, with positive MSM being referred to mainstream HIV care, support and treatment services. Transgender and effeminate MSM (i.e. those who are readily identifiable as MSM) may have lesser access to care and treatment services because of discriminatory staff attitudes or client perceptions that this will be the case. A summary of the main types of interventions implemented by the key partners in each country is in Annex 2: Mapping.

4.8 Implementing partners

Most aspects of prevention programs in most countries are delivered by NGOs and CBOs. This applies to peer and outreach education, condom & lubricant distribution, IEC materials, and drop-in-centres (DIC). Implementing partners for these type of interventions vary by donor and country as follows:

- **USAID:** funds technical assistance agencies (FHI in Cambodia, Indonesia, and PNG, plus KHANA in Cambodia and PSI in Burma) who make sub-grants to NGOs/CBOs for project implementation, except in Vietnam where FHI channels funds through Provincial AIDS Committees which in turn employ MSM to undertake prevention work.
- **Global Fund:** in Cambodia, sub-recipient grants are made to FHI and KHANA who then make sub-grants to NGOs/CBOs already working with MSM. In the Philippines, sub-grants are made to a range of NGOs. The Indonesian Planned Parenthood Association will be the principal recipient for all peer and outreach work, with no sub-recipients. Implementation arrangements beyond this are not clear.
- **3DF:** funded programs in Burma are mostly delivered directly through INGOs, working in collaboration with MSM self-help groups, which generally have no legal status.
- **AusAID:** in Indonesia the HCPI funds a MSM CBO in Bali and in PNG funds an INGO for direct implementation.

Where CBOs are the implementing agencies, prevention programs are usually implemented by MSM CBOs, although mainstream NGOs (i.e. non-MSM) are used to a limited extent in Cambodia and

extensively in the Philippines. Where mainstream NGOs do not use peers for outreach education there are reports of difficulty in establishing rapport with the target group.

For other areas of prevention, the key implementers are as follows:

- **Social marketing:** through targeted media and development of internet sites has been undertaken by advertising agencies and new media companies, contracted by FHI in Cambodia, Indonesia and Vietnam.
- **Condom social marketing:** is implemented by INGOs specialising in this field (primarily PSI, with DKT in some countries), working in collaboration with local NGO/CBOs and primarily funded by USAID.
- **STI and VCT clinics:** government STI and VCT clinics are the predominant service providers to MSM in most countries. INGOs also run clinics for vulnerable populations. In Burma this is the major mode of service delivery, but in other countries there is only a small number of specialist INGO STI & VCT clinics. INGO specialist clinics often play a role in training and desensitising staff in government clinics.

UNAIDS country offices along with some other UN agencies (variable by country) have taken a leading role in promoting the need for national responses to be correlated with the concentrated nature of Asian HIV epidemics and in advocating for increased priority for MSM programs. Primary areas of input have been advocacy in reviewing and formulating NSPs, Global Fund proposals, and technical assistance in strategic framework, program development and indicators for monitoring and evaluation frameworks.

4.9 Quality

Program monitoring for NGO/CBO prevention work is primarily achieved through reporting against output oriented indicators including coverage and activities implemented, field visits by funding agencies, and financial reporting. Quality is not formally measured except through reviews and evaluations, which are uncommon. IBBS data may give some indication of the impact of interventions on behaviour and HIV and STI prevalence, although this is limited due to changes in sampling methodology which makes comparisons with earlier surveys invalid and problems with the quality of sampling. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement. Annex 4 provides a summary of evidence on effective HIV prevention programming.

4.10 Coverage

The types of MSM reached by prevention programs ranges from gay, MSM with some level of personal identity around their sexual practice, MSM with no level of sexual identity related to male-to-male sex, transgenders and male sex workers (MSWs). Available coverage data does not distinguish between sub-groups of MSM, except for Indonesia where coverage of MSM and transgenders is separately reported. The proportion of the TG population reached by programs is generally higher than for other MSM because the number of TGs is considerably smaller, they are more identifiable and have often created their own communities. A number of CBOs also largely cater to transgenders. Where, for example, DIC participants are predominantly transgenders, many other MSM will choose not to participate. MSW specific programs do not exist in any of the six countries. Given the limitations of coverage data it is not possible to determine the extent to which MSWs are reached. Coverage data does not indicate the intensity of coverage (e.g. repeat contact or exposure to multiple interventions).

Coverage by existing programs is largely limited to those who can be reached by peer and outreach education and those who attend DICs and social events. Current programs are primarily reaching more visible MSM, with limited reach to 'hidden' MSM, although coverage of visible MSM is not at

sufficient levels. A consistent finding of the mapping was that current programs are largely reaching lower class MSM, with little penetration into middle and higher class MSM networks.

Table 4 presents coverage levels for HIV prevention programs based on either data or estimates provided by the main implementing NGO/CBOs/TA agencies in each of the six countries. Caution is needed in interpreting the data due to different means of measuring coverage, possible double-counting and the lack of any means of measuring intensity of contact. The use of internet sites has increased coverage in some countries and may give an impression of greater intensity of coverage than is the case. It is clear that coverage levels are well below the level at which any impact will be made on HIV epidemics among MSM, especially when compared to estimates of the total MSM population.

Table 4: Estimated current coverage of prevention programs by country

Country	Estimated current coverage *	Estimated MSM population	Coverage (%)
Burma	83,000	272,000	30.5
Cambodia	15,700	140,000	11.2
Indonesia	332,920	1,148,000	29
Philippines	24,568	610,000	4
PNG	7,500	No estimate	-
Vietnam	24,000	No estimate	-

* Only includes main implementing partners for MSM-specific programs. Excludes Global Fund projects which have recently commenced/not yet commenced in Cambodia and Indonesia

Data from all countries consistently indicates that utilisation by MSM of STI and VCT services is low. For example, in Cambodia, while NGO/CBOs prevention services reached an estimated 15,700 MSM in 2008, only 3,400 MSM, or 21.6% of those reached by other elements of prevention programs, attended either a government or NGO STI clinic in the same year.¹⁸ IBBS data indicates that having an STI check-up in the last 3 months ranged between sites from 18 to 86 percent in Indonesia (significantly higher for transgenders) and from 18 to 68 percent in Vietnam. HIV testing rates were similarly variable but overall low. In Cambodia 68 to 75 percent of MSM had been tested at least once for HIV but in Vietnam the range was from 15 to 16 percent. Having an HIV test in the last year ranged from 22 to 86 percent in Indonesia (higher for transgenders), and in the Philippines 16 percent of MSM had been HIV tested in the past year. The primary reasons for the low utilisation of STI services appear to be perceptions by MSM of judgemental attitudes by service providers, poor health seeking behaviours (self-treatment), and a limited understanding of the need for regular STI check-ups. There is no data available from any country on MSM utilisation of HIV care and treatment services.

The geographic coverage of MSM programs is primarily concentrated in capital cities and some principal provincial cities. In all countries, there are large provincial centres with no or very limited MSM programs. Details of the extent of geographic coverage for each country is as follows:

- **Burma:** programs in more than 15 sites.¹⁹
- **Cambodia:** Phnom Penh and 10 provincial cities.
- **Indonesia:** Jakarta and 7 provinces (FHI programs) and 12 Global Fund sites from mid-2009.
- **PNG:** Port Moresby and 3 provincial cities, plus non-MSM specific work in 6 economic enclaves.
- **Philippines:** 21 Global Fund sites (with all funding ceasing by September 2010).
- **Vietnam:** Hanoi and Ho Chi Minh City plus 4 provincial cities.

¹⁸ NCHADS, 2008.

¹⁹ For Burma and Indonesia it is not clear whether programs of different INGOs/NGOs/CBOs are all operating in separate sites or whether there are multiple programs in the one site.

4.11 Regional level response

In the last four years there has been a significant increase in the regional level response to HIV epidemics among MSM by multilaterals, regional level technical assistance agencies and through the formation of a regional coalition and sub-regional networks. The regional response has primarily centred on advocacy for a scaled-up response, development of policy programmatic advice, providing technical assistance to the country level, some training, and promoting networking between governments, multilaterals, donors, and community organisations. Collectively, regional activities have contributed significantly to raising awareness of the need for a scaled-up response and in providing leadership and strategic direction. Mapping of the regional response is in Annex 2.

UNAIDS co-sponsors have been active in according high priority to supporting the development of national responses with a focus on key populations at higher risk for HIV, including MSM, within the context of Asia's concentrated HIV epidemics. While UNAIDS and UNESCO have had identifiable programs of work in HIV and MSM for some years, they have now been joined by UNDP's Asia Regional Centre and WHO WPRO who are now actively engaged. It is anticipated that this will help to significantly strengthen the regional response, with flow-on effects to the country level. The roles and work of each of these UNAIDS agencies is documented in Annex 2: Mapping. To date, other UNAIDS co-sponsors have not played a significant regional level role in the HIV and MSM response.

FHI's Asia Regional Office in Bangkok provides technical assistance to its MSM country programs through the Regional Technical Advisor for Male Sexual Health. FHI's Regional Technical Advisor for Sexual and Reproductive Health provides technical advice to FHI country programs and governments and NGOs on strengthening STI and sexual health components of the MSM response. HPI & Burnet are currently reviewing levels of expenditure for HIV and MSM programs in Mekong countries and estimating resources needed to scale up a comprehensive package to achieve 80 percent coverage, coupled with development of a tool for countries to use for costing the comprehensive package of interventions.

The Asia Pacific Coalition on Male Sexual Health (APCOM) is a coalition of governments, multilaterals, donors, INGOs, national and sub-regional networks and technical experts. The main focus of APCOM's work has been on advocacy for a scaled-up response. While APCOM is primarily community driven, it has managed to bring together a broad coalition of partners and provided a valuable forum for regional level coordination and joint approaches to work. The Australian Federation of AIDS Organisations (AFAO) has provided organisational development support to APCOM (with AusAID funding and from its own funds) and continues to provide strategic advice to the APCOM Secretariat.

The Purple Sky Network is a sub-regional network of six Greater Mekong countries. Like APCOM it has succeeded in bringing together a broad range of partners, especially governments, CBOs, donors and technical assistance agencies. PSN's key achievements relate to raising the regional and country level awareness of the need to respond to HIV epidemics among MSM, sharing of information and lessons learned, and skills development through trainings.

The Pacific Sexual Diversity Network (PSDN) has also been established, fulfilling a similar function to PSN, although it is in a less developed stage. The Australian Federation of AIDS Organisations (AFAO) is currently providing capacity development for PSDN, with AusAID funding. Consideration is being given to establishment of an HIV and MSM sub-regional network for insular south east Asia.

The Asia Pacific Network of People Living with HIV/AIDS (APN+) MSM Working Group has been active in skills building and undertaking regional level studies on treatment access and mapping of services for the purposes of advocacy related to the needs of positive MSM. APN+ and AFAO have entered into a three year capacity development partnership program, with AusAID funding through the HIV Consortium, a component of which will assist APN+'s work with positive MSM.

AFAO has also been engaged in an assessment of the capacity of MSM CBOs in Mekong countries, documentation of lessons learned from scale-up of MSM programs, and a multi-country leadership and advocacy collaboration which includes MSM, but is not MSM specific.

Key findings

3. MSM have now been included as one of the key populations at higher risk of HIV in the prevention strategy of NSPs in each of the six focus countries, although the level of prioritisation varies significantly between countries. Commitments to MSM programming in NSPs have generally not resulted in a significant level of scaling-up. MSM are generally accorded a lower priority than the other key populations at higher risk of HIV (IDUs, FSWs and their clients). National responses to HIV need to effectively respond to all key populations to bring HIV epidemics under control.
4. The limited HIV and MSM response by NAPs appears to be primarily related to the overall capacity of NAPs and their sub-national structures to provide effective coordination (although this is variable), donor coordination of programs in parallel to government, and the level of priority accorded to MSM programming in relation to other priorities.
5. Funding and coverage levels for MSM prevention programs are low and insufficient to halt HIV epidemics in this population.
6. Reviews and evaluations of MSM programs are uncommon. There is insufficient available data to come to conclusions regarding the quality of MSM prevention programs, although most key informants are of the view that there is room for significant improvement.
7. Technical assistance to NGOs/CBOs has primarily been oriented around delivery of a package of behaviour change interventions, with generally no or limited support for community development and mobilisation approaches.
8. Regional activities have contributed significantly to raising awareness of the need for a scaled-up response and in providing leadership and strategic direction.

5. Key gaps and priority needs

This section identifies key gaps and priority needs for HIV, sexual health and HIV programs for MSM, based on an analysis of the current response in Section 4 and in relation to the comprehensive approach outlined in Section 3.

5.1 MSM national strategic frameworks and operational plans

HIV and MSM responses have been largely donor-driven. Now that NAPs are mostly starting to give higher priority to MSM, this is beginning to change, but a strong donor-driven flavour to the response remains. To achieve scale-up, a greater level of government commitment to addressing HIV epidemics among MSM is needed. This will facilitate funds mobilisation, especially through the Global Fund. NAP ownership of HIV and MSM responses is also essential to ensure sustainability.

A key issue is how to translate the commitment to MSM programming in NSPs into a nationally led effort to scale-up programs. What is needed to guide scaling-up is NAP owned, MSM-specific National Strategic Frameworks and Operational Plan on HIV, AIDS and Sexual Health, as has been done in Cambodia and is planned for Indonesia. Costed operational plans need to detail activities for defined strategies, including outputs, targets, implementing agencies, coordination mechanisms and timeframes. Operational Plans for HIV and MSM should identify specific technical assistance needs and how assistance will be mobilised. Operational plans and their coordination mechanisms provide a vehicle for strengthening the partnership between NAPs, NGOs/CBOs, multilaterals, donors, and technical assistance agencies. Costed operational plans can be used to support donor funds mobilisation, including Global Fund proposals, especially as countries in time move towards applying for funding of their national strategies. Considerable advocacy work may be needed in some countries to get sufficient support for the development of frameworks and plans. In PNG it may be more appropriate to incorporate MSM work within a broader male sexual approach. In countries such as Burma and the Philippines, where there is increasing priority being given to MSM, NAPs may be receptive to the development of such plans.

5.1.1 Country led coordination

Given the diversity of players it is essential that there be effective country-led coordination mechanisms for MSM programs to ensure alignment and harmonisation. This can be facilitated by the establishment of MSM Technical Working Groups (TWG) under the auspice of the NAP to bring together all key parties on a regular basis, as is the case in Cambodia. For these mechanisms to work effectively they require good secretariat support from the NAP by an officer with knowledge of HIV programming. TWGs have an important role to play in the ongoing identification of technical assistance needs and ensuring the coordination across technical assistance providers and implementing agencies.

5.2 Strategic information

5.2.1 MSM population size estimation.

Perhaps the most significant obstacle to NAPs according a higher priority to MSM is the common perception that the number of MSM in their country is quite small. This is understandable given cultural factors which has meant that MSM, except for transgenders, were until recently completely hidden, with most remaining so. If the head of a NAC thinks that the number of males who have sex with males in their country is say 100,000 and the estimated HIV prevalence is 10 percent, they will give this population a lot less priority than they would if the actual number of MSM was say 400,000.

What is needed is rigorous population-wide national studies, undertaken by locals with suitable expertise, supported by technical assistance, to come up with credible, nationally owned figures. Developing an appropriate methodology and ensuring good field application would be complex, and needs to have full national ownership. What is important to avoid is the methodology used for local population size estimate studies that have been common in many USAID funded projects which basically count visible MSM and result in significant underestimates. These types of studies may have some use for the planning of local CBO interventions in mapping numbers of MSM who can be readily contacted through outreach, but they have no place in national scale population health planning.

It is unlikely that NAPs will start to give sufficient priority to MSM programming until they can be convinced that the number of MSM is significantly greater than they currently believe. Accordingly, funding and technical support for rigorous population size estimations should be accorded high priority.

5.2.2 Information needed to guide program development

Although the Asian Epidemic Model indicates that 80 percent coverage is required to reverse HIV epidemics among MSM, the reality is that this target will not be reached for some time. This makes it imperative that progressive scaling-up targets those MSM most at risk. Viewed through the lens of sub-population groups, degrees of risk may be associated with age, geographical location, occupation, level of identity around male-to-male sex, different sexual networks and the extent to which they overlap, etc. For example it may be that males with a normative male identity have fewer sexual partners compared with other MSM, but this is not known. Currently, epidemiological and social research data of this type to guide program implementation is limited.

There is a need for:

- behavioural research to supplement epidemiological data to identify sub-populations of MSM who are at greatest risk;
- social research on sexual networks and the nature of attitudes and beliefs to inform the design of programs appropriate to particular cultures; and
- evaluation and operational research to strengthen models of HIV prevention.

5.3 Reducing stigma and discrimination

Reducing stigma and discrimination is critical to the success of MSM programs, although this has largely been ignored in every country. What is needed is the development of multi-faceted approaches which result in concrete action. This could range from NAPs taking a public leadership role as has been done in Cambodia, public statements by political, community and religious leaders, advocacy for abolition of sodomy laws and development of legal protection against discrimination, social marketing including addressing how MSM are presented in mainstream media, addressing the widespread discrimination in health services, and CBOs addressing the self-esteem of MSM and of HIV-positive MSM.

5.4 Defining the comprehensive approach

The recent United Nations regional Consultation on Health Sector Response to HIV/AIDS among MSM identified the need for agreement on what constitutes a comprehensive package of HIV and sexual health services for MSM. This will assist with harmonisation of the work of partners. WHO, UNDP, UNAIDS, UNESCO, USAID and APCOM are holding a regional consultation meeting with governments and community partners in June 2009 to develop a single agreed regional comprehensive reference package. It is anticipated that this package will be endorsed by one or more UN agencies and will then be used to guide the development of national responses. The consultation will be followed by a Health Policy Initiative project (HPI) workshop which will train government and community country representatives in a tool to cost the comprehensive package of services in their country at an eighty percent coverage level.

5.5 Coverage, intensity and broadening the range of prevention interventions

5.5.1 Coverage

Modelling indicates that around 60 percent of most at risk populations need to adopt safer behaviours if HIV epidemics are to be reversed. The coverage of prevention programs has to reach about 80 percent for that level of behaviour change to occur.²⁰ Expanding coverage of prevention programs is of critical importance.

5.5.2 Intensity

To be effective prevention programs need not just coverage but also sufficient intensity and breadth. A Thai MSM study indicated that consistent condom use with casual male partners increased among those exposed to a greater number of prevention interventions. Interventions were grouped into five categories: 1) peer education and other types of education, 2) condom and lubricant distribution, 3) targeted media, 4) STI check-up, and 5) VCT. Consistent condom use with casual male partners exposed to one intervention was 61 percent. For those exposed to 2-3 interventions, consistent condom use increased to 73 percent. For those exposed to 4 interventions, consistent condom use was 79 percent and for the full five interventions was 82 percent.²¹ The same Thai study demonstrated that for MSM exposed to all interventions, 68 percent used VCT services and 67 percent used STI services, compared to 52 and 51 percent respectively of MSM who were not exposed to the full-package of interventions. This suggests that some combination or possibly all elements of the package of education interventions may contribute to change in sexual and health seeking behaviours and that this is more likely with exposure to an increased number of interventions.

5.5.3 Segmentation

There is considerable diversity among MSM. This diversity includes but is not limited to gay, identification with culturally specific sexual identity terminology, those with a normative male identity, transgenders, male sex workers and social class. These different groupings of men do not form a homogenous group and often have strong preferences to meet and mix in different circles. The diversity of MSM and their networking means that interventions need to be segmented. Some CBOs work primarily or exclusively with particular categories of MSM. While segmentation is appropriate, if there are no other CBOs undertaking MSM work, the needs of other groups are not met. The programmatic implications is that CBOs need to develop a range of segmented programs or additional CBOs are needed for particular segments.

A concerted effort needs to be made to address the challenge of reaching normative males who have sex with other males. Examples of where this is being done are Burnet's programs in Lao and Burma and the ADB enclaves projects in PNG where a broad male sexual approach is taken that addresses all men, including MSM.

5.5.4 Social marketing

Current MSM programming has an overly strong orientation towards one-to-one and small group peer education which has inherent coverage limitations. The trend towards greater use of social marketing through mass and targeted media, the internet, mobile phones, social networking and new media needs to be strengthened considerably. In recent years HIV and MSM programs have started to use targeted media and internet sites which has increased coverage to some extent, but still at relatively low levels compared to MSM population estimates. The effectiveness of these types of interventions have not

²⁰ Report of the Commission on AIDS in Asia, Redefining AIDS in Asia, 2008. p. 132.

²¹ Source: Thai Ministry of Public Health, BoE, 2007.

been evaluated. While these types of interventions may be of value, it is likely that greater impact will be achieved through commercial web sites where men meet for sex. That, is through the equivalent of outreach through the internet. The rapid rise in sexual networking through national and international web sites requires that prevention programs expand their outreach horizons, especially as this media has good reach into middle and high class MSM. There is considerable potential for development of partnerships with these web sites to develop creative methods of promoting HIV prevention and sexual health. This type of partnership would be best formed on a global or regional level and could be perused by APCOM, the Global Forum on MSM and HIV and/or multilaterals.

The extent to which it is practical to use mass media in communications strategies for MSM needs to be considered, especially in extending reach. Factors to be considered are cost, the type of messages appropriate to mass media and how they can best be conveyed. This would entail a more open acknowledgement of diversity in sexual practice. There are, however, creative ways of using the media in ways which would be acceptable to dominant cultural attitudes. For example, in Cambodia the BBCWST has demonstrated national penetration of HIV health promotion messages through a TV drama series. This type of approach can be very useful in addressing stigma and discrimination. Leadership will be required if greater use is going to be made of mass media for MSM HIV communication strategies.

5.5.5 Structural approaches

Another area for program strengthening is structural approaches to prevention focussing around engagement with entertainment establishments as partners in HIV prevention. This approach, which has not been used extensively in some countries, broadens the reach of prevention interventions to new spaces, raises the visibility of HIV, can help in building community ownership of the response and the engagement of the private sector. Seeking the cooperation of police and local government is another structural approach that can contribute significantly to building an enabling environment for the operation of prevention programs.

5.5.6 Positive MSM

The strong prevention orientation of MSM and HIV programs has resulted in a focus on negative men, with too little attention paid to PLHIV. CBOs need to broaden their approach by developing positive prevention interventions, providing support to HIV-positive MSM and strengthening links with HIV care and treatment programs, as part of a continuum.

5.6 Community development and mobilisation

A finding of Section 4 was that there had been insufficient support for community development and mobilisation approaches by technical assistance agencies. The contribution of this approach to prevention is often ignored in favour of delivering a largely franchised package of behaviour change interventions from a service delivery perspective. There is considerable scope for a greater emphasis on community development and mobilisation approaches.

There is a need for improved dialogue and the development of partnerships between NAPs and CBOs. Often multilaterals, donors and technical assistance agencies have been the main dialogue partners with NAPs on HIV and MSM. This has had the effect of limiting opportunities for CBOs to undertake advocacy and create relationships with NAPs. This does not facilitate longer term sustainability. A community development and mobilisation approach would facilitate the greater involvement of communities of MSM in national responses.

5.7 Developing new strategies for increasing MSM utilisation of STI & VCT clinics

Despite a strong emphasis by CBOs on referral of MSM for STI check-up and VCT, uptake continues to be very low, minimising the prevention benefits of STI control, knowledge of HIV status and

referral to HIV treatment. Access has been limited by stigma, lack of trained personnel to deal with ano-rectal infections, limited facilities, opening hours and client embarrassment. The health sector and CBOs need to develop new strategies for increasing MSM access to high quality testing and care. For reasons of scale and sustainability, a primary reliance on government services is needed, supplemented in the medium-term by a small number of specialist NGO clinics which can play a training and desensitisation role. In addition to improving uptake of STI services and enhancing clinical skills, the capacity of health systems to promote broader male sexual health programs needs to be enhanced.

The Asia Pacific Network of People Living with HIV (APN+) is currently undertaking research on access of MSM to HIV care and treatment services. Potential areas for concern that need to be addressed are stigma and discrimination against clients perceived to be MSM or a reluctance to attend services for fear of discrimination.

5.8 Addressing capacity building and organisational development needs

The Global Fund model is largely dependent on development partners at the global and country level for most aspects of country level technical support. The recent *Evaluation of the Global Fund Partner Environment*²² concluded that there is widespread confusion and systematic problems with the provision of technical assistance to support Global Fund grants. Aspects of this problem include:

- Efficient and effective systems for the provision and coordination of technical support do not yet exist.
- There is confusion among development partners, especially at the country level, regarding their roles and responsibilities in providing technical assistance, plus a lack of sufficient engagement to support grant implementation.
- Capacity at the local level to identify and articulate technical support needs is limited.
- Many Global Fund proposals do not include any or sufficient funding for technical assistance.
- Where technical assistance is included in grants, the funds are often under-utilised.

The evaluation concluded that there is a need for mechanisms to provide appropriate, adequate, timely and quality technical assistance to programs and organisations. A fundamental issue identified is the lack of a well developed overall partnership strategy defining the roles and responsibilities in identifying technical assistance needs and providing technical support. It was recommended that the Global Fund, the World Bank, UNAIDS and WHO develop a Global Partnership Framework which includes clarity on respective roles and responsibilities with regards to financing, technical assistance, coordination and M&E. It was also recommended that development partners strengthen their bilateral engagement in support of grant implementation. Development partners need to tailor their technical assistance programs to support countries in their implementation of Global Fund programs. These recommendations will be considered at the May 2009 meeting of the Global Fund Board.

A key issue is the often limited capacity building component of Global Fund proposals for MSM and other programs, particularly in relation to CBOs. Development partners currently funding MSM programs, (principally USAID) are relied upon to provide capacity building for CBOs that receive Global Fund monies. The extent of capacity building by USAID implementing agencies (e.g. FHI) has, however, been limited by historic funding decisions which accorded higher priority to resourcing interventions compared to capacity development. This deficit in capacity building limits both the quality of programs and the absorptive capacity of CBOs. USAID has indicated that it intends to take advantage of the additional Global Fund monies available for MSM interventions by putting additional resources into capacity building of CBOs, although the mechanisms for how this will be achieved are not yet determined. Even with USAID increasing its MSM program capacity building efforts, the extent of the need means that a significant gap will remain in this area. The level of support for

²² Macro, Evaluation of the Global Fund Partner Environment at Global and Country levels in Relation to Grant Performance and Health System Effects, Including 16 Country Studies. 2008.

organisational development of CBOs has been extremely limited, with capacity building having a strong programmatic flavour.

Key finding

9. The key priority needs for more effective national responses to HIV epidemics among MSM are:
 - the development of nationally owned specific National Strategic Frameworks and costed Operational Plans on HIV, AIDS and Sexual Health;
 - effective, nationally led, partnership coordination mechanisms;
 - improved strategic information in relation to population size estimation and social and behavioural research to guide priorities and program development;
 - concrete actions to reduce stigma and discrimination;
 - agreement between key partners on a comprehensive approach;
 - increasing the coverage and intensity of prevention programs and broadening the range of prevention interventions;
 - strengthening the contribution of community development and mobilisation to prevention programs;
 - developing new strategies for increasing MSM utilisation of STI and VCT clinics;
 - ensuring MSM have good access to stigma-free HIV care and treatment services; and
 - addressing capacity development and organisational development needs, especially in relation to the Global Fund.

6. Opportunities for AusAID support

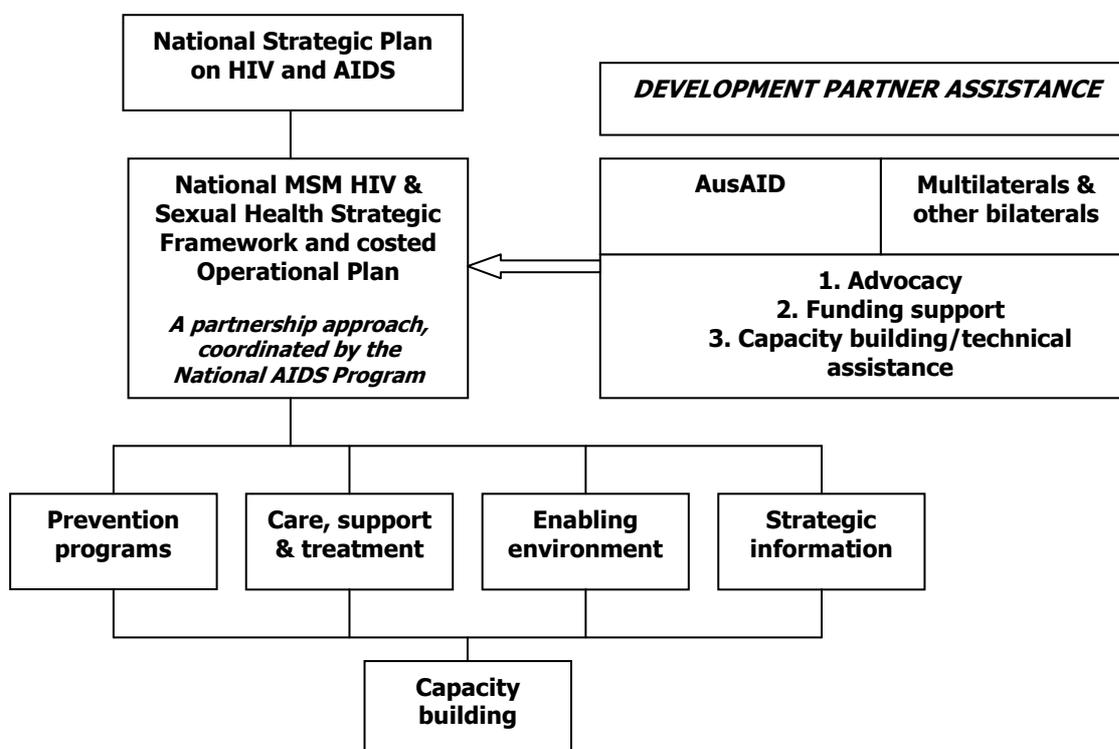
This section outlines opportunities for AusAID support for comprehensive approaches to address HIV epidemics among MSM, based on the key gaps and priority needs outlined in Section 5. The foundation of AusAID’s support should be alignment with NSPs and promotion of a partnership approach. Based on this foundation there are five areas of support that AusAID can consider: 1) technical support to strengthen the capacity of NAPs to lead and coordinate HIV and MSM national responses, 2) technical support for strengthening the health sector response, 3) funding and technical support for civil society prevention programs, 4) supporting social and behavioural research, and 5) addressing stigma and discrimination as a cross-cutting theme.

6.1 The foundation of AusAID’s support: alignment with National Strategic Plans

Consistent with Australia’s commitment to align development assistance with the programs of partner countries, AusAID’s support for HIV and sexual health work among MSM should be aligned with National Strategic Plans on HIV and AIDS, as illustrated in Figure 2, below.

A key finding of Section 5 is the need to translate commitments to address HIV epidemics among MSM contained in NSPs into nationally led programs of action through development of National MSM Strategic Frameworks and costed Operational Plans, as a sub-plan of the NSP. The Operational Plan would be implemented by a range of organisations using a partnership approach with NAPs playing an active leadership and coordination role. The work all partners, supported by a diversity of funding sources, should be aligned with the NAPs MSM Strategic Framework and Operational Plan, along with harmonisation in their work.

Figure 2: AusAID and other development partner support for MSM within National Strategic Frameworks and Operational Plans



6.1.1 Promotion of a partnership approach using role delineation

Using a role delineation approach, different partners would be responsible for implementing different components of the Operational Plan. In each country the respective role of partners would be negotiated between governments, development partners and civil society, based on their comparative advantage and the local context. A broad role delineation that could form the basis of local discussions follows:

National AIDS Programs: leadership, development of Strategic Frameworks, Operational Plans and policies for MSM, coordination of the work of all partners, developing an enabling environment through policies, laws and advocacy, fund mobilisation, and strategic information.

Health systems: development of male sexual programs, ensuring that STI, VCT and care, support and treatment services are MSM-friendly and provided free of discrimination, and ensuring that STI and VCT services have appropriate clinical skills for MSM.

Local government and Provincial AIDS Committees: often play a gatekeeper role in relation to the operations of civil society programs and can have a significant effect on the implementation of governments programs in a decentralised environment.

Law enforcement agencies: such as the police can play a significant positive or negative role in relation to implementation of prevention programs and creation of an enabling environment.

Prevention programs: community based organisations are best positioned to design and implement a range of prevention programs which address the diversity of men who have sex with men, taking a segmented approach for sub-populations.

Mass and new media: an expanded range of organisations need to be involved, ranging from those with expertise in social marketing (e.g. advertising agencies), and those with expertise in new media such as social networking, the internet, and use of mobile phone communication.

Technical assistance: is required for all programmatic areas, including building the capacity of NAPs and community based organisations and may come from a variety of sources such as multilateral and bilateral development partners, international NGOs, regional and national networks, technical support facilities and researchers.

6.2 Five key opportunities for AusAID's support

Based on the foundation of AusAID's support for alignment with NSPs and MSM-specific strategic frameworks, this study has identified five broad opportunities for AusAID support for comprehensive approaches to address HIV epidemics among MSM. These five opportunities are outlined below. As this is a broad scoping exercise the opportunities identified are not highly specific. Further design work is needed. However, the choice of opportunities has been informed by the analysis of the current response in section 4 and the key gaps and priority needs in section 5. These sections give guidance on key areas that need to be addressed for each of the opportunities. Options for funding modalities and other mechanisms for AusAID support for the key opportunities are outlined in Section 7.

6.2.1 Technical support to strengthen the capacity of National AIDS Programs

A key area of AusAID's support should be developing the capacity of NAPs to lead and coordinate national responses to HIV epidemics among MSM. Examples of areas where NAPs need technical assistance are:

- Country owned and derived population size estimations for men who have sex with men.

- Technical assistance to promote appropriate prioritisation of MSM in the next round of NSPs in relation to epidemiological data, the projections of the Commission on AIDS in Asia and current levels of coverage. (The NSPs in all six focus countries end in 2010.)
- Situation and response assessments.
- Development of National Strategic Frameworks and costed Operational Plans on HIV, STIs and MSM.
- Organisational development assistance for national, provincial and district AIDS secretariats to develop structures and systems for the effective coordination of MSM programs.
- Assistance with developing MSM components of Global Fund proposals.
- Program development on enabling environment work for HIV and MSM (e.g. policy development, law reform, measures to address stigma and discrimination).
- Assisting CCMs to implement the Global Fund's Strategy in Relation to Sexual Orientation and Gender Identities.

While there is a need for technical support at the national level, it is important that assessments of support needs also take account of the needs of provincial and district coordination systems.

6.2.2 Support for strengthening the health sector response

Section 5 identified the need for new strategies for increasing MSM access to high quality health care services in the areas of STI, VCT and HIV treatment, informed by lessons learned from the disappointing results of current efforts, especially in relation to STI and VCT service uptake. An opportunity for AusAID is support to strengthen the health sector response. Effective, functioning and non-discriminatory health systems, with interventions linked to knowledge about men's health seeking behaviours, may result in an increase in VCT, and STI and HIV treatment uptake. The focus of AusAID's support should be broad based and could include assistance for health sector programming (e.g. service incentive payments and other performance based approaches), addressing the health seeking behaviours of MSM (e.g. incentives to encourage MSM to seek services), development of partnerships between clinics and CBOs, addressing discriminatory attitudes of service providers and other barriers to access, technical assistance in enhancement of clinical skills, and developing partnerships with private health service providers, including pharmacies.

6.2.3 Funding and technical assistance for civil society prevention programs

Section 4 identified that coverage of existing prevention programs is well below what is required to reverse HIV epidemics among MSM. It is therefore recommended that a priority for AusAID support should be supporting increased coverage of prevention programs. The design of AusAID supported work should be informed by the findings outlined in 5.5 Coverage, intensity and broadening the range of prevention interventions, 5.6 Community development and mobilisation, and 5.8 Addressing capacity building and organisational development needs.

6.2.4 Supporting social and behavioural research

Section 5 outlines broad key priorities for social research. Australia's expertise in social and behavioural research could make a significant contribution to informing MSM programming.

6.2.5 Stigma and discrimination

It was observed in Section 4 that stigma and discrimination is critical to the success of MSM programs, although this is the most ignored area of MSM programming. It is recommended that multi-faceted approaches be developed along the lines proposed in Section 5 as a cross-cutting theme of AusAID's support for MSM programming. This could be achieved by AusAID requiring all that all MSM-related funded activities include concrete initiatives to address stigma and discrimination, except where this was clearly not applicable.

All of the five key opportunity areas should be seen as linked rather than as separate areas of support. For example, strengthening the capacity of NAPs should result in a partnership approach between NAPs and MSM CBOs conducting prevention programs. Similarly, CBOs have an important role to play in partnership with the health sector in improving MSM access to and utilisation of health services. Similarly, the results of social and behavioural research need to be used to inform the design, refinement and delivery of prevention programs. And addressing stigma and discrimination should be a core component of each of the other four key opportunities.

6.3 Areas not recommended for support

Two areas where it is recommended that AusAID does not need to provide support are HIV and STI surveillance and condom social marketing. Surveillance is already supported by CDC GAP or USAID through FHI. Although there are areas where surveillance can be substantially improved, from the perspective of division of labour, this support can be provided by USG programs. Similarly, USAID, with some other donor support, is already providing extensive support for condom social marketing through INGOs. As programs scale-up there may be a need for additional funding to support condom social marketing. This would best be directed to partners already working in this area.

7. Mechanisms for AusAID support

This section commences with an overview of current funding modalities for AusAID's HIV programs and then goes on to outline the perspectives of AusAID country offices on MSM programming and potential funding modalities. This is followed by an exploration of the suitability of a range of funding modalities for the recommended areas of AusAID support outlined in section 6. Lastly, other mechanisms for AusAID support for MSM programming are explored. These are technical assistance and Australia's engagement with the Global Fund.

7.1 Overview of current AusAID HIV funding modalities

AusAID is committed to the Paris Declaration, the Accra Agenda for Action (AAA), and also supports the Three Ones principles and the recommendations of the Global Task Team. This support is increasingly apparent in the funding instruments that AusAID is adopting. This involves a gradual move away from managing contractor projects to programmatic and sector wide approaches aligned with national strategies and partnerships; increasing application of the principles of alignment and harmonisation in AusAID programs, and using modalities that promote country led coordination by partnering with other donors in partnership funding mechanisms that are aligned with national strategies. AusAID also takes a pragmatic approach to decisions on funding modality, taking into account the local context and desired outcomes.

There are significant differences in both the size of AusAID supported HIV programs in the six different countries within the scope of this work and in the ways in which AusAID funds its HIV work. In summary, the different approaches used are:

- Large scale bilateral programs funding government, civil society and the private sector, managed directly by AusAID (PNG) or contracted out (Indonesia), aligned with NSPs and working closely with NACs.
- Direct contracts with NGOs or implementing partners issued and managed by AusAID country offices or Canberra. For example, funding of FHI and KHANA in Cambodia for implementation of the HAARP Country Flexible Program (CFP) and funding to the HIV/AIDS Alliance for the Regional Technical Support Hub.
- Direct contracts with multilaterals and foundations for implementation of projects. For example, funding of UNODC for implementation of the HAARP CFP in Burma, and funding of the Clinton Foundation in a number of countries.
- Funding to multilaterals who then contract with INGOs or the private sector for implementation of projects. For example AusAID funding of the ADB for the economic enclaves and condom social marketing programs in PNG.
- Funding to multilaterals for staffing positions. For example, in Cambodia AusAID is part-funding a most at risk populations technical officer position in UNAIDS.
- Financial contributions to multi-donor funded partnership mechanisms such as the 3DF in Burma and the Indonesia Partnership Fund for HIV/AIDS (IPF).
- Routing funds through government systems for government implementation. For example, the HAARP CFP in Vietnam.
- Funding to UNAIDS Regional Support Team Asia Pacific for specific functions.

Australia has also committed a total of A\$210 million to the Global Fund. As with all Global Fund contributions, these funds are untied and are used to support Global Fund grants for the three diseases. AusAID shares a seat with DFID on the Global Fund Board and is involved in country level Global Fund mechanisms such as CCMs and TWGs in some countries where AusAID is a significant HIV donor.

Decisions to route funding through governments are influenced by partner government preferences and AusAID's assessment of the strength of government systems. In PNG, Sanap Wantaim directs most funding to NGOs, although there is support for some specific activities of government agencies, but no core funding. However, other AusAID funds are contributed to the HSIP trust account managed by the National Department of Health to fund implementation of annual workplan against the National Strategic Health Plan, of which HIV is one of the priorities. In Vietnam all HAARP funding is being channelled through government systems. In Cambodia where AusAID is pooling funds through the Health Sector Support Program (HSSP2) a decision has been made that national programs such as HIV will not receive HSSP2 funds as they have access to the Global Fund and bilateral donor funding.

7.2 AusAID country office perspectives on MSM programming and modalities

Consultations with AusAID country offices revealed a mixed response regarding inclusion of MSM programming into their existing range of activities and a range of preferences for funding modalities. Reservations were expressed by a number of AusAID country offices regarding expanding their HIV work to prioritise men who have sex with men. These concerns focussed around three areas (although not each area of concern was expressed by each country office with concerns):

- Concerns about the additional workload in managing a new area of work with existing staff resources.
- A preference for using any new HIV funds to scale-up existing work relating to injecting drug use.
- Concern that HIV work with MSM does not align with existing AusAID country strategies. This could be seen as a lack of alignment between the new AusAID HIV strategy and AusAID country strategies which may or may not be addressed over time.

7.2.1 Burma

While AusAID aligns its work with the National HIV Strategy, there are policy restrictions that prohibit any direct funding of the Government. The AusAID country office in Burma is not a devolved post. Contracts are administered in Canberra or Bangkok. Limited staff resources in the country office means there is a strong preference for larger programs compared to small activities or channelling funds through multi-donor mechanisms such as the 3DF. For an expansion of MSM work, the country office would prefer allocating additional funds to the 3DF or a select tender among Australian NGOs currently working in Burma. Donor funds to the 3DF are not earmarked so direct expansion of MSM work would only flow from its priority in the National HIV Strategy. The country office does not see HAARP as an appropriate vehicle for funding MSM work in Burma.

7.2.2 Cambodia

The AusAID Country Office expressed the desire to establish a niche in harm reduction and would prefer to spend any newly available funds in scaling up work in this area. Concern was also expressed about insufficient staffing to handle new program areas. One option raised by the country office would be for any new funds to be allocated to HAARP and used for HIV work among MSM with a drugs focus. HAARP could also be used purely as a funding mechanism for funding a fuller range of MSM prevention work. The AusAID country office expressed a preference for direct funding of implementing agencies such as KHANA and FHI rather than the National AIDS Authority, on grounds of efficiency and transparency.

7.2.3 Indonesia

If AusAID was to allocate additional funds for MSM work the AusAID country office would need to ensure that there was support for this type of programming from the NAC. As the NAC has given priority to developing a MSM and HIV National Strategic Framework and costed Operational Plan, it is likely that there would government support. The country office has indicated that it would need to consider funding modality options. This would include channelling funds through the existing bilateral program (HCPI) (although there may be procedural barriers regarding the extent to which existing

contracts can be enhanced), contracts with multilaterals, other bilaterals or their implementing partners or using government systems such as the IPF. The IPF may be the preferred channel. Senior staff from HCPI have indicated a reluctance to broaden their scope of work, especially as the design of the existing bilateral placed an emphasis on concentrating efforts on injecting drug use and prisons.

7.2.4 Papua New Guinea

Sanap Wantaim currently funds NGOs directly as government systems are regarded as too fragile to handle a significant level of funds disbursement. Alignment is achieved through the annual planning process. AusAID in PNG supports addressing HIV among MSM through Sanap Wantaim as is already happening on a reasonably small scale for the Poro Sapot project. Current funding for Sanap Wantaim is fully committed to the end of 2011 so any expansion of MSM work would require additional funding. The view of AusAID in PNG is that any additional funds should be allocated on a non-earmarked basis so that funds can be aligned with national priorities that have local ownership. This is seen as part of a process of gradually getting the buy-in of government on the need for MSM work. AusAID would be in a position to request that priority be given to allocating new funds for MSM work and the reality of current planning processes in PNG is that this would probably occur.

There is also potential for AusAID funding for the health sector to support broad-based men's sexual health programming which would have an MSM component.

7.2.5 Philippines

Current AusAID funding for two multilateral projects that have quite small scale reach to MSM as part of broader target audiences is being redirected to new priorities consistent with the draft AusAID country strategy. The AusAID country office does not have any plans to undertake HIV work with MSM as this is an area that is not covered by its draft country strategy. If funds were made available for MSM work the country office may be prepared to consider funding mechanisms which would minimise AusAID's management responsibilities. These could include use of multilaterals or other organisations to manage funds disbursement and technical assistance.

7.2.6 Vietnam

The AusAID country office indicated that it would prefer to spend any new HIV monies on expanding the coverage of the HAARP CFP as it wishes to have fewer small activities. The capacity of the Country Office to manage new areas of work is limited, and there are no staff with technical expertise in HIV.

7.3 Possible funding modalities

Consistent with Australia's commitment to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, AusAID is seeking to increasingly position itself as working in partnership with governments through alignment with national strategies, institutions and systems and with other development partners, especially in the areas of funding and technical assistance. The AAA also commits signatories to "deepen our engagement with CSOs as independent development actors in their own right whose efforts complement those of government and the private sector" and seeks to improve coordination of CSO efforts with government programs.²³ As indicated in section 6, Australia's support for MSM work should be positioned within support for HIV NSPs and MSM Strategic Frameworks, with responsibility for different components of implementation being allocated on an assessment who is best placed to implement.

²³ Accra Agenda for Action. 2008. p. 4.

The anticipated scaling-up of the overall Australian aid program is intended to be accompanied by reducing the number of new small activities by taking a programmatic approach and efforts to streamline and consolidate existing country program portfolios. This relates to both the aid effectiveness agenda and the feasibility of scaling-up a project based approach to aid. The concerns expressed by country offices outlined above appear to be related to this shift in emphasis. With this in mind, one of the key factors determining which funding modalities should be used for supporting MSM work is consideration of the workload of AusAID country offices. This can be achieved, for example, by developing strategic partnerships with other development partners.

Documents setting out overall strategic directions for AusAID indicate that the aim is to move to a position where the Agency can draw on a wider range of modalities (projects, facilities, technical assistance, multi-donor trust funds, delegated cooperation, program based approaches, budget support) with choice of delivery driven by analysis, country context and dialogue with development partners.²⁴

A range of funding modalities are explored below, some of which are complementary. For example, different funding modalities could be used to support government capacity building and support for CSO HIV programs. Some funding modalities may be more suitable for some countries dependent on the size and nature of AusAID's operations. Factors that have been considered in developing the funding modalities are:

- Existing AusAID in-country HIV activities and associated funding modalities.
- The size of existing AusAID country programs.
- Alignment with NSPs and support for building the capacity of NAPs to effectively lead and coordinate programmatic responses to HIV epidemics among MSM.
- The need to fund civil society organisations who are best placed to implement most aspects of prevention programs for marginalised populations.
- The variable capacity of government systems to disburse money to civil society organisations.
- The need for a strategic and programmatic approach to support for MSM work as opposed to just a collection of projects.
- Utilising AusAID's already well established relationships with multilaterals in leveraging advocacy to and policy engagement with governments.
- The need to minimise administrative burdens on AusAID country offices.
- The need for any funding support to be accompanied by technical assistance to maximise quality.
- The need for funding to have an impact by building on best practice.
- Cost effectiveness, key risks and sustainability.
- Building on pre-existing successful modalities.

7.3.1 A regional technical assistance fund

A key finding of this scoping exercise is the need to enhance the commitment and capacity of NAPs to effectively develop, lead, manage and coordinate the national responses to HIV epidemics among MSM. Examples of areas where NAPs need technical assistance are outlined at 6.2.1 in the previous section. A funding mechanism for how AusAID can support this capacity development is needed, especially in countries where AusAID has only a small HIV program and no staff with HIV technical expertise.

UNAIDS and its co-sponsor organisations have well established and generally close links with NAPs in each of the six focus countries and given their convening power are well placed to advocate for program development in sensitive areas. The Australian Government is committed to working closely with multilateral organisations and AusAID has good relations with UNAIDS and its co-sponsors.

²⁴ *Building on the 2010 Blueprint: A reform agenda for 2015*

It is proposed that AusAID establish a regional technical assistance *fund* to support capacity development of NAPs and other government bodies in the area of HIV and MSM and that the fund be managed by the UNAIDS Regional Support Team for Asia Pacific (RSTAP). If the fund attracts strategically oriented proposals for technical assistance it could have high impact for a relatively low cost. The intention would be to restrict technical assistance to building the capacity of governments. Other funding modalities would be used to support capacity building for civil society.

Initially the fund could be established for a period of three years. The UNAIDS RSTAP would request UNAIDS Joint Country Teams in AusAID's six priority countries to submit, on an annual basis, proposals for technical assistance funding. Funding would be competitive and based on the merit of proposals. Recognising that technical support needs will vary significantly between countries, proposals should be demand driven, with UNAIDS Joint Country Teams working with government, (including advocacy to government), to identify high priority technical support needs for enhancing the government's response to HIV and MSM. Proposals would need to have the endorsement of the NAP and technical assistance providers would need to work closely with NAPs. As the intention of the fund is to build the government's response, the technical assistance should be provided at the country level. While regional level technical assistance proposals could be considered, they should be the exception, and would need to have clear relevance to strengthening government capacity at the country level. A small steering group could be established to develop criteria and guidelines for the operation of the fund and to determine which proposals to fund. The steering group could consist of representatives from AusAID's Bangkok Office, UNAIDS RSTAP, UNDP's Regional HIV Policy Specialist, and two independent persons with expertise in HIV and MSM. A majority of non-UN members provides for accountability.

A significant advantage of this approach is that it leverages the UN's comparative advantage in working with governments by providing the necessary financial resources, while not adding to the workload of AusAID country offices. However, a requirement could be that all proposals have the endorsement of the AusAID country office.

The intention would be to provide a *fund* for technical assistance, but not a *facility*. That is, the cost of technical assistance would be funded, but the UNAIDS Joint Country Team and the NAP would be responsible for sourcing technical support through an existing facility with expertise in providing quality assured technical support. Options include the HIV/AIDS Technical Support Facility for South East Asia and the Pacific (TSF SEAP). Considerations include an analysis of the appropriateness and robustness of the systems and capacity of the TSF SEAP to source, mobilise, manage and quality assure the required technical assistance. Other aspects of the fund management and operation could be provided by the facility, including financial administration and parts of the proposal process.

An option would be for all aspects of the fund to be managed by a facility specialising in technical assistance. This is not recommended. What is needed is a driving force that has leverage with governments to promote effective use of the fund in high priority areas and the UNAIDS RSTAP is well placed to do this. Technical support facilities are too operationally distant from the country level to effectively fulfil this role and have no leverage.

The fund could also receive money from other donors and be supplemented by UN funds. If this was the case, additional countries could be eligible for funding, although AusAID may choose to restrict use of its funds to its six focus countries.

AusAID should conduct an annual internal review of the effectiveness of the fund. Recipients of funds should be required to report on outcomes of the technical assistance immediately following completion of the project and again at 6-9 months post-completion to measure progress. Initially, technical assistance needs are most likely to be foundational in nature. AusAID could continue funding at the end of three years if there was a need for ongoing technical assistance. Funds would generally only be available for short-term technical assistance.

The Indonesian AusAID country office endorses the need for this type of fund, but with its large HIV program and specialist AusAID staff, would prefer that technical support funds for Indonesia be directly allocated to and managed by the country office. This may also be the case in PNG. Other AusAID country offices are supportive of the proposed technical assistance fund being managed by UNAIDS. These offices saw the UN as being a key partner in working with government on HIV and MSM. Some country offices expressed a preference for AusAID allocating the funds directly to UNAIDS country offices rather than a regional mechanism. This is not proposed as well managed regional oversight of the fund is more likely to result in only quality and high priority proposals being funded and also has less administrative burdens.

7.3.2 A technical support *fund* to strengthen the response of the health sector

An option is to set up an additional technical support fund with WHO to develop health system capacity regarding HIV and MSM. Primary focus areas would be on STI treatment, male sexual health and VCT service provision, plus ensuring that MSM have non-discriminatory access to HIV care and treatment services. Development of more effective approaches in these areas could be informed by a regional situation analysis, including detailed studies of barriers to access in a few focus countries. This could be followed by regional guidance from WHO on new approaches, supplemented by WHO auspiced technical support at the country level for implementation of these strategic approaches. All aspects of this work would need to be done in close consultation with national counterparts.

WHO has two regions within Asia and the Pacific. To date, only the WHO Office for the Western Pacific is actively engaged in MSM work. This office covers four of AusAID's focus countries, but not Indonesia and Burma. Collaboration could be sought from WHO's Regional Office for South East Asia to ensure broader geographic coverage.

An alternative to this separate technical support fund would be for WHO to seek technical assistance funds as part of the UNAIDS Joint Country team proposals to UNAIDS RSTAP (see 7.3.1). If this was the case consideration could be given to increasing the pool of available funds.

The proposed partnership with WHO clearly seeks to utilise the organisation's considerable influence with the health sector. However, issues outline in 7.3.1 relating to the risk of poor management of technical assistance may apply. Consideration will therefore need to be given to the capacity of WHO to provide high quality technical support. Options include supplementing WHO's involvement by using an existing facility with expertise in providing quality assured technical support.

As recommended in 6.2.2, the focus of AusAID's support for the health sector should be broad based and could include assistance for health sector programming in addition to technical assistance. Support for broader health sector programming would be provided by other funding modalities rather than the proposed technical support fund. This may include existing AusAID assistance for health sector support programming.

7.3.3 Use of government systems for funds disbursement

AusAID places a strong emphasis on aligning its work with NSPs and has good collaborative relationships with NAPs. AusAID programs have funded NAPs for specific functions but funds disbursement to implementing partners in the six focus countries has not been done through government systems with the exception of the HAARP CFP in Vietnam. If funds for HIV and MSM prevention work at the community level were to be allocated through government systems in Vietnam, there would be a need for technical assistance in how to work effectively with marginalised groups. In Indonesia, some funds disbursement has been done through a partnership fund which has government ownership, but the funds management is done by UNDP. Government systems have not been used because of concerns regarding efficiency and transparency. The view of some key informants is that at this stage of development, the higher priority is to build the capacity of NAPs in core function areas

such as planning and coordination as a means of achieving alignment and harmonisation in the work of partners rather than burdening NAPs with additional functions which could detract from capacity building in these areas. None of the AusAID country offices have expressed a preference for using government systems for disbursement of any funds for MSM work with the exception of Vietnam. In Indonesia use of the partnership fund is an option (see below). In the Philippines, the PNAC does not wish to be involved in funds disbursement.

7.3.4 Existing AusAID HIV bilateral programs

AusAID has two HIV bilateral programs, Sanap Wantaim in PNG and HCPI in Indonesia. Sanap Wantaim is prepared to undertake additional MSM work but would require additional funding and agreement of the NAC. Sanap Wantaim is directly managed by AusAID so possible contractual problems in scaling-up aspects of its work are not a problem. The AusAID country office in Indonesia has indicated that it is prepared to consider supporting HIV and MSM work in the light of the outcomes of the proposed National HIV Strategy for MSM that will be developed later this year under the auspice of the NAC.

7.3.5 Partnership funds

The Indonesia Partnership Fund for HIV/AIDS (IPF) is a multi-donor fund which is housed and owned by the NAC and has broad partnership involvement through its governance structures. The fund has been supported by DFID and AusAID. From 2010 AusAID will be sole donor, although other donor support is being sought. The IPF has been an important source of funding for the NACS and also disburses funds to INGOs, CSOs, multilaterals and bilateral programs. The IPF has provided a government led mechanism for allocating funds direct to CSOs rather than being reliant on only bilateral programs to perform this function. Through government ownership of the mechanism, the IPF is consistent with the principle of alignment and by involving multi-stakeholders it promotes harmonisation in the work of partners. Fund management is contracted to UNDP. Steps are currently being taken to strengthen the management of the IPF and it is anticipated that this will result in stronger systems by mid-2010 which would be the earliest time for AusAID allocating additional funds to support MSM work.

Advantages of channelling any AusAID funds for MSM work through the IPF are:

- It uses a government owned mechanism.
- There is a reluctance to expand the scope of the HCPI for programmatic reasons and possible administrative hurdles.
- It would provide a boost to the work of the IPF at the time that DFID is withdrawing its support.
- It takes advantage of the flexibility of the IPF.

The purpose of AusAID funding would be to resource priority unmet needs identified in National MSM Strategic Plan which the NAC is planning to develop in 2009. These priority areas could be jointly agreed upon by NAC and AusAID in consultation with the IPF's advisory structures. Funds could be allocated by a competitive call for proposals for particular pieces of work or be allocated to organisations with a clear competitive advantage. Any competitive grants process should be tied to clearly specified areas of the MSM strategic plan so as to ensure a programmatic approach to funding. An open call for expressions of interest where organisations could propose the type of work to be done would result in a project approach which would lack strategic and programmatic coherence. Proposals would need to include technical assistance. If AusAID was to provide earmarked funds for MSM work the attitude of the NAC would need to be determined as previous DFID and AusAID funding has not been tied to specific purposes.

With the exception of the 3DF in Burma, partnership funds do not exist in the other focus countries. In those countries where AusAID has only a small HIV program it would be difficult to justify the considerable work involved in establishment of partnership funds.

7.3.6 A funds manager with separate contracted technical support

This type of funding modality could be used for funding HIV and MSM work by civil society. Following initial country-based program design, which would build on the opportunities for AusAID support identified in this report, AusAID country offices would let two contracts; one for a funds manager and one for a technical assistance provider. The funds manager would let contracts and disburse funds to CSOs who were implementing AusAID funded HIV and MSM projects. The technical assistance provider would support the work of civil society organisations in program development and implementation. It would be most preferable for the technical assistance provider to have an existing in-country operational base.

This type of model has been used by AusAID country offices to support other health programs. For example, in the Philippines, AusAID is supporting malaria work by contracting the Tropical Diseases Foundation (TDF), a professional association which is also a Global Fund principal recipient, to be the fund manager, with a separate contract with WHO to provide technical assistance.

The funds manager could be a multilateral organisation (e.g. UNDP) or an organisation like the TDF, where they exist (probably just in the Philippines). The technical assistance provider could be a UN or other organisation. It would be necessary to use technical assistance funds to mobilise either long-term technical assistance or an ongoing series of short-term technical inputs from a person with skills in program development and implementation rather than relying on the existing staff resources of the technical assistance provider.

The advantage of this type of system is that it out-sources funds management and technical assistance to other agencies and minimises the involvement of AusAID country offices to overall contract management. Initial program design work could also be contracted-out. To work successfully it requires high levels of coordination between the funds manager and the technical assistance provider.

This funding modality is primarily an option for those countries:

- where there is no AusAID bilateral program or where it is decided that the bilateral program should not extend its focus to cover MSM work;
- where government systems are not sufficiently robust for disbursement of funds or NAPs do not wish to be involved in funds disbursement; and
- where no other ready funding mechanism such as a partnership fund exists.

Accordingly, the countries to which this funding modality could possibly apply would be Burma, Cambodia and the Philippines.

7.3.7 Use HAARP as a funding mechanism

AusAID's Cambodia country office has indicated it would be prepared to consider using the mechanism it has established for direct management of the HAARP CFP to channel additional funds to MSM. In essence this is a mechanism for direct funding of an INGO (FHI), a national NGO (KHANA) and two CBOs. FHI and KHANA are already undertaking considerable MSM work. The intention would *not* be to broaden the scope of HAARP but only to use an existing mechanism for contract management and funds disbursement. Use of this mechanism would assume that funds would be allocated to FHI and/or KHANA. A concern is limitations associated with the non-comprehensive prevention model implemented by these organisations, although KHANA's approach is broader. HAARP could not be used as a funding mechanism in other countries as funding is channelled direct to one implementing agency such as UNODC or a government and the implementation is solely IDU focussed, whereas FHI and KHANA are undertaking a range of work.

7.3.8 Delegated funding

One option would be to delegate funding for MSM programs to another development partner. The obvious choice would be USAID as it by far the largest funder of MSM programs in the region. This

would have the advantage of administrative ease for AusAID. USAID's HIV programs work in a broader range of countries compared to AusAID which would provide an opportunity to extend HIV and MSM work to countries where AusAID has no HIV program such as Lao. However in the current economic climate, it is unlikely that AusAID would be looking to extend the number of focus countries. The primary disadvantages is that USAID and its implementing agencies have a primary focus on civil society, with a reasonably low level of engagement with governments. The dual approach of working to build the capacity of government responses to HIV and MSM coupled with working with civil society would not occur. In addition, the prevention work of USAID funded implementing agencies is largely oriented around behaviour change communication, with insufficient focus on other elements that go to making a comprehensive prevention package. Delegated funding would also mean that AusAID's MSM work was less likely to draw on Australian expertise. There would also be no identifiable AusAID supported MSM program as it would be subsumed by the identity of the donor partner's program.

7.3.9 Research funding

In PNG, where the bilateral program has a strong interest in supporting research, this is a possible funding source. AusAID's Australian Development Research Awards provide another funding channel, although the researcher driven nature of these awards may mean that they are not responsive to AusAID's programmatic needs. AusAID could also consider commissioning research at either the Canberra or country office level.

7.3.10 Funding of APCOM and sub-regional networks

If AusAID wished to provide funding support for APCOM or sub-regional networks this could be done through AusAID country offices (depending on where the secretariat is based), the AusAID Bangkok Office in the case of APCOM and PSN, delegated funding to another donor supporting these networks or through a multilateral such as UNAIDS. AusAID's current funding support for APN+, APCASO and the Seven Sisters is through delegated funding through UNAIDS RSTAP. AusAID could also support these bodies through technical assistance provided by AFAO, possibly in conjunction with the Alliance's Technical Assistance Hub. Both AFAO and the Alliance have expertise in network management and capacity building.

7.4 Preferred funding modalities

Table 5 (below) lists the key funding modalities that best apply to the circumstances of each of the six focus countries. Where more than one funding modality warrants consideration, options are provided. The main considerations in choosing funding modalities for each country are summarised, along with the preferred option. In some cases, further consideration of options is needed by the HHTG and country offices.

It is recommended that AusAID use different funding modalities for developing the capacity of governments and for supporting HIV programs implemented by CSOs. Generally, the preferred funding option for supporting the capacity of governments is the proposed regional technical assistance fund. The funding modality for supporting CSOs should be based on a consideration of what would work best in different country contexts, as summarised in Table 5.

Table 5: Summary of key funding modality options, main considerations and preferred option

Country	Key funding modality options	Main considerations	Preferred option
<i>All countries</i>	<p>1. Regional Technical Assistance Fund managed by UNAIDS RSTAP</p> <p>2. Regional Technical Support Fund for the health sector</p>	<p>Option 1 leverages the convening power of UNAIDS to build government capacity to lead, manage and coordinate national responses in all six focus countries with minimal administration by AusAID. If implemented strategically it has the potential to have high impact for a relatively modest outlay of funds. Technical assistance for the strengthening the health sector response could be provided through this fund or a separate technical assistance fund established through WHO WPRO (option 2). Strengthening the capacity of NAPs in strategic leadership and coordination of the MSM response is currently the highest priority. If sufficient funds are available, two separate funds would be preferable as it would allow for a broader range and higher quantity of TA.</p>	<p><i>First priority:</i> Regional TA Fund managed by UNAIDS.</p> <p><i>Second priority:</i> Regional health sector TA fund managed by WHO</p>
<i>Burma</i>	<p>1. Three Diseases Fund</p> <p>2. Contracts with existing INGO(s) in Burma</p> <p>3. Outsourced fund manager & contracted TA</p>	<p>Option 1: Additional funds are required for an intensive response to the hyper HIV epidemic among MSM. Funds allocated to the 3DF are not tied so may not be spent on MSM. Minimal administrative burden for AusAID with the 3DF.</p> <p>Option 2: Utilises existing in-country operations and expertise. Non-Australian INGOs should be considered.</p> <p>Option 3: Compared to option 2, reduces the administrative burden on AusAID through less contract management, unless only one existing INGO was contracted under option 2. The funds manager could allocate funds to multiple NGOs, which may have advantages. The advantages of options 2 & 3 is that they ensure funds are directed to scale-up of MSM programs. In the context of Burma's hyper-epidemic among MSM this approach can be justified.</p>	<p>Increased Australian contribution to the 3DF or outsourced fund manager with contracted TA</p>
<i>Cambodia</i>	<p>1. HAARP funding mechanism</p> <p>2. Fund manager with contracted TA</p>	<p>Option 1 is predicated on funding NGOs in receipt of HAARP funding. There are concerns regarding limitations of their prevention programming.</p> <p>Option 2 would facilitate implementation of a comprehensive prevention model and a distinctive AusAID approach</p>	<p>Fund manager with contracted TA</p>
<i>Indonesia</i>	<p>1. HCPI</p> <p>2. IPF</p>	<p>Option 1: There may be administrative barriers to extending the HCPI contract, coupled with a possible desire to maintain the current focus of the bilateral program. If these factors apply, this would mean that consideration of inclusion of MSM in the bilateral program would need to wait till design work which take place in 2015.</p> <p>Option 2: Provides a government owned and aligned flexible funding mechanism</p>	<p>IPF</p>
<i>PNG</i>	<p>Sanap Wantaim</p>	<p>The bilateral program is already implementing some HIV and MSM work and is willing to do more with funding support and the agreement of NAC. Government systems are currently too fragile.</p>	<p>Sanap Wantaim</p>
<i>Philippines</i>	<p>Outsourced fund manager with contracted TA</p>	<p>Reduces the administrative burden on AusAID country office.</p>	<p>Outsourced fund manager with contracted TA</p>
<i>Vietnam</i>	<p>Government systems with contracted technical assistance</p>	<p>Strong desire of the Government for funds to be disbursed through its systems. There would be a need to separately contract technical assistance to support program development and implementation as the VAAC does not have expertise in MSM programming.</p>	<p>Government systems supplemented by contracted technical assistance</p>
<i>Regional Networks</i>	<p>AusAID offices or delegated funding + TA</p>	<p>Delegated funding restricts AusAID's oversight responsibilities. AFAO, possibly in conjunction with the Alliance's Technical Assistance Hub, has expertise in network management and capacity building</p>	<p>Delegated funding + TA through AFAO/Alliance</p>

7.5 Other mechanisms for AusAID's support of MSM programming

The first part of this section reviewed possible funding modalities. The section now goes on to examine other mechanisms for AusAID's support of MSM programming. They are ensuring that technical assistance is available to support program development and implementation and engagement with the Global Fund to maximise the benefits of Australia's investment.

7.5.1 Technical assistance and long-term partnerships

Whichever funding modalities are used in particular countries, it is essential that provision be made for funding technical assistance for program implementation, including capacity building and organisational strengthening, especially for CBOs. Long-term technical assistance using the modality of a funds manager with separate contracted technical support could involve funding of long-term positions in agencies (e.g. MARP/MSM officers in UNAIDS or other UN agencies) and long-term partnerships between key in-country MSM CBOs and MSM CBOs elsewhere in the region and externally. There is also the option of a contracted technical support position in AusAID's Bangkok office to support programs in Burma, Vietnam, Philippines and Cambodia. Alternatively, this type of regional position could be contracted out to a multilateral organisation.

Technical assistance could be provided from a range of sources. Members of AusAID's HIV Consortium for Partnerships in Asia and the Pacific (the Consortium), such as AFAO, are already providing some technical support for HIV and MSM work. The option of utilising the HIV/AIDS Technical Support Facility for South East Asia and the Pacific should also be explored.

AusAID has recently decided to provide funding to the International HIV/AIDS Alliance to support the establishment of a Regional Technical Support Hub which will be hosted by KHANA, an Alliance linking organisation in Cambodia. The Hub will offer demand driven, south-to-south oriented technical support to civil society organisations in the region to strengthen their leadership and capacity in a broad range of HIV-related programming using a diversity of technical assistance modalities. AusAID's funding includes the cost of 180 consulting days for AusAID priority countries. Technical assistance will be available to both Alliance affiliated organisations and more broadly. AusAID funding will be for three years, after which the Hub will need to be self-sustaining. The Hub is well placed to support both Global Fund grant implementation and AusAID funded HIV and MSM work by CSOs. AusAID country offices could play a role in identifying high priority technical support needs for MSM work, and CSOs funded to undertake MSM work should be made aware of the availability of support from the Hub. There is potential for the Hub to work in collaboration with other technical service providers with a community focus such as AFAO and other Consortium partners. This should be encouraged by AusAID to avoid the risk of a multiplicity of technical service providers. Other sources of technical assistance are the HIV/AIDS Technical Support Facility (TSF) Southeast Asia & Pacific and AusAID's Health Resource Facility

Longer-term partnerships could be developed with organisations with extensive MSM and HIV expertise. AFAO and some of its member organisations, along with the Alliance, have extensive experience, in working in tandem with governments and CBOs in advocacy strategies and skills development, community development and mobilisation, and national network development, all of which are significantly under-developed in the regional response. Technical assistance in these areas can be more effectively delivered through ongoing partnerships rather than one-off technical assistance.

7.5.2 AusAID's engagement with the Global Fund

The aid effectiveness agenda means that AusAID needs to work through partnerships to maximise impact. The Global Fund has become the single largest funder of HIV programs in Asia and the Pacific and is therefore a key partner for AusAID. The key to leveraging most from Australia's

investment in the Global Fund is at the country level. In countries where AusAID has a significant HIV program, it can work directly with governments and other partners through membership of the CCM. In countries where AusAID has a small HIV presence, it can work through multilateral organisations at the country and regional level. Australia can also influence Global Fund policies and practices through its membership of the Global Fund Board.

Global Fund proposals

Access to Global Fund grants will be critical in the scaling-up of HIV programs for MSM in Asia Pacific. This makes it essential that a strong effort is put into assisting countries with development of grant proposals. AusAID, either as a member of the CCM or working through multilaterals, can work in partnership with governments and other development partners to ensure that MSM are accorded priority in Global Fund proposals commensurate with NSPs and the local epidemiological context. As the Global Fund moves towards funding of national strategies it will be important to ensure that MSM are meaningfully included in those strategies. This underlines the importance of developing National MSM Strategic Frameworks and costed Operational Plans as a sub-strategy to the NSP.

Ensuring the success of Global Fund grants

At the country level Australia can make key contributions to ensure that grants are being implemented in a way that makes best use of funds. AusAID should use its membership of CCMs and work through UNAIDS and WHO to ensure that all Global Fund proposals for MSM include sufficient technical assistance to support program implementation. In the design of country level HIV and MSM work AusAID should give priority to identifying how it can support technical assistance to existing Global Fund grants for MSM work.

The Global Fund and sexual minorities

Two global level initiatives that may assist in a greater level of funding for MSM work by the Global Fund are plans to appoint five new Technical Review Panel (TRP) members who have expertise in gender and issues faced by sexual minorities, and consideration by the May 2009 meeting of the Global Fund Board of a Strategy on Sexual Orientation and Gender Identity (SOGI). The strategy makes recommendations on improving the expertise of CCMs, revising the guidelines for round 10 proposals, improving TRP guidelines, and Global Fund monitoring, evaluation and reporting mechanisms. AusAID, through its membership of the Global Fund Board is well placed to monitor implementation of SOGI. Where AusAID is a member of CCMs it can promote country level implementation of the SOGI recommendations or request UNAIDS representatives to do so where AusAID is not a CCM member.

The Global Fund and civil society.

Country level Global Fund decision making mechanisms provide an opportunity for civil society to have a place at the table, but the reality has often been that this is tokenistic. The *Evaluation of the Global Fund Partner Environment* recommended strengthening the involvement of civil society in the Global Fund by formalised technical assistance to CSOs, establishment of CSO steering committees to build capacity for engagement with the Fund, and support for CSO organisational and network strengthening. At a county level, AusAID can play a role in encouraging implementation of these recommendations, which all have relevance to MSM programming.

Section 8: Operationalising AusAID's support

Building on the outline in 7.2 of AusAID country office perceptions relating to MSM programming and funding modalities, this section discusses the issue of strategic coherence between *Intensifying the response* and the priorities of AusAID country programs. The section also discusses a phased approach to AusAID support for MSM programming within the context of possible financial constraints as a result of the current global financial crisis.

8.1 Setting and implementing strategic directions

This scoping exercise has been predicated on the basis that additional funds will become available for AusAID's HIV and AIDS work and that some of those funds will be allocated to fund work addressing HIV epidemics among men who have sex with men.

AusAID's *Building on the 2010 Blueprint: A reform agenda for 2015* specifies that AusAID's central office sets strategic directions, with country offices being responsible for program design, implementation and management. The *AusAID 2010 Blueprint* indicates that it is the role of thematic groups to perform the role of ensuring contestability in program design and review and acknowledges that this will lead, at times, to a creative tension with country and regional programs.²⁵

When AusAID's support for HIV programming is compared to its new strategy *Intensifying the response*, support for programs addressing HIV among men who have sex with men would appear to be the most significant gap.

AusAID will need to decide whether any new funding for HIV and AIDS is provided to country programs as earmarked for particular priorities, or whether the funds are provided in an untied manner, with country programs free to determine priorities. Based on consultations with country offices for this scoping exercise, it is unlikely in some countries that any or significant amounts of new AusAID monies available for HIV and AIDS would be allocated to MSM programming for the reasons outlined above.

8.2 Country priorities for MSM work

At the time this scoping exercise was commissioned it was anticipated that AusAID may have significant growth funds available as a result of the Australian Government's commitment to increase the percentage of GNI allocated to ODA. While budget allocations for 2010-2011 are not known, the global financial crisis may, in the short term, limit growth of the aid budget. In the short-term this may limit the amount of new funding that will be available to meet the commitments in *Intensifying the response* to expand AusAID's support in addressing HIV epidemics among MSM. This issue could be approached by:

- Ensuring that AusAID's MSM programming is based on available evidence on efficacy for prevention programming for most at risk populations generally, and for MSM in particular (see Annex 4).
- Examining existing HIV funding allocations against the priorities set out in *Intensifying the response* and possibly making reallocations.

²⁵ pp. 7-8.

- Phasing in AusAID’s support for MSM work, with a concentration on foundation type, lower cost, high impact work in initial years, with increased funding support as additional funding becomes available.
- Initially concentrating AusAID’s support in a number of high priority countries, with a subsequent expansion of the number of countries as more funds become available.

None of these approaches is mutually exclusive and combinations could be used to maximise the geographic impact of AusAID’s support. For example, in initial years when funding was limited, AusAID could support foundational work in all six countries through the proposed Regional Technical Assistance Fund with a concentration on advocacy, strategic information and development of National MSM Strategic Frameworks and costed Operational Plans. This could be accompanied by support for civil society prevention programs in 3-4 countries of high priority.

In the context of limited resources there is an argument for concentrating resources in a few high priority countries in order to maximise impact. It would be desirable over time to expand AusAID’s support to additional countries in light of the low levels of coverage of MSM programs in all countries within scope. Table 6 sets out an approach to phasing in AusAID support for MSM programming in the context of resource constraints.

Table 6: Phased AusAID support for MSM programming in the context of resource constraints

Phase	Options
Phase 1	Funding of the Regional Technical Assistance Fund for use in the 6 focus countries Initial design work on how MSM work will be programmed in 3-4 priority countries, recognising that program development in PNG may be quite slow
Phase 2	Continued funding of the Regional Technical Assistance Fund Funding of MSM programming in 3-4 priority countries
Phase 3	Continued funding of the Regional Technical Assistance Fund (if there is an ongoing need) Extending funding for MSM programming to cover all 6 priority countries

Criteria that could be used to derive a priority order for the six countries within scope are the relative priority of the country for AusAID’s HIV work, the level of commitment by NAP to MSM work (with low commitment being an indicator of the need for support through advocacy and program development), existing coverage levels, total population as bigger populations mean more MSM, HIV prevalence among MSM, and availability of funding from other donors. Application of these criteria requires qualitative judgements which are contestable. The weight given to particular criterion has a significant effect on determining the relative priority order. Based on these criteria, countries can be ranked in the following priority order:

1. Indonesia: is one of Australia’s highest priority countries for development assistance and has AusAID’s second largest bilateral HIV program. Size estimation indicates a large number of MSM but coverage by existing programs is low with many geographic gaps. These programs are primarily supported by USAID, but funding appears to be flat-lined or may decrease slightly. The Global Fund round 8 grant will not significantly increase coverage. The number of donors in Indonesia has shrunk and other donor sources apart from the Global Fund are unlikely. While MSM have been included in the NSP this has not as yet been translated into significant program development, but the NAC is starting to give MSM a higher priority. The forthcoming development of a National MSM Strategic Framework and Operational Plan provides a good opportunity for AusAID to align its support.

2. PNG: is also one of Australia’s highest priority countries for development assistance and has AusAID’s largest bilateral HIV program. Coverage of MSM by existing HIV programs is very low. These programs are primarily supported by AusAID, with a small amount of funding from USAID. While more information is needed to guide program development, there is consensus among technical experts that an enhanced response is needed to address HIV and male to male sex in PNG. Currently there is no Global Fund money specifically targeting MSM. The likelihood of other donors providing

support for MSM work in PNG is very low so AusAID is the most likely source of funding for a scaled-up response. The commitment by the NACS to give priority to MSM is low.

3. Burma: the primary justification for Burma's relatively high ranking is the extremely high rate of HIV prevalence among MSM and the need for an intensive response to bring this epidemic under control. Even if the Global Fund round 9 proposal is successful it will not deliver sufficient resources for the intensive response needed. There is a limited number of donors in Burma.

4. Philippines: the principal reasons the Philippines has been ranked at four is the low but increasing HIV prevalence rates among MSM represents a golden opportunity for prevention interventions. Given the Philippines lower-middle income status, support from other donors is unlikely, with the possible exception of the Global Fund. The Global Fund grants currently supporting MSM work will end shortly, as will limited AusAID support which is being channelled through UN agencies. Size estimation indicates a large number of MSM but coverage by existing programs is very low. Given structural problems in the national AIDS response and the health system, an effective response to HIV among MSM is unlikely without external technical and financial assistance.

5. Vietnam: HIV programs for MSM currently attract a low priority in the NAP. Funding is largely from USAID and the current level of funding is unlikely to increase. Global Fund grants do not include MSM programs. UNAIDS has been strongly advocating for an increased priority for MSM programs and that work may start to show some results in terms of government and donor commitment. The ranking of Vietnam is possibly the most contestable of all the rankings and an argument could be made for moving it up to four.

6. Cambodia: has been accorded the lowest relative ranking as MSM programs are more developed compared to other countries within scope, especially in relation to the size of the population. This is reflected in the existence of a National MSM Strategic Framework and Operational Plan and the largest Global Fund grant for MSM. Nonetheless, coverage is well still below universal access targets.

Annex 3 presents some country specific issues that AusAID should consider in any programming decisions.

8.3 Regional level funding

The focus of the scoping exercise has been on how AusAID can support scaling-up of country level activities as this is where the greatest impact will be made. Regional level funding has not been canvassed, with the exception of supporting country oriented technical assistance and the possibility of supporting APCOM and sub-regional networks.

It has not been possible to make any thorough assessment of the effectiveness of the work of APCOM and the sub-regional networks, although APCOM does appear to have established itself as a key player at the regional level and has forged good working relationships with the key regional players. Perhaps its key contribution has been bringing all the regional partners together to work collaboratively. To date, APCOM has not been able to mobilise sufficient ongoing funding to support its core functions as most funding has been for specific functions (e.g. satellite meetings at conferences) or short-term.

If AusAID wished to consider funding of sub-regional networks, priorities would be the Pacific Sexual Diversity Network and the network that may be formed in insular south east Asia as they cover the geographic areas that attract AusAID's highest priority for HIV programs. PSDN includes PNG and also Pacific island states that are a priority for AusAID (and is already receiving AusAID funded technical support through AFAO). The insular south east Asia network will include Indonesia. The Purple Sky Network is already in receipt of more substantive donor support, compared to these other networks.

Annex 1: Epidemiology – country summaries

Burma

MSM were included in HIV sentinel sero-surveillance (HSS) for the first time in 2007. A sample of 400 MSM was recruited from MSM HIV services in Yangon and Mandalay. HIV prevalence was 29.3 percent, (23.5 % in Yangon and 35 % in Mandalay).²⁶ Compared to other sentinel populations, HIV prevalence among MSM was the highest, with prevalence among IDUs at 29.2 percent. Syphilis prevalence among MSM was zero in Mandalay and 14 percent in Yangon. HIV prevalence peaked in MSM aged 30 and above, but was still high in MSM aged 15-24 at 15.5 percent. Prevalence in this age group may be a proxy for HIV incidence.

The HSS was repeated in 2008 among 400 MSM in Yangon and Mandalay and found an HIV prevalence rate of 28.8 percent with a range between sites of 25-33 percent. Syphilis prevalence was 14.1 percent with a site range of 14.6 to 15.7 percent.²⁷ Behavioural data was not collected in either HSS survey.

Data in both HSS surveys was not disaggregated by MSM and transgender. The facilities in which participants were recruited are heavily patronised by transgenders, so the number of transgenders in the sample may have been high, although no data is available.²⁸

Facility based surveys can be questioned in regards to the representativeness of the sample in relation to the wider population of MSM. A community based IBBS among MSM in Yangon and Mandalay was conducted in early 2009 to obtain a more representative picture of HIV prevalence. Results are currently being analysed. Preliminary data from Yangon indicates that the survey succeeded in recruiting a broad based sample of different types of MSM who predominantly have not had previous contact with NGOs undertaking HIV and MSM work. Preliminary analysis also indicates that HIV prevalence rates are high and similar to the 2007 and 2008 HSS.²⁹

Cambodia

The 2005 STI Sentinel Surveillance (SSS) sampled 547 MSM (male identified 46%, transgender 54%) in Phnom Penh and two provincial cities. In Phnom Penh, HIV prevalence among transgenders was 17 percent and among other MSM was 5 percent. In Battambang and Siem Reap, HIV prevalence among transgenders was 2 percent. No cases of HIV were found among male identified MSM outside Phnom Penh. Most other SSS data was not disaggregated by male identified MSM and transgenders. A summary of key data is presented in Table 7.

²⁶ Myanmar Ministry of Health and WHO Myanmar, Report of the HIV Sentinel Sero-surveillance Survey, 2007, Myanmar.

²⁷ Oscar Bareneche, WHO Myanmar, personal communication, April 2009. Report not yet published.

²⁸ *ibid.*

²⁹ *ibid.*

Table 7: Cambodia IBBS data, 2005³⁰

Indicator	All MSM (Range between sites %)
HIV prevalence	1 - 9
Any STI	7 - 10
Two or more male partners: last month	63 - 74
Two or more female partners: last year (for male identified MSM)	80 - 87
Consistent condom use with casual male partners: last month	23 - 55
Consistent condom use with casual female partners: last month	24 - 77
Ever tested for HIV	68 - 75

Indonesia

The 2007 IBBS surveyed MSM in 6 large cities and transgenders in 5 large cities, with biological data being collected in 3 cities. A summary of key results is presented in Table 8.

Table 8: Indonesia IBBS data, 2007³¹

Indicator	MSM (Range between sites %)	Transgender (Range between sites %)
HIV prevalence	2 - 8	14 - 34
Any STI	29 - 34	42 - 55
Median number of male partners: last month	2 - 10	1 - 4 *
Consistent condom use receptive anal: last month	13 - 26	15 - 50
Consistent condom use insertive anal: last month	14 - 29	-
Comprehensive HIV & STI knowledge	6 - 40	-
Contact with NGO outreach: last year	32 - 75	-
STI check-up: last 3 months	18 - 68	44 - 86
HIV test: past year	22 - 53	33 - 86

* Median number of male clients for anal sex: last week

PNG

There is no meaningful epidemiological data in PNG on HIV transmission among population groups. An IBBS has not been conducted and for case surveillance, mode of transmission is not reported in 87 percent of cases.³²

The Philippines

The Philippines 2007 IBBS which surveyed 1,059 MSM, with no disaggregation of data for male identified MSM and transgenders, found an HIV prevalence rate of 0.3 percent. This low level is consistent with the low level of HIV in the general population. A summary of key data is presented in Table 9.

National HIV and AIDS case reporting data has shown a significant increase in cases among MSM over the period 2005-2008, albeit from a low base. Case reporting data indicates that the number of newly reported HIV and AIDS cases attributable to homosexual and bisexual contact increased from

³⁰ NCHADS. Survey on STDs among brothel-based female sex workers, MSM and Police in Cambodia, 2007. IBBS.

³¹ Indonesia National AIDS Commission, Integrated Biological and Behavioural Surveillance among Most at Risk Group in Indonesia, 2007.

³² National Department of Health, The 2007 STI, HIV and AIDS Annual Surveillance Report.

61 (32% of all cases) in 2005 to 247 (67% of all cases) in 2008. Over this same period, cumulative HIV and AIDS cases among MSM almost doubled to 1,097.³³ This could indicate the start of a significant epidemic among MSM in the Philippines, especially given the low HIV knowledge and reasonably low levels of consistent condom use, as reported by the IBBS.

Table 9: Philippines IBBS data, 2007³⁴

Indicator	All MSM (%)
HIV prevalence	0.3
Sexual intercourse with more than one partner: last year	40
Condom use at last sexual intercourse	45
Comprehensive HIV knowledge	10
Reached by HIV prevention program: last year	19
HIV test: past year	16

Vietnam

The 2005-2006 IBBS surveyed 790 MSM in Hanoi and Ho Chi Minh City. Data was not disaggregated between male identified MSM and transgenders. However, transgenders made up only a small proportion of the sample.

Table 10: Vietnam IBBS data, 2005-06³⁵

Indicator	All MSM (Range between sites %)
HIV prevalence	5 - 9
Any STI	7 - 12
Two or more male partners: last month	44 - 70
Sex with a female partner: last year	40 - 40
Consistent condom use with consensual male partners: last month	29 - 37
Consistent condom use with consensual female partners: last month	17 - 24
Comprehensive HIV knowledge	18 - 46
Received information on safe sex: last 6 months	53 - 60
STI check-up: last 3 months	18 - 68
Ever had voluntary HIV test	15 - 16
Ever injected drugs	4 - 9

³³ Source: Philippines National Centre for Disease Prevention and Control.

³⁴ Philippine National AIDS Council, UNGASS Country Report 2006-2007.

³⁵ Vietnam Ministry of Health, Results from the HIV/STI Integrated Biological and Behavioural Surveillance in Vietnam 2005-2006.

Annex 2: Mapping

This Annex presents the mapping of the response to HIV epidemics among MSM in each of the six focus countries, followed by mapping of major activities being undertaken at the regional level. The information for the mapping was collected from documents and interviews. The purpose of the mapping was to capture only significant HIV and MSM activities. Given the broad geographic scope of work only a limited number of interviews were possible in each country, concentrating on the key partners in the MSM response. There may be some gaps in the mapping but these would generally be of non-significant activities. Caution should be used in interpreting data on coverage of programs as definitions of coverage may differ and data could include repeat contacts with the one person. Coverage data does not give any indication of the intensity of coverage. Unless otherwise specified, funding figures are grants to NGOs/CBOs and do not include the cost of TA or overheads of organisations making the grants.

2.1 Burma

MSM included in NSP?	Yes. MSM included as part of a focus on populations at higher risk. These populations are the highest priority for HIV prevention. The 2006-2010 strategy is quite detailed, with MSM specific outputs and outcomes in prevention, empowerment, strengthening the enabling environment, and care, support and treatment.
MSM included in NSP Operational Plan?	Yes. The Operational Plan 2008-2010, which is aligned with the NSP, ranks MSM as the second highest priority population, after programs for sex workers and their clients. It sets a 23% MSM coverage target for prevention programs by 2010 (approx 55,000). Total annual cost of the prevention program to achieve this coverage level is estimated to be US\$3 million (may be a significant underestimate). Geographical priorities are set. Good quality plan.
MSM included in national M&E framework?	Yes. Specific MSM indicators.
MSM specific Strategic Framework and Operational Plan?	No. While the overarching NSP Operational Plan 2008-2010 (see above) provides clear overall strategic directions, a greater level of operational detail is needed for program development and a more coordinated approach.
MSM coordination mechanism?	MSM come under the Sexual Transmission Working Group, a partnership forum chaired by the NAP, with UNAIDS providing the secretariat. Reported as not operating effectively, especially in relation to coordination. An MSM NGO working group has recently been established.
Other Government policy documents on MSM?	No
Legal status of male-to-male sex?	Sodomy is a criminal offence. No legal protections for the human rights of MSM.
Assessment of level of priority for MSM in the NAP	MSM are now attracting higher priority in response to epidemiological data, although the response is largely donor-driven. A higher level of leadership and coordination by the NAP is needed.
MSM population size estimate	272,000: based on 2% of males aged 15-49 having sex with males in the past year (Derived by external TA). Quoted in NSP. Level of national ownership not known.
MSM included national HIV surveillance system?	Yes (with support from WHO)
Extent of social research	Very limited
Government funding for MSM interventions?	No earmarked funding
Global Fund grant for MSM interventions?	No, but applying for round 9. Proposal will prioritise care and treatment. MSM work allocated 6% of total grant
Other major donors contributing to MSM work	<ul style="list-style-type: none"> • Major Donor: Three Diseases Fund (3DF) provides grants to Alliance, AMI, CARE, Myanmar Anti-Narcotics Association, MSF-H, PGK, PSI, and World Vision for MSM work aligned with NSP. Funding is not separated by target group and an estimate of MSM expenditure is not available. 3DF funding spans 2006-2011 & totals US\$100m. Donors are Australia, European Commission, the Netherlands, Norway, Sweden, and the UK. The 3DF provides 40% of total HIV funding for Burma • AusAID: contributes A\$15 million to 3DF over 2007-2011. Not tied to one disease or any specific area such as MSM. Also funds some MSM work by Australian

	<p>NGOs through the Periodic Fund for Humanitarian Assistance to Burma (small amounts).</p> <ul style="list-style-type: none"> • USAID: (managed from Regional Mission, Bangkok) main partner is PSI, with some funding to the Alliance. Estimated annual MSM funding is \$600,000. PSI contract ends in 2010. Nature of next USAID design unknown but not envisaged to be significantly different. • UNFPA: funds PSI. Funding level of MSM component unknown • Gates Foundation: funds PSI. Funding level of MSM component unknown • EC: funds the Alliance & MDM. Funding level of MSM component unknown <p>UNAIDS estimates that 6% of all HIV funds in Burma are expended on HIV and MSM work</p>
Main MSM implementing partners	<ul style="list-style-type: none"> • PSI's: Targeted Outreach Program is by far the largest MSM program in Burma, operating in Yangon, Mandalay and 13 major provincial cities. Provides peer outreach, condom & lubricant social marketing, DICs, STI clinics (13 sites), VCT (2 sites), care & support for MSM PLHIV (7 sites). PSI assisted with formation of National MSM Network & National Positive MSM Network. Estimate of MSM expenditure not available. • The Alliance: builds MSM CBOs and informal MSM groups to respond to HIV and sexual health through peer education, workshops, DICs, & referral to VCT & STI services in Yangon, Mandalay & six provincial cities. • CARE: operates an MSM prevention oriented project in Yangon, Mandalay and five other provinces, working with MSM self-help groups • Burnet: works with NGOs/CBOs taking a broad male sexuality/male sexual health approach, including a focus on MSM • MSF Holland: has 20 clinics in Myanmar providing STI, VCT and HIV care and treatment to a range of clients, including MSM. Also employ some MSM peer outreach educators. • World Vision: reaches some MSM as part of its more broadly targeted HIV prevention and care, support and treatment work in 6 provinces • MDM: conducts a VCT and care & treatment clinic in Yangon and one province, with some community outreach. • Government health services: through 44 AIDS/STI teams. Not MSM specific. • UNAIDS: active role in advocating for MSM and NSP, Operational Plan & GF proposal development.
Main activities	<p>Outreach and peer education, condom & lubricant distribution & social marketing, IEC development & distribution, DICs, community mobilisation, advocacy, referral to VCT, STI clinics and care & treatment services. Distinctive: extensive development of INGO VCT/STI clinics, integrated with MSM DICs in major centres</p>
Coverage of MSM interventions	<ul style="list-style-type: none"> • Geographic: Yangon and more than 14 provincial cities • Target groups: gay, MSM non-self identified, MSW, TG • PSI: estimates current annual coverage of 75,000 MSM. Details of intensity of coverage not available. • 3DF: in 2007 implementing partners reached 7,285 MSM with prevention activities, 659 with STI services, and 867 with VCT. Condom & lubricant distribution: 194,500 units.

2.2 Cambodia

MSM included in NSP?	<p>Yes. MSM included as a priority population for prevention (2006-2010). Priority populations are not ranked, however commercial sex workers and their clients are in effect the number one priority. No priority differentiation with other priority populations but MSM are clearly accorded a high priority.</p>
MSM included in NSP National Operational Plan?	<p>Yes. This is a broad level overview document providing indicative key activities only.</p>
MSM included in national M&E framework	<p>Yes, specific MSM indicators</p>
MSM specific Strategic Framework and Operational Plan?	<p>Yes, 2008-2011 plan developed by National AIDS Authority and partners. Aligned with NSP, Global Fund grant and other donor funded activities. Sets a target of 60% MSM coverage with a comprehensive prevention program by mid-2011 (will not be achieved with current funding)</p>
MSM coordination mechanism?	<p>MSM TWG convened by National AIDS Authority involving a broad partnership. Effectiveness could be significantly improved. Needs a better functioning NAA secretariat and greater commitment by some partners.</p>

Other Government policy documents on MSM	National Policy and Strategy on STIs Prevention and Care includes MSM clinical guidelines.
Legal status of male-to-male sex	No laws prohibiting male-to-male sex. No legal protections for the human rights of MSM.
Assessment of level of priority for MSM in the NAP	The NAA has taken on a leadership role, although its capacity in coordination needs to be strengthened.
MSM population size estimate	140,000: based on 4% of males aged 15-49 having sex with males in the past year (Global Fund round 7 proposal). Not an official government figure.
MSM included national HIV surveillance system?	Yes (surveillance conducted with support of US CDC GAP)
Extent of social research	Limited
Government funding for MSM interventions?	No earmarked funding
Global Fund grant for MSM interventions?	Yes: round 7. US\$6 million 2009-2013, plus some limited non-earmarked MSM funds in round 5
Other major donors contributing to MSM work	<ul style="list-style-type: none"> • Major donor: USAID: funding TA agencies (FHI, KHANA, PSI, PACT) who make sub-grants to CBOs (MSM & non-MSM). Current contracts end Nov 2010. Focus of new USAID contract unknown. Funds not allocated by target group. Funding level of MSM component unknown • EC: low level of funding to KHANA. Funding level of MSM component unknown • AusAID: HAARP CFP will have an MSM component. Funding level of MSM component unknown • ADB: new mobile population project will reach MSM as part of broader targeting • DFID: funding PSI for condom social marketing: non-MSM specific. Funding ends 2013
Main MSM implementing partners	<ul style="list-style-type: none"> • FHI: conducts the largest MSM program in Cambodia funding 8 CBOs/NGOs undertaking prevention work primarily in Phnom Penh and 3 provinces, plus one small HIV treatment centre for most at risk populations. Estimate US\$300,000 from USAID & US\$300,000 from Global Fund annually, including TA & overheads. • KHANA: funding 3 CBOs undertaking prevention work in 7 provinces: grants total US\$139,200 (annual). • PSI: nationwide condom social marketing. Not possible to identify MSM component of funding. • PACT: capacity building of CBOs (due to end in Nov 2009) • Pharmaciens Sans Frontieres: STI/VCT clinic in Phnom Penh targeting MSM and other vulnerable populations. USAID funded. Funding level of MSM component unknown • Marie Stopes: STI clinics in Phnom Penh & 2 provinces (Global Fund round 7). Funding level of MSM component unknown • Government health services: VCT sites, STI clinics and ART treatments sites. Has been MSM-oriented training of staff in 10 of 32 STI clinics. • National MSM Network: funded by KHANA, FHI, PACT • UNAIDS: active role in advocating for MSM and NSP, Operational Plan & GF proposal development.
Main activities	Outreach and peer education, condom & lubricant distribution & social marketing, IEC development & distribution, DICs, community mobilisation, local level advocacy, referral to VCT, STI clinics and care & treatment services. Distinctive: Development of branded DICs (Mstyle) linked to broader social marketing and internet site, incorporating community development. FHI operated ambulatory HIV treatment facility in Phnom Penh specifically for MSM and sex workers.
Coverage of MSM interventions	<ul style="list-style-type: none"> • Geographic: MSM HIV prevention programs in Phnom Penh and 10 Provincial cities: KHANA will work in 2 new provinces in 2009. • Target groups: gay, MSM non-self identified, MSW, TG • FHI: 8,000 (current coverage estimate) • KHANA: 7,700 (2008). Target for 2009 is 9,250 • STI clinics: 3,400 MSM attendances at government (10%) and NGO (90%) STI clinics in 2008 • Global Fund: it is estimated that an additional 13,000 MSM will be reached annually with GF round 7 funds by 2013 (commenced in 2009) • PSI: MSM specific data not available on condoms sold/distributed to MSM but condoms readily available through social marketing and CBO distribution.

2.3 Indonesia

MSM included in NSP?	The 2007-2010 Strategy identifies MSM and transgender and MSWs as populations at higher risk for HIV.
MSM included in NSP Operational Plan?	The Indonesia National HIV & AIDS Action Plan 2007-2010 provides very broad level overall directions for operationalising the NSP. The Action Plan states that the main targets for the prevention program are IDUs and SWs, including MSW & TGSW, and the clients of sex workers. While not explicitly stated, other MSM & TG (i.e. non-sex workers) are a second-order priority.
MSM included in national M&E framework?	Yes, specific MSM and TG indicators
MSM specific Strategic Framework and Operational Plan?	No, but the NAC has requested AusAID's support in developing an MSM Strategic Framework and costed Operational Plan. AusAID has agreed to this request and the work will be completed in the second-half of 2009.
MSM Coordination mechanism?	In 2008 NAC established a MSM Working Group. Meetings are infrequent.
Other Government policy documents on MSM?	No
Legal status of male-to-male sex?	No laws prohibiting male-to-male sex. No legal protections for the human rights of MSM.
Assessment of level of priority for MSM in the NAP	Implementation of the NAP clearly indicates IDUs are the number one priority, followed by SWs and their clients. MSM appear to be the third highest priority for prevention work, not that this is explicitly stated. Recently, MSM have started to attract a greater level of priority from government, but this has not yet been reflected by any significant increase in program activity.
MSM population size estimate	Number of MSM estimated to be between 384,000 and 1,148,000. The mid-point estimate is based on 3% of adult males aged 15-49 having sex with males in the past year. Estimated number of transgender sex workers ranges from 21,000 to 35,000. Number of clients estimated at between 62,000 to 104,000. (Ministry of Health estimates, although level of national ownership not known)
MSM included national HIV surveillance system?	MSM & TG included as one of the populations in the Department of Health/NAC IBBS for most-at-risk groups (with funding and TA from FHI)
Extent of social research?	Limited
Government funding for MSM interventions?	No earmarked funding
Global Fund grant for MSM interventions?	Yes, MSM included in round 8 grant for 12 high priority provinces, involving BCC through peer education & outreach, condom social marketing, capacity building of local implementers and STI service provision. Rollout to commence in July 2009. The Indonesian Planned Parenthood Association will be the PR for all peer outreach & education activities. No sub-recipients will be used. The IPPA does not previous experience with MSM programs and may need substantial technical assistance. Some informants are of the view that there is insufficient TA built into the grant. The round 9 proposal seeks to expand the MSM components of round 8 to the 18 provinces not included in round 8.
Other major donors contributing to MSM work	<ul style="list-style-type: none"> • USAID: is the major donor for HIV and MSM work. Funding to FHI for sub-grants to CBOs with an MSM-specific focus totals US\$915,000 in 2009 and for organisations with a MSM components as part of broader work totals US\$190,000 (excluding TA and overhead). FHI's USAID contract ends September 2009. A continuing focus on most-at-risk populations is expected, with a possible small decrease in MSM funding. USAID also funds Constella Futures to implement the Health Policy Initiative project. MSM funding component not known. • AusAID 1: The main focus of the bilateral program is on IDU and prisons in Jakarta and West Java. To date the prisons work has not included a significant work on male-to-male sexual transmission. In Bali AusAID funds YGD, a local CBO, for MSM-specific work (A\$95,000 annually till Dec 2009. Renewal possible). Currently not undertaking MSM-specific work in Papua or West Papua. • AusAID 2: In 2009 AusAID will fund technical assistance for the NAC to develop a MSM & TG Strategic Framework and costed Operational Plan, as a sub-strategy of the NSP. • AusAID 3: funding to AFAO to assist in the development of the Indonesia Gay, Transgender and MSM Network (GWL-INA). Initial work funded by AHAPI grant of A\$189,000 for this & 4 other projects. Current year: A\$26,500, years 2-3 TBC. • UNAIDS: has primarily been involved in advocacy with the NAC leadership relating to universal access for MSM and the Human Rights Commission and some limited funding and capacity building for MSM and TG networks

<p>Main MSM implementing partners</p>	<ul style="list-style-type: none"> • FHI: is working in Jakarta and 8 priority provinces through sub-grants to 5 CBOs. • YGD: HIV & STI prevention work among MSM, MSW & TG • AFAO: assisted in the development of the GWL-INA through funding and facilitating consultations across 3 regions, mentoring and support for a national meeting. Currently conducting a scoping study to identify future capacity building needs for the GWL-INA. (See also AFAO regional level work, listed later in this Annex.) • Burnet: has been supporting the formation of the MSM Network • Health Policy Initiative: in conjunction with Burnet Indonesia conducted a 5 day training workshop in 2008 for 15 MSM & TG community leaders to develop advocacy skills and develop a national level advocacy plan. HPI has also funded mapping and a situation response assessment which are incomplete and has provided assistance to the MSM working group in NAC. HPI has indicated that it is unlikely to continue with MSM work. • DKT: runs a large condom social marketing program. No MSM-specific component
<p>Main activities</p>	<ul style="list-style-type: none"> • FHI: BCC through outreach and peer education, condom & lubricant distribution & social marketing, IEC development & distribution, DICs, referral to VCT, STI clinics and care & treatment services. Distinctive: Targeted media through MSM internet site combined with links to hotline service & SMS gateways, with local social events. Structural interventions through advocacy to entertainment establishment/male massage parlours re BCC, condom social marketing & STI/VCT services • YGD: BCC through outreach, STI screening & care, IEC dissemination, counselling, support for PLHIV, DIC.
<p>Coverage of MSM interventions</p>	<ul style="list-style-type: none"> • Geographic: Jakarta and 12 provinces • Target groups: gay, MSM non-self identified, MSW, TG • FHI: estimates current coverage is 29% of MSM based on population size estimation of 1,148,000. A significant increase in coverage was achieved in 2007-08 through a program-wide emphasis on expanding coverage and synergies between the internet site and other interventions. • Global Fund: 32,000 MSM and 4,000 TG. Some stakeholders believe these targets will not be met. • YGD (Bali): coverage data not available

2.4 Papua New Guinea

<p>MSM included in NSP?</p>	<p>Yes, MSM are included as one of the groups at particular risk for HIV in the context of the need for prevention programs to address the general population and 'high-risk' groups. No priority differentiation with other priority populations. MSM are not included in Health Sector Strategic Plan for STI, HIV and AIDS, 2008-2010.</p>
<p>MSM included in NSP Operational Plan?</p>	<p>The NAC coordinates development of the annual activity plan which includes the activities of all partners. Existing MSM activities are included. At present the plan primarily documents partner activities rather than determining what activities should be funded.</p>
<p>MSM included in national M&E framework?</p>	<p>No MSM indicators</p>
<p>MSM specific Strategic Framework and Operational Plan?</p>	<p>No</p>
<p>MSM Coordination mechanism?</p>	<p>No MSM specific coordination mechanism. Coordination of NSP implementation is the responsibility of NACS and the NSP Steering Group that consists of NAC, NACS, other government partners & development partners. MSM have not been a priority for these bodies.</p>
<p>Other Government policy documents on MSM</p>	<ul style="list-style-type: none"> • National HIV Prevention Strategy: currently being developed. First draft included MSM • NAC National Research Agenda: MSM listed as one of many prioritised research areas, including factors which create vulnerability, understanding sexual networks & support networks, MSM preferences re prevention methods & health and support services, and evaluation of interventions • NAC National Gender Policy and Plan on HIV & AIDS: MSM included in relation to targeted and gender sensitive programs for BCC, HIV prevention for female partners of MSM, & access to care and treatment

Legal status of male-to-male sex	Sodomy is a criminal offence. AusAID has provided technical assistance to support law reform in this area. No legal protections for the human rights of MSM or other vulnerable groups under the HIV/AIDS Management and Prevention Act or other legislative instruments
Assessment of level of priority for MSM in the NAP	No real commitment to address MSM by NACS. A general lack of recognition that male-to-male sex occurs.
MSM population size estimate	No
MSM included national HIV surveillance system?	Existing data very limited and confined to case reporting. Plans to include MSM in a national IBBS
Extent of social research	Limited. Evaluation of Poro Sapot Project includes data on MSM sexual practices
Government funding for MSM interventions?	No earmarked funding
Global Fund grant for MSM interventions?	No. A small male sexual health component (non-MSM specific) will be included in the round 9 proposal
Other major donors contributing to MSM work	<ul style="list-style-type: none"> • AusAID 1: Sanap Wantaim, the PNG – Australia HIV and AIDS Program, 2007-2010 is a A\$100 million bilateral program supporting PNG’s National Strategic Plan on HIV/AIDS 2006-2010. The only MSM-specific activity is the Poro Sapot Project. • AusAID 2: is one of the donors supporting the ADB’s economic enclaves project with a focus male sexual health and the national condom social marketing project. Non-MSM specific, but with some MSM reach. • AusAID 3: The PNG Australia Sexual Health Improvement Program, a 5 year A\$24 million initiative, involving partnerships between Australian NGOs and PNG organisations in 8 provinces. Works with communities and existing health services to increase access to improved sexual health services, with some male sexual health work. Not MSM-specific • AusAID 4: is supporting the NDoH in building 38 STI clinics and training staff, including on sexuality issues and discrimination (not MSM-specific) • AusAID 5: has commissioned the University of NSW and La Trobe University to undertake social research. See main activities below. • USAID: (managed from Regional Mission, Bangkok) funding of FHI. MSM component estimated to be US\$375,000 annually (including FHI TA and overheads) Contract ends September 2012.
Main MSM implementing partners	<ul style="list-style-type: none"> • Poro Sapot: implemented by Save the Children PNG, is a peer based FSW & MSM BCC intervention in Port Moresby, Lae, Goroka & Kainantu. Operates a STI & VCT clinic in Port Moresby. Annual funding of A\$1.6 million for FSW and MSM work (predominantly spent on FSWs). Working with PASHIP in some sites to improve MSM access to STI clinics • FHI: funds Hope World Wide to conduct BCC outreach interventions in Port Moresby with MSM, MSW & FSW in different locations to Poro Sapot, with referrals to two STI/VCT clinics, linked to a continuum of care for PLHIV clients. • AFAO: will commence an 18 month project in 2009 to foster the development of MSM leadership capacity and provide opportunities for MSM networking and learning, in conjunction with Poro Sapot. Funded by AusAID Sanap Wantaim. Funding levels to be determined • Economic Enclaves Project: working with the private sector in 6 locations focussing on male sexual health with integration of male-to-male sex into all peer training. US\$25 million ending in mid-2011. Non-MSM specific. • PSI: ADB condom social marketing and BCC project implements behaviour change interventions in rural economic enclaves with most at risk populations, using a broad male sexual health approach, which reaches some MSM. Funding ends in early 2010. • Tingim Laip: is currently managed by Burnet and operates in 36 sites across 11 provinces. It is the largest community based HIV prevention program in PNG, targeting most vulnerable populations in settings throughout the country where HIV transmission is known to be high. MSM is not a specific target group but may be reached through other interventions. Phase 2 will be tendered shortly and has potential for increasing MSM work. • Igat Hope: the national PLHIV organisation has an MSM sub-group. Igat Hope is funded by AusAID. • PNG Friends Frangipani: is a national network of male and female sex workers devoted to advocating for human rights and improved service provision for FSW and MSM. The network provides peer support and sexual health education, and is involved in legal advocacy

Main activities	<ul style="list-style-type: none"> • Poro Sapot and FHI/Hope World Wide: outreach and peer education, condom & lubricant distribution & social marketing, IEC development & distribution, DICs, community mobilisation, sensitisation of police and other local gatekeepers, referral to VCT, STI clinics and care & treatment services. • Other projects: male sexual approach in broadly targeted programs, including reach to MSM • Research: There are two components of the UNSW/La Trobe research relevant to MSM: 1) PNG: Question 'an examination of the variety of male sexualities (including minorities, such as MSM and transgenders) and contemporary male sexual practice in PNG, and 2) Pacific: studies to explore & describe the social & cultural dynamics and contexts of male to male sex in the Pacific, in collaboration with the Pacific Sexually Diverse Network. A four year project, currently in year 1.
Coverage of MSM interventions	<ul style="list-style-type: none"> • Geographic: Poro Sapot & FHI: Port Moresby, Lae, Goroka & Kainantu. Other projects with male sexual health approach: broader geographic coverage • Target groups: gay, MSM non-self identified, MSW, TG, men • Poro Sapot: 3,800 new contacts and 3,700 contacts with existing clients in 2008 • FHI: was unable to provide coverage data • Overall coverage: estimated that prevention services reach 9% of MSM. Basis for calculation not known. (Source: Draft PNG National HIV Prevention Strategy, 2008)

2.5 The Philippines

MSM included in NSP?	Yes. The 4 th AIDS Medium Term Plan 2005-2010 (AMTP) states that prevention efforts for MSM and other highly vulnerable groups (SWs & their clients & IDUs) need to be intensified. Prevention priorities are primarily focussed on these vulnerable groups, although there is no clear prioritisation between the groups. However, the 2008 Mid Term Review of the AMTP concluded that "MSM present the biggest threat of an accelerated growth of HIV in the Philippines" and that the national response should prioritise targeted interventions to vulnerable groups over general population interventions.
MSM included in NSP Operational Plan?	Yes. Document could not be sourced for review.
MSM included in national M&E framework?	Yes, MSM-specific indicators
MSM specific Strategic Framework and Operational Plan?	No
MSM Coordination mechanism?	No MSM-specific mechanism. The Philippines National AIDS Council is responsible for coordinating the national HIV response. Financial and human resource capacity are low. Coordination of Global Fund grant implementation occurs through the CCM and its HIV TWG. The DoH National AIDS & STI Prevention and Control Program is responsible for the health sector response and convenes the AIDS Project Coordination Group consisting of DoH, development partners and implementation agencies.
Other Government policy documents on MSM?	No
Legal status of male-to-male sex?	No laws prohibiting male-to-male sex. No legal protections for the human rights of MSM. Legal and policy restrictions on condom promotion limit the effectiveness of HIV programs
Assessment of level of priority for MSM in the NAP	The AMTP Mid-Term Review and interviews indicate that MSM are now regarded as the highest priority group for prevention work. However, this has not been reflected in an enhanced response. This may reflect funding and capacity limitations.
MSM population size estimate	Population estimation ranges from 203,000 to 610,000. Derived by a series of DoH organised workshops in 2007. Estimate will be revised in July 2009. Low estimate based on 2003 National Demographic Health Survey: 0.9% of general population males had sex with another man in the last year. High estimate based on 2005 Cebu study: 3% of men had oral or anal sex with another man in the last year.
MSM included national HIV surveillance system?	Yes, included in passive case reporting system and IBBS
Extent of social research?	Very limited
Government funding for MSM interventions?	No earmarked funding

Global Fund grant for MSM interventions?	Yes. Global Fund round 3 grant from August 2004 – July 2009 includes interventions for most at risk populations, including MSM in 11 sites. The round 5 grant, ending in September 2010 expanded coverage for vulnerable populations, including MSM, to 21 sites. Sub-recipients are 8 NGOs for round 3 and 11 NGOs for round 5. Each NGO is required to work with all vulnerable groups. One is a gay NGO. It is not possible to estimate expenditure on MSM programs as funds are allocated on a block grant basis. The round 6 grant has a very small most at risk population focus, which includes MSM as part of a broader targeted approach. All Global Fund grants are aligned to the broad strategic directions in the AMTP. Conflicting information was provided on the focus of the Philippines round 9 proposal, but it is likely to include an MSM component.
Other major donors contributing to MSM work	There is no other significant ongoing MSM funding in the Philippines. Smaller HIV and MSM work is outlined below: <ul style="list-style-type: none"> • UNDP: will shortly commence a 1 year project in the Philippines that will provide a sociological and behavioural profile of MSM and HIV, map and analyse the effectiveness of existing community based MSM and HIV programs, and identify and cost appropriate intervention and program models for MSM. There will be a focus on how to strengthen the capacity of local MSM groups to advocate effectively with local government. US\$150,000 • AusAID 1: funds UNICEF’s 6th Country Program for Children in the Philippines. HIV is one of six components of this program. HIV funding in 2009 was US\$0.25 million but only a small component of this was MSM-related. AusAID does not intend to continue HIV funding to UNICEF Philippines. Funding ends in 2009 but a 2 year no-cost extension has been given. • AusAID 2: funds UNFPA to undertake life-skills adolescent and reproductive health work. A\$1.3 million 2005-2009. Non-MSM specific but with some reach to MSM. AusAID will reorient UNFPA funding to maternal and child health.
Main MSM implementing partners	<ul style="list-style-type: none"> • Global Fund: Mainly mainstream NGOs and one gay NGO. • Department of Health: government sexual health clinics are almost exclusively used by female (90%) and male (7%) sex workers. Other MSM do not commonly use these clinics. • UNICEF: implements its HIV work through the City Health Office and NGOs in Davao. • UNFPA: life-skills work with adolescents is undertaken in school and in the community through youth centres, local government and CBOs.
Main activities	<ul style="list-style-type: none"> • Global Fund: BCC through outreach and peer education, condom & lubricant distribution, small group education sessions, referral to VCT, STI clinics and care & treatment services. Distinctive: most implementation is being done by non-gay/MSM NGOs. BCC interventions are often generic rather than containing MSM-specific messaging. There have been concerns over the quality of MSM work by some mainstream NGOs. • UNICEF: the main focus of work is SWs and out-of-school-youth and children. In 2008 outreach activities reached young MSM for STI screening & treatment. In 2009 15 young MSM were trained in peer education. UNICEF intends to continue working with young MSM after the AusAID funding ceases. • UNFPA: MSM-relevant life skills work is primarily undertaken at the community level, rather than in schools and involves HIV and sexual health information and BCC.
Coverage of MSM interventions	<ul style="list-style-type: none"> • Geographic: Global Fund: Manila and selected provincial capital cities, although coverage in Manila where there are large numbers of gay and MSM is very limited. UNICEF: Davao. UNFPA: 1 city & 10 provinces. • Target groups: gay, MSM non-self identified, MSW, TG • Global Fund: Round 3: 16,592 individuals (2008). Round 5: 7,976 individuals (2008). Global Fund targets have been met. • UNICEF: no coverage data available • UNFPA: no coverage data available

2.6 Vietnam

MSM included in NSP?	Not included in the National Strategy on HIV/AIDS Prevention and Control. This document was issued in 2004. A number of more recent HIV policy and sub-strategy documents include MSM (see below).
MSM included in NSP Operational Plan?	Vietnam does not have a single NSP Operational Plan. There are nine Action Plans in different areas (see below).

MSM included in national M&E framework?	No
MSM-specific Strategic Framework and Operational Plan?	No
MSM Coordination mechanism?	UNAIDS provides secretariat support to the national MSM Working Group. Participants include government, INGO, NGOs, development partners and researchers. The primary function of the WG is seen by some as information sharing, with limited effective coordination. Provincial MSM Working Groups have been established in Hanoi, Ho Chi Minh City and one province. All have some level of government involvement. The Harm Reduction Department in the Vietnam Administration of HIV/AIDS Control previously had an MSM key point officer. This has been replaced with a generalist position.
Other Government policy documents on MSM?	Yes. The Party Central Committee Directive on Strengthening Leadership in HIV/AIDS Prevention and Control in the New Situation (2005) mentions homosexuals as one of the 'high risk groups' and the need to 'renovate, diversify' and provide information and education to high risk groups, including male homosexuals. The Law on HIV/AIDS Prevention and Control (2006) lists homosexuals as one of a number of groups to be given priority access to information and education on HIV prevention. This is reiterated in the MoH National Program of Action on Information, Education, BCC in HIV/AIDS Prevention and Control till 2010 (2007) which sets a target of 80% condom use for MSM. The MoH Action Plan on STI Prevention and Control till 2010 (2007) lists MSM as a target group. The MoH National Action Plan on Harm Reduction Interventions in HIV Prevention 2007-2010 mentions developing a network to provide lubricant for condom use for MSM. None of these plans set out MSM-specific programs.
Legal status of male-to-male sex?	No laws prohibiting male-to-male sex. No legal protections for the human rights of MSM.
Assessment of level of priority for MSM in the NAP	Current implementation of the NAP clearly indicates IDUs are the number one priority, followed by FSWs and their clients. MSM appear to be the third priority for prevention work. However, the NAP has not been active in addressing MSM. The response has been almost entirely donor-driven.
MSM population size estimate	No national estimate. UNAIDS is considering what would be an appropriate methodology for a national size estimation. Some local size estimations undertaken by INGOs. E.g. Ho Chi Minh City (HCMC) 35,000
MSM included national HIV surveillance system?	MSM are not included in the government's HIV sentinel surveillance. An IBBS, including MSM, was conducted by the National Institute of Hygiene and Epidemiology with funding and TA from FHI. The 2009-2010 IBBS will expand MSM sampling to include 2 additional provinces, in addition to Hanoi and HCMC.
Extent of social research?	Limited
Government funding for MSM interventions?	No earmarked funding
Global Fund grant for MSM interventions?	No. Vietnam plans to submit a round 9 proposal. Information on whether this will include an MSM component was not available.
Other major donors contributing to MSM work	<ul style="list-style-type: none"> • PEPFAR: is the major donor for HIV and MSM work. There are no other donors providing significant levels of support for MSM-specific work. The vast majority of PEPFAR funds for MSM work go to FHI to conduct BCC oriented interventions in partnership with NGOs/CBOs. PEPFAR is also providing small amounts of funding to one INGO and one NGO to undertake MSM prevention work. PSI receives PEPFAR funding to undertake condom and VCT social marketing (not MSM-specific). UNAIDS Vietnam receives PEPFAR funding to undertake MSM advocacy work and to coordinate information sharing. No increase in PEPFAR funding for MSM is expected. USAID was not able to provide a funding figure for MSM work. • AusAID: has approved ADRA funding to Burnet for a MSM research project in Vietnam
Main MSM implementing partners	<ul style="list-style-type: none"> • FHI: is undertaking MSM work in Hanoi, Ho Chi Minh City, Danang, Nha Trang and Can Tho through funding agreements with Provincial AIDS Committees. The PAC is responsible for overseeing the program which is implemented by MSM recruited for this purpose. An advertising agency is contracted to manage an MSM web site. MSM specific grants/contracts total an estimated US\$0.5 million per year, plus US\$0.25 million per year in FHI TA, management and overheads. The PEPFAR contract with FHI expires in September 2011. • Other PEPFAR funding: PEPFAR also provides non-MSM specific funding to Medicines du Monde which undertakes MSM prevention work, linked to clinical services as part of its community outreach to most at risk populations. PEPFAR is

	<p>also funding the STD/HIV/AIDS Prevention Centre, a national NGO, to undertake MSM prevention work in Haiphong.</p> <ul style="list-style-type: none"> • PSI: undertakes national condom and lubricant condom social marketing but does not have a MSM-specific program. • UNAIDS: has been taking a lead role in coordination, advocacy and capacity building. • WHO: has not had any significant involvement in MSM work but wishes to become more involved. Possible areas are advocacy to the health sector at national & provincial levels (the NAP is within the MoH), assisting with development of national health sector strategies and guidelines, and technical assistance to improve surveillance.
Main activities	<ul style="list-style-type: none"> • FHI: BCC through outreach and peer education, condom & lubricant distribution & social marketing, IEC development & distribution, DICs, referral to care & treatment services. Distinctive: STI clinical services and VCT are offered in all DICs, and referrals to other services are also made to provide client choice. Increasingly making STI referrals to a network of trained private practitioners. Targeted media through MSM internet site. Structural interventions through advocacy to entertainment establishments to gain access and with local authorities re condom distribution in entertainment establishments. • UNAIDS: Secretariat for the National MSM Working Group, MSM technical needs assessment and capacity development work plan, development of a stigma & discrimination tool kit, advocacy training, national workshop to review the HIV and MSM response. National guidelines on MSM interventions are to be developed. • Burnet: ADRA funded research, to be conducted in 2010, will model sexual and social networks of urban men who have sex with men & women and examine ways of effectively providing sexual health and risk information.
Coverage of MSM interventions	<ul style="list-style-type: none"> • Geographic: Hanoi, Ho Chi Minh City plus the main city in 4 provinces. No MSM programs in the other 57 provinces. • Target groups: gay, MSM non-self identified, MSW, TG • FHI: 24,000 MSM in 2008 • Others: coverage data not available

2.7 Regional level

Only regional level activities that have links with any of the six countries within the scope of this work have been included. Where activities were linked to other countries outside the scope of this work the description focuses only on the work done in the country or countries within the scope of this work.

DONORS	
AusAID	
Risks & responsibilities	AusAID provided A\$70,000 to support the Consultation on Male Sexual Health and HIV in Asia Pacific, (Risks and Responsibilities) held in 2006.
AFAO: Has received AusAID funding for the following regional or multi-country activities	<ul style="list-style-type: none"> • PSDN: AFAO & ACON are undertaking a 3 year capacity development project with the Pacific Sexual Diversity Network in the areas of management and leadership, community organisation governance and skills transfer through three one week workshops and ongoing mentoring. PSDN is made up of CBOs from Fiji, Samoa, Vanuatu, the Cook Islands, Tonga, and <i>Papua New Guinea</i>. Year 1: A\$132,000; Years 2-3 TBC. • AFAO/APCASO Leadership & Advocacy Collaboration: strengthening advocacy and leadership capacity of HIV CBOs through development of a tool kit and country level training and follow-up support. Training was conducted in Indonesia in 2007 and AFAO subsequently provided support for a Community Advocacy Network to link CBOs. This is a non-MSM specific project which included MSM CBOs. Funded through AusAID AHAPI funding. AFAO's support for the advocacy project in Indonesia will continue and also be expanded to additional countries over the next 3 years. (Cambodia, Lao & Vietnam). • Mekong capacity building assessment: a joint AFAO/ACON/Rainbow Sky Association of Thailand project to identify the capacity development needs of MSM CBOs in Cambodia, Lao and Vietnam and develop a south-south model for capacity development. Work undertaken in 2008-2009. Funded by AHAPI grant of A\$189,000 for this & 4 other projects • AFAO: documenting lessons from Asian region scale-up of MSM programs and

	<p>supporting Asia-Pacific participation at the Mexico IAC and MSM pre-conference satellites. Funded by AHAPI grant of A\$189,000 for this & 4 other projects</p> <ul style="list-style-type: none"> • APCOM: strengthening governance, strategic management and advocacy capacity of APCOM through a medium-term consultancy. Funded by AHAPI grant of A\$189,000 for this & 4 other projects
USAID	
Regional Development Mission Asia	The RDMA manages USAID HIV funding for Burma and PNG. RDMA staff have played an active role in supporting regional MSM networks and engagement with other development partners. USAID HIV funding for Cambodia, Indonesia and Vietnam is managed by in-country USAID missions.
Multilaterals	
UNDP	<p>UNDP is the lead agency for MSM and has an regional HIV Policy Specialist based in Bangkok working exclusively on MSM. The regional level role has not as yet been fully defined, but it will centre around a coordinating role with other UN agencies and addressing gaps in the UN response, advocacy, knowledge development, legal issues, and fostering greater civil society engagement with governments. In 2009 the UN will release a global framework document on HIV and MSM which will define the UN's overall role and that of each UNAIDS co-sponsor.</p> <p>Planned areas of work for UNDP include:</p> <ul style="list-style-type: none"> • A desk review of restrictive legislation in relation to MSM and the impact this has on HIV and MSM programs. • The UNDP regional centre will be assisting its country offices to take on a greater role in HIV and MSM, but work plans have yet to be defined with the exception of the Philippines (see mapping for the Philippines, 2.5 above). • Co-sponsoring with APCOM and other UN agencies the regional consultation to define the comprehensive package of interventions for MSM in relation to HIV and sexual health.
UNAIDS	<p>The UNAIDS Regional Support Team for Asia Pacific has given high priority to supporting the development of national responses with a focus on key populations at higher risk for HIV, including MSM, within the context of Asia's concentrated HIV epidemics. Key activities have been:</p> <ul style="list-style-type: none"> • Analysis of strategic information to be used in advocacy with governments • Advice on best practice approaches • Support for the work of the Commission on AIDS in Asia • Regional advocacy, including publications such as <i>Men who have sex with men: the missing piece in national responses to AIDS in Asia and the Pacific</i> • Support for UNAIDS joint country teams in relation to NSP development, GF proposals and implementation of grants, advocacy, and mobilising technical support for national level work • Support for the ADB regional HIV Data Hub • Support for APCOM and sub-regional MSM networks including funding for the cost of APCOM Board meetings, secretariat functions and the web site (US\$60,000) <p>An AusAID funded Australian Youth Ambassador MSM Capacity Development Officer has been placed in the UNAIDS RSTAP for 2008-2010. This position has worked on the range of UNAIDS activities outlined above and has a special focus on working in capacity development with some CBOs and participated in the AFAO Mekong capacity building assessment (see AFAO above).</p>
UNESCO	<p>Key areas of work for UNESCO have been:</p> <ul style="list-style-type: none"> • Improving the standards of outreach and peer education through support for development of a reference manual for peer and outreach workers which has been translated into a number of languages. • Ethnographic research on MSM in Cambodia and Lao. • Advocacy for the inclusion of vulnerable populations more explicitly in school based programs • Supporting sub-regional MSM networks • Development of policy papers in conjunction with APCOM <p>UNESCO received US\$0.25 million from USAID to support its MSM work from July 2008 - June 2010.</p>
WHO	The WHO 2008 Global Consultation on HIV and MSM and the 2009 WPRO Technical Consultation on Health Sector Response to HIV/AIDS Among MSM signalled a significantly greater involvement of WHO in this area of the HIV response. The 2009 regional Technical Consultation recommended establishment of a broad based regional MSM and HIV Task Force to strengthen advocacy initiatives and the active engagement of the health sector. The Task Force will be co-chaired by WHO and

	APCOM. The focus of WHO's work will be on strengthening the capacity of health systems to respond to the HIV and sexual health needs of MSM with quality services. Key areas of work for WHO will be advocacy, policy advice, development of guidelines, and addressing stigma and discrimination within the health sector, through working with national health systems, UN partners, and regional MSM networks.
Other UN agencies	To date, other UN agencies have not had a significant involvement in HIV and MSM work.
<i>Regional technical assistance agencies</i>	
Family Health International	FHI's Asia Regional Office in Bangkok provides technical assistance to its MSM country programs through the Regional Technical Advisor for Male Sexual Health. FHI is developing a global MSM strategy to guide its work. FHI has also been an active partner in regional level dialogue on MSM through APCOM, UN technical consultations and in its support for the Purple Sky Network. FHI's Regional Technical Advisor for Sexual and Reproductive Health has provided technical advice to FHI country programs and governments and NGOs on strengthening STI and sexual health components of the MSM response. This has included development of guidelines, input to the development of national guidelines, advice on testing regimens, and training of clinicians.
Health Policy Initiative	Key activities for the Bangkok based USAID funded HPI Greater Mekong and China project are: <ul style="list-style-type: none"> • A 2008 survey to map donor expenditure on HIV and MSM in the Mekong sub-region. • Currently conducting a study reviewing current levels of HIV expenditure for HIV and MSM programs in 6 countries, including Burma, Cambodia and Vietnam and estimate resources needed to scale up a comprehensive package to 80% coverage, coupled with development of a tool for countries to use for costing the comprehensive package of MSM interventions. • Development of an HIV and MSM advocacy curriculum and advocacy training of MSM CBOs at the country level, with small grants for implementation of advocacy initiatives. • Technical support for the Purple Sky Network
Burnet Institute	The Burnet Institute is working with HPI under a sub-grant arrangement. It undertook the 2008 survey of MSM donor expenditure in the Mekong sub-region, is undertaking the current resource needs study and development of the costing tool, and is also conducting the advocacy training. Burnet is planning to undertake modelling of HIV epidemics among MSM, incorporating epidemiological, behavioural and ethnographic data to assist with identifying priority MSM sub-populations.
<i>Regional and sub-regional HIV & MSM coalitions and networks</i>	
APCOM	The Asia Pacific Coalition on Male Sexual Health, established in 2007, is a coalition of governments, multilaterals, donors, INGOs, national and sub-regional networks, and technical experts. The APCOM Board provides a forum for regional level coordination between these partners. While APCOM membership is broadly based, it is primarily community driven. The main focus of APCOM's work is advocacy in promoting the need to scale-up national and regional responses to HIV epidemics among MSM. It also promotes good practice through sharing of lessons learned, knowledge and expertise. Main activities have centred around development of policy briefs and advocacy papers, participation in regional meetings, working with the mass media, supporting the development of sub-regional networks, and the organisation of pre-conference satellites at international and regional HIV conferences. APCOM has developed productive working relations with key multilaterals and USAID. APCOM has received funding from UNAIDS RSTAP, UNDP, UNESCO, Hivos, TSF SEAP, and AFAO, at relatively low levels and usually for specific activities. APCOM is seeking to mobilise longer term funding.
Purple Sky Network	The PSN is a sub-regional network to support HIV and MSM work in Cambodia, southern China, Lao, Burma, Thailand and Vietnam. It was established in 2005. The Network consists of Country Focal Points, a Regional Technical Board and a Coordinating Secretariat. At the country level, PSN working groups made up of local and international NGOs, NAPs and donors have been established to promote supportive policy, coordination and improved interventions. Annual regional network meetings are held with government and CBO representatives from each country and regional representatives of multilaterals and technical assistance agencies. The Network has facilitated sharing of information across countries, greater dialogue between NAPs and CBOs, and in raising the profile of HIV and MSM work at the country and regional levels. It has conducted regional level behaviour change communication and advocacy training and conducted a south-to-south exchange workshop in southern China. A capacity building needs assessment and development

	<p>plan has been completed. The PSN is currently establishing a data base to document all HIV and MSM services in the greater Mekong sub-region, which will be updated regularly. PSN is funded by CDC GAP, USAID RDMA, FHI, HPI and hosted by AMFAR.</p>
<p>Proposed HIV and MSM Network for insular south east Asia</p>	<p>A meeting of MSM will be held prior to the Bali ICAAP to consider forming a HIV and MSM network for south east Asia, similar to Purple Sky</p>
<p>APN+</p>	<p>The Asia Pacific Network of People Living with HIV has established a regional MSM Working Group, with full-time secretariat support. Specific activities include:</p> <ul style="list-style-type: none"> • A 17 country study mapping services available for HIV positive MSM. • A five country needs assessment for positive MSM, including Burma, Indonesia and PNG. • A six country study of positive MSM access to HIV treatment, including Burma and Indonesia (current project) • Skills building of working group members to promote country level work • Regional advocacy related to study findings <p>AusAID is funding APN+, however this funding supports other aspects of the organisations work. The working group's activities are currently funded by PACT till September 2009.</p>

Annex 3: Country specific issues

This Annex outlines some country specific issues that AusAID should consider in developing support for HIV and MSM programming. Within the context of a broad scoping exercise, this list is not intended to be comprehensive.

Burma

Key issues are:

- With hyper epidemic levels of HIV among MSM in Burma, it is essential that prevention programs place a particularly strong emphasis on HIV testing and have strong links with care and treatment services.
- Prevention programming for HIV positive MSM needs to be prioritised.
- Despite the difficulties of registration for CBOs in Burma, INGOs in Burma have demonstrated that working with informal CBOs is possible.

Cambodia

Key issues are:

- AusAID's HAARP CFP will be conducting a rapid assessment in the first half of 2009 which will shape the nature of the program, including the extent to which MSM are included. The 2007 Cambodian BSS indicates that 5% of MSM had injected in the last year and 19% of MSM and 9% of transgender had used amphetamine type stimulants in the last year.³⁶ While drug use is a risk for HIV among Cambodian MSM, sexual transmission is clearly the main risk and AusAID supported programs should have a dual but prioritised focus.
- Of the five countries included in the AusAID scoping exercise, Cambodia has the most developed MSM programs for its population size, largely due to USAID funding, supplemented recently by the Global Fund. While program coverage has increased both within Phnom Penh and the provinces, it is still significantly below what is required to control the epidemic. Reasonably old data (2005) indicates high HIV prevalence among MSM in Phnom Penh and high levels of STIs and sexual risk practices in both the capital and large provincial cities.
- The skills of peer educators in the delivery of quality behaviour change messages and in dealing with attitudes and beliefs are limited. (This may be a common issue across all countries)
- MSM use of STI services has not increased despite capacity building of services.
- Scale-up of MSM programs has placed considerable strain on CBOs due to limited absorptive capacity. This suggests a focus on organisational strengthening is needed.
- The potential for community mobilisation has not been adequately realised.

Indonesia

Key issues are:

- Geographic coverage of existing MSM programs is limited.
- Coverage of transgenders is high, while coverage of male identified MSM is much lower.
- The Australia-Indonesia Partnership for HIV plans to fund the Indonesian National AIDS Commission to engage technical assistance to undertake a review of current MSM programs and develop a focussed national strategy for HIV prevention and care among MSM. This work will be completed in the second half of 2009 and will provide a good basis for planning possible AusAID support, aligned to the new NAC MSM strategy.
- There is potential for exploring MSM-related programming in the prisons work funded by HCPI.

³⁶ NCHADS, Behavioural Sentinel Surveillance 2007. 2008. Powerpoint presentation.

PNG

MSM now have a greater profile in the national response but all current activities are occurring through donor supported programs and lack scale and national and provincial support. The Independent Review Group on HIV/AIDS concluded that national and provincial players have failed to understand the importance of HIV prevention work with MSM.³⁷

Suggested priorities in PNG are:

- Advocacy to government on the need for a higher priority to be accorded to MSM.
- Social and behavioural research to fill the many information gaps as a basis for program development.
- Expanding the scale of the Poro Sapot project which is doing effective work with male sex workers and MSM with some degree of identity in relation to their sexual practice.
- Building on current broad based approaches to male sexual health promotion, including male-to-male sex, such as the ADB economic enclaves project and initiatives to strengthen the capacity of STI clinics to promote male sexual health.

The Philippines

Key issues:

- Compared to other countries in South East Asia, the Philippines has low HIV prevalence, although there are signs of a rapid increase in HIV prevalence among MSM. However, due to limitations in surveillance data, the size of the HIV epidemic in MSM does not appear to be adequately quantified.
- Condom promotion is restricted by government policy and conservative social attitudes.
- Only a few CBOs are involved in MSM interventions. There is a need to empower MSM support groups and develop the capacity of CBOs for peer education and outreach.
- The capacity of sexual health clinics (referred to as Social Hygiene Clinics in the Philippines) to conduct government-led programs for MSM needs to be strengthened.
- Middle class MSM have proved difficult to reach so coverage is low.
- Formative research is needed on the vulnerabilities to HIV of young professional MSM in Manila.

Vietnam

Key issues:

- Given the low priority accorded to MSM by the NAP, advocacy appears to be the main priority in the short term.
- In time as the NAP takes a greater leadership role in addressing HIV among MSM, the secretariat for the MSM TWG should be transferred from UNAIDS to VAAC.
- Geographic coverage of HIV and MSM programs is limited to a small number of large cities. There is no coverage in many medium to large cities or rural areas.

³⁷ PNG Independent Review Group on HIV/AIDS, September 2008 Report. p. 8 & p. 12.

Annex 4: Evidence for effective HIV prevention programming

This Annex summarises key findings from a series of articles in *The Lancet* in 2008 which reviewed evidence for efficacy in a broad range of HIV prevention programmes, including those for most vulnerable populations, including MSM.³⁸ Key findings from the reviews were:

- Combination prevention (i.e. multiple approaches) is essential since HIV prevention is neither simple or simplistic. To achieve significant reduction in HIV transmission, widespread and sustained efforts and a mix of communication channels is needed to disseminate messages to motivate people to engage in a range of options to reduce risk. Success in HIV prevention results from a complex combination of strategies and several risk-reduction options, with strong leadership and community engagement that is sustained over a long period of time.
- Interventions derived from behavioural science have a role in HIV prevention, but are insufficient when used by themselves to provide substantial and lasting reductions in HIV transmission between individuals or in communities. Behavioural strategies need to be combinations of approaches at multiple levels of influence. Behavioural HIV prevention also needs to be integrated with biomedical (including condom promotion) and structural approaches, promotion of social justice and human rights, and treatment for HIV and STI infections. Top-down approaches can be adept at packaging and branding replicable strategies such as behaviour change communication and social marketing, while bottom-up approaches are useful for supporting local innovation and ownership. Both approaches have experienced successes and limitations.
- Local engagement by using the creativity and energy of people who are most affected to develop messages and strategies to motivate behaviour change is important. It is necessary to create an enabling environment that allows members of a community to act on their own behalf in response to their perceived needs.
- Peer education is especially effective if it involves participation and collaboration with vulnerable groups who are often alienated from formal service providers and government structures. Peer education has been demonstrated to be effective in increasing condom use and reducing STIs in Asia. Peer education can be successfully coupled with network-based interventions which involve gaining access to social and sexual networks through key individuals, identifying members of the networks, training network leaders as peer educators, disseminating risk reduction messages, and assessing effects.
- Community mobilisation is an essential component of effective HIV prevention. A US CDC assessment of reputationally strong HIV prevention programs in the USA demonstrated that community based programs succeeded only if there was strong institutional support through organisational development, and capacity to implement and sustain the program.
- HIV prevention programs cannot succeed in the long-term without addressing the drivers of HIV risk and vulnerability in different settings. Structural approaches therefore need to be incorporated into HIV prevention. Structural factors include the physical, social, organisational, cultural, community, economic, legal and policy features of the environment that affect HIV vulnerability. The defining aspects of structural approaches is that they aim to change the social, economic, political, or environmental factors that determine HIV risk and vulnerability in specific contexts. Structural approaches are not easily transferable when the activities involved are designed for specific local contexts. (See the Glossary for a definition of structural approaches.)

³⁸ Coates, T.J. et. al., Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet* 2008; 372: 669-84. Gupta, G.R. et. al., Structural approaches to HIV prevention. *Lancet* 2008; 372: 764-75. Imrie, J. et. al., Biomedical HIV prevention – and social science. *Lancet* 2008; 370: 10-11. Merson, M.H., The history and challenge of HIV prevention. *Lancet* 2008; 372: 475-88.

- Structural approaches can result in activities or services being delivered to individuals. However, the approach is different from individually oriented behaviour change because it addresses the factors affecting individual behaviour, rather than targeting the behaviour itself.
- There is increasing evidence, including among sex workers and MSM, that community structures and systems (e.g. social support networks) can make populations less vulnerable to HIV.
- Investments in HIV prevention should be integrated with health system strengthening and training of community health workers who can generate and respond to community responses that are essential to HIV prevention.
- Data on the efficacy of biomedical HIV prevention interventions does not necessarily demonstrate effectiveness. Efficacy demonstrates health improvement under ideal circumstances, in expert hands, rather than effectiveness in impact on health at a population level under real-world conditions. Even large scale biomedical trials collect only limited data on social or cultural acceptability, and intervention uptake beyond the trial setting.
- Small scale, isolated programs, even if effective, will not bring HIV epidemics under control. National efforts, tailored to their epidemics, which bring quality interventions to scale and address environmental factors and vulnerability, are needed.
- National level prevention successes have been associated with government leadership and community activism. Leadership and activism are also essential for sustaining and renewing prevention responses.

Annex 5: Terms of reference

Scoping Exercise: Recommendations for AusAID support to comprehensive approaches to address HIV infection among men who have sex with men in the Asia-Pacific Region –

1. Background

Strategy

- i. In early 2009 the Australian Government will launch a new international development strategy for HIV *Intensifying the Response: Halting the spread*. The strategy will guide Australia's international development assistance on the epidemic and replaces *Meeting the Challenge* launched in 2004.
- ii. The strategy aims to make a significant and sustained effort to achieve the MDG target of halting and beginning to reverse the spread of HIV and AIDS by 2015, by assisting partner countries to achieve universal access to HIV prevention, treatment, care and support.
- iii. Through the strategy's six priorities, Australia will support partner countries to: intensify HIV prevention, optimise the role of health services within HIV responses, strengthen coordination and capacity to scale up HIV responses, review legal and policy frameworks to enable effective responses to HIV, build the evidence base for an effective HIV response, and demonstrate and foster leadership on HIV.

Men who have sex with men

- iv. In the Asia Pacific region, men who have sex with men represent a significant and growing component of HIV epidemics. Success in addressing HIV transmission in this population will have a direct and significant impact on the size of national epidemics and the cost of responses. Yet this group has largely been ignored in most HIV responses to date. Projections indicate that unless effective prevention services are intensified, by 2020 around 46 per cent of new infections in Asia will be men who have sex with men, up from around 13 per cent today.
- v. In Papua New Guinea, Pacific Island countries and the Indonesian provinces of Papua and West Papua, the populations at higher risk are less defined than in the rest of the Asia Pacific region. This requires a broad approach to address issues of risk behaviour in the general population, including men who have sex with men.
- vi. *Intensifying the Response: Halting the spread* uses the comprehensive program to prevent HIV infections among men who have sex with men recommended by the Commission on AIDS in Asia (2008) as the standard package of interventions. Referred to in the strategy as "comprehensive approaches", this includes: intensive HIV education (especially peer education), provision of condoms and water-based lubricants, access to services for managing sexually transmitted infections, as well as support for local advocacy (including improved legal and policy environments) and self-organisation (civil society strengthening).

Proposed Scoping Study

- vii. New and expanded areas of work under Australia's new strategy include a focus on prevention among men who have sex with men, the greater involvement of people living with HIV, and legal and policy enabling environments. The Australian Agency

for International Development (AusAID) has undertaken to conduct scoping exercises to map and review current activities related to these three areas, identify gaps in current and planned interventions, and identify opportunities for AusAID to maximise its support (through multilateral, bilateral and non government channels).

- viii. This proposed scoping exercise will look at preventing HIV infection among men who have sex with men in Indonesia, Vietnam, Cambodia, Burma, Philippines and Papua New Guinea. Australia has significant technical expertise in this area and can add value.
- ix. AusAID recognises in recent years there has been increased international attention to addressing HIV prevention among men who have sex with men and a subsequent flurry of research studies and reviews of this area. Some recent reviews have identified a need for improved research into size estimations, behavioural surveillance and broader data collection. Due to the high level of interest and activity in this field, any AusAID analysis and support should build on and complement current and planned interventions and emerging international best practice.
- x. In line with the Paris Declaration and Accra Agenda for Action, AusAID supports working through government systems where possible, in partnership with the UN in accordance with the agreed regional Division of Labour, and harmonised with other donors including through delegated responsibility. This scoping exercise does not favour any particular mechanisms of support and should explore the full range of aid modalities.

2. Objectives of the assignment

- i. The objective of this assignment is to undertake a scoping exercise (mapping, review and analysis) of interventions addressing the rapid rise of new HIV infections among men who have sex with men in the Asia Pacific region.
- ii. The second objective is to provide AusAID with recommendations for maximising the impact of AusAID's contribution to comprehensive approaches to MSM as outlined in *Intensifying the response: Halting the spread of HIV* (2009).

3. Scope of the assignment

- i. Review and analyse national strategic plans, other relevant policy documents of identified partner countries (Indonesia, Vietnam, Cambodia, Burma, Philippines, and PNG) and regional documents against a comprehensive approach to men who have sex with men.
- ii. Map and review existing AusAID activities addressing HIV epidemics among men who have sex with men, describe the activities and approach undertaken to date, including coverage, quality, resourcing and lessons learned.
- iii. Identify other key stakeholders addressing HIV prevention among men who have sex with men and describe their significant activities and approach, including geographic location, coverage, quality, sources of financial support and duration/end dates, where available.
- iv. Identify the gaps (geographic, programmatic and efficacy) in existing work (when compared to the recommended comprehensive approach).

- v. Identify opportunities for AusAID (in order of priority) to fill these gaps and support the implementation of *Intensifying the response: Halting the spread of HIV*, taking into account:
 - i. Regional and national strategic plans, regional and country contexts/needs and divisions of labour
 - ii. Accra Agenda for Action
 - iii. AusAID's international development strategy for HIV Intensifying the Response: Halting the spread, country strategies, HIV programs and priorities
 - iv. future plans of other donors (including the Global Fund) and opportunities for collaboration and delegation
 - v. how to involve and best utilise people living with HIV and MSM
 - vi. how to integrate with existing and planned sexual and reproductive health services
 - vii. resources at AusAID country offices
- vi. Recommend a range of options (in order of priority) for maximising AusAID's impact, taking into account:
 - i. AusAID's comparative advantage
 - ii. how impact will be measured
 - iii. cost effectiveness, key risks and sustainability
 - iv. role and resourcing of AusAID's Health and HIV Thematic Group and country offices
 - v. possible partners

4. Suggested methodology

- i. This scoping study consists of 2 phases. The first part of this scoping study involves attendance at the WHO/WPRO – UNDP – UNAIDS *Technical Consultation on Health Sector Response to HIV/AIDS among Men who have sex with Men*, in Hong Kong, 18-20 February, to gather information and identify key informants as essential background to Phase 2 of the scoping study. This may include: key stakeholders, key issues, needs, gaps, and opportunities in the health sector response to HIV/AIDS among men who have sex with men in Asia and the Pacific, and will serve to inform Phase 2.
- ii. Phase 2 of this scoping exercise will be conducted as a desk-based review consisting of a literature review and consultation with officers from AusAID, partner governments, development partners (donors and non government organisations) and civil society organisations.
- iii. It is expected key AusAID contacts in-country and Canberra, as identified by the Health and HIV Thematic Group, will be consulted by telephone/email to inform the analysis and identify in-country contacts from partner governments, development partners and civil society.
- iv. The literature review will analyse relevant documentation including national strategic plans, policy documents, research papers, programme reports, and existing databases of government and non government agencies involved in MSM activities.
- v. Two powerpoint presentations of the draft findings and recommendations will be held in Canberra with nominated AusAID country offices and with non-AusAID stakeholders via video/teleconference.

5. Deliverables

- i. A draft final report of not more than 40 pages (excluding annexes) should be provided in electronic form (MS Word) to the Health and HIV Thematic Group, AusAID by COB 28 April 2009.
- ii. A final report of not more than 40 pages (excluding annexes) should be provided in electronic form (MS Word) to the Health and HIV Thematic Group, AusAID by COB 4 June 2009.
- iii. The report will include:
 - An executive summary
 - Overview of contextual information
 - Key findings including mapping of MSM activities in the Asia Pacific region by country and organisation (governments, development partners, civil society organisations)
 - Succinct analytical section identifying options for AusAID support and recommendations
 - Summary of the methodology, sources and persons consulted
 - Powerpoint presentation of key findings and recommendations

Annex 6: Methodology

Key steps

The scoping exercise involved the following key steps:

1. Document review

The categories of documents reviewed included:

- National strategic plans on HIV and AIDS, including national strategic plans on HIV and MSM, where they exist, and other relevant policy documents
- Global Fund proposals
- UNGASS reports
- Mapping studies on HIV and MSM programs
- Reports on the epidemiology of HIV and STI among MSM
- Articles from the peer review literature relevant to this work (i.e. related to epidemiology, and programmatic needs, quality and efficacy)
- Work plans or other documents describing current and planned MSM activities by agencies (regional level and for countries within scope), where available from stakeholders
- Program/project evaluations and reviews, where available from stakeholders
- Regional and national reviews on responses to HIV epidemics among MSM

The key information that was extracted from these documents primarily fell into the following categories:

- Existing strategic and policy frameworks
- Existing and planned HIV and MSM services, including types of services, coverage, quality, lessons learned and financing
- Information on the efficacy of services
- The range of services that constitute a comprehensive approach
- The epidemiology of HIV and STIs among MSM

2. Key informant interviews

Key informant interviews were conducted with:

- AusAID Canberra staff
- AusAID country office staff in the six focus countries
- Partner governments, development partners and civil society organisations in the six focus countries
- Regional organisations undertaking MSM work (multilaterals, regional offices of bilateral donors, regional offices of technical assistance agencies, regional MSM networks)
- Australian experts with knowledge of MSM work in Asia Pacific

Key informant interviews were used to supplement mapping information not available in documents by collecting descriptive information on MSM projects. The interviews also had a strong focus on addressing the analytical aspects of this work in areas such as the extent of government commitment, the enabling environment, the role of government in coordinating MSM programs, quality, efficacy, key gaps, and strategic priorities. Interview formats for different categories of key informants were prepared and sent to people prior to interview.

3. Mapping

The purpose of the mapping was to identify existing activities of AusAID and others in addressing HIV epidemics among MSM in order to identify gaps (geographic, programmatic and efficacy) in

existing work when compared to the recommended comprehensive approach. Information for mapping was obtained from the document review and key informant interviews.

At the country level, mapping encompassed the following areas:

- Inclusion of men who have sex with men in the National Strategic Plan and related documents
- Existence of a national strategic framework and costed operational plan for men who have sex with men
- Identification of significant sources of funding for MSM programs by source (government, Global Fund, multilateral and bilateral development partners)
- Identification of the work of technical assistance agencies and civil society organisations (CSOs) undertaking significant MSM activities. The mapping included describing the key activities and approaches undertaken, including target groups, geographic location, coverage, and sources of financial assistance

Mapping at the regional level identified the existing and planned work of the regional offices of multilaterals, bilaterals, technical assistance agencies, and regional and sub-regional MSM and PLHIV networks.

4. Analysis

Following completion of the document review and key informant interviews an analysis of all information was undertaken to develop key findings and recommendations related to the Terms of Reference. The analysis went beyond an examination of descriptive information from the mapping by undertaking a critical assessment of the types of interventions most needed to effectively address the rapid rise of new HIV infections among MSM in Asia and the Pacific. This analysis was informed by lessons learnt, best practices and approaches, and challenges and successes in implementation and coordination.

5. Report

The draft report was reviewed by the AusAID Health Resource Facility (AHRF), as part of their quality assurance function. Following feedback from the HRF, the draft report was revised, re-submitted to the AHRF and then submitted to AusAID's Health and HIV Thematic Group (HHTG).

The HHTG circulated the draft report to relevant country offices and stakeholders with an invitation for written feedback.

The consultant made a presentation on the draft report to a meeting of Australian stakeholders, followed by discussion and feedback. The report was also presented to a separate meeting of the HHTG and AusAID country offices (by teleconference).

Following written and oral feedback received from AusAID and Australian stakeholders, the draft report was finalised and submitted to the AHRF and the HHTG.

6. Scope

The countries included within the scoping exercise were Burma, Cambodia, Indonesia, Papua New Guinea, the Philippines and Vietnam. Regional level work by multilaterals, bilaterals, technical assistance agencies and civil society networks was also within the scope of work.

7. Limitations

The following limitations applied to this work:

- The scope of work (six countries and regional level work) was quite broad. With the time available it was necessary to limit the number of key informant interviews. In selecting key informants priority was given to organisations with significant MSM activities. There was liaison with AusAID country offices in choosing country level key informants. Priority was also given to interviewing representatives of NAPs. Despite follow-up it was not possible to set up interview times with some of these people.
- Time limitations meant that it was not possible to interview all organisations undertaking MSM activities. This means that there are some gaps in the mapping. However, as all major implementing agencies were interviewed, these gaps do not detract significantly from the overall picture from the mapping.
- It was not feasible within the timeframe to undertake a detailed mapping of existing HIV and sexual health programs for men who have sex with men. This is not a significant limitation as the purpose of the mapping was to identify gaps (geographic, programmatic and efficacy) in existing work. Highly detailed mapping was not needed for this purpose. The mapping was oriented towards providing an overall picture of current programs as a basis for AusAID's planning.
- Where programs for MSM are funded as part of a broader program reaching other target groups, it was usually not possible to obtain information on the expenditure for MSM components, although estimates were sometimes provided.
- The scoping exercise was conducted as a desk study from Bangkok. All interviews in the focus countries were conducted by telephone, somewhat limiting communication. Regional level interviews with Bangkok-based stakeholders were conducted face-to-face.

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Annex 8: Key Informants

The following persons and organisations made inputs to the scoping exercise primarily through interviews and in some instances through written responses to questions:

Name	Position	Organisation
AusAID HHTG/Head Office		
Sue Elliot	Director	Health & HIV Thematic Group, AusAID
Robyn Biti	HIV Advisor	AusAID
Prue Borthwick	HIV Program Manager	Health & HIV Thematic Group, AusAID
Steve Hogg	Senior Associate	Operations Policy & Support, AusAID
Multilaterals: regional level		
Edmund Settle	HIV Policy Specialist	UNDP Regional Centre in Bangkok
Geoff Manthey	Regional Program Advisor	UNAIDS Regional Support Team Asia Pacific
Robert Sutherland	Capacity Development Officer, MSM	UNAIDS Regional Support Team Asia Pacific
Jan de Lind van Wijngaarden	Regional HIV/AIDS Advisor	UNESCO Asia-Pacific Regional Bureau for Education
Fabio Mesquita	Technical Officer, Harm Reduction HIV/AIDS & STI	WHO Western Pacific Regional Office
Bilaterals: regional level		
Phillippe Allan	Minister Counsellor	AusAID Bangkok
Cliff Cortez	Regional Team Leader, HIV/AIDS	USAID Regional Development Mission Asia
Technical assistance agencies: regional level		
Philippe Girault	Technical Advisor, Male Sexual Health	Family Health International Asia Pacific Regional Office
Graham Neilsen	Technical Advisor, Sexual and Reproductive Health	Family Health International Asia Pacific Regional Office
Felicity Young	Chief of Party	Health Policy Initiative/Asia RTI International
Frits van Griensven	Chief, Behavioural Research Section	US Centres for Disease Control and Prevention Southeast Asia Regional Office
Brad Otto	Asia Regional Representative	Burnet Institute, Bangkok
Fiona Barr	Regional Program Development Advisor	International HIV/AIDS Alliance, Bangkok Office
Elden Chamberlain	Regional Representative	International HIV/AIDS Alliance, Bangkok Office
Networks: regional level		
Shivananda Khan	Chairperson	Asia Pacific Coalition on Male Sexual Health
Paul Causey	Executive Management Consultant	Asia Pacific Coalition on Male Sexual Health
Addy Chen	Coordinator, APN+ Positive MSM Working Group	Asia Pacific Network of People Living with HIV/AIDS
Burma		
Bernie Pearce	First Secretary	AusAID, Burma
Sun Gang	Country Coordinator	UNAIDS, Myanmar
Oscar Barreneche	Medical Officer, HIV/AIDS	WHO, Myanmar
Habibur Rahman	Manager, MSM Program	PSI, Myanmar
Choo Phuah	Country Director	International HIV/AIDS Alliance, Myanmar
Tammy Hasselfeldt	Assistant Country Director	CARE, Myanmar
Naing Maung	Health Department Coordinator	World Vision Myanmar
Mikko Lainejok	Chief Executive Officer	Three Diseases Fund
Attila Molnar	Monitoring and Evaluation Officer	Three Diseases Fund
Nu Nu Aye	HIV Specialist	Three Diseases Fund
Cambodia		
Lia Burns	Senior Program Coordinator	AusAID, Cambodia
Teng Kunthy	Secretary General	National AIDS Authority, Cambodia
Tony Lisle	Country Coordinator	UNAIDS, Cambodia
Caroline Francis	Deputy Director	Family Health International, Cambodia

Name	Position	Organisation
Nou Vannary	Team Leader, Technical Support & Best Practices	Khmer HIV/AIDS NGO Alliance
Phal Sophat	Manager	Men's Health Social Services
Indonesia		
Ibu Nafsiah Mboi	Executive Director	Indonesia National AIDS Commission
Linette Collins	HIV Advisor	AusAID, Indonesia
Robert Mangani	Country Director	Family Health International, Indonesia
Jim Johnson	Deputy Director, Operations	Family Health International, Indonesia
Tono Permana	Coordinator	Indonesian Male Sexual Health Network
Tim McKay	Team Leader	HIV Cooperation Program for Indonesia
Abby Ruddick	Deputy Team Leader – Capacity Development Adviser	HIV Cooperation Program for Indonesia
Steve Wignal	Chief Operations Officer	South East Asia Infectious Disease Clinical Research Network, Network Coordinating Centre, Eijkman Oxford Clinical Research Unit
Dede Oetomo	Founder	GAYa NUSANTARA Foundation
Nancy Fee	Country Coordinator	UNAIDS, Indonesia
Ashley Heslop	Program Officer	UNAIDS, Indonesia
Claudia Surjadjaja	Chief of Party	Health Policy Initiative, Indonesia
Papua New Guinea		
Anne Malcolm	Director	Papua New Guinea – Australia HIV & AIDS Program (Sanap Wantaim)
Greg Law	Advisor	Sexual Health & STI, Disease Control Branch, National Department of Health, PNG
Nayer Kaviani	Country Director	Family Health International, PNG
Christopher Hershey	Poros Sapot Project Manager	Save the Children, PNG
Kel Browne	Deputy Project Manager	HIV Prevention and Control in Rural Development Enclaves
Carla Lopez	Behaviour Change Intervention Manager	PSI, PNG
Philippines		
Jimmy Loro	Program Officer	AusAID, Philippines
Ferchito Avelino	Executive Director	Philippine National AIDS Council
Gerard Belimac	Program Manager	National AIDS and STI Prevention and Control Program, Department of Health
Philip Castro	Program Manager, Field Operations	Tropical Diseases Foundation (Global Fund PR)
Fe Cabral	Program Officer	UNDP, Philippines
Gudron Nadoll	Program Officer	UNICEF, Philippines
Jonas Bagas	Board Member	TLF Share Collective
Jovanni Templonuevo	National Professional Program Officer	UNFPA
Vietnam		
Katja Selkimaki-Gray	Activity Manager, Health Sector	AusAID Vietnam Country Office
John Eyres	Senior Technical Advisor, Drug Rehabilitation & HIV Prevention	USAID/Vietnam
Don Colby	Director	Harvard Medical School AIDS Initiative in Vietnam
Ludo Bok	Program Officer	UNAIDS, Vietnam
My Linh Nguyen	Program Officer	UNAIDS, Vietnam
Zhao Pengfei	Technical Officer, HIV Prevention	WHO, Vietnam
Vu Ngoc Bao	Program Manager	Family Health International
Australian key informants		
Don Baxter	Executive Director	Australian Federation of AIDS Organisations
David Traynor	International Programs	Australian Federation of AIDS Organisations
Mike Toole	Head	Centre for International Health, Burnet Institute
Gary Dowsett	Deputy Director	Australian Research Centre in Sex, Health and Society
John Godwin	Consultant	
Michael Buggy	Assistant Director	Albion Street Centre

