





# Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region



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Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region

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# Acronyms



|        |                                                    |
|--------|----------------------------------------------------|
| AIDS   | acquired immunodeficiency syndrome                 |
| APCOM  | Asia Pacific Coalition on Male Sexual Health       |
| ART    | antiretroviral therapy                             |
| ARV    | antiretroviral                                     |
| ATS    | amphetamine-type stimulants                        |
| BCC    | behaviour change communication                     |
| BMI    | body mass index                                    |
| CBO    | community-based organization                       |
| CITC   | client-initiated testing and counselling           |
| DIC    | drop-in centre                                     |
| DOTS   | directly observed treatment, short-course          |
| EIA    | enzyme immunoassay                                 |
| EPT    | expert patient trainer                             |
| GIPA   | greater involvement of people living with HIV      |
| HAV    | hepatitis A virus                                  |
| HBV    | hepatitis B virus                                  |
| HCV    | hepatitis C virus                                  |
| HCW    | health-care worker(s)                              |
| HHV    | human herpesvirus                                  |
| HIV    | human immunodeficiency virus                       |
| HIV-DR | HIV drug resistance                                |
| HPV    | human papillomavirus                               |
| IBBS   | integrated biological and behavioural surveillance |
| IC     | infection control                                  |
| ICF    | intensified case finding                           |
| IEC    | information, education and communication           |
| INH    | isonicotinic acid hydrazide (isoniazid)            |
| IPT    | isoniazid preventive treatment                     |
| KS     | Kaposi sarcoma                                     |
| MDR    | multidrug-resistant                                |
| M&E    | monitoring and evaluation                          |
| MSM    | men who have sex with men                          |
| MSW    | male sex worker                                    |
| MTCT   | mother-to-child transmission (of HIV)              |

## Acronyms

|        |                                                                                        |
|--------|----------------------------------------------------------------------------------------|
| NGO    | nongovernmental organization                                                           |
| NSP    | needle and syringe programme                                                           |
| OI     | opportunistic infection                                                                |
| OST    | opioid substitution therapy                                                            |
| PCP    | <i>Pneumocystis jiroveci</i> pneumonia (earlier known as <i>Pneumocystis carinii</i> ) |
| PEP    | post-exposure prophylaxis                                                              |
| PrEP   | pre-exposure prophylaxis                                                               |
| PITC   | provider-initiated testing and counselling                                             |
| PLHIV  | people living with HIV                                                                 |
| PWID   | people who inject drugs                                                                |
| RAR    | rapid assessment and response                                                          |
| RDA    | recommended daily allowance                                                            |
| STI    | sexually transmitted infection                                                         |
| TB     | tuberculosis                                                                           |
| TG     | transgender people                                                                     |
| UN     | United Nations                                                                         |
| UNAIDS | Joint United Nations Programme on HIV/AIDS                                             |
| UNDP   | United Nations Development Programme                                                   |
| UNESCO | United Nations Educational, Scientific and Cultural Organization                       |
| UNGASS | United Nations General Assembly Special Session                                        |
| UNICEF | United Nations International Children's Emergency Fund                                 |
| VCT    | voluntary counselling and testing                                                      |
| WFP    | World Food Programme                                                                   |
| WHO    | World Health Organization                                                              |
| XDR    | extensively drug-resistant                                                             |



# Acknowledgements



This document entitled *Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region* was developed on a decision of the “Consultation on health sector response to HIV/AIDS among men who have sex with men” held in Hong Kong (China) in February 2009, and organized by WHO Regional Office for the Western Pacific, UNDP, UNAIDS and the Department of Health of Hong Kong (China).

The scope of the document was later discussed in the Regional Consensus Meeting on “Developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia and the Pacific” held in Bangkok, Thailand in June 2009, which was convened by UNDP, UNESCO, UNAIDS and WHO, in collaboration with the Association of Southeast Asian Nations, USAID and the Asia Pacific Coalition on Male Sexual Health.

The development of this document was coordinated by Dr Massimo Ghidinelli and Dr Fabio Mesquita; Mr Michael Buggy and Dr Timothy Barnes of Albion Street Centre, Australia, WHO Collaborating Centre and Mr David Lowe contributed most of the writing.

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# Foreword



Both the Report of the Commission on AIDS in Asia, “Redefining AIDS in Asia: Crafting an Effective Response” (2008) and the Report of the Commission on AIDS in the Pacific, “Turning the Tide: An Open Strategy for a Response to AIDS in the Pacific” (2009) clearly recommend that the control of the epidemic in the Region would imply focusing on the most-at-risk populations, including men who have sex with men (MSM) and transgender persons. The documents call for the urgent scale-up of strategies to prevent the transmission of HIV, and to ensure greater access to treatment, care and support for those already in need. Finally, they also insist that in the Asia-Pacific context, a comprehensive and effective response would need to address the issue of punitive laws and increase social protection of the most vulnerable populations.

The HIV epidemic among MSM and transgender persons is escalating globally, and currently represents a major source of new infections in many countries in Asia and the Pacific. The burden and the complexities related to this growing problem and to the comprehensive and effective responses constitute a serious crisis for health systems and service providers.

In September 2008, WHO, UNDP and UNAIDS convened a global consultation on “Prevention and treatment of HIV and other sexually transmitted infections among MSM and transgender populations” in Geneva, an event that marked the return of the HIV epidemic among MSM to the global agenda of the health sector.

Within the Asia Pacific region, this unfolding crisis was taken as a call to bring together civil society, community activists, development partners, donors and UN agencies (particularly UNDP, UNAIDS, UNESCO and WHO) to inform and articulate a strengthened health sector response, and create synergies with other initiatives being undertaken. This has been accomplished by utilizing the regional foundation formed by the Asia Pacific Coalition on Male Sexual Health (APCOM).

In February 2009, the WHO Regional Office for the Western Pacific, in collaboration with UNDP, UNAIDS, APCOM and the Department of Health, Hong Kong SAR (China), organized the first “Consultation on Health Sector Response to HIV/AIDS Among MSM in Asia Pacific” in Hong Kong (China). This event succeeded in mobilizing a wide range of stakeholders and

increasing the focus on the paucity of established health interventions capable of halting the HIV epidemic among MSM and transgender persons in the region.

All these efforts paved the way for a “Regional Consensus Meeting on Developing a Comprehensive Package of Services to Reduce HIV among MSM and Transgender Populations in Asia and the Pacific” held in Bangkok, Thailand in June 2009, which was convened by UNDP, UNESCO, UNAIDS and WHO, in collaboration with the Association of South East Asian Nations, USAID and APCOM.

The health sector is an important partner in the urgently needed response to the escalating problem of HIV transmission among men who have sex with men and transgender persons. The health sector is crucial to advocate and promote male sexual health; generate and analyze strategic information; involve health systems in effective prevention activities; improve access to care, support and treatment; and develop health systems free of stigma and discrimination, therefore guaranteeing sustainability.

It is against this background of extraordinary mobilization that the present document *Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific Region* was developed to articulate clearly the contribution that the health sector could provide to respond to the HIV crises among MSM and transgender persons in the Region.

The document was conceived as a joint collaboration among the WHO Regional Offices for the Western Pacific and South-East Asia, UNDP Asia Pacific Regional Centre, UNAIDS, APCOM and the Department of Health, Hong Kong SAR (China).

In essence, the present document describes the priority health sector interventions recommended to achieve universal access for the prevention, treatment, care and support of HIV and sexually transmitted infections among MSM in the broader perspective of male sexual health. It summarizes key policy and technical recommendations developed by WHO related to each priority health sector intervention. It guides the selection and prioritization of interventions for HIV prevention, treatment, care and support. Finally, it directs readers to key resources of WHO and other organizations containing the best available information on the health sector response to HIV among MSM.

Relying on a rigorous background of male sexual health and strategic information, this document is, to the extent possible, based on scientific evidence and programmatic experience in prevention, care, support and treatment of HIV, as well as male sexual health. It is also intended to be as specific as possible for its implementation in the context of Asia and the Pacific, addressing a broad audience including public health decision-makers, national AIDS

programme managers, health care providers, community-based organization managers, MSM living with and affected by HIV, and development agencies.

This document will be a fundamental tool to contribute to halting the HIV/AIDS epidemic in Asia and the Pacific Region and to help countries in achieving universal access towards the Millennium Development Goals.



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# Purpose, target readers and structure of this document



## Purpose of this document

The purpose of this document is:

1. to describe the priority health sector interventions needed to achieve universal access to prevention, treatment, care and support for HIV and sexually transmitted infections (STIs) by men who have sex with men (MSM);
2. to summarize key policy and technical recommendations developed by the World Health Organization (WHO) for each of the priority health sector interventions;
3. to guide the selection and prioritization of interventions for HIV prevention, treatment, care and support for MSM; and
4. to direct readers to key resources of WHO and other organizations, which contain the best available information on the health sector response to HIV and AIDS for MSM.

## Target readers

This document is intended for a broad range of readers including public health decision-makers, national AIDS programme managers, health-care providers, managers of community-based organizations (CBOs) for MSM, civil society, people living with and affected by HIV, and development partners.

## Structure of the document

This document is structured as follows:

### **Glossary**

A glossary of key terms is provided at the beginning of this document.

### **Consensus statement**

The Consensus Statement on the Comprehensive package of HIV interventions and sexual health services for men who have sex with men (MSM) and transgender populations (TG) in Asia and the Pacific is given after the Glossary. This Statement was agreed upon at a Regional Consensus Meeting in 2009.

### **Chapter 1: Introduction**

This chapter outlines the purpose of this document, provides definitions of MSM, TG and the health sector; gives an overview of the epidemiology of HIV and STI among MSM in Asia and the Pacific;

outlines the priority areas and guiding principles for the health sector response; emphasizes the importance of a broad, inclusive partnership, and the need for an enabling environment to mount an effective and comprehensive response.

### ***Chapter 2: Prevention***

This chapter describes how the health sector can maximize its role in providing HIV prevention programmes for MSM, with an emphasis on collaboration with CBOs. An overview of the key issues in HIV prevention for MSM is provided along with a description of the priority interventions. The recommended approach to prevention for particular subpopulations is also outlined.

### ***Chapter 3: Sexual health***

This chapter addresses the sexual health needs of MSM, emphasizing the importance of the central role played by CBOs in developing services. The specific needs of MSM are outlined, with recommendations to ensure that interventions for STI prevention and care are integrated or closely coordinated with the wider response to HIV among MSM.

### ***Chapter 4: Care, support and treatment***

This chapter outlines treatment interventions, and addresses the issues of adherence, prophylaxis, co-morbidity with other infections and diseases, mental health, vaccinations and nutritional care.

### ***Chapter 5: Strategic information***

This chapter highlights the importance of strategic information to guide planning, decision-making, implementation and accountability, and recommends the types of strategic information that are essential. The chapter also emphasizes the importance of data quality and using data effectively for programme improvement.

### ***Chapter 6: Strengthening health systems***

This chapter considers the ways that gaps and failures within health systems can be addressed and rectified to provide equitable and sustained health for all. Recommendations focus upon an inclusive and collaborative approach throughout the various levels and components of health systems. In considering MSM issues, the focus is on integration and linkage of services, strengthening the health workforce, financing, leadership and governance, coalition-building and partnerships, and addressing stigma and discrimination.

### ***Key resources***

Key resources that provide additional information for each priority intervention are listed in each chapter by the title of the resource along with a web-page link. Annex I, Key resources, provides additional information on each of the key resource documents. This includes descriptions of the type of document, target audience, focus of implementation and usually a synopsis of the document. A common numbering system is used for the key resources listed in each chapter and the full list of key resources in Annex I. As more evidence and additional guidance and tools become available, it is intended that the references and tools will be updated.

# Glossary



|                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Behaviour change communication | Behaviour change communication is the process by which information and skills are shared and disseminated to people in specific target audiences with the intention of influencing them to adopt sustained changes in behaviours and attitudes, or to engage in other health-seeking behaviour.                                                                                                                                                                                                                                                                                                                                               |
| Case surveillance              | Reporting by health-care providers to health authorities of every diagnosed case of HIV and/or AIDS. Requirements for reporting – by name, code or anonymously – vary between jurisdictions.                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Enabling environment           | The social, legal and environmental determinants that facilitate safe behavioural choices and encourage those most vulnerable to and living with HIV to participate at all levels of the response to the epidemic                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Health sector                  | The health sector is wide-ranging and encompasses organized public and private health services, including those for health promotion, disease prevention, diagnosis, treatment and care; health ministries; nongovernment organizations (NGOs); community groups; professional organizations; as well as institutions that directly input into the health-care system (e.g. the pharmaceutical industry, teaching institutions). Health services for the diagnosis and treatment of disease and the maintenance of health are key components of the health sector but are only one aspect of the broad health sector response that is needed. |

HIV epidemics

*Low-level HIV epidemics*

Although HIV may have been prevalent for many years, it has never spread to substantial levels in any subpopulation. Recorded infection is largely confined to individuals with higher risk behaviour (e.g. men who have sex with men [MSM], sex workers and people who inject drugs [PWID]). Numerical proxy: HIV prevalence has not consistently exceeded 5% in any defined population.

*Concentrated HIV epidemics*

HIV has spread rapidly in a defined subpopulation(s), but is not well established in the general population. The future course of the epidemic is determined by the frequency and nature of links between highly infected subpopulations and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined subpopulation but is below 1% among pregnant women in urban areas.

*Generalized HIV epidemics*

HIV is firmly established in the general population. Although subpopulations at high risk may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of subpopulations at higher risk for infection. Numerical proxy: HIV prevalence is consistently over 1% among pregnant women.

Integrated biological and behavioural surveillance

Measures HIV prevalence, and often sexually transmitted infection (STI) prevalence, in a defined population(s) at a point in time, as well as behavioural and demographic data to provide a better understanding of the dynamics of the epidemic. When these surveys are repeated over time, trends in the epidemic become apparent.

Men who have sex with men

A behavioural term that refers to biological males who have sex with other biological males, regardless of sexual orientation or gender identity. As the term MSM includes biological males who have sex with other biological males, references in this document to MSM should be read as including transgender people (TG), unless otherwise indicated.



|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Sentinel surveillance    | The systematic, ongoing collection and analysis of data from certain sites (hospitals, health centres, STI clinics) selected for their geographical location, medical specialty and populations served, and considered to have the potential to provide an early indication of changes in the level of disease                                                                                                                                                                                                      |
| Sexual health            | A state of physical, emotional, mental and social well-being related to sexuality; and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.                    |
| Structural interventions | Public health measures that implement or change laws, policies, physical structures, social or organizational structures or standard operating procedures to effect beneficial environmental or social change that will improve health status at a population level. Structural interventions include programmes or policies that change the environment in which risk behaviour occurs. Examples include laws requiring seat belts or interventions to make condoms available in all entertainment establishments. |
| Transgender people       | Transgender people are individuals whose gender identity and/or expression of their gender differ from social norms related to their gender of birth. The term transgender people describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another.                                                                                                                                                                                                             |

# Consensus statement: comprehensive package of interventions



Consensus Statement on the Comprehensive package of HIV interventions and sexual health services for men who have sex with men and transgender populations in Asia and the Pacific

*The following Consensus Statement was agreed to by all government, community and development partner participants at the Regional Consensus Meeting on Developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia–Pacific, held in Bangkok in June–July 2009.*

This Asia–Pacific Regional Consensus Meeting recognized that the significant and increasing burden of HIV infections documented among men who have sex with men (MSM) and transgender persons (TG) in many countries of the region constitutes an urgent health and development crisis. This Consensus Statement describes the key components of a multisectoral, comprehensive package of interventions and sexual health services that will provide a continuum of prevention, care, treatment and support services to reduce the incidence and impact of HIV among the broad range of MSM and TG in Asia and the Pacific.

It is therefore recommended that comprehensive national responses incorporate effective, scaled-up prevention activities for HIV and sexually transmitted infections (STIs), along with care, treatment and support services, all guided by strategic information. The meeting further recognized that enabling environments, strategic partnerships and collaborations that include governments, communities and development partners are essential for the design, costing and implementation of comprehensive responses.

Prevention activities must target the diversity of MSM and TG, including those living with HIV, and address their sexual health needs through a variety of approaches and combinations of interventions. Innovative use of the mass and targeted media, including the internet, should be an integrated component in the delivery of prevention messages, health promotion and social support services. Commodities such as condoms and lubricants should be readily available and widely promoted. Prevention activities should be strengthened using a variety of channels in locations where high-risk behaviour may occur and include structural interventions.

Key issues that should be strongly considered in prevention programming, taking into account legal and policy constraints, include sexual risk-taking linked to recreational drug use among MSM, as well

as access to clean needle-and-syringe programmes for MSM who also inject drugs; along with the availability of programmes to prevent male-to-male sexual transmission in prisons and other closed settings.

To maximize service utilization and coverage, access to STI management, HIV counselling and testing and, where appropriate, structured referral mechanisms to health, social services and peer support groups need to be increased. This can be achieved through implementation of interventions such as peer outreach, drop-in centres (DICs), and mobile clinics that seek to provide services, in addition to standard public health settings.

Addressing stigma and discrimination, enhancing the appropriate clinical skills and knowledge, sensitizing health-care workers, removing structural barriers to appropriate delivery of services, and enhancing health-seeking behaviours of MSM and TG are also essential to programme success. Consequently, an increased proportion of MSM and TG living with HIV will realize their right to positive health, including access to existing public health services for antiretroviral therapy (ART), other life-saving therapies, and targeted prevention and care through community programmes designed and run by and for MSM living with HIV, as well as the provision of clinical management for coinfections such as tuberculosis (TB) and hepatitis.

The meeting also recognized the potential of existing and emerging biomedical prevention technologies to increase the impact of prevention programming, and recommended urgent consideration of these developments such as the use of pre- and post-exposure prophylaxis. Similarly, it was recognized that a successful comprehensive response requires that specific attention be paid to the non-HIV health needs of MSM and TG.

The meeting concluded that strategic information is essential to guide the planning, design and monitoring of appropriate interventions, as well as allocation of resources. Meeting participants agreed that monitoring and evaluation (M&E) systems need to be built around programmes in order to provide data that will demonstrate the extent and intensity of coverage of the comprehensive package required to promote health behaviours and reduce HIV and STI incidence.

While biobehavioural information is increasingly becoming available, gaps remain in the knowledge base, especially on issues relating to the changing nature of the epidemic, impacts on affected communities, population size estimates and sociocultural determinants. Further investment and harmonization of surveillance, sociobehavioural and operational research, with the substantive involvement of MSM and TG or affected communities, are needed.

The meeting supported the recommendation of the report of the Commission on AIDS in Asia that comprehensive interventions for HIV among MSM and TG in Asia-Pacific be fully integrated and costed into national plans. Consequently, M&E processes to address the quality, effectiveness and coverage of comprehensive interventions need to be conducted.

The meeting recognized that an enabling environment is essential for an effective and comprehensive response to HIV among MSM and TG in Asia and the Pacific. The meeting also agreed that the establishment of broad-based partnerships, mutual recognition of roles and responsibilities, and commitment to rights-based approaches are essential to address restrictive legal and regulatory frameworks, and stigmatizing and discriminatory social norms. Such partnerships would also promote appropriate policy development, and the meaningful engagement and mobilization of affected communities.

Further, increased investment in developing the organizational and technical capacities of all partners, particularly of community-based organizations, is necessary for an effective response.

The Regional Consensus Meeting concluded that effective action on the recommended key components of comprehensive responses can only move forward with the continued synergy of governments, communities and development partners, working together towards a continuum of prevention, care, treatment and support for MSM and TG in Asia and the Pacific.

# I. Introduction



The significant and increasing burden of HIV infection documented among men who have sex with men (MSM) and transgender persons (TG) in many Asia–Pacific countries constitutes an urgent health and development crisis. This document defines the priority interventions required by the health sector to meet the HIV and sexual health needs of MSM and TG in the region. These priority interventions have been informed by two regional consultations: the Consultation on the “Health sector response to HIV/AIDS among men who have sex with men”, held in Hong Kong (China) in February 2009, and the Regional Consensus Meeting on “Developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia–Pacific”, held in Bangkok in June–July 2009.

## I.1 Definition of men who have sex with men and transgender people

The term “men who have sex with men” is a behavioural term which refers to biological males who have sex with other biological males, regardless of sexual orientation or gender identity.

There is considerable diversity among MSM who self-identify as males. Male-identified MSM do not necessarily have a sense of identity or community based on their male-to-male sexual practice, although an increasing number of men in Asia and the Pacific do have such an identity. The term MSM includes men who identify as gay, homosexual or with terminology particular to the local language that has culturally specific meaning, and also includes bisexual and heterosexual men who at times have sex with other men. In Asia and the Pacific, significant numbers of MSM see themselves as normative males and do not identify with labels or terminology that imply self-identity related to male-to-male sex. Many MSM also have sex with females and large numbers are married, usually due to social pressure. The term MSM also includes male sex workers (MSWs) who have male clients.

As the term MSM includes biological males who have sex with other biological males, it is an inclusive term that encompasses people with a transgender identity, who usually do not self-identify as men. Broadly speaking, TG comprises individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term “transgender people” describes a wide range of identities, roles and experiences, which can vary considerably from one culture to another. While many biological males who have sex with other males may display, to widely varying degrees, what are traditionally thought of as female characteristics, not all males who display feminine characteristics would regard themselves as a TG or a woman. As the term MSM is used as an inclusive

behavioural term referring to biological males who have sex with other biological males, references in this document to MSM should be read as including TG, unless otherwise indicated.

## 1.2 Epidemiological and behavioural situation of HIV and STI among MSM in Asia–Pacific

### 1.2.1 MSM population size estimation

A meta-analysis of international studies on male sexual behaviour and/or MSM population characteristics found that data on the lifetime prevalence of sex among males ranged from 3% to 5% in East Asia and 6–12% in South and South-East Asia. Sex among males in the past year was approximately half that of lifetime figures.<sup>1</sup> Size estimation studies have been undertaken in a number of Asian countries, with some results being lower than the ranges mentioned above. Disagreement on size estimation methodologies and the validity of results is not uncommon. Estimating the size of the MSM population is also discussed in section 5.1.

### 1.2.2 HIV prevalence data

While MSM make up a relatively small proportion of the total population, HIV prevalence among MSM can account for a significant proportion of the total HIV epidemic. It is estimated that, in 2005, MSM accounted for 30.3% of the total adult HIV prevalence in Bangkok, which was 1.4% (Tim Brown, personal communication, 2007). In Asia, MSM are disproportionately affected by the HIV epidemic, with the odds of MSM having HIV infection being 18.7 times higher than that in the general population.<sup>2</sup> In China, the odds of MSM having HIV infection are 45 times higher than in the general population. The Asian Epidemic Model projects that unless effective prevention measures are intensified, by 2020, around 46% of new infections in Asia will be among MSM, up from 13% in 2008.<sup>3</sup>

In many Asian countries, HIV epidemics are concentrated, with HIV prevalence among MSM exceeding 5% in locations where cross-sectional studies have been conducted. Other Asian countries have to date experienced low-level HIV epidemics, although data indicate that the prevalence of HIV among MSM in some of these countries is rising rapidly. In the Pacific, most countries are currently experiencing low-level epidemics, with the exception of Papua New Guinea which has a generalized epidemic (see the Glossary for definitions of low-level, concentrated and generalized HIV epidemics). There are very little data on HIV infection among MSM in the Pacific.

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1 Caceres C et al. Estimating the number of men who have sex with men in low and middle income countries. *Sexually Transmitted Infections*, 2006, 82:3-9.

2 Beral S et al. Elevated Risk for HIV infection among men who have sex with men in low- and middle-income countries 2000–2006: a systematic review. *PLoS Medicine*, 2007, 4:e3339.

3 Commission on AIDS in Asia. *Redefining AIDS in Asia. Crafting an effective response. Report of the Commission on AIDS in Asia*. New Delhi, Oxford University Press, 2008.

In recent years, a picture of significant HIV epidemics among MSM has emerged from cross-sectional surveillance studies in a number of countries. Data on HIV prevalence rates in a selection of countries is presented in Table I. HIV prevalence rates among MSM identified by these studies include: Bangkok 30.8% (2007), Yangon 28.8% (2008), Phnom Penh 8.7% (2005), Hanoi 9.4% (2006), Chengdu 9.1% (2007), Jakarta 8.1% (2007), Vientiane 5.6% (2007) and the Philippines 0.3% (2007).<sup>4</sup> In India, HIV prevalence among MSM ranged from 0.4% to 17% between districts, and prevalence was greater than 5% in 19 out of 37 sentinel sites in 2007.<sup>5</sup> Cross-sectional HIV prevalence studies among MSM have not been conducted in the Pacific.

**Table I: HIV prevalence among MSM in selected countries<sup>4,5\*</sup>**

| Country                     | HIV prevalence all MSM (%) | HIV prevalence male-identified MSM (%) | HIV prevalence transgender (%) |
|-----------------------------|----------------------------|----------------------------------------|--------------------------------|
| Phnom Penh, Cambodia – 2005 |                            | 5                                      | 17                             |
| China – 2007†               | 0.5–9.1                    |                                        |                                |
| India – 2007†               | 0.4–17                     |                                        |                                |
| Indonesia – 2007†*          | -                          | 2.0–8.1                                | 14–34                          |
| Vientiane, Lao PDR – 2007   |                            | 5.6                                    |                                |
| Yangon, Myanmar – 2008      | 28.8                       | -                                      | -                              |
| Kathmandu, Nepal – 2007     | 3.3                        |                                        |                                |
| Pakistan – 2007             | 2.8                        |                                        |                                |
| Philippines – 2007          | 0.3                        | -                                      | -                              |
| Bangkok, Thailand – 2007    |                            | 30.7                                   | 11.5                           |
| Viet Nam – 2006†            | 5.3–9.4                    | -                                      | -                              |

† A range is provided as HIV prevalence varied by site and aggregated data are not available.

\* The sample size for cross-sectional studies varies from study to study and those surveyed may not be representative of the broad diversity of MSM and TG.

### 1.2.3 HIV trends among MSM in developed nations and regions

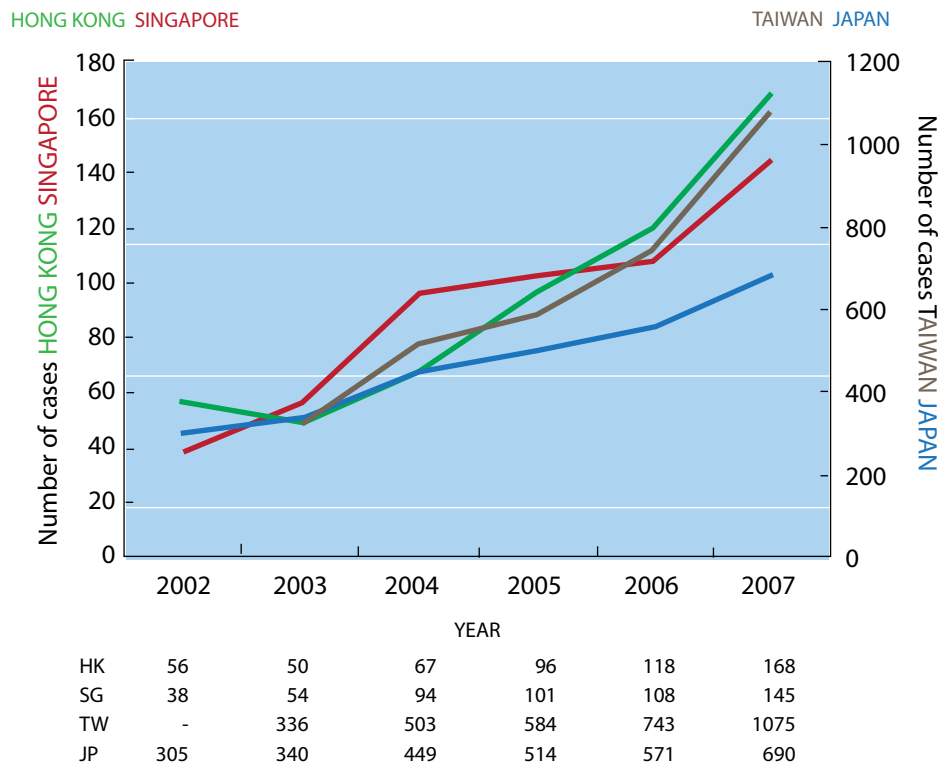
In developed nations and regions in Asia experiencing low-level HIV epidemics, case surveillance data show an upward trend in HIV infection among MSM. The data presented in Figure I show significant increases in newly diagnosed HIV infections among MSM in Hong Kong (China), Singapore, Taiwan (China) and Japan between 2002 and 2007, with the number of new cases either doubling or more than tripling. In all four jurisdictions, MSM have contributed the single largest number of new HIV cases and, in some places, the majority of new HIV cases.

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 van Griensven F et al. Global epidemic of HIV infection among MSM. *Current Opinion in HIV and AIDS*, 2009, 4: 300–307.

Cross-sectional surveys in 2007 among male-identified MSM in Tokyo and Singapore found HIV prevalence rates of 4.4% and 4.2%, respectively.

**Figure 1: Number of reported newly diagnosed HIV infections among MSM in Hong Kong (China), Singapore, Taiwan (China) and Japan, 2002–2007<sup>5</sup>**



### 1.2.4 STI prevalence

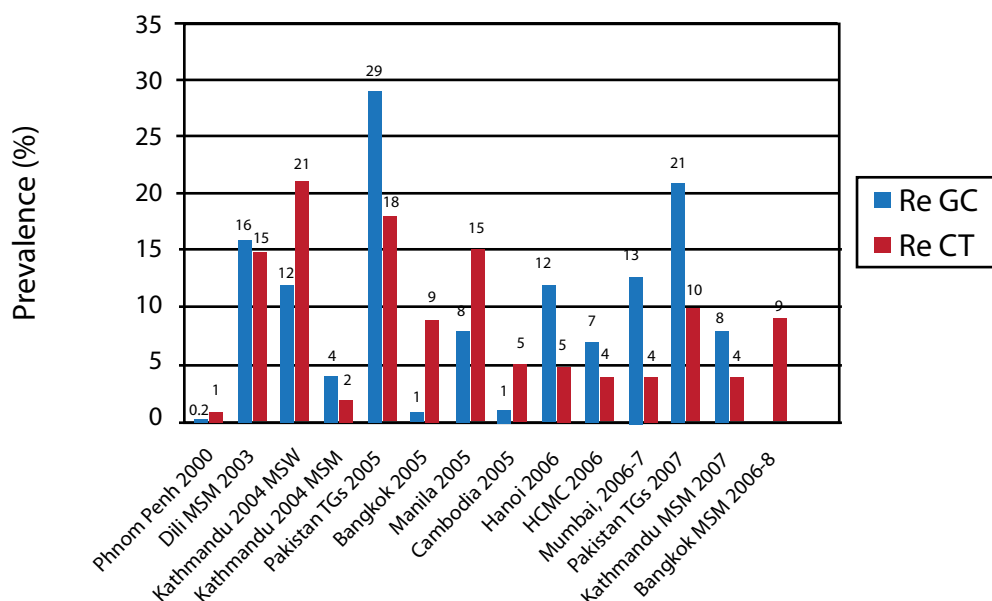
Prevalence rates for any sexually transmitted infection (STI) among MSM vary widely from country to country but are generally high to very high. Surveillance indicates a high prevalence of both asymptomatic infections and anorectal symptoms (e.g. burning, itching, bleeding and discharge) and a poor correlation between symptoms and STIs.<sup>6</sup> The highest STI rates are seen in TG, although there are no data on neovaginal STIs. (The term neovagina refers to a vagina created by surgical technique in male-to-female gender reassignment.)<sup>6</sup> Prevalence of any STI among MSM identified in cross-sectional studies include: Phnom Penh 9.7% (2005), Indonesia 38% (2007), Kathmandu 28.7% (2005), Bangalore

<sup>6</sup> Neilsen G. *Epidemiology and clinical management of sexually transmitted infections among men who have sex with men*, Family Health International, presented at an MSM Meeting on STI Management, Ministry of Public Health Thailand, January 2009.



41.4% (2007) and Viet Nam 16–22% (2005–06).<sup>7,8,9,10</sup> In Bangladesh, the percentage of MSWs and TG reporting STI symptoms in the past year was between 35% and 45% for MSWs and 44% for TG.<sup>11</sup> The data indicate a wide range of prevalence rates of rectal gonorrhoea and chlamydial infection among MSM in Asia, as shown in Figure 2 below.

**Figure 2: Prevalence of rectal gonorrhoea and chlamydial infection among MSM in Asia, 2000–08<sup>6</sup>**



The prevalence of syphilis also varies widely (lifetime or current syphilis) among MSM in Asia: Bangkok MSM 4.3% (2006–08), Beijing MSM 9.9% (2006), Cambodian MSM 0.4% and TG 1.4% (2005), Lahore MSW 5.7% and TG 11.5% (2006), Karachi MSW 36.8% and TG 60.2% (2006), and Kathmandu MSM 7.3% and MSW 14.0% (2005).<sup>6</sup>

### 1.2.5 HIV and STI risk behaviours

Among MSM, the higher risk for HIV and STI infection is due to network effects.<sup>12</sup> Any sexual network in which people have multiple and concurrent sex partners is especially conducive to the spread of

7 Indonesia Department of Health. *Integrated biological-behavioural surveillance of most-at-risk groups*. Jakarta, MOH, 2007.

8 NCHADS. *2005 Cambodia STI prevalence survey*. Phnom Penh, MOH, 2008.

9 Viet Nam Ministry of Health. *Results from the IBBS in Viet Nam 2005–2006*. Ha Noi, MOH, 2006.

10 National AIDS Control Organization (NACO), New Delhi, India, 2007.

11 Bangladesh National AIDS/STD Programme. *Behavioural surveillance survey round VI, 2006–2007*. Dhaka, MOH, 2008.

12 Garnett GP, Ghani AC. The use of simulation models in exploring the influence of network structures on the epidemiology of sexually transmitted diseases. In: *The network paradigm in research on drug abuse, HIV, and other blood-borne and sexually transmitted infections: new perspectives, approaches and applications*. Proceedings of the NIDA/CAMCODA Working meeting May 3–4, Washington DC, NIDA/CAMCODA, 2002:63–69.

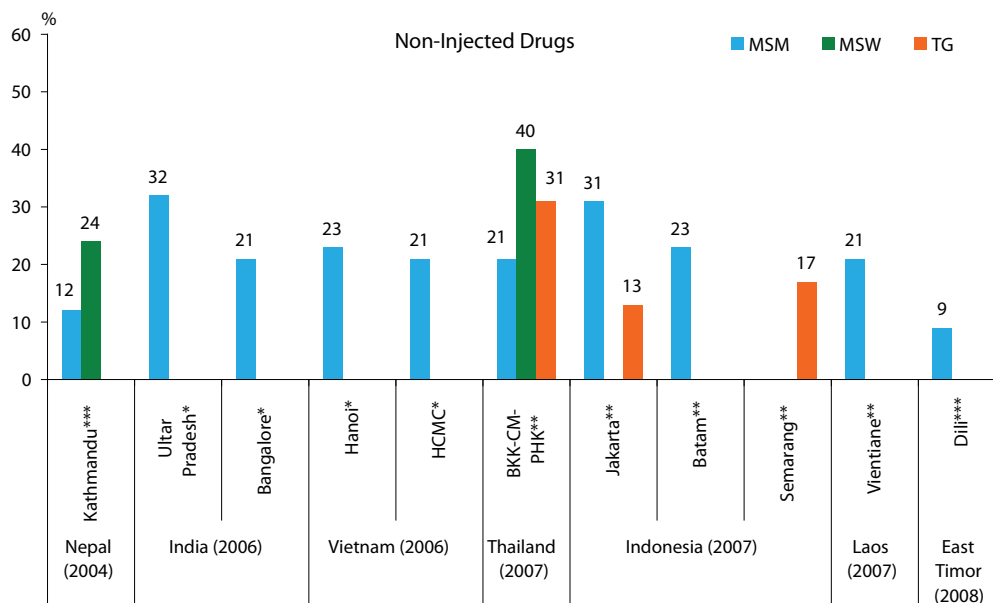
HIV. There is solid evidence of high rates of HIV risk behaviours among MSM in all countries where studies have been conducted. Unprotected anal sex is the highest risk practice for sexual transmission of HIV among MSM.

Behavioural data show high numbers of casual male sex partners. For example, in Cambodia, the number of MSM with two or more male partners in the past month ranged from 63% to 74% between survey sites. Consistent condom use with casual male partners in the past month is variable but generally low, ranging from 23% to 55% in Cambodia, 29–37% in Viet Nam, 13–26% for receptive anal intercourse in Indonesia, 45% for last sexual intercourse in the Philippines, 56% for last sex in Kathmandu, and 39% for sex with commercial male partners in India.

A common finding of all cross-sectional surveys is that many MSM also have high numbers of casual female sex partners, but fewer than the number of male partners. In Viet Nam, 40% of MSM had a female partner in the past year and in Cambodia, 80–87% of MSM had more than two female partners in the past. Consistent condom use with female partners was low.

Data from cross-sectional surveys indicate variable but high rates of non-injecting drug use by MSM, MSWs and TG in some Asia–Pacific countries (Figure 3).

**Figure 3: Non-injecting drug use by MSM, MSWs and TG in selected countries, 2004–2008<sup>13</sup>**



\* Ever used \*\* Used in the past 3 months \*\*\* Used in the past 12 months

Injecting drug use by MSM was considerably lower than non-injecting drug use: Thailand 0%, Jakarta 3% (2007), Dili 3% (2008), Nepal 3% (2004), Ho Chi Minh City 4% and Hanoi 9% (2006).<sup>13</sup>

13 Girault P. MSM and drug use in the Asia Pacific Region. ICAAP IX, Satellite Meeting, MSM Cross-Cutting Issues, 2009. Data from IBBS/National Surveillance.

While the primary risk factor for HIV infection among MSM is sexual transmission, use of non-injectable drugs may increase sexual desire and decrease inhibitions, resulting in multiple partners and unprotected anal intercourse. The use of non-sterile drug injecting equipment also poses a risk for HIV transmission. Drug use may also result in other physical and psychological health problems.

### **1.2.6 HIV prevalence, incidence and risk in MSM subpopulations**

The disaggregation of HIV prevalence and risk behaviour data by MSM subpopulations in cross-sectional studies enables the identification of groups of MSM who are at greatest risk for HIV. However, the extent of disaggregation by subpopulation is generally limited.

HIV prevalence among TG is usually higher than among male-identified MSM, although this has not been consistently confirmed in some studies (e.g. in the 2005 HIV cross-sectional survey among Thai MSM, HIV prevalence among male-identified MSM in Bangkok was 28.3% compared with 11.5% among TG).<sup>14</sup> This reflects the higher risk of HIV transmission for receptive anal intercourse. While this should inform prevention priorities, it needs to be balanced against the considerably larger population size of male-identified MSM compared to TG.

There is a paucity of HIV incidence studies among MSM in the region. Incidence data are particularly valuable for identifying those subpopulations of MSM who are most at risk and can be used in setting priorities for prevention programmes. In the Bangkok MSM Cohort Study, cumulative HIV incidence from 2006 to 2009 in a cohort of 1002 MSM was 29.9% for MSM aged 18–22 years, 18.9% for those aged 23–29, and 12.1% for those aged 30–56.<sup>15</sup> This clearly indicates that, at least in Bangkok, young MSM are at particularly high risk.

An example of the value of disaggregation of data by HIV prevalence and risk is a 2005 Thai study of men who have sex with men only (MSM-only) and behaviourally bisexually active men. HIV prevalence was 8.7% among bisexual men and 21.2% among MSM-only. Consistent condom use with male partners was higher among bisexual men (77.6%) compared with MSM-only (62.9%), and lower with female partners (44.4%). The lower rate of HIV prevalence among bisexual men may be attributed to higher levels of consistent condom use with male partners and lower levels of receptive anal intercourse. However, the low rate of consistent condom use with female partners could contribute to epidemiological bridging of the HIV epidemic among MSM to the general population.

14 HIV prevalence among populations of MSM, Thailand 2003 and 2005. *MMWR Morbidity and Mortality Weekly Reports*, 2006, 55:844–848.

15 van Griensven F. *HIVVCT and Bangkok MSM Cohort Study at the Silom Community Clinic*. Bangkok, CROI, Montréal, February 2009.

### **1.2.7 The potential for rapid increases in HIV prevalence among MSM**

Where cross-sectional HIV prevalence studies have been repeated, they have demonstrated the potential for HIV epidemics among MSM to increase rapidly, in some instances to hyperepidemic levels. For example, HIV prevalence among MSM in Bangkok increased from 17.3% in 2003 to 28.3% in 2005, and then to 30.7% in 2007.<sup>14</sup> In Indonesia, HIV prevalence among male-identified MSM in Jakarta increased fourfold, from 2.0% to 8.1% between 2003 and 2007.<sup>16</sup> In China, HIV prevalence among MSM increased from 0.4% to 5.8% from 2004 to 2006.

## **1.3 The health sector response**

As demonstrated by the epidemiological data, there is an urgent need to address epidemics of HIV and other STIs among MSM and TG. Implementation of a comprehensive package of priority interventions and services for MSM and TG in Asia and the Pacific should be considered a priority for all subregions and countries as part of efforts to ensure universal access to HIV prevention and care services.

WHO has previously identified five priority areas for the health sector's contribution to the multisectoral response to HIV in order to make significant progress towards achieving the goal of universal access. These priority areas are as follows:<sup>17</sup>

1. Enabling people to know their HIV status
2. Maximizing the health sector's contribution to HIV prevention
3. Accelerating the scale-up of HIV and AIDS treatment and care
4. Strengthening and expanding health systems
5. Investing in strategic information to guide a more effective health response.

These priorities have full applicability to addressing HIV and STI epidemics among MSM and TG. This document outlines priority interventions specific to MSM, which are needed to address each of these priority areas.

### **1.3.1 Definition of the health sector**

The health sector is wide-ranging and encompasses organized public and private health services, including those for health promotion, disease prevention, diagnosis, treatment and care; health ministries; nongovernment organizations (NGOs); community groups; professional organizations; as well as institutions that directly input into the health-care system (e.g. the pharmaceutical industry, teaching institutions).<sup>18</sup> Health services for the diagnosis and treatment of disease and the maintenance

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16 Indonesia National AIDS Commission. *Integrated biological and behavioural surveillance among most at risk groups in Indonesia, 2003 and 2007*. Jakarta, MOH, 2008.

17 WHO. *Towards universal access. Scaling up priority HIV interventions in the health sector. Progress report*. April 2007. Geneva, WHO/UNAIDS/UNICEF, 2007.

18 WHO. *Global health sector strategy for HIV/AIDS 2003–2007: providing a framework for partnership and action*. Geneva, WHO, 2002.

of health are key components of the health sector but are only one aspect of the broad health sector response that is needed.

### 1.3.2 **Guiding principles for the health sector response**

The principles that should guide the health sector response to HIV epidemics among MSM include:<sup>19</sup>

- ensuring the full involvement of government, nongovernmental and private sector organizations, and of civil society, including CBOs working with MSM and TG, through a broad-based partnership approach;
- tailoring interventions to where the burden of the disease lies, taking into account the nature of the epidemic and the context in specific settings (e.g. HIV prevalence and risk behaviour, cultural traditions, social attitudes, and political, legal and economic constraints);
- creating a supportive enabling environment by addressing stigma and discrimination in both the health-care services and the broader society, applying human rights principles and promoting gender equity, as well as reforming laws and law enforcement to ensure support for a public health response to HIV and AIDS;
- ensuring equitable access to health-care services for MSM and TG;
- providing a comprehensive approach, with a continuum of prevention, care, support and treatment services;
- providing a combination of prevention interventions, delivered at scale and with intensity to maximize effectiveness; and
- ensuring that interventions and services are, to the largest extent possible, evidence based.

## 1.4 A partnership approach

The effective implementation of priority interventions for marginalized groups such as MSM is dependent on the strength of a coordinated and participatory framework in the national response to HIV, coupled with a commitment to promote human rights and fundamental freedoms. The health sector needs to consult and collaborate with MSM leaders and communities in all phases of the design and implementation of policies regarding health and social services.

The scaling-up of a comprehensive package of HIV services and interventions for MSM requires the mobilization of a broad range of partners. While the role of partners will differ somewhat from country to country, a broad role delineation that can be used as a basis for national-level discussions is given below:

- **National AIDS Commission/Authority:** in some countries, it is the overarching body, with competencies in multisectoral coordination, laws and advocacy, fund-raising, policy-making, etc.
- **National AIDS Programmes:** these are usually linked to the Ministry of Health, and provide leadership; develop strategic frameworks, operational plans and policies for MSM; coordinate the work of all partners; develop an enabling environment through policies, laws and advocacy; mobilize funds and provide strategic information.

19 WHO. *Priority interventions: HIV/AIDS prevention, treatment and care in the health sector*. Geneva, WHO, 2008. [http://www.who.int/hiv/pub/priority\\_interventions\\_web\\_c1.pdf](http://www.who.int/hiv/pub/priority_interventions_web_c1.pdf). (The principles mentioned under section 1.3.2 include those identified in the WHO publication and some additional principles.)

- **Local government and Provincial AIDS Committees:** these provide local-level leadership and coordinate the work of partners in a multisectoral decentralized environment.
- **Local government and Provincial AIDS Programmes:** they are usually from the health sector, and contribute to HIV and STI prevention programmes; development of sexual programmes for men by ensuring that STI, HIV counselling and testing, and care, support and treatment services are MSM-friendly and provided free of discrimination; that STI and HIV counselling and testing services have the appropriate clinical skills required for MSM; and collect and analyse strategic information.
- **Law enforcement agencies:** such as the police can facilitate the implementation of prevention programmes and contribute towards the creation of an enabling environment.
- **CBOs working with MSM:** such organizations are best positioned to design and implement a range of peer prevention programmes, taking a segmented approach to effectively reach a diverse range of MSM. Other roles include psychosocial support for all MSM including HIV-positive MSM, advocacy, building a supportive social environment for the operation of MSM programmes, and collecting and analysing strategic information. They are usually considered as part of the health sector response. In countries where no formal civil society organizations exist, governments can work with informal groups or networks of MSM.
- **Mass and targeted media:** these range from those with expertise in social marketing (e.g. health promotion experts, advertising agencies), and those with expertise in social networking media, to the internet and use of mobile phone communication.
- **Development partners:** they include multilateral and bilateral agencies, international NGOs, and regional and national networks. They provide technical support facilities and researchers, financial support, technical advice and capacity development for partners.

## 1.5 Enabling environment for effective interventions

The effectiveness of the HIV response will depend not just on implementation of priority interventions but on whether the broad social environment supports or hinders MSM programmes. Creation and strengthening of an enabling environment is essential for priority interventions to have the greatest impact. An enabling environment includes the social, legal and environmental determinants that facilitate and promote safe behavioural choices, and encourages those most vulnerable to and living with HIV to participate at all levels of the response to the epidemic.

MSM, particularly visibly identifiable MSM and TG, are subject to high levels of discrimination in their everyday lives, including by the health sector. Stigma and discrimination undermine the operation of HIV and MSM programmes in many ways. The stigma associated with male-to-male sex results in most MSM being secretive about their sexual practices. This in turn makes it hard for prevention programmes and health services to reach MSM.

1. Because most MSM are not visible within society, national AIDS programmes may think that the number of people engaged in male-to-male sex is significantly lower than the case may be.
2. The weight of societal stigma can effect self-esteem and have a negative effect on personal health-protective behaviour. Many MSM are reluctant to access STI and HIV testing and treatment services

for fear of discrimination. Stigma can result in embarrassment in purchasing condoms and reluctance to access MSM prevention services, such as drop-in-centres (DICs).

3. Hostility towards MSM programmes from police and other officials can make it difficult to provide services such as outreach.
4. Feminized MSM and TG are particularly subject to stigma and discrimination due to their visibility and their non-compliance with dominant social norms relating to masculine identity.

Reducing stigma and discrimination is critical to the success of MSM programmes. Multifaceted approaches that involve concrete action are needed. These could include national AIDS programmes taking a public leadership role; public statements by political, community and religious leaders; advocacy for abolition of sodomy laws and development of legal protections against discrimination; social marketing campaigns, including addressing how MSM are presented in the mainstream media; addressing discrimination in the health services; and initiatives to develop the self-esteem of MSM, in particular, HIV-positive MSM. Collaboration between national AIDS programmes and the health sector and MSM community organizations in stigma reduction provides for a potentially powerful synergy of government and community players.

Male-to-male sexual behaviour remains a criminal offence in eighteen Asia–Pacific countries. This contributes directly to the stigma associated with male-to-male sex and drives MSM underground, making it more difficult for prevention programmes to reach them. These restrictive laws also provide a legal basis for police harassment of MSM. Repeal of these laws by parliament, or decisions by courts that such laws violate the constitutional rights of MSM, as occurred in the New Delhi High Court in 2009, will significantly contribute to the creation of an enabling environment. Other legal issues that can hinder the environment in which HIV programmes operate are laws and regulations that limit the open promotion of condoms, those that allow possession of a condom to be used in relation to enforcement of anti-sex work laws, and enforcement of anti-sex work legislation that drives sex workers underground.

The involvement of MSM in community responses to HIV through self-organization provides a good mechanism for programmes to reach MSM and also presents the opportunity to establish community norms around safe sex behaviour. Support for the development of MSM CBOs, built around a model of MSM engagement and involvement in the response, contributes to a positive social environment that encourages and supports behaviour change. The provision of social support services can contribute to meeting the broader, non-HIV needs of MSM and result in a reduction of their vulnerability to HIV.

### **Key resources**

**Understanding and challenging HIV stigma. Toolkit for action.** <http://www.changeproject.org/technical/hivaids/stigma.html>

**The Yogyakarta Principles. Principles on the application of international human rights law in relation to sexual orientation and gender identity.** [http://www.msmasia.org/tl\\_files/resources/09-05/Yogyakarta\\_Principles\\_EN.pdf](http://www.msmasia.org/tl_files/resources/09-05/Yogyakarta_Principles_EN.pdf)

**Overcoming legal barriers to comprehensive prevention among men who have sex with men and transgender people in Asia and the Pacific – symposium report.** <http://>

[www.nfi.net/downloads/knowledge\\_centre/Useful%20documents/2009-UNDP-9thICAAP-Legal%20symposium%20report.pdf](http://www.nfi.net/downloads/knowledge_centre/Useful%20documents/2009-UNDP-9thICAAP-Legal%20symposium%20report.pdf)

## 1.6 Priority interventions: an overview

The priority interventions set out in chapters 2–4 are the complete set of interventions recommended by WHO as necessary to mount an effective and comprehensive health sector response to the HIV and sexual health needs of MSM.

Universal access in the health sector requires that the priority interventions be delivered in ways that are accessible and acceptable to and affordable for MSM, and of satisfactory quality. The full package of priority interventions is aspirational. The actual package of priority interventions chosen by each country should be based on practical considerations such as the nature of the HIV and STI epidemics among MSM, contextual issues such as culture, the country's approach to service delivery (e.g. mix of public, nongovernment and private providers), and the availability of financial and human resources.

The selection of priority interventions and target populations needs to be based on a clear understanding of the epidemiology of HIV infection among MSM – who is being infected, where, how and why – together with an understanding of the most appropriate interventions for the particular setting. To effectively curtail transmission, services for prevention must reach those geographical areas and MSM subpopulations where HIV is spreading most rapidly. Interventions must be at sufficient scale and intensity to achieve impact. Similarly, effective services for treatment, care and support must be fully accessible and available to MSM.

This document focuses on health sector-specific priority interventions which were identified by the Regional Consensus Meeting on “Developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia and the Pacific”. A full outline of a comprehensive response, including those beyond the role of the health sector, can be found in the report of the Regional Consensus Meeting.

### Key resources

**Regional Consensus Meeting. Developing a comprehensive package of services to reduce HIV among men who have sex with men and transgender populations in Asia and the Pacific.** [http://content.undp.org/cms-service/download/asset/?asset\\_id=2199799](http://content.undp.org/cms-service/download/asset/?asset_id=2199799)

**Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender populations. Report of a technical consultation, September 2008.** [http://www.who.int/hiv/pub/populations/msm\\_mreport\\_2008.pdf](http://www.who.int/hiv/pub/populations/msm_mreport_2008.pdf)

**Health sector response to HIV/AIDS among men who have sex with men. Report of the Consultation.** [http://www.wpro.who.int/NR/rdonlyres/717E0EBA-EEFA-4FFD-88ED-5FCAA791A99B/0/MSMReport\\_HOK\\_Feb2009\\_forweb.pdf](http://www.wpro.who.int/NR/rdonlyres/717E0EBA-EEFA-4FFD-88ED-5FCAA791A99B/0/MSMReport_HOK_Feb2009_forweb.pdf)

**UNAIDS action framework: universal access for men who have sex with men and transgender people.** [http://data.unaids.org/pub/Report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf)



**Policy brief: HIV and sex between men.** [http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm_en.pdf)

**The value of investing in MSM programs in the Asia-Pacific region: policy brief.** [http://www.healthpolicyinitiative.com/Publications/Documents/407\\_I\\_The\\_Value\\_of\\_Investing\\_in\\_MSM\\_Programs\\_in\\_the\\_Asia\\_Pacific\\_Region\\_FINAL\\_HPI\\_only.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/407_I_The_Value_of_Investing_in_MSM_Programs_in_the_Asia_Pacific_Region_FINAL_HPI_only.pdf)

## 2. Prevention



This chapter first outlines the responsibilities of the health sector in maximizing its contribution to HIV prevention for MSM. This is followed by an overview of key issues in HIV prevention for MSM, which identifies the core components of comprehensive prevention. Additional details are then provided on key components of prevention which can be supported by and/or provided by the health sector (promotion of condom use, peer and outreach education, DICs, communication strategies, post-exposure prophylaxis [PEP], and other biomedical interventions). Finally, the chapter reviews prevention needs and approaches for particular subpopulations of MSM.

### 2.1 Maximizing the health sector's contribution to HIV prevention

Primary prevention of HIV transmission requires implementation of a variety of approaches and combinations of interventions, involving the health and other sectors and CBOs. The prevention benefits of HIV counselling and testing, and STI diagnosis and treatment are discussed in Chapter 3.

The health sector, in collaboration with other sectors and the community, is responsible for configuring and supporting comprehensive programmes and service delivery models that address the needs of MSM. It must also ensure that these services are accessible, acceptable and equitable.

HIV prevention interventions in the health sector should include:

- interventions aimed at changing behaviour;
- those aimed at addressing cultural norms, social attitudes and behaviours that may increase people's vulnerability to STI and HIV infection; and
- biomedical interventions such as promotion of condoms, lubricants, and clean needles and syringes.

CBOs who work with MSM have comparative advantages in undertaking many HIV prevention activities, especially in areas such as peer and outreach education, condom distribution, development of targeted media campaigns and DICs. Their comparative advantages relate to the power of well-designed and -delivered peer education, an understanding of the needs of MSM, greater access to MSM, and the potential for engaging MSM in a community-driven response to HIV.

Depending on the available resources, the work of MSM CBOs may largely be confined to capital cities or a limited number of large cities. To achieve sufficient coverage (the extent of which should be determined through analysis of strategic information and planning), others, including the health sector and non-MSM NGOs and CBOs, need to be involved in the delivery of HIV prevention interventions

in locations where MSM CBOs are not working. This can best be done by involving MSM in either paid or voluntary positions, and with technical assistance from MSM CBOs working in other locations.

Specific areas where the health sector, MSM CBOs and informal MSM community networks can work together include:

- provision of health sector expertise in health promotion for the design of prevention messages and media campaigns;
- assistance with interpreting the results of biobehavioural surveys and their implications for target-setting and priority-setting in prevention programmes;
- the joint identification of priority “hot-spots” for HIV transmission among MSM;
- providing HIV testing and counselling, and STI screening and management services at DICs and through mobile outreach;
- inculcating cultural sensitivity to MSM among health-care workers and an awareness of the specific health and social support needs of MSM, through technical assistance from MSM CBOs; and
- encouraging MSM CBOs to have a visible presence in HIV testing and counselling and STI services (e.g. volunteers at the reception and in waiting areas), to make these services more MSM-friendly and accessible.

### **Summary of key recommendations**

As part of ensuring a continuum of prevention, care, treatment and support services, it is essential for the health sector to be a full partner in HIV prevention programmes for MSM. The health sector and MSM CBOs need to work collaboratively to share their complementary expertise and comparative advantages. In areas where MSM CBOs are not working or do not exist, the health sector should determine the need for HIV prevention services among MSM, in consultation with MSM leaders in the community, and jointly develop and implement priority interventions.

## **2.2 Key issues in HIV prevention for MSM**

The use of multiple priority prevention interventions (i.e. combination prevention) is essential to achieve a significant reduction in HIV transmission. A mix of communication channels should be used to disseminate behaviour change messages to motivate MSM to adopt one or more options for reducing their risk for acquiring HIV and other STIs. A combination of behaviour change approaches needs to be integrated with biomedical interventions such as condom and lubricant promotion and PEP. Structural approaches that aim to change the social, community, cultural, physical, legal and policy factors that determine HIV risk and vulnerability should be used. (See the Glossary for a definition of structural interventions.) For example, provision of condoms and lubricant in entertainment establishments changes the physical environment by making the means of prevention readily available and, if combined with behavioural interventions, can reduce risk. Community structures and systems (e.g. DICs and social support networks) can also make populations less vulnerable to HIV. The creation of an environment that engages the creativity and energy of community members to develop responses to their perceived needs is important. The promotion of human rights, including a reduction in stigma and discrimination, is another essential component of HIV prevention for MSM.

Strategic information should be used to design prevention interventions by identifying factors related to heightened risk for HIV infection such as age, geographical areas (i.e. “hot-spots”), subpopulations (e.g. MSWs, TG) and drug use.

It is critical to complement HIV prevention for those who are uninfected with prevention for those who are already living with HIV. For those living with HIV, preventing transmission of HIV to others is only one of their needs. Other needs include preventing illness, receiving care for opportunistic infections (OIs), accessing and adhering to antiretroviral treatment (ART), and dealing with the double stigma of male-to-male sex and HIV infection. Interventions are essential to address the needs of MSM living with HIV so that they can engage in sexual activity without fear of transmitting the virus to their sexual partners and children.

### **Summary of key recommendations**

The priority interventions for a comprehensive approach to HIV prevention include using a range of communication channels and methods to deliver behaviour change communication (BCC) messages, distribution and social marketing of condoms and lubricant, peer and outreach education, DICs, structural interventions, PEP, knowledge of HIV status, and STI diagnosis and treatment.

Interventions that will contribute positively to HIV prevention programmes include the promotion of human rights, including a reduction in stigma and discrimination, social support to reduce vulnerability, and the engagement and mobilization of a community-led response.

While prioritizing HIV prevention interventions, there should be an emphasis on interventions that are likely to have the greatest impact and can be implemented at sufficient scale to have this impact. Interventions should be tailored to the nature of the epidemic in specific settings, including prioritization of subgroups of MSM most at risk, as well as the capacity of the health, CBO and other services in those settings.

Due to the diversity among MSM, HIV prevention programmes need to take a segmented approach if they are to effectively reach a broad range of MSM. All HIV prevention programmes for MSM should encompass HIV prevention for both those who are HIV-uninfected and those living with HIV.

### **Key resources**

**Practical guidelines for intensifying HIV prevention: towards universal access.** [http://data.unaids.org/pub/Manual/2007/20070306\\_prevention\\_guidelines\\_towards\\_universal\\_access\\_en.pdf](http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf)

**HIV and men who have sex with men in Asia and the Pacific. UNAIDS Best Practice Collection.** [http://data.unaids.org/Publications/IRC-pub07/jc901-msm-asiapacific\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc901-msm-asiapacific_en.pdf)

**Male to male sexualities and sexual behaviours in South Asia. A training manual for developing sexual and reproductive health programs.** [http://www.nfi.net/downloads/knowledge\\_centre/NFI%20publications/Training%20resources/decision%20makers%20training%20manual.pdf](http://www.nfi.net/downloads/knowledge_centre/NFI%20publications/Training%20resources/decision%20makers%20training%20manual.pdf)

**Development manual. Developing community-based organisations addressing HIV/AIDS, sexual health, welfare and human rights issues for males-who-have-sex-with-males, their partners and families. Books 1–6.** [http://www.nfi.net/training\\_resources.htm#l](http://www.nfi.net/training_resources.htm#l)

**An introduction to promoting sexual health for men who have sex with men and gay men. A training manual.** [http://www.aidsportal.org/Article\\_Details.aspx?ID=506](http://www.aidsportal.org/Article_Details.aspx?ID=506)

**Between men: HIV STI prevention for MSM.** <http://www.aidsalliance.org/publicationsdetails.aspx?id=84>

**Standard package of activities. Men who have sex with men.** [http://www.aidsalliance.org/includes/Publication/Package\\_of\\_Activities\\_MSM.pdf](http://www.aidsalliance.org/includes/Publication/Package_of_Activities_MSM.pdf)

**Working with men, responding to AIDS. Gender, sexuality and HIV – a case study selection.** <http://www.aidsportal.org/store/501.pdf>

**Structural approaches to HIV prevention.** [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)60887-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60887-9/fulltext)

**Asia Pacific Coalition on male sexual health.** website <http://www.msmasia.org/>

### 2.3 Promoting and supporting condom use

The male latex condom is the single most efficient and available technology to reduce the transmission of HIV and other STIs. Condoms are a key component of combination prevention strategies. In studies of HIV-serodiscordant heterosexual couples, the correct and consistent use of male condoms reduces the risk of HIV transmission through vaginal sex by 99%. While no studies have been undertaken for MSM, male condoms may offer similar levels of protection against HIV. It is essential that both condoms and water-based lubricants be used for anal sex. To reduce the risk of condom breakage during anal sex, additional lubricant should be used.

Provision of free condoms and lubricant to those most in need, combined with social marketing strategies to increase the demand and supply of condoms and lubricant at subsidized cost, are essential HIV prevention interventions. Condoms and lubricant need to be distributed and marketed to MSM in diverse ways including by peer educators, at health facilities and DICs, entertainment establishments (bars, saunas, commercial sex venues) and through retail outlets. The owners of entertainment establishments are often willing to cooperate with HIV prevention programmes but may have concerns about providing condoms and lubricant as the police may use their availability as evidence of commercial sex or, in some countries, of sodomy, taking place on these premises. Health authorities can reinforce advocacy by CBOs to entertainment establishments and consider introducing the use of regulations to mandate the provision of condoms in these venues. Widespread social marketing of condoms and lubricant through a variety of outlets is needed to make condoms readily available to MSM who cannot be reached by peer educators or those who do not use health and entertainment facilities.

Social marketing of condoms for MSM is predominantly focused on the male condom, although the female condom has been socially marketed to MSM as an additional prevention method in some Asian

countries. Although there is some evidence that supports the equal efficacy of the female condom compared with the male condom in preventing STIs during vaginal sex, there are currently no data on the efficacy of the female condom for anal sex.<sup>20</sup> A limited number of small-scale studies on use of the female condom for anal sex have found that users had widely different experiences and views on acceptability. Some safety concerns have been identified by these studies, indicating a possible need for modification of product design for suitability in anal sex. The need for peer training in the use of the female condom for anal sex has been emphasized by some studies.<sup>21, 22, 23</sup>

### **Summary of key recommendations**

Distribution and social marketing of male condoms and lubricant should be scaled up as part of comprehensive HIV prevention programmes for MSM. These interventions should ensure that quality condoms and lubricant are accessible to MSM at the time and places they are needed, and that people have the knowledge, skills and motivation to use these products correctly and consistently. Health authorities should advocate to the owners of entertainment establishments on the need for condoms and lubricant to be readily available and consider the use of regulatory powers where persuasion fails. Condoms and lubricant should be widely available in closed settings.

The health sector, as part of a multisectoral response, should provide guidance on sex education, school-based HIV education, mass media communications and educational messaging, and other behaviour change interventions designed to increase the demand for and use of condoms and lubricant by MSM. Health facilities in contact with MSM should actively promote correct and consistent condom and lubricant use.

Due to the limitations of previous small-scale studies on the safety and acceptability of the female condom for use in anal sex, additional research is needed, along with clinical trials to compare the efficacy of the female condom with that of the male condom.<sup>20</sup>

### **Key resources**

**Position statement on condoms and HIV prevention.** [http://www.who.int/hiv/pub/prev\\_care/statement/en/](http://www.who.int/hiv/pub/prev_care/statement/en/)

**Faculty of Family Planning & Reproductive Health Care clinical guidance.**

**Male and female condoms.** [http://www.ffprhc.org.uk/admin/uploads/999\\_CEUguidanceMaleFemaleCondomsJan07.pdf](http://www.ffprhc.org.uk/admin/uploads/999_CEUguidanceMaleFemaleCondomsJan07.pdf)

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20 Kelvin EA et al. Adding the female condom to the public health agenda on prevention of HIV and other sexually transmitted infections among men and women during anal intercourse. *American Journal of Public Health*, 2009, 99:985–987.

21 Gibson S et al. *Experiences of 100 men who have sex with men using the Reality Condom for anal sex.* *AIDS Education and Prevention*, 1999, 11:65–71.

22 Gross M et al. *Use of Reality “female condoms” for anal sex by US men who have sex with men.* *American Journal of Public Health*, 1999, 89:1739–1741.

23 Celum CL et al. *Acceptability and safety of the reality condom for anal sex.* XIV International AIDS Conference, 2002, MoPeD3656.

### **Adding the female condom to the public health agenda on prevention of HIV and other sexually transmitted infections among men and women during anal intercourse.**

<http://www.ajph.org/cgi/content/abstract/99/6/985>

## **2.4 Peer and outreach education**

Peer education is the use of trained people to undertake educational activities with their peers to develop knowledge, skills and attitudes that will enable them to be responsible for and protect their own health, and prevent HIV and STIs. A peer educator works on a one-to-one or group basis with MSM within and outside his or her social network. An outreach worker actively searches for MSM, mainly outside his or her own social network, particularly in locations where risk activities take place. Outreach and peer educators use their knowledge to inform others, reflect positive attitudes and are role models for their peers.

The focus of peer and outreach education is on the following:<sup>24</sup>

1. Providing correct information about HIV transmission, prevention, safe sex and substance use;
2. Promoting and providing condoms and lubricant, along with information, education and communication (IEC) materials on sexual transmission, and the role of substance use in HIV transmission;
3. Promoting positive attitudes towards condom use and developing condom use and safe sex negotiation skills. Where there is evidence of MSM injecting drugs, peer outreach should include provision of sterile injecting equipment;
4. Promoting the need for regular STI check-ups and treatment of STIs as a means of reducing HIV transmission risk, with referral to MSM-friendly STI services;
5. Encouraging HIV testing and promoting the benefits of knowing one's HIV status, along with referral to testing sites;
6. Encouraging those reached by peer education to influence their peers and clients to adopt safe sexual and drug-use practices, and to access STI and HIV testing and counselling services;
7. Promoting monitoring of one's health status for those who are HIV positive;
8. Assisting peers in dealing with sexual harassment and developing skills for avoiding violence and rape;
9. Providing discussion and support relating to sexuality, including the social, emotional and psychological aspects of having a sexual identity, behaviour or preference which is different from the mainstream, along with referral to support services; and
10. Assisting peers in dealing with stigma and discrimination based on sexual identity or practice, HIV status or involvement in sex work.

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,

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24 *Peer and outreach education for improving the sexual health of men who have sex with men. A reference manual for peer and outreach workers.* USAID, FHI, PSI Asia, International HIV/AIDS Alliance, UNESCO, Purple Sky Network, 2007.

training network leaders as peer educators, disseminating risk reduction messages and assessing the effects of interventions. Peer and outreach education primarily reaches MSM who have some level of identity related to male-to-male sex and MSWs who are relatively easy to reach. Coverage of “hidden” MSM by peer and outreach education is very challenging and usually limited. There may also be limits on the extent to which peer education can be scaled up to achieve a high level of coverage. Other interventions, such as the use of a variety of communications strategies, are needed to reach “hidden” MSM (see section 2.6 below).

### **Summary of key recommendations**

Peer and outreach education is a key component of comprehensive HIV prevention programmes for MSM. It provides a means of delivering behaviour change interventions and creating community norms around safe sex. Peer and outreach education also promotes utilization of other components of the comprehensive package such as access to and use of condoms and lubricant, HIV testing and counselling, and STI diagnosis and treatment. It is likely to be most effective when intensity is achieved through repeat contact. Peer and outreach education should be a priority intervention for localities where there are significant numbers of MSM and high levels of risk behaviour. Due to the one-to-one and small-group nature of most peer and outreach education, there are limits on the numbers of MSM who can be reached by this type of intervention.

In areas where no MSM CBOs are working, health services such as STI clinics should consider the need for supporting local peer and outreach education by MSM.

### **Key resources**

**Peer and outreach education for improving the sexual health of men who have sex with men. A reference manual for peer and outreach workers.** <http://www.unescobkk.org/education/hivaids/aids-news/hivaids-news-details/article/peer-and-outreach-education-for-improving-the-sexual-health-of-men-who-have-sex-with-men-a-referenc/>

**Male sexual health behaviours and STD/HIV prevention. A training manual for peer educators.** [http://www.nfi.net/downloads/knowledge\\_centre/NFI%20publications/Training%20resources/Peer%20Manual%20copy.pdf](http://www.nfi.net/downloads/knowledge_centre/NFI%20publications/Training%20resources/Peer%20Manual%20copy.pdf)

**Behavioural strategies to reduce HIV transmission: how to make them work better.** [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)60886-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60886-7/fulltext)

## **2.5 Drop-in centres**

DICs, or male health centres, have been used extensively in HIV programmes for MSM to provide safe, accepting and non-judgemental spaces for both HIV-negative and HIV-positive MSM, where they can receive information, advice and psychosocial support. DICs also provide a place for distribution of condoms, lubricant and IEC materials; a site where HIV counselling and testing, and STI diagnosis and treatment can take place as a core component of service delivery, or through regular mobile clinics, or through referral to clinics; and a venue for “edutainment”, small group interventions and workshops. DICs can also play an important role in community mobilization and engagement with HIV and sexual



health through promotion of social networking. The primary limitations of DICs are that coverage can be limited, MSM with no or limited identity around their sexual practices may be reluctant to visit, and they sometimes primarily cater to one segment of MSM, which may make other subgroups of MSM reluctant to visit.

### **Summary of key recommendations**

DICs are an essential component of MSM HIV programmes as they provide a hub for a wide range of HIV prevention and support activities. Health services such as HIV testing and counselling, and STI clinics and HIV treatment services should have well-established links with DICs to ensure continuity of service provision.

## **2.6 Communication strategies**

IEC messages on HIV and sexual health need to reach a broad range of MSM, including those living outside capital cities, and hard-to-reach MSM who have limited involvement with social or community networks. It is likely that communication strategies will be more effective if MSM have exposure to a range of messages and communication interventions using different media, accompanied by intensity of exposure. The range of communication channels to be used includes leaflets, posters, targeted mass media, broader mass media, internet sites for social and sexual networking, hotlines and mobile phones (e.g. SMS messaging).

The extent to which it is practical to use mass media in communication strategies for MSM needs to be considered, especially in extending reach. Factors to be considered are cost, the type of messages appropriate for the mass media and how they can best be conveyed. There are creative ways of using the media in ways that would be acceptable to dominant cultural attitudes, such as the use of drama series. This type of approach can be very useful in addressing stigma and discrimination. Political and health sector leadership is needed to support the use of the mass media for HIV communication strategies for MSM.

### **Summary of key recommendations**

Due to the inherent limitations on the extent to which peer and outreach education can be scaled up to achieve high national coverage of MSM, mass and targeted media have an important role to play in reaching a broader range of MSM, particularly those who are hard to reach. The impact of communication strategies is likely to be higher if a range of messages and communication interventions are deployed using different media, accompanied by intensity of exposure. Health promotion experts in the health sector should provide technical assistance to CBOs for the development of communication strategies.

### **Key resource**

**Guide to participatory production of resources for HIV prevention among vulnerable populations.** <http://www.ovcsupport.net/sw21318.asp>

## 2.7 Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) for HIV involves the short-term use of antiretroviral (ARV) drugs to reduce the risk of HIV infection in individuals who may have been exposed to HIV.

### **Summary of recommendations**

WHO recommends that PEP for HIV be made available to all HIV-negative people who may have been exposed to HIV through sexual assault, and to health and other workers who have an occupational exposure. Governments can consider whether to also make PEP available to persons who have had a high-risk single or episodic exposure to HIV through consensual sex. This could include condom breakage or failure to use a condom. However, PEP is not recommended for people with chronic exposure to HIV (e.g. consistent failure to use condoms or a regular pattern of inconsistent condom use). CBOs should act as a referral point for MSM who may be eligible for PEP by facilitating access to health-care facilities where PEP is available.

Decisions on whether to offer PEP should be based purely on clinical considerations of risk and should not be related to any involvement in activities considered illegal by national legislation such as male-to-male sex or sex work. Health authorities need to sensitize health-care workers on the need to use only clinical criteria for assessing risk.

Sexual and other health facilities should have up-to-date policies and procedures for managing PEP. Management of non-occupational PEP should include evaluation of the person with potential exposure to HIV; counselling; assessing the HIV status of the source if possible; provision of ARVs based on defined protocols; presumptive treatment for STIs; and follow-up counselling.

### **Key resource**

**Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.** [http://whqlibdoc.who.int/publications/2007/9789241596374\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf)

### **Other potential biomedical interventions**

#### ***The prevention benefits of ART***

When appropriately taken, ART can suppress the level of HIV viral load to undetectable levels in the plasma of a substantial proportion of individuals infected with HIV. Data from studies of HIV-serodiscordant heterosexual couples, analyses of the effects of ART on mother-to-child transmission (MTCT) of HIV and modelling studies support the notion that by lowering viral load in treated, adherent people living with HIV (PLHIV), ART is effective in preventing transmission. It is therefore likely that universal access to ART for PLHIV can, at a population health level, significantly reduce HIV transmission.<sup>25</sup>

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25 Dieffenbach CW, Fauci AS. Universal voluntary testing and treatment for prevention of HIV transmission. *Journal of the American Medical Association*, 2009, 301:2380–2382.

The prevention benefits of ART are maximized where there is good adherence to drug regimens and alertness for the emergence of ARV drug resistance.<sup>26</sup> The emergence of resistance has the potential for contributing to the rebound of viral load and affecting the efficacy of ART in preventing transmission. In addition, modelling of the effects of significantly increased unsafe sex during the implementation of an ART programme showed increased transmission, leading to a loss of the prevention benefits of expanded treatment. It is therefore essential that the prevention benefit of ART be seen not as a stand-alone strategy but rather as a strategy to be used in combination with other prevention approaches such as consistent use of condoms and lubricants.

### **Pre-exposure prophylaxis**

Pre-exposure prophylaxis (PrEP) for HIV refers to a prevention strategy in which HIV-negative people take a single or a combination of ARV drugs on a regular basis to reduce their risk of acquiring HIV. Clinical trials are currently under way to determine whether potential PrEP drugs could reduce, in adults, the chance of becoming infected with HIV. If one or more drug is found to be safe and effective for PrEP, this may provide a significant additional intervention for HIV prevention programming.<sup>27</sup>

It is, however, unlikely that any new PrEP strategy could be 100% effective, and clinical trials may not be able to precisely determine the level of efficacy. Even if PrEP is only able to reduce the risk of acquiring HIV, it has the potential to make a significant contribution to prevention efforts. PrEP would need to be used in combination with current HIV prevention methods such as the use of condoms, treatment of STIs, knowledge of HIV status, and risk reduction counselling. However, if people using PrEP significantly reduced their rates of safe behaviour they could place themselves at an increased risk of infection.

Another risk is that if a person taking PrEP becomes HIV infected and continues taking PrEP medications for some time, this person is likely to develop resistance to the ARV being used. Although other ARV drugs could be available, treatment options would be reduced, and it is possible that drug-resistant viral strains would be transmitted to another person.

Issues to be considered in the light of forthcoming data from PrEP trials are: what level of efficacy would warrant widespread delivery, which populations would benefit most from PrEP, where would targeted versus more generalized delivery be the most appropriate, and which settings are appropriate for PrEP? Depending on the results of PrEP trials, health authorities should work collaboratively with MSM CBOs to consider how best to address issues of access and delivery of PrEP for MSM.

If PrEP is found to be safe and effective, other issues that would need to be considered are cost-effectiveness, funding feasibility in the light of competing priorities such as achieving universal access for those already infected with HIV, and how to develop thoughtfully planned programmes that integrate PrEP into existing prevention programmes.

26 Velasco-Hernandez JX et al. Could widespread use of combination antiretroviral therapy eradicate HIV epidemics? *Lancet Infectious Diseases*, 2002, 2:487–493.

27 Paxton LA, Hope T, Jaffe H. Pre-exposure prophylaxis for HIV infection: what if it works? *Lancet*, 2007, 370:89–93.

Data on the efficacy of biomedical HIV prevention interventions does not necessarily demonstrate real-world effectiveness.<sup>28</sup> Where clinical trials are able to demonstrate efficacy, this may be under ideal circumstances, utilizing the guidance of experts. The results are not necessarily transferable in relation to impact on health at a population level, under real-world conditions. Factors that can limit efficacy are social and cultural acceptability, the level of intervention uptake beyond the trial setting, unintended consequences, and programme design and efficiency.

### **Key resource**

**Anticipating the results of PrEP trials.** 2008. <http://www.avac.org/prep08.pdf>

### **Microbicides**

Microbicides are topical substances, usually in the form of gels or creams, which are applied to the rectum (or vagina) to reduce HIV transmission. To date, trials of microbicides have not demonstrated effectiveness in preventing HIV transmission. Use of nonoxinol-9 as a rectal lubricant has been shown to be toxic. Studies are currently evaluating topical ARV agents. A major concern regarding the use of ARV agents as microbicides is the emergence of drug resistance if users became HIV infected, as absorption of the ARV into the blood stream would be the equivalent of monotherapy. Other second- and third-generation microbicide trials are under way.

### **Male circumcision**

There is no definitive evidence that male circumcision reduces the risk of HIV transmission in male-to-male sex. HIV prevalence rates in Asia and the Pacific are insufficient to justify inclusion of male circumcision as a component of HIV prevention.

## **2.8 Prevention for particular populations**

The wide diversity among MSM, which is reflected in different social and sexual networks, means that prevention programmes need to take a segmented approach to effectively reach a broad range of sexually active MSM. Priorities for targeting particular groups of MSM with prevention programmes should be based on national and local assessments of who is at greatest risk.

This subsection identifies the particular prevention needs of some key MSM subpopulations, but is not intended to suggest that these are necessarily subpopulations with the highest priority. It should be remembered that large numbers and perhaps a majority of MSM at risk for HIV infection do not fall within any of the particular subpopulations listed below. For example, a concerted effort needs to be made to reach normative males who have sex with other males, and who are often hidden due to the stigma associated with male-to-male sex.

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28 Imrie J et al. Biomedical HIV prevention – and social science. *Lancet*, 2007, 370:10–11.

### **2.8.1 HIV prevention for MSM living with HIV**

Addressing the prevention needs of PLHIV is a critical challenge for the health sector. Expanding access to HIV testing and ART will increase the number of PLHIV who can benefit from comprehensive HIV prevention, treatment and care services in the health sector.

Most PLHIV will remain sexually active. Health-care providers should respect their right to do so and support them and their partners in preventing further HIV transmission, including through the provision of condoms. For some, knowledge about their HIV infection may not prompt a change in behaviour to reduce further HIV transmission, and additional support may be needed through follow up and counselling. Provision of psychosocial support will reduce HIV-related stigma and isolation, and create an environment which will be conducive to safe behaviour. Adherence counselling can play a role in prevention by contributing to maintenance of low viral loads.

HIV-negative partners in serodiscordant couples (where one partner is HIV negative and the other HIV positive, including female partners) are at high risk for HIV infection and represent an important group for prevention efforts. Evidence from studies of HIV-serodiscordant couples shows that counselling and condom provision are effective in reducing HIV transmission.

#### **Summary of key recommendations**

Within a context of shared responsibility, PLHIV and their partners should be counselled about safer sex to prevent HIV transmission. They should also be provided with condoms, accompanied by education on condom use and negotiation. Counselling for PLHIV should emphasize the need to protect their health by avoiding acquisition of STIs and possible infection with a different strain of HIV. Ongoing support to HIV-positive MSM for HIV prevention will be maximized if there are good links between treatment services and CBOs working with MSM and PLHIV, with all services taking an active role in positive prevention and support.

Ongoing behavioural counselling and psychosocial support should be given to HIV-serodiscordant couples, including those involving female partners, through couple counselling and support groups that cover topics such as reducing the risk of HIV transmission, couple communication and condom use.

In addition to integrating positive prevention into all aspects of HIV and MSM prevention programmes, prevention interventions specifically designed to address the needs of HIV-positive MSM are needed.

#### **Key resources**

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Positive prevention: HIV prevention with people living with HIV. A guide for NGOs and service providers.** <http://www.hivpolicy.org/Library/HPP001333.pdf>

### **2.8.2 Transgender people**

Biobehavioural surveys usually show that TG have a higher HIV and STI prevalence and risk compared with other MSM. Related factors appear to be a gender–power imbalance, receptive anal intercourse, engagement in sex work by a reasonably high proportion of TG, higher rates of drug use, and injection of hormones with unsterile equipment. Due to their high visibility and the negative social attitudes to feminized males, TG commonly encounter stigma and discrimination from society and health services, adding to their vulnerability. Other factors which contribute to the vulnerability of TG include generally lower levels of education, high mobility, rejection by families, harassment by the police, subjection to violence and high rates of unemployment.

TG have additional health-care needs related to their gender identity, which include psychosocial support and gender reassignment.

#### **Summary of key recommendations**

HIV prevention programmes should accord high priority to TG in all settings through specially targeted programmes. In addition to the full range of prevention interventions, these programmes need to place special emphasis on developing advocacy skills related to the special needs of TG, self- and community empowerment, psychosocial support and counselling, and capacity building.

The generally higher levels of HIV prevalence among TG mean that there is a greater need for programmes that focus on positive prevention and place emphasis on the continuum of prevention to care, treatment and support.

In addition to the full package of HIV prevention services, the health sector needs to provide services that address the psychosocial and mental health needs of TG, including services related to gender identity. Additional interventions are needed for TG who are sex workers (see section 2.8.3 below).

#### **Key resource**

Transgender HIV/AIDS health services. Best Practice guidelines. <http://www.careacttarget.org/library/tgguidelines.pdf>

### **2.8.3 Male and transgender sex workers**

Male and transgender sex workers may be at heightened risk for acquiring HIV due to a large number of sexual partners. This in turn can place their clients and regular partners (male and female) at higher risk. The evidence base is firmly established to support a range of interventions to prevent transmission of HIV and other STIs in sex work settings, provide care and support services, and empower sex workers to improve their own health and well-being. Interventions need to be tailored to the different settings in which sex work takes place, including brothel and other entertainment establishments, bars and clubs, street and park settings, and homes. Where male and transgender sex workers use drugs, including injection drugs, there is a need for prevention interventions such as harm reduction programmes to address the heightened risk for HIV transmission.

In some countries, a high proportion of TG is involved in sex work. They may have a heightened vulnerability to HIV due to being the receptive sexual partner and gender–power imbalances.

### **Summary of key recommendations**

Systematic collection of strategic information on HIV and other STIs among male and transgender sex workers and their clients is required to guide comprehensive programme design and implementation. Programme planning needs to include formative assessments to determine the needs and vulnerabilities of male and transgender sex workers, and they should proactively be involved in the design and delivery of programmes.

A comprehensive set of interventions is recommended, aimed at achieving consistent condom use and safe sex, reducing STI incidence, and maximizing the involvement and control of male and transgender sex workers over their working and social conditions.

The health sector, in collaboration with other sectors, should promote legal and social frameworks that are rights-based and consistent with public health and HIV prevention goals.

Priority prevention interventions for male and transgender sex workers include:

- Conducting BCC through peer outreach
- Promoting and supporting consistent condom and lubricant use
- Detecting and managing STIs
- Enabling sex workers to know their HIV status
- Providing HIV treatment and care
- Preventing and treating viral hepatitis
- Preventing HIV transmission through injecting and non-injecting drug use
- Providing social support, including income generation schemes and legal services

HIV and STI prevention activities for male and transgender sex workers can be delivered in health facilities, community settings and through peer education, with collaboration between the health services and CBOs.

### **Key resources**

**Toolkit for targeted HIV/AIDS prevention and care in sex work settings.** <http://whqlibdoc.who.int/publications/2005/9241592966.pdf>

**Manual: tips, tricks and models of good practice for service providers considering, planning or implementing services for male sex workers.** [http://www.gtsexual.red2002.org.es/documentos/Manual\\_de\\_buenas\\_practicas\\_para\\_servicios\\_dirigidos\\_a\\_hombres\\_trabajadores\\_sexuales\\_ENMP.pdf](http://www.gtsexual.red2002.org.es/documentos/Manual_de_buenas_practicas_para_servicios_dirigidos_a_hombres_trabajadores_sexuales_ENMP.pdf)

### **2.8.4 Interventions for MSM who use drugs**

Although HIV infection among MSM is primarily sexually transmitted, in particular countries or localities, injecting drug use among some MSM can be an additional risk factor for acquiring HIV infection. There is overwhelming evidence of the effectiveness of harm reduction programmes in preventing HIV among people who inject drugs (PWID). Needle and syringe programmes (NSPs) and drug dependence treatment (opioid substitution therapy [OST]) should be available for those MSM who need these services, through linkages and referrals to existing services, in addition to other elements of the HIV prevention package for MSM.

Methamphetamines (also known as amphetamine-type stimulants [ATS]) are the main illicit drugs used by MSM in Asia. All users, whether dependent or not and whether regular or recreational users, are vulnerable to HIV and hepatitis B and C infections either from sharing contaminated needles or engaging in unsafe sex while intoxicated. Currently, the most effective treatments for methamphetamine addiction are behavioural interventions. Treatment options include pharmacological, psychosocial, behavioural and cognitive approaches, including risk reduction. Most psychosocial interventions demonstrate positive effects for some clients, but no one approach or a combination of approaches is helpful for all. There is a need to tailor interventions and treatment to users to address the specific difficulties presented by ATS users. Risk reduction strategies should be used to prevent users from becoming dependent and prevent those who inject drugs from bloodborne diseases. Risk reduction approaches should include the following:

- messages targeted at ATS users;
- peer approaches, including education and counselling, information about drug use and HIV, and where to access services;
- provision of condoms and lubricant, and safe sex education;
- counselling to prevent switching to injecting drug use; and
- provision of clean needles and syringes for those who inject drugs.

In addition, use of alcohol and other non-injected drugs is associated with unsafe sexual behaviour. As indicated in section 1.2.5 above, there is evidence of reasonably high rates of non-injecting drug use among MSM and TG in Asia. Interventions addressing non-injecting drug use among MSM and other drug users are generally limited because of the absence of non-opioid substitution therapy. Behavioural interventions, including psychotherapy, psychosocial support and counselling to encourage behavioural and emotional change can be used for non-injecting drug users. These interventions also complement approaches such as NSPs and substitution treatment.

#### **Summary of recommendations**

HIV prevention programmes for MSM should make clean needles and syringes available, preferably directly or through referral, and have well-established referral links with drug dependence programmes.

HIV prevention programmes for MSM need to develop expertise in the drug-related aspects of HIV and STI prevention, guided by harm reduction principles, and in collaboration with existing national and regional harm reduction networks. In addition to providing access to sterile needles and syringes



and referral to OST, CBOs working with MSM need to develop targeted multimedia campaigns addressing drug use, and provide behavioural interventions such as counselling and support groups.

### **Key resources**

**Policy and programming guide for HIV/AIDS prevention and care among injecting drug users.** [http://www.who.int/hiv/pub/prev\\_care/policyprogrammingguide.pdf](http://www.who.int/hiv/pub/prev_care/policyprogrammingguide.pdf)

**Module 5: managing non-opioid drug dependence. Treatment and care for HIV-positive injecting drug users.** [http://www.searo.who.int/LinkFiles/Publications\\_Module\\_05\\_Treatment\\_&\\_Care\\_for\\_HIV\\_positive\\_IDUs.pdf](http://www.searo.who.int/LinkFiles/Publications_Module_05_Treatment_&_Care_for_HIV_positive_IDUs.pdf)

**Treatment for amphetamine dependence and abuse. Cochrane review issue 3 (2009).** <http://www.cochrane.org/reviews/en/ab003022.html>

**A four-pillars approach to methamphetamine. Policies for effective drug prevention, treatment, policing and harm reduction.** <http://www.drugpolicy.org/docUploads/FourPillarsMethamphetamine.pdf>

### **2.8.5 Prisoners and people in other closed settings**

The prevalence of male-to-male sex is higher in prisons and closed settings than in the community. It is in the interest of public health that all people in these settings have access to HIV prevention, treatment and care. They are entitled to the same standard of health as all other members of society.

A wide range of services is required for people in prisons and similar settings, including education on HIV and STI, distribution of condoms and lubricant, provision of clean needles and syringes, OST, treatment for STIs, HIV testing and counselling, PEP and provision of ART. Prison authorities should work with people in other branches of the criminal justice system, and with health authorities and NGOs to ensure continuity of care, including ART, from the community to the prison and back to the community, and also between prisons.

### **Summary of recommendations**

Prisons and other closed settings should offer a full range of HIV prevention, treatment and care services and commodities, including condom provision, harm reduction services, treatment for STIs, HIV testing and counselling, PEP and ART.

### **Key resources**

**Effectiveness of interventions to address HIV in prisons (Evidence for action series).**

<http://www.who.int/hiv/topics/idu/prisons/en/index.html> and [http://www.who.int/hiv/idu/OMS\\_E4Acomprehensive\\_WEB.pdf](http://www.who.int/hiv/idu/OMS_E4Acomprehensive_WEB.pdf)

**Module 2: comprehensive services for injecting drug users. Treatment and care for HIV-positive injecting drug users.** [http://www.searo.who.int/LinkFiles/Publications\\_Module\\_02\\_Treatment\\_&\\_Care\\_for\\_HIV\\_positive\\_IDUs.pdf](http://www.searo.who.int/LinkFiles/Publications_Module_02_Treatment_&_Care_for_HIV_positive_IDUs.pdf)

### **2.8.6 Specific considerations for HIV prevention in young MSM**

Epidemiological data from a number of countries indicate high rates of infection among young MSM (which includes adolescents and youth 10–24 years of age). Therefore, services for MSM should also be designed or modified to be youth-friendly, or supplemented with services specifically geared to the youth. In order for young males who have sex with other males to benefit from HIV prevention, health services must take their unique concerns and needs into consideration. In terms of content, the basic package of interventions to prevent HIV is much the same for young people as it is for adults. However, young people are unlikely to use available services unless:

- staff have been trained to understand young people and their concerns, and address any needs relating to consent and confidentiality;
- services are conscious of the need to deal with young people's concerns regarding coming to terms with their sexual identity or practice;
- facilities and services have been designed or modified to be adolescent/youth-friendly with consideration given to convenient opening times, affordability and privacy; and
- attention is paid to fostering community support for youth-friendly services, and attracting young people to those services.

Prevention services for adults can be modified so that they are also appropriate for young people, but there should also be youth-specific prevention in settings where young people are more likely to access them. These may include schools, universities, MSM CBOs and DICs, youth clubs, bars and clubs, saunas, popular places where youth meet (“hang-outs”), workplaces and pharmacies. The health sector should support community outreach to young people by providing guidance and linkages between services in the health and other sectors.

There is a need for an adolescent-friendly HIV policy in relation to the provision of condoms and sterile needles and syringes to people below 18 years of age, and clear guidance to health sector staff on any legal restrictions that may apply. The health sector should play a stewardship and advocacy role for young people and ensure a supportive political, legal and social environment that takes into account the specific needs of young people.

The health sector also has a responsibility to ensure that there is serological and behavioural surveillance for HIV to provide strategic information on young MSM (see section 5.2). This requires data to be disaggregated by age and analysed for policy and programme guidance.

#### **Summary of recommendations**

Prevention programmes provided by the health sector and CBOs for young males who have sex with other males should include:

- information and counselling to help young people acquire the knowledge and skills required to delay sexual initiation, limit the numbers of sexual partners, use condoms correctly and consistently, avoid substance use or, if injecting drugs, use sterile equipment;
- promotion and distribution of condoms and lubricant for sexually active young people;
- access to harm reduction programmes for young people who are drug users;

- diagnosis and treatment of STIs;
- HIV testing and counselling; and
- access to HIV treatment and care services.

**Key resources**

**Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries.** [http://whqlibdoc.who.int/trs/WHO\\_TRS\\_938\\_eng.pdf](http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf)

**Global consultation on the health services response to the prevention and care of HIV/AIDS among young people.** <http://whqlibdoc.who.int/publications/2004/9241591323.pdf>

**Adolescent friendly health services: an agenda for change.** [http://whqlibdoc.who.int/hq/2003/WHO\\_FCH\\_CAH\\_02.14.pdf](http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf)

## 3. Sexual health



This chapter outlines the sexual health needs of MSM and the importance of the connection between the prevalence of STIs and HIV infection among MSM. This is followed by recommendations to enhance and improve sexual health services to encompass and include the needs of MSM and their partners. The chapter also considers issues regarding the detection and management of STIs, the importance of enabling people to know their HIV status, recommendations regarding provider-initiated testing and counselling (PITC), and the significance of counselling in HIV management. Finally, the chapter considers the needs of female partners of MSM and strategies to ensure that their needs are addressed effectively.

### 3.1 Sexual health needs of MSM and TG

Similar behaviours put people at risk for both STIs and HIV. People with STIs may be at higher risk of acquiring or transmitting HIV infection and there is evidence of a high prevalence of STIs among MSM in the region. The sexual health needs of MSM should be prioritized to ensure optimum health outcomes across these sections of the community.

Most countries in the region demonstrate limited training in and sensitivity to the health-specific needs of MSM, particularly in the planning and delivery of STI services. There is regional variance in service providers with the need for government, private and NGO/CBO organizations to work together more collaboratively to better address the sexual health needs of MSM.

There are reports of ongoing stigma and discrimination experienced by MSM in generalist STI services, and clients may elect to attend private services. However, there is limited access to private services and attendant potential cost issues for most, especially if not provided by CBOs or NGOs. Providing services for STIs requires policies, procedures and health-care worker training to encourage MSM to access STI services. Staff attitudes, opening times, confidentiality, cost of services and the health-seeking behaviours of MSM are all factors that should be considered in designing and delivering these services. The issue of the gender of sexual partners is rarely explored, practitioners are unlikely to consider pharyngeal and anorectal symptoms, and/or screening for STIs, and most facilities are unlikely to have IEC relevant to MSM.

STI services are often best located in environments of high STI incidence, such as within sex work districts, and sex worker and MSM organizations. The use of mobile clinics and reproductive health and primary care clinics should also be optimized, using the experiences of other settings to avoid

any problems already identified. Engagement with the private sector can help increase the quality and reach of services.

For MSM, it is important to adapt and disseminate STI diagnosis and treatment guidelines (where possible, evidence based) that include screening based on potential sexual practices and consider a role for presumptive treatment. In all settings, it is important to ask clients about sexual practices, and guidance should be provided on managing symptoms and reducing practices that increase the chances of transmission of infection. PITC protocols should be integrated within STI services.

Referral of partners of MSM is an important element in providing STI services to these populations, and consideration must also be given to female partners of MSM (see section 3.5).

Involvement of the MSM and TG community and peer-based groups in the development of STI services is essential to ensure that services are correctly targeted and planned, and are appropriate for the needs of MSM.

### **Summary of recommendations**

- “Strategic health facilities”, ideally located in areas of higher MSM and /or TG concentration/ congregation, should be developed.
- MSM services should be provided in general STI clinics rather than identified MSM clinics, which may be considered indiscreet and discourage attendance. Conversely, it may be deemed preferable to have MSM-specific facilities in some local contexts, at least as referral or centres of excellence.
- Health-care practitioners at all levels of service provision should be sensitized to MSM and transgender clients.
- Sexual history-taking should include specifics about the gender of partners and sexual activities, and should clearly address the possibility of anal and oral sexual activities.
- STI management, where possible, should include pharyngeal, perineal and anorectal examination and specimen collection.
- STI services should actively promote the use of condoms and water-soluble lubricant, offer sexual health education covering STI and HIV transmission, symptom and management advice, and provide counselling services.
- Health-seeking behaviour should be built through provision of MSM- and TG-friendly and competent services; increasing awareness and education around STI symptoms and management; promotion of early treatment at medical facilities; reduction of stigma and discrimination; and promotion of STI services through outreach and other counselling activities.
- Access to STI services should be increased and should be within the financial resources of the local setting.
- Partner referral should be encouraged.
- Appropriate facilities and commodities should be available, adequate and used, including private examination areas, anosopes, specimen sampling equipment, and common reagents and medical treatment supplies.
- The technical capacity of services catering to MSM and TG should be enhanced.
- PITC protocols should be integrated within STI services.

- Where appropriate and in certain settings, STI management services should be augmented, with pharmacists targeted to be upskilled in conducting basic STI interviews, counselling and dispensing of pre-packaged STI treatments.
- Comprehensive guidelines for STI management among MSM should be developed and disseminated through the inclusion of MSM-specific guidelines in existing national STI guidelines.
- A comprehensive package of services should be aimed for, through linkages between STI and HIV services offering care, prevention and treatment services, and community and peer support groups.
- A demand for services should be created, which is best achieved as the result of prevention/education outreach through community- and peer-based organizations.
- “Invisible” MSM should be reached through creating awareness among providers of general STI services of the possibility of MSM activities, and enhancing their ability to address and manage these in an appropriate manner.
- STI services should be developed in closed settings such as prisons and labour camps where male-to-male sexual behaviours and sexual violence is often prevalent.

## 3.2 Detection and management of sexually transmitted infections

Programmes for the prevention and treatment of STIs, especially among populations at higher risk for sexual transmission of HIV, remain important elements of HIV prevention programmes.

Services for STI prevention, case management and partner treatment also contribute to HIV prevention by promoting correct and consistent condom use, and supporting health education and behaviour change. A range of models for delivering STI services is required to ensure that MSM and TG populations have access to these services. STI services provide opportunities for access to HIV testing and counselling, and can provide a sensitive indicator for measuring the effectiveness and impact of HIV prevention programmes, and verifying the reported use of condoms during sexual encounters.<sup>29</sup>

### **Summary of recommendations**

WHO recommends that countries expand the provision of good-quality and targeted STI care for MSM and TG into primary health care, sexual and reproductive health, and HIV services. Comprehensive STI services include:

- diagnosis by syndrome or etiology wherever laboratory tests are available;
- increased awareness of anorectal/pharyngeal STI infections, and addressing these issues in national STI management guidelines, building capacity through curricula education, clinic observation and refresher training;
- provision of effective treatment at the first encounter;
- reduction in further risk-taking behaviour through age-appropriate education and counselling;
- promotion and provision of condoms and lubricants, with clear guidance on correct and consistent use;

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29 Steen R et al. Control of sexually transmitted infections and prevention of HIV transmission: mending a fractured paradigm. *Bulletin of the World Health Organization*, 2009, 87:858–865. doi: 10.2471/BLT.08.059212 <http://www.who.int/bulletin/volumes/87/11/08-059212/en/index.html>

- notification and treatment of STIs in sexual partners, when applicable;
- provision of rapid test screening and treatment for syphilis;
- provision of HIV testing and counselling in all settings that provide management of STIs; and
- provision of hepatitis and human papillomavirus (HPV) vaccines to prevent genital and liver cancers.

For primary care settings in low- and middle-income countries, WHO recommends syndromic management of STIs in patients presenting with consistently recognized signs and symptoms. In some settings where there is a high likelihood of infection(s), presumptive treatment of individuals or populations may be considered, particularly as part of a comprehensive intervention package, and should be evidence based. Periodic presumptive treatment with good coverage can have an impact in places where STI control is poor, and where MSM and TG have limited access to preventive and curative services. This is, however, not a stand-alone intervention, and should be embedded in a package of other services, including syndromic case management, regular screening for syphilis, and promotion of condom use.

Treatment for each syndrome should be directed against the main organisms responsible for the syndrome within that geographical setting. National guidelines based on identified patterns of infection and disease should be developed and disseminated to all providers of STI care.

Every country should ensure that interventions for STI prevention and care are integrated or closely coordinated with national AIDS programmes.

### **Key resources**

**Global strategy for the prevention and control of sexually transmitted infections, 2006–2015: breaking the chain of transmission.** <http://www.who.int/reproductivehealth/publications/rtis/9789241563475/en/index.html>

**Guidelines for the management of sexually transmitted infections.** <http://www.who.int/hiv/pub/sti/en/STIGuidelines2003.pdf>

**Periodic presumptive treatment for sexually transmitted infections: experience from the field and recommendations for research.** <http://www.who.int/reproductivehealth/publications/rtis/9789241597050/en/>

**IUSTI Asia Pacific Branch clinical guidelines for sexual health care of men who have sex with men.** [http://www.iusti.org/sti-information/pdf/IUSTI\\_AP\\_MSM\\_Nov\\_2006.pdf](http://www.iusti.org/sti-information/pdf/IUSTI_AP_MSM_Nov_2006.pdf)

**WHO training modules for the syndromic management of sexually transmitted infections.** <http://www.who.int/reproductivehealth/publications/rtis/9789241593407index/en/>

### 3.3 Enabling people to know their HIV status

Increasing the numbers of people who know their HIV status — especially among most-at-risk populations including MSM, through HIV testing and counselling — is key to expanding access to HIV prevention, treatment and care.

WHO guidance on HIV testing and counselling aims to achieve synergies between medical ethics, human rights, and clinical and public health objectives. The fundamental principles of HIV testing are that it must be voluntary, accompanied by basic pre-test information to enable the client to make an informed and voluntary decision (informed consent), confidential, accompanied by counselling and linked to HIV services, as an element of a continuum of prevention, care and treatment for HIV.

#### **Key resources**

**UNAIDS/WHO policy statement on HIV testing.** <http://www.who.int/hiv/pub/vct/statement/en/index.html>

**Opening up the HIV/AIDS epidemic: guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting.** [http://data.unaids.org/publications/IRC-pub02/jc-execsumm\\_en.pdf](http://data.unaids.org/publications/IRC-pub02/jc-execsumm_en.pdf)

#### **3.3.1 Voluntary counselling and testing (VCT)**

Client-initiated testing and counselling (CITC), also called voluntary counselling and testing (VCT), occurs when people come to a service to find out their HIV status.

CITC emphasizes individual risk assessment and counselling that addresses the implications of taking an HIV test and the strategies for reducing risk. Counselling covers prevention both prior to and after receiving the test results and, if the results are positive, referral to care, treatment and support services.

#### **Summary of recommendations**

For MSM and TG, the programmatic focus should be on increasing access to and uptake of counselling and testing among these groups, using a variety of approaches. Innovative methods should be ensured of reaching subgroups within the MSM and TG populations including, for example, outreach work and peer involvement. A major issue would be to address stigma and discrimination around MSM and testing.

These recommendations are in line with guidance from WHO and UNAIDS, which advocate that both known and innovative approaches be used to scale up and expand access to CITC. These approaches should optimize convenience for clients, decentralize services and provide testing and counselling in a wide variety of settings—including health facilities, community-based locations and workplaces—and through outreach services that may be stationary or mobile. They should offer services outside



normal working hours and remove any financial barriers to testing and related services. CBOs that specialize in working with MSM and TG should be considered essential for either providing VCT to these populations or providing referral links to VCT services.

### **Key resources**

**WHO HIV testing and counselling (TC) toolkit.** <http://www.who.int/hiv/topics/vct/toolkit/en/index.html>

**WHO SEARO. Targeted VCT intervention – men who have sex with men (MSM)** [http://www.searo.who.int/LinkFiles/Training\\_Materials\\_voluntary-module3-4.pdf](http://www.searo.who.int/LinkFiles/Training_Materials_voluntary-module3-4.pdf)

### **3.3.2 Provider-initiated HIV testing and counselling (PITC)**

PITC occurs when HIV testing and counselling is recommended by health-care providers as a standard part of medical care to individuals attending health facilities. The purpose of PITC is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status.

PITC is recommended in the presence of signs and/or symptoms that are related to HIV infection, and for family members and partners of PLHIV. Depending on the epidemiological context, recommendations may extend to specific groups of patients accessing health facilities (patients with TB and STIs, pregnant women), and those with specific behaviours (PWID, MSM, commercial sex workers).

#### **Summary of recommendations**

HIV testing and counselling is recommended for all MSM whose clinical presentation might result from underlying HIV infection. Testing and counselling is also recommended prior to provision of PEP for HIV.

WHO and UNAIDS recommend that PITC start with basic pre-test information provided either on an individual or group basis. PITC should require informed consent, with the client given all necessary information to make a rational decision, and the opportunity to decline testing. This opportunity should be given in private, in the presence of a health-care provider. Post-test counselling should be tailored to the test result and, in the case of a positive result, should be more extensive. As with all HIV testing, confidentiality should be guaranteed and health providers should take measures to ensure that this guarantee is upheld.

The UNAIDS/WHO guidance on PITC specifies situations in which health-care providers should recommend testing and counselling based on the characteristics of the epidemic in a given setting. PITC is not recommended for all patients attending health facilities, but should be considered in a range of specific situations, e.g. where patients have come for STI or TB services.

### **Key resources**

**WHO and UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities.** [http://whqlibdoc.who.int/publications/2007/9789241595568\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)

**WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children.** <http://www.who.int/hiv/pub/guidelines/HIVstaging150307.pdf>

**Recommendations for human immunodeficiency virus (HIV) screening in tuberculosis (TB) clinics.** <http://www.cdc.gov/tb/publications/factsheets/testing/HIVscreening.htm>

## **3.4 Counselling**

Counselling is an essential component of HIV services, and requires specific skills and competencies from health workers and lay providers.

Counselling is particularly important for MSM in dealing with identity, disclosure, stigma and discrimination, all of which impact significantly upon HIV and sexual health. Counselling is also important for TG undergoing hormone treatment and/or surgery for gender reassignment.

WHO and UNAIDS recommend “beneficial disclosure” where HIV-positive individuals themselves notify sexual or drug-injecting partners of their HIV status, where appropriate, and this should form an important element of counselling for HIV-positive MSM. Informing partners is an effective means of reducing HIV transmission. It also facilitates prevention, care, support and adherence to treatment, and promotes greater openness about HIV within communities.

### **Summary of recommendations**

Counselling is required in a range of clinical situations:

1. to deal with sexual and/or gender identity in the context of sexual health;
2. to help patients cope with challenges and fears related to the diagnosis of HIV, transmission to sexual partners and other family members;
3. to help patients prioritize problems and find their own solutions, especially those who are depressed or anxious;
4. to address other aspects of HIV prevention, care and treatment (post-testing counselling);
5. to disclose HIV status and negotiate safe sex and condom use;
6. to help patients cope with the need for lifelong ART; promote and maintain adherence;
7. to intervene in crisis situations (e.g. bereavement or to prevent suicide); and
8. to help patients with issues around substance use, especially methamphetamine use, and transmission risk.

Health-care workers, including counsellors, also require support to prevent and respond to burnout. Health-care workers require adequate training to provide appropriate counselling and support to MSM and TG populations, in order to avoid stigma and discrimination, and ensure engagement between services and patients.

**Key resource**

**Basic counselling guidelines for ARV programmes.** [http://whqlibdoc.who.int/publications/2005/9241593067\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593067_eng.pdf)

**3.5 Female partners**

Significant proportions of MSM and TG have female sexual partners; quoted variously at 25–35%. In some countries of the region, this is believed to be much higher, for example, in Viet Nam, 40% of MSM had a female partner in the past year and in Cambodia, 80–87% of MSM had more than two female partners in the past year. MSM and TG presenting for STI and HIV services need to be questioned about their female as well as male partners.

MSM who have regular female partners are likely to be reluctant to initiate condom use, and partner testing and treatment with these female partners.

The social aspects of MSM and female partners, especially married MSM, are extremely complex and often lead to sexual risk-taking.

**Summary of recommendations**

It is important that persons diagnosed to be HIV positive or with STIs are encouraged and supported to disclose their status to all of their sexual (and needle-sharing) partners, both male and female, and to propose HIV testing and counselling and STI management to these partners.

It is equally important that they be supported in these endeavours. Testing and counselling of sexual (and needle-sharing) partners can be done either in the health facility— for example, following counselling of a couple — or through referral to another facility that welcomes CITC.

Services that cater for women such as family planning and antenatal clinics need to consider that their patients may have male partners who have had sex with men and encourage STI screening.

The complex social aspects involving married MSM must be considered when providing sexual health care for men who fall into this category.

**Key resources**

**WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities.** [http://whqlibdoc.who.int/publications/2007/9789241595568\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)

**Opening up the HIV/AIDS epidemic: guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting.** [http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp\\_en.pdf](http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp_en.pdf)

## 4. Access to care, support and treatment



This chapter approaches the management of HIV in MSM on the basis of a continuum of care following diagnosis through before and after the introduction of ART. It considers disease prophylaxis together with issues around ART. In addition, the management of HIV-related conditions such as nutritional care, palliative care, mental health and vaccinations is considered. Emphasis is given to TB and hepatitis infections, and to TG-specific health concerns. Lastly, consideration is given to laboratory and technical issues.

### 4.1 Continuum of care

Comprehensive care involves a network of resources and services, which provide holistic, comprehensive, wide-ranging services for PLHIV and their families. The continuum of care commences at diagnosis and includes care provided by the clinic, hospital, community and home over the course of the management of HIV.

Care must include clinical management, direct patient care, education, prevention, counselling, palliative care and social support.

MSM may present later and less frequently to services that are perceived as not accepting and this may lead to poorer health outcomes. In addition, MSM frequently lack family and community support.

#### **Summary of recommendations**

Priority must be given to engaging and maintaining MSM in HIV care with services that offer an enabling environment in which stigma and discrimination are minimized. MSM should be given supportive access to the full range of services in which staff are sensitized to their issues and needs. Peer support and counselling should be actively encouraged to increase the uptake and output of services.

#### **Key resources**

**WHO. SEARO. Continuum of care. Fact sheets. HIV/AIDS for nurses and midwives.**

[http://www.searo.who.int/LinkFiles/Publications\\_FactSheet-HIV-AIDSNurses.pdf](http://www.searo.who.int/LinkFiles/Publications_FactSheet-HIV-AIDSNurses.pdf)

**FHI. Scaling up the continuum of care: a new toolkit for implementers working in the Asia–Pacific Region.** [http://www.fhi.org/en/HIVAIDS/pub/res\\_CoC\\_toolkit.htm](http://www.fhi.org/en/HIVAIDS/pub/res_CoC_toolkit.htm)

## 4.2 Treatment and care interventions

Management of the full range of HIV-related conditions should be based on clear guidelines and standardized protocols. Following the establishment of a diagnosis of HIV infection, supported by laboratory tests, including confirmatory tests as stipulated by national HIV testing guidelines, HIV-positive MSM would be referred to HIV services for the management of HIV infection.

As a long-term, potentially manageable condition, HIV demands chronic ongoing care. While MSM living with HIV may be engaged prior to, during or following the introduction of ART, integral to their health and that of their partners at all stages is HIV prevention for MSM living with HIV (see section 2.8.1).

### 4.2.1 Co-trimoxazole prophylaxis

Co-trimoxazole is an effective, well-tolerated and inexpensive antibiotic used to prevent *Pneumocystis jiroveci* pneumonia (PCP) and toxoplasmosis in immunocompromised persons with HIV. It is also effective against other infectious and parasitic diseases, and should be an essential part of pre- and post-ART care, where appropriate.

#### Summary of recommendations

WHO recommends that the criteria for co-trimoxazole use in PLHIV be adapted, depending on the disease burden in different settings.

#### Key resource

**Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults: recommendations for a public health approach.** [http://whqlibdoc.who.int/publications/2006/9789241594707\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9789241594707_eng.pdf)

### 4.2.2 Isoniazid preventive treatment (IPT)

Prevention and treatment of TB in PLHIV is an urgent priority for both HIV and TB programmes. The three I's – isoniazid preventive treatment (IPT), intensified case finding (ICF) for active TB, and TB infection control (IC) – are key public health strategies to decrease the impact of TB on PLHIV (see section 4.6.1).

#### Summary of recommendations

TB preventive therapy with isonicotinic acid hydrazide (isoniazid, INH) is safe and effective in PLHIV, and reduces the risk of TB by 33–62%. Screening and diagnosing TB in PLHIV can be challenging but TB in PLHIV is curable. TB infection control is essential to keep vulnerable patients, health-care workers and the community safe from getting TB.

### **Key resources**

**Three I's Meeting: intensified case finding (ICF), isoniazid preventive therapy (IPT) and TB infection control (IC) for people living with HIV.** [http://www.who.int/hiv/pub/meetingreports/WHO\\_3Is\\_meeting\\_report.pdf](http://www.who.int/hiv/pub/meetingreports/WHO_3Is_meeting_report.pdf)

**Isoniazid preventive therapy (IPT) for people living with HIV.** [http://www.stoptb.org/wg/tb\\_hiv/assets/documents/IPT%20Consensus%20Statement%20TB%20HIV%20Core%20Group.pdf](http://www.stoptb.org/wg/tb_hiv/assets/documents/IPT%20Consensus%20Statement%20TB%20HIV%20Core%20Group.pdf)

### **4.2.3 Treatment preparedness and adherence support**

Interventions to ensure treatment preparedness and adherence support optimize the effectiveness of ART and minimize the development of drug resistance. The ability of MSM to follow treatment plans is frequently compromised by various factors, including stigma and discrimination (which is frequently experienced by many patients and their families), treatment costs they cannot afford, and the nature and tolerability of available ART. The level of readiness among patients to follow health-care provider recommendations is a major factor that benefits from MSM-sensitive and -supportive information, education and counselling. Practical matters, such as the need for free or affordable transportation to and from treatment centres, and convenient opening hours for patients are high priorities.

Community and patients' organizations can play key roles in supporting adherence through peer support and monitoring, home visits and other means. Informal or formal social support from family, friends, the community and patients' organizations has consistently been shown to be important for treatment preparedness, adherence and good health outcomes.<sup>30</sup>

### **Summary of recommendations**

Interventions for treatment education and adherence should be tailored to the particular needs of each MSM. Health-care workers should be prepared to assess their patients' readiness to adhere to treatment, offer ongoing advice and support to achieve it, and monitor progress at every contact.

Effective adherence support interventions for MSM, many of whom have poor family support, include client-centred behavioural counselling, support from peer educators trained as "expert patients", and community treatment supporters. These interventions involve encouraging people to disclose their HIV status and providing them with treatment tools such as pillboxes, diaries and patient reminder aids in a supportive, non-judgemental environment. Services such as nutrition support and transport assistance should also be explored as potential measures to improve adherence.

### **Key resources**

**Adherence to long-term therapies: evidence for action.** [http://www.who.int/chp/knowledge/publications/adherence\\_introduction.pdf](http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf)

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30 Rueda S et al. Patient support and education for promoting adherence to highly active antiretroviral therapy for HIV/AIDS. *Cochrane Database of Systematic Reviews*, 2006, Issue 3. Art. No.: CD001442. DOI: 10.1002/14651858.CD001442.pub2.<http://www.cochrane.org/reviews/en/ab001442.html>

#### **4.2.4 Antiretroviral therapy (ART)**

A public health approach to ART facilitates quality HIV treatment for all who need it, and is an essential component of reaching the goal of universal access. It promotes simplified and standardized clinical decision-making, drug regimens and formularies, and patient data recording systems. It requires that national drug prescription and clinical care guidelines be supported by regular supplies of quality-assured drugs, and that these drugs be made available to patients free at the point of service delivery.

Early referral to ART services and measures to retain patients in care are essential to the achievement of good patient and programme outcomes. However, MSM may have delayed presentation to and anticipate or encounter discrimination at services providing ART management, risking reduced attendance and poorer outcomes.

MSM living with HIV who are eligible for initiation of ART will start treatment according to the provisions of national ART guidelines, including access to recommended first-line and, when appropriate, second-line regimens.

Special consideration would need to be given to the following situations:

1. MSM who use alcohol and illicit drugs may have difficulties adhering to and fully benefiting from ART. However, treatment initiation should not be delayed or withheld.
2. Hormonal therapy in TG patients should not adversely affect the efficacy of ART; however, some of the drugs used for ART may affect hormonal levels (see section 4.3).

Communication and counselling efforts should therefore be intensified and focus on these aspects.

To maintain the effectiveness of first- and second-line ART regimens, WHO recommends that countries develop a national strategy for prevention of, and surveillance and monitoring for, HIV drug resistance. WHO also recommends any expansion or improvement in laboratory services that may be necessary for the diagnosis and treatment of HIV, OIs and related conditions, and to support monitoring of treatment effectiveness.

#### **Summary of recommendations**

Regular, routine periodic clinical and immunological staging to determine eligibility for treatment is recommended for all MSM living with HIV. The use of alcohol or illicit drugs should not prevent MSM from gaining full assessment for and access to ART, although this may require additional counselling and support efforts.

WHO recommends that criteria for starting ART be defined in national protocols and that these be based on the minimum clinical data and, wherever available, CD4 counts.

TG receiving hormonal therapy should be assessed for the need for changes in hormonal dosage with the introduction of or alterations in ART, and be carefully monitored for medication toxicities. Notwithstanding the availability of specific ARV agents varying between countries of the region,

WHO guidelines for the initiation of preferred ART recommendations are appropriate for MSM and TG. These recommendations are reviewed and updated regularly, and readers are encouraged to check for updates.

Patients who develop failure of their first-line therapy will need to switch to second-line regimens. Treatment failure is recognized by using, at a minimum, clinical criteria and CD4 cell count thresholds and, where feasible, the results of viral load monitoring. WHO recommends changing the entire drug regimen where possible if treatment failure has occurred, and current resources should be consulted for alternative regimens.

### **Key resources**

**WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children.** <http://www.who.int/hiv/pub/guidelines/HIVstagingI50307.pdf>

**Rapid advice. Antiretroviral therapy for HIV infection in adults and adolescents. 2009 revision.** [http://www.who.int/hiv/pub/arv/rapid\\_advice\\_art.pdf](http://www.who.int/hiv/pub/arv/rapid_advice_art.pdf)

**HIV–drug interactions.** <http://www.hiv-druginteractions.org>

**IMAI–IMCI chronic HIV care with ARV therapy and prevention: interim guidelines for health workers at health centre or district hospital outpatient clinic.** English: [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

**Prioritizing second-line antiretroviral drugs for adults and adolescents: a public health approach. Report of a WHO working group meeting, Geneva, Switzerland, 21–22 May 2007.** [http://www.who.int/hiv/pub/meetingreports/Second\\_Line\\_Antiretroviral.pdf](http://www.who.int/hiv/pub/meetingreports/Second_Line_Antiretroviral.pdf)

**Prequalification programme: a United Nations Programme managed by WHO.** <http://apps.who.int/prequal/>

**HIV/AIDS treatment and care: clinical protocols for the WHO European Region.** English: <http://www.euro.who.int/document/e90840.pdf>

**WHO consultation on ART failure in the context of a public health approach: 2008 meeting report.** [http://www.who.int/hiv/pub/arv/art\\_failure\\_meeting.pdf](http://www.who.int/hiv/pub/arv/art_failure_meeting.pdf)

### **4.2.5 Prevention, surveillance and monitoring of HIV drug resistance**

Given the high replication and mutation rates of HIV and the necessity for lifelong ART, the emergence of some level of HIV drug resistance (HIV-DR) is inevitable. However, the risk of HIV-DR, seen most commonly secondary to suboptimal adherence, can be reduced with appropriate actions to engage and retain MSM in supportive ART management.

### **Summary of recommendations**

Key interventions for preventing and managing HIV-DR include:

- promoting the use of standard ART regimens;



- supporting the use of standardized individual treatment records;
- actively monitoring adherence;
- minimizing barriers to adherence, particularly adverse effects and continuity of supply;
- providing quality assurance/control for drugs, and an adequate and continuous drug supply;
- preventing HIV transmission by persons receiving ART;
- monitoring programmes for “early warning” of HIV-DR;
- doing surveillance for HIV-DR transmission, and monitoring the emergence of HIV-DR in treated populations; and
- taking appropriate actions based on the results of monitoring and surveillance.

### **Key resource**

**HIV drug resistance.** [http://www.who.int/hiv/drugresistance/WHO\\_HIVDR\\_strategy.pdf](http://www.who.int/hiv/drugresistance/WHO_HIVDR_strategy.pdf)

#### **4.2.6 Managing opportunistic disease and co-morbidities**

Standardized clinical protocols should reflect the burden of HIV and prevalent co-morbidities. Certain conditions such as oral candidiasis and oral hairy leukoplakia are common among MSM with HIV and may signify disease progression. Standard clinical care should manage the common acute and chronic conditions associated with HIV.

Regular screening for active TB is recommended for MSM living with HIV, including those already on ART (see section 4.6.1).

### **Key resources**

**IMCI chart booklet for high HIV settings.** [http://whqlibdoc.who.int/publications/2008/9789241597388\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241597388_eng.pdf)

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Global action plan for the prevention and control of pneumonia (GAPP): report of an informal consultation.** [http://whqlibdoc.who.int/publications/2008/9789241596336\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241596336_eng.pdf)

#### **4.2.7 Nutritional care and support**

While MSM with HIV have increased energy needs, symptoms of HIV may lead to decreased appetite, difficulty in swallowing and malabsorption. These, combined with factors such as a lack of regular access to a nutritious balanced diet, mean that the interactions between HIV and nutrition are complex. ART and OI medications may impact on nutritional status by inducing anorexia, nausea or diarrhoea, which may also lead to reduced adherence which, in turn, may lead to virological failure. Alcohol intake and the use of illicit drugs, particularly amphetamines, by MSM can adversely affect appetite and intake, resulting in worsened nutritional status and weight loss.

Evidence-based nutrition interventions should be part of all national HIV care and treatment programmes. The diet and nutritional status (weight and weight change, height, body mass index [BMI] or mid-upper arm circumference, symptoms) of PLHIV should be routinely assessed. Assessment of diet should aim to ensure that the intake of protein, total calories and micronutrients is adequate for the patient's energy needs, and that potential drug–food (including herbal and traditional remedies) interactions are avoided. Individual and household food security commonly impact on nutritional status and should be evaluated.

MSM experiencing lipodystrophy with fat loss may adopt unhealthy eating patterns in an unsuccessful attempt to restore lost body fat and thereby potentially elevate blood lipid levels.

#### **Summary of recommendations**

WHO recommends that all adults should receive one recommended daily allowance (RDA) of micronutrients, regardless of their HIV status. This is best provided by food, including fortified food. Where the micronutrient content of the daily diet is inadequate, a daily multimicronutrient supplement is required. There is no evidence for increased protein requirement exceeding that of a balanced diet, where protein contributes about 10–15% of the total energy intake.

Dietary history should be taken and advice given in the context of medication-induced adverse effects, regardless of apparent BMI gains.

Whenever feasible, MSM who lack the means to meet their basic dietary needs should be assisted in achieving food security through measures such as income assistance or direct provision of food.

#### **Key resources**

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Nutrient requirements for people living with HIV/AIDS.** <http://www.who.int/nutrition/publications/hivaids/9241591196/en/>

**Integrating nutrition and food assistance into HIV care and treatment programmes: operational guidance.** [http://www.who.int/hiv/topics/treatment/who\\_wfp\\_nutrition.pdf](http://www.who.int/hiv/topics/treatment/who_wfp_nutrition.pdf)

**WHO Executive Board EB116/12 116th Session 12 May 2005: nutrition and HIV/AIDS.** [http://www.who.int/gb/ebwha/pdf\\_files/EB116/B116\\_12-en.pdf](http://www.who.int/gb/ebwha/pdf_files/EB116/B116_12-en.pdf)

#### **4.2.8 Managing diarrhoea**

Chronic persistent diarrhoea is common in MSM with HIV, and may be difficult to diagnose and manage. While opportunistic causes of diarrhoea increase with immunosuppression, all MSM engaging in sexual activities involving oral–fecal contact are at increased risk for acute pathogen-related disease. Additionally, some ARVs may induce diarrhoea regardless of the level of immune suppression or restoration.

**Summary of recommendations**

Thorough risk assessment is necessary for all MSM presenting with diarrhoea. Clinical protocols should cover case management for the full range of opportunistic pathogens. Dietary interventions can assist with medication-induced diarrhoea, thereby enhancing adherence, and MSM should be counselled about the risks associated with oral–fecal contact.

**Key resource**

**Implementing the new recommendations on the clinical management of diarrhoea: guidelines for policy makers and programme managers.** [http://whqlibdoc.who.int/publications/2006/9241594217\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9241594217_eng.pdf)

**4.2.9 Managing HIV-related conditions**

At a minimum, case management protocols for MSM with HIV should include the conditions listed below, as well as other locally prevalent conditions, particularly malaria and TB, including infection with multidrug-resistant (MDR) and extensively drug-resistant (XDR) strains. These conditions include both HIV-related opportunistic diseases and disturbances secondary to commonly used ART. Descriptions of the conditions and their management can be found in the resources below.

**Infections**

- Bacterial
- Viral
- Protozoal
- Fungal

**Neurological conditions****Skin disorders****Malignancies**

- AIDS-defining malignancies
- Kaposi sarcoma
- Hepatocellular carcinoma

**Cardiovascular**

- Atherosclerosis
- Cardiomyopathy

**Metabolic conditions**

- Impaired glucose tolerance
- Dyslipidaemia
- Lipodystrophy
- Lactic acidosis
- Peripheral neuropathy

MSM have susceptibility to the usual range of opportunistic diseases but are at increased risk for developing Kaposi sarcoma (KS) from the sexual transmission of human herpesvirus 8 (HHV8). In addition to visceral and mucosal involvement, KS may produce rapidly developing and extensive stigmatizing skin lesions. Prompt introduction of ART is the most effective management option;

however, severe disease may require chemotherapy or radiotherapy. Chronic infection with hepatitis B virus (HBV) and hepatitis C virus (HCV) in MSM with HIV has an accelerated clinical course and increased progression to hepatocellular carcinoma (see section 4.6.2). HPV is associated with oropharyngeal, penile and anal cancer (the incidence of which is 35 times higher in MSM in general and 100 times higher in those who are HIV positive).

Drugs used for ART have a range of potential adverse effects (including rash and gastrointestinal disturbances) and, with ongoing use, produce a variety of metabolic disturbances. Lipodystrophy, most particularly atrophy of the facial fat pads and limb fat can be rapid and severe, especially with stavudine use. Great distress is frequently caused by these changes in appearance, particularly in MSM concerned with their looks or relying on them for sex work. Fear of development of lipodystrophy may delay initiation of, or lead to reduced adherence to, or abrupt termination of, ART. Other metabolic disturbances include dyslipidaemia with raised levels of cholesterol and triglycerides, impaired glucose tolerance and diabetes mellitus, renal disease with nephropathy and osteopenia/osteoporosis.

#### **Key resources**

**IMAI-IMCI chronic HIV care with ARV therapy and prevention: interim guidelines for health workers at health centre or district hospital outpatient clinic.** English: [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

**IMAI acute care.** English: [http://www.who.int/hiv/pub/imai/en/acutecarerev2\\_e.pdf](http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf)

**IMCI chart booklet for high HIV settings.** [http://whqlibdoc.who.int/publications/2008/9789241597388\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241597388_eng.pdf)

**Policy for prevention of oral manifestations in HIV/AIDS: the approach of the WHO Global Oral Health Programme.** <http://adr.iadrjournals.org/cgi/reprint/19/1/17.pdf>

**HIV-related opportunistic diseases.** [http://whqlibdoc.who.int/unaid/1998/a61273\\_eng.pdf](http://whqlibdoc.who.int/unaid/1998/a61273_eng.pdf)

**Malaria and HIV interactions and their implications for public health policy.** <http://whqlibdoc.who.int/publications/2005/9241593350.pdf>

#### **4.2.10 Palliative care**

Palliative care can improve the quality of life of patients facing life-threatening illness and of their families and carers. It offers prevention and relief of suffering by means of early identification, assessment and treatment of pain and other physical, psychosocial and spiritual needs. It calls for a multidisciplinary team approach that addresses the needs of patients and their carers to cope during both illness and death. MSM are at risk for poorer access to palliative care as they are often displaced from the family and traditional community support. With illness, they may face social rejection and poverty issues that prevent them from obtaining psychological, physical and medical support measures.

A central focus of palliative care is pain assessment and treatment, with the use of opioid and non-opioid analgesics according to an analgesic ladder. The analgesics are provided together with non-medical treatments. This requires addressing any limitations in access to opioid analgesics, as well

as reservations some health workers may have about prescribing or administering analgesics. MSM with illicit drug use may have an inadequate response to standard doses of analgesics or have therapy denied or withdrawn on the basis of their drug use.

### **Summary of recommendations**

Sensitive and supportive palliative care services should be available to MSM in all settings, and community-based care is frequently required to replace or supplement family support. Pain demands both targeted management of the cause and control of the pain itself. The analgesic ladder should be utilized to provide the most acceptable level of pain management. Opiate-dependent MSM need careful assessment and monitoring of pain levels and analgesic requirements. Standard treatment regimens may fail to give adequate symptom relief and prescribers must be prepared to provide increased doses to ensure optimum pain control.

### **Key resources**

**Palliative care: symptom management and end-of-life care.** <http://www.who.int/hiv/pub/imai/genericpalliativecare082004.pdf>

**WHO's pain ladder.** <http://www.who.int/cancer/palliative/painladder/en/index.html>

**Caregiver booklet: symptom management and end of life care (draft).** <http://www.who.int/hiv/pub/imai/patient/en/index.html>

**Restoring hope: decent care in the midst of HIV/AIDS.** <http://www.palgrave.com/products/title.aspx?PID=323603>

## **4.3 Transgender health**

In addition to mental health issues (see section 4.4), TG have multiple health concerns that need to be addressed. They are frequently discriminated against by general health-providing services and have poor and inconsistent access to hormonal, psychological and gender reassignment services. They often have higher rates of HIV infection and exposure to other STIs.

TG tend to have more involvement in sex work, and a deterioration in their appearance, from advancing HIV or secondary to adverse effects of ART such as lipodystrophy, may not only impact significantly on self-esteem but threaten their ability to continue working.

Hormonal therapy for TG is an essential tool for their transitioning to and better functioning in the adopted gender, and is most commonly administered by injection. The availability and cost of hormones will vary between locations, and reliable and affordable access to them is fundamental to the management of TG.

Drug–drug interactions between ART and hormones (see section 4.2.4) have not been well studied and recommendations for TG are generally based on data from women receiving hormonal contraception and ART. With the exception of estrogen, which reduces amprenavir and fos-amprenavir levels, evidence supports that there is no likely adverse effect on ART levels and anticipated response among

TG taking hormonal supplementation. Supplemented hormone levels may, however, be increased or decreased by concomitant ART (e.g. estrogen levels are significantly increased by efavirenz, indinavir, atazanavir, and decreased by nevirapine, lopinavir, ritonavir).

Many TG have inadequate access to counselling and support, despite high needs secondary to psychosocial issues such as gender confusion, substance use, limited work options, financial hardship and a low level of community inclusion.

As with the obtaining of equipment to inject drugs, TG may have difficulty in accessing clean and appropriate hormone injecting equipment requiring them to share or reuse equipment. This puts them at risk for bloodborne virus infections and septic complications. In many locations, surgical procedures associated with gender reassignment are poorly regulated and technical expertise may be lacking, resulting in high infection and complication rates.

Long-term hormonal therapy presents TG with a range of potential health problems. Estrogen therapy can cause a rise in liver enzymes, particularly in the presence of chronic liver disease. There is an increased risk of breast cancer following prolonged use, although lower than the rate in natal females. Blood pressure may increase and there is an increased incidence of cerebrovascular and cardiac disease following estrogen therapy. The rate of deep vein thrombosis is increased (particularly in the presence of smoking), as is impaired glucose tolerance in those with elevated BMI. Post gender reassignment, TG will retain their prostate, although they are at reduced overall risk for prostate cancer while receiving estrogen.

#### **Summary of recommendations**

TG should have access to sensitized service providers who are able to address their specific needs, and to a reliable source of hormones and clean injecting equipment. They require regular STI screening and should receive hepatitis A virus (HAV) and HBV vaccinations where appropriate, as well as HPV vaccine.

An acceptable standard of psychological assessment and support should be available at all stages to TG and accompany gender reassignment surgery that is of a standard, so as to minimize the risk of complications and maximize the aesthetic and functional outcomes.

Long-term hormonal management needs to address reduction of risk for developing cardiovascular, breast and metabolic diseases. Monitoring should include regular liver enzyme testing, particularly in those TG with chronic liver disease or taking ART. Ongoing assessment of potential drug–drug interactions should be conducted to ensure maximum response to all therapies with minimized risk of adverse effects.

**Key resources**

**HIV/AIDS and the transgendered person.** <http://www.cdc.gov/lgbthealth/pdf/FS-Transgender-06192007.pdf>

**Transgender HIV/AIDS health services. Best Practice guidelines.** <http://www.careacttarget.org/library/tgguidelines.pdf>

**The World Professional Association for Transgender Health's standards of care.** [http://www.wpath.org/publications\\_standards.cfm](http://www.wpath.org/publications_standards.cfm)

**Tom Waddell Health Center, San Francisco Department of Public Health. Protocols for hormonal reassignment of gender.** <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>

**4.4 Mental health**

Prevention and treatment of mental health disorders, and provision of psychological and social support are often neglected in MSM with HIV, despite these being critical components of care. HIV infection itself can lead to poor mental health conditions including impaired cognition. Timely ART effectively reduces the risk of developing HIV-related encephalopathy.

MSM may be overtly ostracized and discriminated against on the basis of appearance and behaviour, and often experience reduced familial and social support. Higher rates of harassment and physical assault are encountered, particularly by feminized MSM and TG.

Conditions common among PLHIV include depression, anxiety and substance use, with higher rates frequently reported among MSM, many of whom experience confusion, guilt and shame over their orientation or sexual activities. Many TG face confusion over sexual roles and variability of gender identity and, particularly while transitioning, there may be elements of their appearance that give rise to ridicule and social censure while limiting employment potential.

Alcohol and illicit drug use are significant risk factors for unsafe sex and HIV transmission among MSM. Mental health problems at all levels can interfere with treatment adherence, adversely affecting management outcomes.

Promoting and supporting mental health throughout the spectrum of HIV disease requires a number of interventions, including psychosocial support, basic counselling for depression, and psychotherapeutic interventions to address recognized psychiatric disorders. Brief interventions can address harmful and hazardous alcohol use. Mental health-related issues for MSM with HIV should be addressed at all levels of the health system.

**Summary of recommendations**

MSM should have access to a full range of appropriate psychosocial and psychotherapeutic interventions. Their specific needs should be addressed through sensitization of health-care providers and access to

peer-based support services. Delirium, dementia, suicide, major depression, psychoses and anxiety disorders all need specific interventions and may require psychotropic medication.

### **Key resources**

**Psychiatric care in ARV therapy (for second level care): module 3 WHO mental health and HIV/AIDS series.** [http://whqlibdoc.who.int/publications/2005/9241593083\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593083_eng.pdf)

**Psychosocial support groups in antiretroviral (ARV) therapy: module 4 in the WHO mental health and HIV/AIDS series.**

Series 1: [http://whqlibdoc.who.int/publications/2005/9241593040\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593040_eng.pdf)

Series 2: [http://whqlibdoc.who.int/publications/2005/9241593067\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593067_eng.pdf)

Series 3: [http://whqlibdoc.who.int/publications/2005/9241593083\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593083_eng.pdf)

Series 4: [http://whqlibdoc.who.int/publications/2005/9241593105\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593105_eng.pdf)

Series 5: [http://whqlibdoc.who.int/publications/2005/9241593091\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593091_eng.pdf)

**IMAI–IMCI chronic HIV care with ARV therapy and prevention: interim guidelines for health workers at health centre or district hospital outpatient clinic.** [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

## **4.5 Vaccinations**

WHO expert committees are currently reviewing recommendations on catch-up vaccinations for adults with HIV, and readers are encouraged to check for updated guidance. Vaccine-preventable diseases are among the major causes of illness among MSM with HIV. MSM are at an increased risk for acquiring hepatitis B infection and HIV-related immune suppression is associated with increased incidence of chronic infection. Although the incidence of hepatitis A infection in the region is high in general, MSM may be at greater risk for infection through sexual activities involving fecal–oral contact. Reduction in the efficacy of hepatitis A and B vaccinations is related to the degree of immunosuppression induced by HIV. HPV-associated cancers have a higher incidence in MSM and recent evidence supports the use of HPV vaccine in MSM. While PLHIV generally are recommended influenza vaccination, for strains with increased virulence such as H1N1, vaccination should be actively encouraged.

### **Summary of recommendations**

MSM who are susceptible (i.e. antibody to hepatitis B core antigen negative) and have not been vaccinated previously) should receive the full course of hepatitis B vaccination. Vaccine response can be measured and, if suboptimal, revaccination considered. In settings where serological testing is not available, the full course of hepatitis B vaccination should be given to all MSM.

Hepatitis A vaccination should be given to all non-immune MSM and HPV vaccine recommended where available.



**Key resources**

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Hepatitis A vaccination.** <http://www.who.int/vaccines/en/hepatitisa.shtml>

**Hepatitis A vaccination (2009). CDC. English** <http://www.cdc.gov/hepatitis/HAV/HAVfaq.htm#vaccine>

**Hepatitis B vaccination.** <http://www.who.int/mediacentre/factsheets/fs204/en/index.html>

**Hepatitis B vaccination (2009). CDC. English** <http://www.cdc.gov/hepatitis/HBV/HBVfaq.htm#recctbl>

**Vaccine-preventable diseases, vaccines and vaccination.** [http://whqlibdoc.who.int/publications/2005/9241580364\\_chap6.pdf](http://whqlibdoc.who.int/publications/2005/9241580364_chap6.pdf)

**4.6 Coinfections (TB and hepatitis)**

There is a high regional incidence of a number of diseases and, of particular importance to MSM with HIV, are TB and viral hepatitis.

**4.6.1 Tuberculosis**

In the Asia–Pacific region, TB is a leading cause of HIV-related morbidity and mortality. In some countries, up to 80% of MSM with TB are coinfecting with HIV, and MSM living with HIV are more likely to have reactivation of and reinfection with TB. This is of increasing concern given the emergence of TB drug resistance, including MDR and XDR disease. While TB may develop at any stage in the course of HIV infection, the incidence and diversity of clinical presentations increases with the severity of immunosuppression. The directly observed treatment, short-course (DOTS) principles are well recognized as the most effective approach to managing TB in PLHIV.

Tolerability of and adherence to TB treatment regimens may deteriorate with HIV disease progression and in the presence of ART. Consideration must be given also to additive toxicities, drug–drug interactions and the potential impact of a high pill burden on adherence.

**Summary of recommendations**

WHO recommends that TB and HIV/AIDS control programmes collaborate through an established coordinating body, usually a working group, according to the provisions of the Interim Policy on Collaborative TB/HIV activities to implement such activities.

Intensified TB case finding among PLHIV is essential since TB is a curable disease. Intensified HIV case finding in people with TB is also essential. WHO strongly recommends TB screening for all MSM with HIV; they should be provided with information that addresses the risk for acquiring TB, ways of reducing exposure, clinical manifestations of TB, risks of transmitting TB to others, and given TB treatment support. MSM who inject drugs require specific targeting due to their increased

risk for severe disease. WHO recommends scaling up access to culture-based diagnosis for PLHIV. Recommended TB treatment based on a four-drug initial phase and a two-drug continuation phase remains the same for all adults with HIV.

### **Key resources**

**A revised framework to address TB–HIV co-infection in the Western Pacific Region.**

[http://www.wpro.who.int/publications/PUB\\_9789290613879.htm](http://www.wpro.who.int/publications/PUB_9789290613879.htm)

**A guide to monitoring and evaluation for collaborative TB/HIV activities: field test version.** [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.342.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.342.pdf)

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Guidelines for the prevention of tuberculosis in health care facilities in resource-limited settings.** [http://whqlibdoc.who.int/hq/1999/WHO\\_TB\\_99.269.pdf](http://whqlibdoc.who.int/hq/1999/WHO_TB_99.269.pdf)

English Addendum: [http://whqlibdoc.who.int/hq/1999/WHO\\_TB\\_99.269\\_ADD\\_eng.pdf](http://whqlibdoc.who.int/hq/1999/WHO_TB_99.269_ADD_eng.pdf)

**The global plan to Stop TB, 2006–2015.** English: <http://www.stoptb.org/globalplan/assets/documents/GlobalPlanFinal.pdf>

**Tuberculosis care with TB–HIV co-management: Integrated Management of Adolescent and Adult Illness (IMAI).** [http://whqlibdoc.who.int/publications/2007/9789241595452\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595452_eng.pdf)

Facilitator’s guide: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_fac.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_fac.pdf)

Participant’s manual: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_partman.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_partman.pdf)

**International Standards for Tuberculosis Care: diagnosis, treatment and public health** [http://www.who.int/tb/publications/2006/istc\\_report.pdf](http://www.who.int/tb/publications/2006/istc_report.pdf)

### **4.6.2 Viral hepatitis**

There are high rates of sexual transmission of HBV among MSM and the resultant chronic liver disease is now becoming a significant cause of morbidity and mortality among MSM with HIV. MSM have higher rates of HBV/HIV coinfection than heterosexual persons and this rate is further increased in those who inject drugs.

While HAV is endemic in many areas and a significant proportion of MSM will have been infected prior to becoming sexually active, non-immune MSM may be at increased risk for acquiring hepatitis A through oro–anal sexual practices. Acute HAV infection can be severe and even life-threatening in the presence of immune suppression or with HBV and/or HCV coinfection.

HCV and HIV coinfection is particularly frequent in areas with a high prevalence of PWID. Furthermore, HCV transmission among MSM through sexual activity in the absence of injecting drug use is increasingly being reported. Additional practices placing TG at risk for HBV and HCV infection

include hormone injecting related to gender reassignment with other-than-recommended clean equipment, and surgical procedures in which universal precautions are not observed.

Liver toxicity and related morbidity are not uncommon with the use of ART in the presence of underlying chronic HBV and/or HCV infection. Chronic HBV and HCV infection have accelerated disease progression in the presence of HIV-related immunosuppression and are risk factors for the increased development of and more rapid progression to cirrhosis and hepatocellular carcinoma.

### **Summary of recommendations**

WHO recommends that national health authorities establish prevention and treatment strategies for HBV and HCV in HIV-coinfected individuals. MSM should receive HBV and HAV vaccination if not immune, or routinely, where testing is not available.

### **Key resources**

#### **HIV/AIDS treatment and care for injecting drug users: clinical protocol for the WHO**

**European Region.** [http://www.euro.who.int/document/SHA/e90840\\_chapter\\_5.pdf](http://www.euro.who.int/document/SHA/e90840_chapter_5.pdf)

#### **Management of hepatitis C and HIV coinfection: clinical protocol for the WHO**

**European Region.** [http://www.euro.who.int/document/sha/e90840\\_chapter\\_6.pdf](http://www.euro.who.int/document/sha/e90840_chapter_6.pdf)

**Hepatitis B (2009) WHO.** [http://www.who.int/immunization\\_delivery/new\\_vaccines/hepb/en/index.html](http://www.who.int/immunization_delivery/new_vaccines/hepb/en/index.html)

**Hepatitis B factsheet (2009) WHO.** <http://www.who.int/mediacentre/factsheets/fs204/en/>

**Hepatitis B (2009) WHO-WPRO. English** [http://www.wpro.who.int/health\\_topics/hepatitis\\_b/](http://www.wpro.who.int/health_topics/hepatitis_b/)

**Hepatitis C factsheet (2010) WHO.** [http://www.who.int/immunization/topics/hepatitis\\_c/en/index.html](http://www.who.int/immunization/topics/hepatitis_c/en/index.html)

**Hepatitis C (2009) CDC. English** <http://www.cdc.gov/hepatitis/HCV/index.htm>

**WHO EURO hepatitis website. WHO-EURO** [http://www.euro.who.int/aids/hepatitis/20070621\\_1](http://www.euro.who.int/aids/hepatitis/20070621_1)

## **4.7 Substance use**

MSM in the region have significant levels of non-injecting substance use, particularly of ATS, “poppers” (amyl and other nitrites) and alcohol, the use of which are commonly associated with the search for and participation in sexual activities. Heightened arousal and disinhibition through substance use are associated with an increase in sexual behaviours that carry an increased risk for transmission of HIV and other STIs. Substance use involving sharing of injecting equipment carries an even higher risk of direct transmission of HIV and hepatitis, and the sharing of snorting equipment has been shown to be a risk factor for HCV transmission. While drug and alcohol use may be seen to complicate both the prevention and treatment of HIV infection, they should not be regarded as barriers to accessing ART or OI management. Evidence supports the benefit of these measures in MSM who may continue to use substances, particularly where they have access to counselling and adherence support.

Measures effective at reducing HIV transmission attributable to drug and alcohol use include HIV testing and referral to treatment, NSPs, OST and behavioural interventions targeting HIV risk behaviours among both HIV-infected and HIV-uninfected MSM. Health-care workers must address the issues of illicit drugs and alcohol use as mainstream medical problems in order to provide optimal care for relevant HIV-infected MSM.

### **Key resources**

**Management of substance abuse. (WHO)** [http://www.who.int/substance\\_abuse/en/](http://www.who.int/substance_abuse/en/)

**Treatment approaches for drug addiction. (NIDA)** [http://www.nida.nih.gov/PDF/InfoFacts/IF\\_Treatment\\_Approaches\\_2009\\_to\\_NIDA\\_92209.pdf](http://www.nida.nih.gov/PDF/InfoFacts/IF_Treatment_Approaches_2009_to_NIDA_92209.pdf)

**Operational guidance for the management of opioid dependence. (WHO SEARO)** [http://www.searo.who.int/LinkFiles/Publications\\_guidelines\\_management\\_opioid\\_\\_in\\_SEAR.pdf](http://www.searo.who.int/LinkFiles/Publications_guidelines_management_opioid__in_SEAR.pdf)

**Comprehensive management of substance abuse. (NIH US)** <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A49769>

**Drug abuse and addiction. Signs, symptoms and help for drug problems.** [http://www.helpguide.org/mental/drug\\_substance\\_abuse\\_addiction\\_signs\\_effects\\_treatment.htm](http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm)

**Over the influence: the harm reduction guide to managing drugs and alcohol.** <http://www.drugpolicy.org/library/bookstore/denning0204.cfm>

## **4.8 Laboratory issues**

Accurate and reliable clinical laboratory testing is an essential component of a public health approach to disease management. Health-care workers need laboratory services in order to assess the status of a patient's health, make accurate diagnoses, formulate treatment plans, and monitor and predict the benefits and adverse effects of treatment. Laboratory services should provide accurate, reliable and timely results.

CD4+ lymphocyte count remains the most specific marker of HIV-related immune suppression, and the basis on which ART initiation and OI risk and prophylaxis decisions are most accurately made. Measurement of HIV viral load can be of benefit in monitoring HIV disease progression but is most useful (in combination with CD4+ count) for assessing the response to ART where the goal is to achieve and maintain the HIV viral load below a “detectable” level (most usually below 50 copies/ml). In many situations, access by MSM to CD4+ count and HIV viral load testing is limited by the relative expense (and limited availability) of such testing. Access to basic haematology and biochemistry (particularly liver function) testing is important for decisions related to ART selection as well as for monitoring the response to ART, adverse medication effects and co-morbidities such as hepatitis infection(s).

### **Summary of recommendations**

WHO recommends that national health authorities be guided by HIV programme staff and national technical experts, and develop a consolidated plan with complete financial data for strengthening

laboratory capacity and identifying the HIV-related diagnostic reagents, technologies and equipment that are appropriate for their country.

Increasing the access to CD4+count and HIV viral load testing is important to improve decision-making in ART initiation and OI management, and to allow more accurate assessment of the response to ART. The goal is to reduce treatment failure and development of viral resistance, thereby improving the long-term health outcomes of MSM with HIV.

### **Key resources**

**HIV testing in the WHO Western Pacific Region.** <http://www.wpro.who.int/NR/rdonlyres/B85A6824-0F2B-486A-A7BF-A380FD145B24/0/HIVtestingintheWesternPacificRegion.pdf>

**Diagnosis and testing. Resources on testing for HIV/AIDS including information about test sites and counseling.** <http://sis.nlm.nih.gov/hiv/diagnosis.html>

**Consultation on technical and operational recommendations for clinical laboratory testing harmonization and standardization: helping to expand sustainable quality testing to improve the care and treatment of people infected with and affected by HIV/AIDS, TB, and Malaria(22–24 January 2008, Maputo, Mozambique).** [http://www.who.int/diagnostics\\_laboratory/3by5/Maputo\\_Meeting\\_Report\\_7\\_7\\_08.pdf](http://www.who.int/diagnostics_laboratory/3by5/Maputo_Meeting_Report_7_7_08.pdf)

**Summary of WHO recommendations for clinical investigations by level of health care facility.** <http://www.who.int/hiv/amds/WHOLabRecommendationBylevelFinal.pdf>

#### **4.8.1 Laboratory services for HIV diagnosis**

Adequate quantities of high-quality laboratory services, skills and commodities are required to meet the increased demand for HIV testing. WHO laboratory recommendations for HIV testing cover: selection of affordable technologies;

- strategies and algorithms for HIV testing protocols suited to different purposes, e.g. for blood transfusion safety, surveillance or clinical care; and
- quality assurance and good management of testing and laboratory systems.

WHO recommendations describe various testing strategies appropriate for different HIV testing purposes. These strategies take into consideration the characteristics of the epidemic and HIV prevalence in the populations to which the people being tested belong. A testing algorithm describes the combination and sequence of specific HIV assays used for a given HIV testing strategy.

WHO recommendations for the selection and use of HIV antibody tests are currently being updated.

#### **Summary of recommendations**

National HIV testing guidelines should provide specific testing algorithms for each of the testing purposes, and specify which test kits should be used and in what order. Selection of test kits and the order in which they are used are critically important for the good performance of the testing algorithm. Particulars covering serial testing, parallel testing, quality management systems and the types of HIV tests can be found in the key resources below.

**Key resources**

**Guidelines for assuring the accuracy and reliability of HIV rapid testing: applying a quality system approach.** [http://whqlibdoc.who.int/publications/2005/9241593563\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593563_eng.pdf)

**Overview of HIV rapid test training package.** <http://wwwn.cdc.gov/dls/ila/hivtraining/Overview.pdf>

**HIV rapid test training: framework for a systematic roll-out.** <http://wwwn.cdc.gov/dls/ila/hivtraining/Framework.pdf>

**HIV testing in the WHO Western Pacific Region.** <http://www.wpro.who.int/internet/resources.ashx/HSI/docs/HIV+testing+in+the+Western+Pacific+Region.pdf>

## 5. Strategic information



Strategic information is essential information and knowledge that guides health policy, planning, resource allocation, programme development, service delivery and accountability. There is a need for countries to invest in strategic information to guide programme planning as part of scaling up their responses to HIV and MSM to achieve universal access. The main areas where strategic information is needed to guide national responses to HIV among MSM are as follows:

- What is the size of the sexually active MSM population?
- What is the magnitude of and trends in STIs, HIV and related behaviour among MSM?
- What are the key social and behavioural information needs to guide MSM interventions?
- What is the availability, coverage, outcomes and impact of interventions for MSM?
- What resources are available for MSM interventions?

This information can be collected by:

1. Estimating the size of the MSM population
2. Biological and behavioural surveillance
3. Social and operational research
4. Programme monitoring and evaluation

This chapter outlines key strategic information needs in each of these four areas and concludes with recommendations for using strategic information more effectively for programme improvement.

### 5.1 Estimating the size of the MSM population

The stigma faced by MSM in all countries in Asia and the Pacific means that large numbers of MSM go to great lengths to keep secret the fact that they engage in male-to-male sexual activities. This makes it very difficult to come up with reliable estimates of the number of MSM in a country or a particular locality. Having a dependable estimate of the number of sexually active MSM is essential for national and local planning, and resource allocation. Knowing the number of sexually active MSM allows for measurement of coverage for existing prevention programmes and setting targets for scale-up. While information on HIV prevalence rates gives an indication of the burden of disease among MSM, it is also necessary to know the MSM population size in order to plan a sufficient response. A combination of data on HIV prevalence and population size will allow estimation of the number of MSM infected with HIV, which is an important input to overall health services planning.

For planning HIV prevention programmes, an estimate of the number of males who have had sex with other males in the past year, rather than lifetime prevalence of male-to-male sex, gives a better indication of the total population that may be at risk for HIV. When combined with behavioural surveillance data on the extent of safe and unsafe sexual practices (i.e. consistent condom use for anal sex and number of sexual partners), population size estimation data can be used for approximating the number of MSM at highest risk for HIV. However, if the MSM included in the behavioural surveillance survey are not fully representative of the whole MSM population, adjustments will need to be made if the results are to be extrapolated in this way. HIV surveillance data on the geographical distribution of HIV infection and high-risk activity among MSM can also be combined with size estimation data to identify high-prevalence “hot-spots” for intensive HIV prevention interventions, while recognizing that prevention interventions are also needed in lower-prevalence areas.

While different approaches have been used, no standard methodologies for estimating the size of the MSM population are available. Methodologies based on counting the number of MSM in particular locations will miss MSM who have different social and sexual networks not involving those locations, including the increasing number of MSM who find sex through the internet or non-public locations.

### **Summary of recommendations**

There is a need for clear and possibly standardized definitions of MSM and subpopulations of MSM, and what constitutes high-risk behaviour for HIV. Population size estimates should desirably attempt to determine the number of MSM in particular subpopulations, especially for TG and sex workers, as these two subpopulations are thought to be generally at higher risk for HIV and require specific programmatic approaches.

There is a need for agreement between governments, MSM community representatives and technical experts on appropriate methodologies for population size estimation. A joint approach is important to ensure that the methodology is appropriate and that there will be joint ownership of the results. Methodologies should be informed by CBO knowledge of MSM social and sexual networks and the expertise of technical experts. There is a need for global and/or regional advice on best practice approaches to MSM population size estimation to guide work at the country level.

### **Key resources**

**Estimation of the size of high risk groups and HIV prevalence in high risk groups in concentrated epidemics.** [http://www.epidem.org/Publications/Amsterdam%20Report\\_July%202009.pdf](http://www.epidem.org/Publications/Amsterdam%20Report_July%202009.pdf)

**Estimating the number of men who have sex with men in low and middle income countries.** [http://sti.bmj.com/cgi/content/abstract/82/suppl\\_3/iii3](http://sti.bmj.com/cgi/content/abstract/82/suppl_3/iii3)

**Epidemiology of male same-sex behaviour and associated sexual health indicators in low- and middle-income countries: 2003–2007 estimates.** [http://sti.bmj.com/cgi/reprint/84/Suppl\\_1/i49](http://sti.bmj.com/cgi/reprint/84/Suppl_1/i49)



## 5.2 Surveillance for HIV, STIs and related behaviours

National HIV surveillance provides essential data to understand the magnitude of the epidemic among MSM, assess the burden of disease, monitor trends over time, guide development of interventions and evaluate their impact. Second generation HIV surveillance combines repeat surveys for HIV, STIs and risk behaviours together with sociodemographic characteristics of the target populations selected according to epidemic status. Integrated biological and behavioural surveillance (IBBS) surveys for HIV and STIs in the same population have been shown to be efficient. Where resources are sufficient, HIV incidence data can provide valuable information on those MSM subpopulations at heightened risk for HIV.

In addition to collecting data through HIV surveillance, statistical modelling with the use of surveillance data as key input improves the understanding of HIV epidemics by better identifying trends in HIV prevalence among MSM and estimates of the number of HIV-infected MSM. WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) provide technical assistance and training to country teams to generate country estimates.

Due to the stigma associated with male-to-male sex and the criminal status of anal sex in some countries, health systems have a particular obligation to ensure the confidentiality of all HIV surveillance data involving MSM.

### **Summary of recommendations**

Surveillance systems need to be adapted and modified to meet the specific needs of each type of epidemic. The health sector plays the lead role in comprehensive HIV surveillance. In countries where MSM have been observed to contribute to the spread of HIV, they need to be included as a core group in national serological and behavioural surveillance. National HIV/AIDS programmes are currently investing in the development of systems that provide data in a routine, standard manner, with a consistency of methods, tools and populations surveyed. A comprehensive HIV and STI surveillance system should include MSM-specific elements on the following:

- HIV infection and AIDS case reporting;
- HIV and STI sentinel surveillance among MSM attending designated clinics (if these clinics are available);
- IBBS among MSM selected by a probability-based sampling method; and
- where feasible, HIV incidence data among MSM should, ideally, also be collected.

IBBS surveys should be conducted on a regular, periodic basis to monitor trends in HIV and STI prevalence and related behaviours, as existing data have shown that the HIV infection level among MSM in Asia can increase rapidly over relatively short periods of time. IBBS surveys need to capture a broad sample of MSM both geographically and from different subpopulation groups, and take care to ensure that the sample is not overly dominated by one or more subpopulation. Results should be disaggregated by MSM subpopulations to readily identify differences in the burden of disease, risk behaviour, dynamics of the epidemic and priority groups. Studies should identify factors associated with HIV prevalence and higher levels of risk practice. These may include, for example, age, place of

residence, educational level, inconsistent condom use (possibly with particular types of partners), drug use, a reported history of STIs, and migration. Use of a consistent methodology over time will enable comparisons between different surveys and analysis of trends. This, however, needs to be balanced against the possible need to improve sampling and other aspects of the methodology.

### **Key resources**

**Guidelines for second generation HIV surveillance: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2000. (A revised version will be available at some point in 2010.)** [http://www.who.int/hiv/pub/surveillance/en/cds\\_edc\\_2000\\_5.pdf](http://www.who.int/hiv/pub/surveillance/en/cds_edc_2000_5.pdf)

**Guidelines for effective use of data from HIV surveillance systems, 2004.** <http://www.who.int/hiv/strategic/surveillance/en/useofdata.pdf>

**The pre-surveillance assessment: guidelines for planning serosurveillance of HIV, prevalence of sexually transmitted infections and the behavioural components of second generation surveillance of HIV, 2005.** <http://www.who.int/hiv/pub/surveillance/psaguidelines.pdf>

**Guidelines on protecting the confidentiality and security of HIV information: proceedings from a workshop, May 2006. Interim guidelines.** [http://data.unaids.org/pub/manual/2007/confidentiality\\_security\\_interim\\_guidelines\\_15may2007\\_en.pdf](http://data.unaids.org/pub/manual/2007/confidentiality_security_interim_guidelines_15may2007_en.pdf)

**Guidelines for measuring national HIV prevalence in population-based surveys.** <http://www.who.int/hiv/pub/surveillance/guidelinesmeasuringpopulation.pdf>

**HIV surveillance training modules, WHO Regional Office for South-East Asia.** [http://www.searo.who.int/LinkFiles/Publications\\_Module-1.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-1.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_Module-2.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-2.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_Module-3.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-3.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_Module-4.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-4.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_Module-5.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-5.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_Module-6.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-6.pdf)

[http://www.searo.who.int/LinkFiles/Publications\\_facilitator.pdf](http://www.searo.who.int/LinkFiles/Publications_facilitator.pdf)

## **5.3 Research**

An effective response to HIV and AIDS requires that interventions be continually improved over time. Sufficient strategic information cannot be generated from surveillance and routine programme monitoring and evaluation (M&E). Additional information needs to be collected through research. Sustained research efforts enable the evolution of policies, programmes and interventions, based on new evidence.

### **Key resource**

**Global consultation on MSM and HIV/AIDS research.** [http://www.amfar.org/uploadedFiles/Articles/Articles/Around\\_The\\_World/MSM/Global%20Consultation%20on%20MSM-FINAL.pdf?n=6150](http://www.amfar.org/uploadedFiles/Articles/Articles/Around_The_World/MSM/Global%20Consultation%20on%20MSM-FINAL.pdf?n=6150)

### 5.3.1 Social research

There is a need for more qualitative and quantitative social research on MSM behaviours, attitudes, beliefs, identities, psychosocial needs, social and sexual networking, and the dynamics of risk-taking in various social settings. This type of information can be particularly useful in designing targeted interventions for different MSM subpopulations. It is imperative that progressive scaling-up targets those MSM most at risk. Degrees of risk may be associated with age, particular geographical locations, occupation, level of personal identity with male-to-male sexual practice, different sexual networks and the extent to which they overlap. Currently, social research data in these areas are limited. While IBBS surveys provide some behavioural data, more in-depth social and behavioural research is needed to guide programme development.

#### **Summary of recommendations**

Countries should determine social research priorities on HIV and MSM based on their local context and needs, through consultation with CBOs, the ministry of health, development partners and researchers. Research needs to be conducted through a partnership approach involving CBOs, MSM, public health workers, clinicians and researchers.

### 5.3.2 Operational research

Operational research covers all programme areas and is vital to improving programme operations and making the most effective use of available resources. Operational research involves the use of systematic research techniques to gather evidence to inform programmes, using a variety of qualitative and quantitative methods, and through a multidisciplinary approach. Examples of research areas are factors that influence the uptake of HIV testing and counselling and STI check-ups, approaches to obtaining higher and more consistent levels of condom use, and effective ways of sustaining safe-sex behaviours.

#### **Summary of recommendations**

Countries should determine HIV and MSM operational research priorities based on their local context and needs through consultation with CBOs, the ministry of health, development partners and researchers. Rapid assessments of what is known about a selected topic can be used to formulate research questions. Research needs to be conducted through a partnership approach involving CBOs, MSM, public health workers, clinicians and researchers.

#### **Key resources**

**Guide to operational research in programs supported by the Global Fund.** [http://www.who.int/hiv/pub/epidemiology/SIR\\_operational\\_research\\_brochure.pdf](http://www.who.int/hiv/pub/epidemiology/SIR_operational_research_brochure.pdf)

**Framework for operations and implementation research in health and disease control programmes.** <http://www.theglobalfund.org/documents/me/FrameworkForOperationsResearch.pdf>

**HIV testing, treatment, and prevention: generic tools for operational research.** <http://www.who.int/hiv/pub/vct/en/>

## 5.4 Monitoring and evaluation

Monitoring and evaluation (M&E) are essential for measuring progress, guiding programme planning and implementation, and for accountability. Monitoring is the routine tracking of essential data related to the implementation of a programme by measuring inputs, processes, outputs, outcomes and impacts. Evaluation assesses the effectiveness of a programme by analysing monitoring indicators and other information.

The WHO framework for monitoring the health sector's response towards universal access (see key resources below), provides a core set of indicators to monitor the scale-up of priority health sector interventions for HIV prevention, treatment, care and support, as well as policy and programmatic questions related to the national response. MSM-specific indicators requested for reporting in the WHO framework are:

- percentage of MSM who received an HIV test in the past 12 months and who know their results;
- percentage of MSM reached with HIV prevention programmes in the past 12 months;
- percentage of men reporting the use of a condom the last time they had anal sex with a male partner;
- percentage of MSM who are HIV infected; and
- prevalence of active syphilis among MSM.

MSM-specific national policy and programmatic questions are:

- How many districts (or administrative units) in your country show evidence that most-at-risk populations, including MSM, play an important role in HIV transmission (e.g. >10% of reported HIV cases)?
- How many of these districts ensure availability of condoms/needles targeted to most-at-risk populations?
- Does the country carry out systematic surveillance in most-at-risk populations, including MSM, and report annually?
- Have sexual and drug-use behaviour surveys (behavioural surveillance surveys) been conducted in the country? In which years?

Key monitoring indicators for MSM required by the United Nations General Assembly Special Session (UNGASS), of which the majority are also part of the WHO monitoring framework are:

- percentage of MSM who received an HIV test in the past 12 months and know their results;
- percentage of MSM reached with HIV prevention programmes;
- percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission;
- percentage of men reporting the use of a condom the last time they had anal sex with a male partner;
- percentage of MSWs reporting the use of a condom with their most recent client;

- percentage of MSM who are HIV infected; and
- percentage of MSWs who are HIV infected.

The UNGASS indicators measure key outcomes in relation to coverage, knowledge and behaviour, and the impact of MSM programmes in relation to the number of MSM with HIV infection.

Countries are reporting the WHO framework for monitoring health sector responses and UNGASS indicators periodically within a harmonized reporting process. These indicators should be regarded as a starting point. Most MSM programmes will need to track additional indicators, although the number of indicators should be limited so as not to overburden projects. Some indicators will be for internal monitoring as not all data need to be reported upwards.

At the programme or service delivery level, monitoring may ideally include:

- input indicators (e.g. budgets, human resources);
- process indicators (e.g. training, interventions to review and update procedures, availability and adequacy of national policies and guidelines);
- Service availability: number and percentage of targeted service delivery points for MSM per MSM population (need for a clear definition of service delivery points for numerator, and estimated size of MSM population for denominator);
- output indicators (e.g. newly trained peer educators, communication materials produced, geographical coverage of interventions);
- outcome indicators (e.g. increased uptake of services, increased knowledge of HIV, behavioural change); and
- impact indicators (e.g. changes over time of the prevalence of HIV).

While many indicators are used for the routine tracking of key information about a programme and its intended outcomes, there is also a need for a better understanding of the quality and intensity of implementation of packages of services. Better measures of programme coverage are also needed, including denominator data.

Data for monitoring the health sector response to HIV and MSM are available from several sources. These include routine data collected from the health services, mapping of available services, second generation HIV surveillance, specific surveys and quality audits.

Compared with monitoring, evaluation of HIV and MSM programmes in Asia and the Pacific has been largely neglected. Given the needs to learn from current practices, measure their effectiveness and improve the quality of interventions, greater emphasis should be placed on reviews and evaluations of MSM programmes.

### **Summary of recommendations**

In support of the aim of one country-level M&E system, reporting of core UNGASS indicators and the health sector monitoring framework needs to be sustained and the quality improved. Additional indicators should be included from existing government and donor sets as much as possible, considering

the resources and capacity available. Selection of indicators should include the monitoring of inputs, service availability, outputs, outcomes and impact. Indicators need to be defined and measured in a consistent and standard manner in order to assess trends and measure progress towards goals. To the extent possible, monitoring systems should capture data disaggregated by age, sex, geographical regions and subpopulations. There is a need for more evaluations of HIV prevention programmes targeting MSM, particularly in developing and middle-income countries.

### **Key resources**

**Monitoring and reporting on the health sector's response towards universal access to HIV/AIDS treatment, prevention, care and support 2009–2010. WHO framework for global monitoring and reporting.** [http://www.who.int/hiv/universalaccess2010/hiv\\_me\\_framework\\_2009-10.pdf](http://www.who.int/hiv/universalaccess2010/hiv_me_framework_2009-10.pdf)

**A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations.** [http://data.unaids.org/pub/Manual/2007/JC1519\\_me\\_Framework\\_en.pdf](http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf)

**Behaviour change and HIV prevention: (re)considerations for the 21st century.** [http://www.globalhivprevention.org/pdfs/PWG\\_behavior%20report\\_FINAL.pdf](http://www.globalhivprevention.org/pdfs/PWG_behavior%20report_FINAL.pdf)

## **5.5 Using strategic information effectively for programme improvement**

The main reason for generating strategic information is to provide evidence to inform the development of MSM-related policies, strategies and interventions at all levels of the health system, broadly defined. This means that strategic information should be linked to the need for evidence, with data being presented in ways that make them easy to understand and use. Plans for disseminating evidence should keep different audiences in mind, including political decision-makers, programme planners and managers in government and CBOs, PLHIV and MSM. The health sector and researchers need to play a proactive role in assisting MSM CBOs and other organizations involved in service delivery to analyse the implications of surveillance data and research findings for designing and refining interventions.

An analytical approach known as data triangulation integrates multiple data sources to improve the understanding of a problem and validate existing data. It is used to better guide programmatic decision-making.

### **Key resources**

**HIV triangulation resource guide: synthesis of results from multiple sources for evaluation and decision-making.** <http://www.who.int/hiv/pub/surveillance/triangulation/en/index.html>

**Guidelines for effective use of data from HIV surveillance systems, 2004.** <http://www.who.int/hiv/strategic/surveillance/en/useofdata.pdf>

**Male to male sex in Asia** [http://www.mapnetwork.org/docs/MAP\\_&M%20Book\\_04July05\\_en.pdf](http://www.mapnetwork.org/docs/MAP_&M%20Book_04July05_en.pdf)

### 5.5.1 Situation analysis

Planning and programming for the response to HIV among MSM must be linked to regular reviews of the epidemiological situation, research findings and programme performance. Both national HIV/AIDS programmes and their implementing partners need to have a clear understanding of the country situation in order to prioritize and tailor MSM interventions. For example, it is important to know the geographical areas and subpopulation groups with the highest prevalence of HIV and risk behaviour to guide prioritization and targeting.

Rapid assessment and response (RAR) methods can be used to generate information in situations where data are needed quickly, when time or cost constraints rule out using more conventional research techniques, and when current, relevant data are needed to develop, implement, monitor or evaluate programmes. RAR methods use existing information from multiple sources and are flexible and cost-effective. They can provide information on the country situation or context; target populations and settings; risk behaviours; and HIV infection and other HIV-related outcomes and responses. Both qualitative and quantitative methods and data should be considered. All RARs should include recommendations and plans of action. They should be developed with community participation.

#### Summary of recommendations

HIV programme managers in government and NGOs and CBOs need to regularly track, analyse and use data from multiple sources, including:

- biological and behavioural sentinel and periodic surveillance
- HIV and AIDS case reporting from the health services
- STI surveillance data
- patient data from testing and counselling services and STI clinics
- situation assessments, mapping studies and rapid assessments among MSM
- social, ethnographic and behavioural research
- operational research
- periodic programme reviews and evaluations

#### Key resource

**Rapid assessment and response: adaptation guide on HIV and men who have sex with men (MSM-RAR).** [http://www.who.int/entity/hiv/pub/prev\\_care/en/msmrrar.pdf](http://www.who.int/entity/hiv/pub/prev_care/en/msmrrar.pdf)

### 5.5.2 Setting targets

The setting of universal access targets emphasizes the need to implement HIV interventions for MSM at scale to achieve a public health impact. Targets are also necessary to monitor progress. Modelling indicates that about 60% of most-at-risk populations need to adopt safer behaviours if HIV epidemics among them are to be reversed. It is also estimated that the coverage of prevention interventions has to reach about 80% for that level of behaviour change to occur.<sup>31</sup>

31 *Redefining AIDS in Asia: crafting an effective response. Report of the Commission on AIDS in Asia.* New Delhi, Oxford University Press, 2008:132. [http://data.unaids.org/pub/Report/2008/20080326\\_report\\_commission\\_aids\\_en.pdf](http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf)

### **Summary of recommendations**

A number of factors need to be considered in setting targets for scaling up priority health sector interventions for MSM, including:

- the epidemiological context, geographical distribution and population size;
- the programmatic context and service delivery infrastructure in health and CBO services, including available human and financial resources;
- assessing current coverage and the possible impact under different target scenarios; and
- developing plans and time-bound interim or progressive targets for scaling-up towards a standard or benchmark.

Target-setting must be integrated with programme planning and budgeting to make it a realistic exercise. Targets should also be informed by situation analyses and information on current programme activities through M&E data. Targets should be regularly evaluated and revised as necessary.

### **Key resources**

A number of documents give generic advice on setting targets for HIV prevention. No specific advice has been developed on setting targets for MSM. However, other advice on target-setting for specific groups, such as PWID, provides a guide on how to go about setting population-specific targets.

#### **Setting national targets for moving towards universal access: operational guidance.**

[http://data.unaids.org/pub/Guidelines/2006/20061006\\_report\\_universal\\_access\\_targets\\_guidelines\\_en.pdf](http://data.unaids.org/pub/Guidelines/2006/20061006_report_universal_access_targets_guidelines_en.pdf)

#### **Considerations for countries to set their own national targets for HIV prevention, treatment and care.**

[http://data.unaids.org/pub/Report/2006/Considerations\\_for\\_target\\_setting\\_April2006.pdf](http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf)

#### **Technical guide for countries to set targets for universal access to HIV**

**prevention, treatment and care for injecting drug users.** <http://www.who.int/hiv/idu/TechnicalGuideTargetSettingApril08.pdf>

### **5.5.3 Data quality**

Strategic information is largely dependent on the quality of data. This includes collecting the optimal amount of data, reducing the burden of data collection, using clear definitions, conducting local quality control and checks, training, and providing feedback to data collectors and users to improve data quality. The following criteria are recommended to assess the quality of data and indicators:<sup>32</sup>

- **Timeliness:** the period between data collection and its availability to end-users and publication
- **Periodicity:** the frequency with which an indicator is measured

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32 Health Metrics Network. *An assessment tool*. <http://www.who.int/healthmetrics/tools/hisassessment/en/index.html>



- **Consistency:** clear definitions; the internal consistency of data with a dataset, as well as consistency between datasets over time, including ensuring that the same source population is being surveyed over time; and the extent to which revisions follow a regular, well-established and transparent schedule and process
- **Representativeness:** the extent to which the data adequately represent the population and subpopulations being studied
- **Disaggregation:** the availability of data by age, geographical region, socioeconomic status, subpopulation, etc.
- **Confidentiality, data security and data accessibility:** procedures to maintain confidentiality and protect the data through storage standards and back-up

### ***Summary of recommendations***

Data quality assessments should be carried out periodically to identify weaknesses in data collection and reporting systems, and to improve data quality and accuracy.

### ***Key resource***

**Routine data quality assessment tool (RDQA): guidelines for implementation.** <http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/RDQA%20Guidelines-Draft%207.30.08.pdf>

## 6. Strengthening health systems



WHO defines a health system as “the sum total of all the organizations, people and actions whose primary intent is to promote, restore or maintain health”. A country’s health system embraces those who try to influence the determinants of health, as well as those who deliver health-improving services. So defined, a health system is more than the pyramid of facilities owned by government, private business and NGOs, and of the health-care workers and support personnel who staff those facilities.

In the context of MSM, a health system includes those living with HIV: peer educators who deliver BCC; organizations run by and for MSM and TG which distribute preventive literature and condoms; legislators who adopt health and safety and antidiscrimination laws; those who enforce the laws; and so on.

WHO believes that health systems should be founded on the principles enshrined in the Declaration of Alma-Ata: universal access, equity, participation and multisectoral action, all within a framework of gender equality and human rights.<sup>33</sup>

With respect to MSM and HIV, health systems should have multiple goals, including improving health in ways that are equitable, responsive, financially fair, and make the best use of available resources. By expanding coverage to reach an increasing number of MSM with ever more effective health interventions, these goals can be attained.

While the structure and operations of health systems vary from country to country and from area to area within countries, WHO has identified six building blocks of all health systems. These include:

1. Service delivery
2. Health workforce
3. Information
4. Medical products, vaccines and technologies
5. Financing
6. Leadership and governance

“Health systems strengthening” can be defined as improving these six building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health

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33 Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf)

services and health outcomes. Information on each of these building blocks is detailed in the WHO resource entitled *Priority interventions*.<sup>19</sup> Readers are referred to this resource for general information on strengthening and expanding health systems.

This chapter focuses on areas specific and pertinent to MSM and TG in relation to these building blocks. These include:

- Service delivery
- Integration and linkage of services
- Demand and access
- Health workforce
- Financing
- Leadership and governance
- Coalition building and partnerships
- Involving MSM/TG
- Involving civil society
- Stigma and discrimination

This chapter will not focus on strategic information as it has been covered earlier in chapter 5, or on medical products, vaccines and technologies, which have been developed in chapters 2 and 4.

## 6.1 Service delivery

Good health services are those that deliver effective, safe, high-quality health interventions to the people who need them, when and where they need them, and with minimum wastage of resources. Service delivery aimed at MSM must take into account the divergent needs of this group and the subgroups within it. These interventions may target individuals or entire subgroups within the MSM community, and may be defined by geography (e.g. large urban centres or rural areas) or identity (e.g. gay, bisexual, transgender, normative males, etc.). Health services should take into account that MSM living with HIV often face stigma and discrimination. Reaching these individuals and groups with HIV prevention, treatment and care requires special interventions that are often best delivered through outreach, community groups, or their own organizations. Those planning and implementing HIV-related service delivery programmes should consider the need for integration and linkage of health services; infrastructure and logistics; demand for services; and management.

### 6.1.1 *Integration and linkage of health services*

There are no universal models for good service delivery. However, in the case of HIV-related services, it is agreed that services should be delivered across a continuum of prevention and care. This requires integrated and linked service provision at all levels of the health system, from primary to secondary to tertiary (specialist) care, embracing all elements of the health system, including home-based and community-based outreach care. “Linkage” refers to a relationship – for example, between a local health centre and a district hospital. “Integration” refers to delivering multiple services or interventions

to the same patient by an individual health-care worker or by a team of health-care workers and, possibly, workers from other fields. Strong linkages (with referral and coordination between service providers) and integrated services are needed in particular areas of health care for MSM, such as sexual health care, mental health care, and care for PLHIV. All of these may involve a range of services and service providers, and must include home-based and community-based services. A particularly strong case can be made for integrating MSM HIV-related services into sexual health-care service delivery, though conversely, there is also a case for keeping such services separate, though with strong linkages between them.

These integrated services should include: promotion of condom and lubricant use among MSM; education on sexual health for MSM living with HIV; and MSM- and TG-friendly health services covering sexual health and HIV.

### **Summary of recommendations**

Services for HIV should be linked and/or integrated with other services in the health sector, including those for TB and sexual health. They should also be linked or integrated with services provided by other sectors, such as education and social welfare, and with those provided within homes and communities by families, international and national NGOs, MSM and TG CBOs, faith-based organizations and groups or networks of PLHIV, including those specifically working with MSM. All of these services should be provided as close to clients as possible.

However, when considering the integration of health services, planners should opt for a pragmatic approach that takes into account and balances the specific needs of MSM, the characteristics of the particular health system, and the aim of providing a comprehensive package of services.

### **Key resources**

**Integrated health services: what and why?** [http://www.who.int/healthsystems/service\\_delivery\\_techbrief1.pdf](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf) [http://www.who.int/hiv/pub/imai/imai\\_publication\\_diagram.pdf](http://www.who.int/hiv/pub/imai/imai_publication_diagram.pdf)

**Interim policy on collaborative TB/HIV activities.** [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_eng.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_eng.pdf)

**Ensuring the sexual and reproductive health of people living with HIV: policies, programmes and health services.** <http://www.who.int/reproductivehealth/publications/rtis/rhatters/en/index.html>

**Redefining AIDS in Asia – crafting an effective response: report of the Commission of AIDS in Asia.** [http://data.unaids.org/pub/Report/2008/20080326\\_report\\_commission\\_aids\\_en.pdf](http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf)

### **6.1.2 Demand and access**

In health service planning, most attention usually goes to planning on the supply side of services. The question as to whether the services will be used is often neglected, even when it is clear that there are factors that could limit demand. Denial, fear, stigma, discrimination, and high costs are among the factors that limit demand for and uptake of health services, particularly in the context of MSM.

**Summary of recommendations**

Raising demand among MSM requires an understanding of the user's perspective, raising public awareness and overcoming cultural, social or financial obstacles, stigma and discrimination. Overcoming such obstacles demands various forms of social engagement in planning, delivery and monitoring services. In the case of HIV-related services, MSM and TG living with HIV, together with CBO and peer-based services, should be involved in the design, management, delivery and monitoring of services. This can ensure that services meet their unique needs and concerns, such as fear of disapproval or open hostility on the part of staff, and fear of disclosure of their HIV status or sexuality and the possible consequences.

**Key resources**

**Preparing for treatment programme.** <http://www.who.int/3by5/partners/ptp/en/>

**Missing the target #5: improving AIDS drug access and advancing health care for all**  
<http://www.aidstreatmentaccess.org>

**Service delivery model on access to care and antiretroviral therapy for people living with HIV/AIDS.** [http://www.ifrc.org/cgi/pdf\\_pubshealth.pl?service-delivery-en.pdf](http://www.ifrc.org/cgi/pdf_pubshealth.pl?service-delivery-en.pdf)

**6.2 Health workforce**

Effective service provision requires trained service providers working with the right attitude, knowledge and skills, commodities (medicines, disposables, reagents) and equipment, and with adequate financing. It also requires an organizational environment that provides the right incentives to providers and users.

Working in the field of HIV may also be unpopular with some health-care workers because they fear becoming infected with HIV or TB, or because they cannot relate easily to clients, including MSM and TG, and because of risk behaviours of which they may disapprove.

It is essential that health-care workers dealing with MSM and TG have an understanding of and willingness to care for patients who might have a different sexuality and lifestyle from themselves. It is important that they have an ability to provide care in a non-judgemental manner.

Having a workforce where some staff are themselves MSM or TG would help to break down the barriers of stigma and discrimination encountered by people in these groups.

Health workforces that have strong links and cooperative partnerships with community- and peer-based MSM and TG organizations will assist in reducing stigma and discrimination.

**Summary of recommendations**

To counter difficulties in motivating health workers and reducing stigma and discrimination, WHO recommends the following actions:

- training (additional) health workers on specific topics such as sexual history-taking, identifying specific signs/syndromes related to MSM;
- sensitizing health workers to work with PLHIV, including MSM and TG;

- ensuring that health workers have access to prevention and other HIV- and TB-related services;
- recruiting MSM and TG into health-care positions, where possible and practical; and
- encouraging cooperative partnerships between health-care workers and MSM and TG CBOs and peer groups.

### **Key resources**

**Tools for planning and developing human resources for HIV/AIDS and other health services.** [http://www.who.int/hrh/tools/tools\\_planning\\_hr\\_hiv-aids.pdf](http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf)

**Joint ILO/WHO guidelines on health services and HIV/AIDS.** [http://whqlibdoc.who.int/publications/2005/9221175537\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9221175537_eng.pdf)

**Task-shifting: treat, train and retain. Global recommendations and guidelines.** <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>

**IMAI-IMCI task-shifting implementation support brochure.** [http://www.who.int/hiv/pub/imai/IMAI\\_IMCI\\_taskshifting\\_brochure.pdf](http://www.who.int/hiv/pub/imai/IMAI_IMCI_taskshifting_brochure.pdf)

## **6.3 Financing**

After the UN General Assembly's Declaration of Commitment on HIV/AIDS in 2001, funding for the response (including the health sector response) increased sharply each year until it reached an estimated US\$ 10 billion in 2007. However, even in countries where funding is available, its distribution to most-at-risk populations, including MSM, is often inadequate. Underreporting of the incidence of HIV among MSM contributes to poor allocation of funds. Legislation and the social lack of acceptability of male-to-male sex further compound the problem of funding the health sector to provide services to these groups. These funding problems probably make up a large proportion of the US\$ 8 billion gap that WHO and UNAIDS have estimated between what was available and what was actually needed to scale up the response to HIV at an acceptable pace.

External and domestic government funding for the HIV response has increased considerably, but many MSM living with HIV still find it difficult to access essential services. Even when drugs are provided free of charge, they incur out-of-pocket expenditures for the treatment and prevention of concurrent diseases and OIs, laboratory diagnosis, and formal and informal fees. This limits their access to essential services when they are poor, or depend on others to cover their health-care costs.

### **Summary of recommendations**

Health systems should have funding available to provide services to all groups affected by HIV, especially most-at-risk populations including MSM. WHO recommends:

- the distribution of HIV funding based upon realistic and accurate strategic information including MSM size estimates, data on HIV prevalence and projections;
- ensuring that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole; and
- that countries implement a public health approach to scale-up services and also adopt a policy of

free access to basic HIV services at the point of service delivery, including consultation fees, HIV testing and ART.

### **Key resources**

**Costing guidelines for HIV/AIDS intervention strategies.** [http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines\\_en.pdf](http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines_en.pdf)

**Achieving universal health coverage: developing the health financing system.** [http://www.who.int/health\\_financing/documents/pb\\_e\\_05\\_1-universal\\_coverage.pdf](http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf)

**WHO discussion paper: the practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care.** <http://www.who.int/hiv/pub/advocacy/promotingfreeaccess.pdf>

## **6.4 Leadership and governance**

Good leadership and governance can ensure that strategic policy frameworks exist and are combined with effective oversight, coalition building, provision of appropriate regulations and incentives, attention to system design and accountability.

All issues dealing with MSM are more complex than those for the wider population, and so leadership in this area has an even greater significance.

Leaders with consistent messages are needed to counter stigma and discrimination; support the involvement of MSM and PLHIV in the response to HIV; ensure equity in access to services; deal with the gender and sexuality dimensions of the epidemic; speed progress towards reducing the gap between the resources available and resources required to scale up the response; and achieve the goal of universal access. Leaders with consistent messages are also needed to help people envision a better future, and to achieve that future through research and innovation that finds new tools, and new ways of putting them to effective use.

In addition to the traditional sources of leadership (e.g. political, business, religious and general community), it is important that networks of MSM and TG, and individuals both within and external to these networks, have visibility and the opportunity to provide leadership and direction.

Governance needs to continue to evolve with a commitment by parliamentarians and other governing individuals, the health sector and government agencies to include the voices of the MSM and TG communities to ensure that HIV interventions, national AIDS plans and action frameworks include the needs of MSM.

HIV policy and legislation should reflect the needs of MSM. Other areas of legislation which either ignore or hinder the needs of MSM at risk for or living with HIV need to be challenged, reviewed and altered. Laws relating to sodomy and sex work contribute to the marginalization of MSM and their sexual health and should be repealed, and advocacy for such legislative reform is required through positive leadership.

Effective leadership will create momentum for and provide oversight of the HIV response. It is defined both by its actions and by its outcomes. Leadership should create an environment that accelerates scaling up of the response to HIV among MSM, defines the values and principles that should underlie the process, holds the different stakeholders accountable, and supports innovation to maximize the impact of the interventions.

A number of outputs should be expected of leadership. These include the development, implementation and adaptation of strategic policy frameworks, policies, legislation and regulations that create a favourable environment for an effective response to HIV among MSM, together with coalitions and partnerships that contribute to a better response, and new and more effective interventions.

To promote and support effective coordination, health sector stakeholders should participate in and liaise regularly with key country mechanisms that have a coordination function, such as National AIDS Councils/Commissions, Country Coordinating Mechanisms, UN Theme Groups and donor forums. They should also secure the commitment of stakeholders from other sectors to actively participate in and commit to development and implementation of the response to HIV among MSM. For the health sector, establishing and strengthening coalitions and partnerships with a range of stakeholders (e.g. NGOs, CBOs and faith-based organizations, MSM and TG groups, MSM living with HIV, academic institutions and the private sector) are critical to scaling up to universal access.

Leadership should also support innovation and foster an environment that promotes human rights, and the reduction of stigma and discrimination.

### **Key resources**

**The Global Fund country coordinating mechanisms (CCMs) website.** <http://www.theglobalfund.org/en/ccm/>

**“Three ones“ key principles: coordination of national responses to HIV/AIDS: guiding principles for national authorities and their partners.** [http://data.unaids.org/UNA-docs/Three-Ones\\_KeyPrinciples\\_en.pdf](http://data.unaids.org/UNA-docs/Three-Ones_KeyPrinciples_en.pdf)

**WHO’s global health sector strategy for HIV/AIDS 2003–2007.** [http://www.who.int/hiv/pub/advocacy/GHSS\\_E.pdf](http://www.who.int/hiv/pub/advocacy/GHSS_E.pdf)

**International guidelines on HIV/AIDS and human rights: 2006 consolidated version.** [http://whqlibdoc.who.int/unaid/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/unaid/2006/9211541689_eng.pdf)

**The Sydney Declaration: good research drives good policy and programming – a call to scale up research.** <http://www.iasociety.org/Default.aspx?pageId=63>

## **6.5 Coalition building and partnerships**

For the health sector, building coalitions and partnerships with a range of stakeholders is critical to scaling up towards universal access. In the case of HIV among MSM, it is crucial that these stakeholders include MSM and TG individuals and groups.



### 6.5.1 Involving MSM and TG

MSM and TG are a vital resource in the response to the HIV epidemic among these groups. The involvement of MSM in advocacy efforts, policy dialogue, service delivery, and the effort to reduce stigma and discrimination is central to the linkages and collaborative work of all sections of the health sector. Innovative mechanisms must be developed to involve them in HIV-related services, e.g. on clinical teams, as links with communities, as community health workers and on working groups addressing issues such as policy and legislation.

To be effective in these roles, MSM require training, appropriate supervision and remuneration.

#### **Summary of recommendations**

WHO, United Nations Development Fund (UNDP), UNAIDS, United Nations Educational, Scientific and Cultural Organization (UNESCO), Asia Pacific Coalition on Male Sexual Health (APCOM) and many other partners believe that the meaningful involvement of MSM and TG is central to an effective, rights-based HIV response. They should be engaged in all aspects of planning, implementing, monitoring and evaluating health sector responses to HIV at the global, regional, national and local levels; this includes the development and adaptation of normative policies, tools and guidelines, and the delivery of services.

#### **Key resources**

**The greater involvement of people living with HIV (GIPA): UNAIDS policy brief.** [http://data.unaids.org/pub/BriefingNote/2007/JC1299\\_Policy\\_Brief\\_GIPA.pdf](http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf)

**Healthy alliances in HIV prevention.** <http://www.library.nhs.uk/publichealth/ViewResource.aspx?resID=323705>

### 6.5.2 Involving civil society

In many countries, CBOs that provide support, advice and advocacy for MSM and TG already exist. While governments, particularly ministries of health, may take overall responsibility for health sector responses to HIV, it is essential that MSM and TG CBOs are consulted and actively involved in the planning and response to HIV among these groups. Community mobilization is key to promoting HIV testing, counselling and prevention, preparing people for treatment, and providing adherence support. Civil society organizations complement and supplement formal health services by playing key roles in HIV education and prevention; creating a demand for HIV services; ensuring that HIV/AIDS services are acceptable to MSM and of good quality; preparing people for treatment through information and education; supporting adherence to treatment; and providing other forms of prevention, care and support. These roles need to be reinforced as much as possible through providing adequate resources for MSM community health activities, and building strong links between health services and MSM CBOs.

#### **Summary of recommendations**

National health sector strategies and plans should call for the active and meaningful engagement of civil society and MSM and TG CBOs in strategic planning, programme development, implementation, and M&E. These nongovernment players can play critical roles in expanding access to services for MSM.

There should be country mechanisms to ensure that all providers of HIV-related services in the health sector meet minimum standards and comply with national guidelines and recommendations.

Appropriate referral and communication systems should be established or expanded and strengthened to ensure continuity of care and services across the different sectors and service providers.

### **Key resources**

**Scaling up effective partnerships: a guide to working with faith-based organisations in the response to HIV and AIDS.** <http://www.e-alliance.ch/media/media-6695.pdf>

**Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS.** [http://www.who.int/hiv/pub/prev\\_care/en/37564\\_OMS\\_interieur.pdf](http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf)

**Universal access targets and civil society organizations: a briefing for civil society organizations.** [http://www.unaids.org/unaidresources/images/Partnerships/061126\\_CSTargetsetting\\_en.pdf](http://www.unaids.org/unaidresources/images/Partnerships/061126_CSTargetsetting_en.pdf)

**Scaling up for better health.** [http://www.who.int/healthsystems/strategy/IHP\\_update6\\_12Mar.pdf](http://www.who.int/healthsystems/strategy/IHP_update6_12Mar.pdf)

## **6.6 Stigma and discrimination**

Stigma and discrimination aimed at MSM and TG are often prevalent within the health services and have been consistently identified as critical obstacles to the provision and uptake of health sector interventions. Stigma or, more correctly, stigmatization, devalues MSM because of their sexual behaviour and it is often followed by unfair and unjust treatment. Stigmatization of MSM results in harassment, violence, and a reluctance to disclose their sexuality to female sexual partners, family members and health-care providers. The consequences can result in these groups having poorer access to HIV prevention, care and treatment services.

Coupled with the stigma and discrimination that MSM often encounter, those also living with HIV have the added burden of stigmatization of PLHIV. Perversely, stigma relating to HIV can be prevalent within the MSM and TG communities, leading to MSM living with HIV often being reluctant to disclose their status even within their community groups.

Though stigma and discrimination are often pervasive throughout societies, they are seldom adequately addressed in national responses to HIV. Both can be tackled through simple and practical measures within a health system, such as providing people with accurate information that allays their fears and dispels their misconceptions about MSM and HIV and its transmission. The health sector can also advocate for and play its part in implementing a multifaceted national approach to combating stigma and discrimination. In order to reduce stigma and discrimination in health facilities, health-care workers' attitudes towards MSM need to be addressed. These efforts will help countries reach targets for universal access for MSM in need of sexual health and HIV services, and for MSM living with HIV, while promoting respect for human rights.

### **Summary of recommendations**

Strategic information about stigma and discrimination should be systematically collected using existing tools (e.g. questionnaires used in behavioural surveillance) to measure their prevalence and impact on the response to HIV.

Efforts to reduce stigma and discrimination should be included in national strategic planning and programming activities.

Health-care workers should be provided with training on non-discrimination, and codes of conduct and oversight for service providers should be established.

As planners scale up national responses to stigma and discrimination (and thus access to HIV prevention, treatment and care), they should employ a range of approaches to prevent and reduce stigma and discrimination among different key groups (politicians, religious leaders, health authorities, law enforcers and so on). In this way, they can challenge stigma and discrimination in institutional settings and build capacity for recognizing human rights, including the establishment and enforcement of human rights legislation.

### **Key resources**

International guidelines on HIV/AIDS and human rights: 2006 consolidated version.

[http://whqlibdoc.who.int/un aids/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/un aids/2006/9211541689_eng.pdf)

Reducing HIV stigma and discrimination: a critical part of national AIDS programmes.

[http://data.unaids.org/pub/Report/2008/jcl420-stigmadiscrimi\\_en.pdf](http://data.unaids.org/pub/Report/2008/jcl420-stigmadiscrimi_en.pdf)

Priority interventions: HIV/AIDS prevention, treatment and care in the health sector. [http://www.who.int/hiv/pub/priority\\_interventions\\_web.pdf](http://www.who.int/hiv/pub/priority_interventions_web.pdf)

# References



## Chapter I: Introduction

### **Enabling environment**

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**UNAIDS Action Framework: universal access for men who have sex with men and transgender people** (2009) Type of document: Policy brief, advocacy. Target audience: Policy-makers, national programme managers. Implementation focus: Global, national. Available at: [http://data.unaids.org/pub/Report/2009/jc1720\\_action\\_framework\\_msm\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1720_action_framework_msm_en.pdf)

**Policy brief: HIV and sex between men.** (2006) UNAIDS. English. Type of document: Policy brief, advocacy. Target audience: Policy-makers, national programme managers. Implementation focus: Global, national. Available at: [http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm_en.pdf)

**The value of investing in MSM programs in the Asia-Pacific region: policy brief.** (2008) USAID Health Policy Initiative, APCOM. English. Type of document: Policy brief, advocacy. Target audience: Policy-makers, national programme managers. Implementation focus: National. This policy brief compares the overall expenditure on HIV prevention with the expenditure for MSM programmes alone. It also discusses the sources of funds and resource requirements for MSM programmes, and shows the gap between current expenditures and resources needed for an effective prevention programme for MSM. Determining the resource needs and resource gaps for MSM prevention programmes is critical for successful resource mobilization. Available at: [http://www.healthpolicyinitiative.com/Publications/Documents/407\\_I\\_The\\_Value\\_of\\_Investing\\_in\\_MSM\\_Programs\\_in\\_the\\_Asia\\_Pacific\\_Region\\_FINAL\\_HPI\\_only.pdf](http://www.healthpolicyinitiative.com/Publications/Documents/407_I_The_Value_of_Investing_in_MSM_Programs_in_the_Asia_Pacific_Region_FINAL_HPI_only.pdf)

## Chapter 2: Prevention

### **Key issues in approaches to HIV prevention for MSM**

**Practical guidelines for intensifying HIV prevention: towards universal access.** (2007) UNAIDS. English. Type of document: Policy brief, advocacy. Target audience: Programme planners, programme managers, policy-makers. Implementation focus: National, district. These guidelines are designed to provide programme managers and other readers with practical guidance to tailor their HIV prevention activities so that they respond to the epidemiological scenario of the country and populations that remain most vulnerable to, and at risk for, HIV infection. Available at: [http://data.unaids.org/pub/Manual/2007/20070306\\_prevention\\_guidelines\\_towards\\_universal\\_access\\_en.pdf](http://data.unaids.org/pub/Manual/2007/20070306_prevention_guidelines_towards_universal_access_en.pdf)

**HIV and men who have sex with men in Asia and the Pacific.** UNAIDS Best Practice Collection. (2006) UNAIDS. English. Type of document: Best practice review. Target audience: Programme planners and managers. Implementation focus: Global, national and subnational. Reviews the lessons learnt from six different MSM HIV programmes in Asia and the Pacific. Available at: [http://data.unaids.org/Publications/IRC-pub07/jc901-msm-asiapacific\\_en.pdf](http://data.unaids.org/Publications/IRC-pub07/jc901-msm-asiapacific_en.pdf)

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**Development manual. Developing community-based organisations addressing HIV/AIDS, sexual health, welfare and human rights issues for males-who-have-sex-with-males, their partners and families. Books 1–6.** (2005) Naz Foundation International. Type of document: Training manual. Target audience: Programme managers in NGOs and CBOs. Implementation focus: National and subnational. Available at: [http://www.nfi.net/training\\_resources.htm#1](http://www.nfi.net/training_resources.htm#1)

**An introduction to promoting sexual health for men who have sex with men and gay men. A training manual.** Naz Foundation (2001) English. Type of document: Training manual. Target audience: Programme managers in NGOs and CBOs. Implementation focus: National and subnational. This manual comprises training modules which provide a clear understanding of the sexuality and sexual health of MSM. It addresses how to raise awareness of these sensitive issues, and how to integrate them into NGO programmes. Available at: [http://www.aidsalliance.org/graphics/secretariat/publications/msm1101\\_naz\\_msm\\_manual.pdf](http://www.aidsalliance.org/graphics/secretariat/publications/msm1101_naz_msm_manual.pdf)

**Between men: HIV STI prevention for MSM.** (2003) International HIV/AIDS Alliance. English. Type of document: Operational guidelines. Target audience: Programme managers, CBOs. Implementation focus: National. This guideline provides ideas for developing prevention programmes with and for MSM. It discusses sexual health, assessment of vulnerability and risk for HIV, as well as other key issues to consider when designing HIV/STI prevention programmes for MSM. Available at: [http://www.aidsalliance.org/graphics/secretariat/publications/msm0803\\_between\\_men\\_Eng.pdf](http://www.aidsalliance.org/graphics/secretariat/publications/msm0803_between_men_Eng.pdf)

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## Condoms

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**Faculty of Family Planning & Reproductive Health Care clinical guidance. Male and female condoms.** (2007) United Kingdom Royal College of Family Planning and Reproductive Health Care, Clinical Effectiveness Unit. Type of document: Evidence. Target audience: Policy-makers, health workers. Implementation focus: National. Evidence-based recommendations on the use of male and female condoms to prevent pregnancy and reduce the risk of STIs. Available at: [http://www.ffprhc.org.uk/admin/uploads/999\\_CEUguidanceMaleFemaleCondomsJan07.pdf](http://www.ffprhc.org.uk/admin/uploads/999_CEUguidanceMaleFemaleCondomsJan07.pdf)

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**Peer and outreach education for improving the sexual health of men who have sex with men. A reference manual for peer and outreach workers.** (2007) USAID, FHI, PSI Asia, International HIV/AIDS Alliance, UNESCO, Purple Sky Network. English, Chinese, Lao and Thai. Type of document: Field reference manual. Target audience: Peer and outreach workers. Implementation focus: Project level. The manual helps peer and outreach workers sustain and update accurate knowledge about HIV/STI and sexual health issues. Users of the manual can access a web site to discuss its use, ask questions, provide feedback and check for more information: [www.unescobkk.org/hiv aids](http://www.unescobkk.org/hiv aids) Available at: <http://www.unescobkk.org/education/hiv aids/aids-news/hiv aids-news-details/article/peer-and-outreach-education-for-improving-the-sexual-health-of-men-who-have-sex-with-men-a-referenc/>

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**Guide to participatory production of resources for HIV prevention among vulnerable populations.** (2005) International HIV/AIDS Alliance. English. Type of document: Guidelines Target audience: NGOs and CBOs Implementation focus: National and subnational. This document is an introductory guide to producing IEC materials for use in HIV prevention and care programmes with “key populations” (e.g. MSM, PWID, PLHIV and sex workers). Available at: [http://www.aidsalliance.org/graphics/secretariat/publications/iec\\_guide.pdf](http://www.aidsalliance.org/graphics/secretariat/publications/iec_guide.pdf)

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**Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection.** (2007) WHO and ILO. English. Type of document: Normative guidelines. Target audience: National programmes for adaptation. Implementation focus: Global, national. These guidelines focus on occupational exposure to HIV and exposure through sexual assault, and identify exposure

situations in which PEP may be appropriate. The guidelines also summarize evidence and provide WHO recommendations. They are based on an expert meeting held in 2005. Available at: [http://whqlibdoc.who.int/publications/2007/9789241596374\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf)

### ***Pre-exposure prophylaxis***

**Anticipating the results of PrEP trials. (2008) AIDS Vaccine Advocacy Coalition.** English. Type of document: Policy brief, advocacy. Target audience: Policy-makers and programme planners. Implementation focus: Global, national. This report provides a background on PrEP research, the status of current clinical trials, and issues of effective delivery should PrEP prove safe and effective. Available at: <http://www.avac.org/prep08.pdf>

### ***Prevention among people living with HIV***

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings. (2008) WHO.** English. Type of document: Evidence-based guidelines. Target audience: National programmes, PLHIV organizations and other CBOs. Implementation focus: National and subnational. This document reviews the evidence and contains recommendations for interventions to prevent HIV, STI and other infections and reduce illness associated with HIV infection among PLHIV. Available at: [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Positive prevention: HIV prevention with people living with HIV. A guide for NGOs and service providers. (2007) International HIV/AIDS Alliance.** English. Type of document: Guidelines. Target audience: NGOs, service providers, and PLHIV and their partners. Implementation focus: Service delivery. This document is a resource to help NGOs and service providers working across the spectrum of HIV prevention, treatment, care and support services to take steps towards integrating HIV prevention for, by and with PLHIV. The guide can also be used by individuals living with HIV and their partners. Available at: [http://www.aidsalliance.org/graphics/secretariat/publications/Positive\\_prevention.pdf](http://www.aidsalliance.org/graphics/secretariat/publications/Positive_prevention.pdf)

### ***Transgender people***

**Transgender HIV/AIDS health services. Best Practice guidelines. (Undated) San Francisco Department of Public Health.** English. Type of document: Normative guidelines. Target audience: Programme planners, programme managers and implementers. Implementation focus: National and district. This best practice publication contains guidelines on health literacy, communication and language, mistrust and stigma, creation of a transgender culturally competent environment, needs assessment, a literature review and summary of best practice standards. Available at: <http://www.careacttarget.org/library/tgguidelines.pdf>

### ***Male sex workers***

**Toolkit for targeted HIV/AIDS prevention and care in sex work settings. (2005) WHO.** English. Type of document: Evidence, policy and advocacy; programme planning and management; operational guidelines. Target audience: Programme managers, programme planners and implementers. Implementation focus: National, district. This toolkit can be used to support the development and scale-up of effective HIV interventions in sex work settings. It also describes a useful framework for classifying interventions in sex work settings. Annotations are provided for documents that can be useful in diverse settings. Available at: <http://whqlibdoc.who.int/publications/2005/9241592966.pdf>

**Manual: tips, tricks and models of good practice for service providers considering, planning or implementing services for male sex workers. (2002) European Network Male Prostitution.** Type of document: Evidence, policy and advocacy; programme planning and management; operational guidelines. Target audience: Programme managers, programme planners and implementers. Implementation focus: National, district.



This manual compiles models of good practice and advice on practical key issues such as starting activities, methods and services, training, networking and data collection. Available at: <http://www.correlation-net.org/enmp/downloads/manual1.pdf>

### **MSM who use drugs**

#### **Policy and programming guide for HIV/AIDS prevention and care among injecting drug users.**

(2005) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Policy-makers, programme managers. Implementation focus: Global, national. The guide summarizes the principles from policies and programmes that have worked well in responding to HIV/AIDS epidemics among PWID. It aims to assist programme managers to apply these principles while taking local circumstances into account. Available at: [http://www.who.int/hiv/pub/prev\\_care/policyprogrammingguide.pdf](http://www.who.int/hiv/pub/prev_care/policyprogrammingguide.pdf)

**Module 5. Managing non-opioid drug dependence. Treatment and care for HIV-positive injecting drug users.** (2007) ASEAN, USAID, WHO, FHI. English. Type of document: Training manual. Target audience: Drug and alcohol services and health-care workers. Implementation focus: National and district. The manual describes common amphetamine-type stimulants and their pattern of use in Asia, the symptoms of non-opioid dependence and medications used to deal with these symptoms, and relapse prevention approaches. Available at: [http://www.searo.who.int/LinkFiles/Publications\\_Module\\_05\\_Treatment\\_&\\_Care\\_for\\_HIV\\_positive\\_IDUs.pdf](http://www.searo.who.int/LinkFiles/Publications_Module_05_Treatment_&_Care_for_HIV_positive_IDUs.pdf)

**Treatment for amphetamine dependence and abuse. Cochrane review issue 3.** (2009) Cochrane Collaboration. English. Type of document: Systematic evidence-based review. Target audience: Policy-makers and clinicians. Implementation focus: National. Available at: [www.cochrane.org/reviews/en/ab003022.html](http://www.cochrane.org/reviews/en/ab003022.html)

**A four-pillars approach to methamphetamine. Policies for effective drug prevention, treatment, policing and harm reduction.** (2008) Drug Policy Alliance. English. Type of document: Policy guidelines. Target audience: Policy-makers. Implementation focus: National. Contains a range of evidence-based policy proposals for national responses to methamphetamine use centred around four pillars: prevention, treatment, policing and harm reduction. Available at: <http://www.drugpolicy.org/docUploads/FourPillarsMethamphetamine.pdf>

### **Prisons and closed settings**

**Effectiveness of interventions to address HIV in prisons (Evidence for action series website).** WHO, UNODC, UNAIDS. English, Russian, Spanish, Chinese. Type of document: Normative guidelines. Target audience: Correctional and health sector managers and programme planners. Implementation focus: National. The website consists of a collection of resources including: a comprehensive review of the evidence for HIV services in prisons; a policy brief on HIV reduction in prisons; and technical papers on prison interventions. The technical papers address prevention of sexual transmission; needle and syringe programmes and decontamination strategies; drug dependence treatments; HIV care, treatment and support. Available at: <http://www.who.int/hiv/topics/idu/prisons/en/index.html>

#### **Effectiveness of interventions to address HIV in prisons (Evidence for action technical papers)**

Available at: [http://www.who.int/hiv/idu/OMS\\_E4Acomprehensive\\_WEB.pdf](http://www.who.int/hiv/idu/OMS_E4Acomprehensive_WEB.pdf)

**Module 2: Comprehensive services for injecting drug users. Treatment and care for HIV-positive injecting drug users.** (2007) ASEAN, USAID, WHO, FHI. English. Type of document: Training manual. Target audience: Drug and alcohol services and health-care workers. Implementation focus: National and district. The manual outlines the range of treatment and care services that are recommended in closed settings. Available at: [http://www.searo.who.int/LinkFiles/Publications\\_Module\\_02\\_Treatment\\_&\\_Care\\_for\\_HIV\\_positive\\_IDUs.pdf](http://www.searo.who.int/LinkFiles/Publications_Module_02_Treatment_&_Care_for_HIV_positive_IDUs.pdf)

## Young people

**Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries.** (2006) WHO, UNAIDS Inter-agency Task Team on Young People. English. Type of document: Evidence, policy and advocacy. Target audience: Policy-makers, programme managers. Implementation focus: National. This publication covers the findings of a systematic review of the effectiveness of interventions for preventing HIV in young people. It includes interventions delivered through schools, health services, mass media, communities, and to young people who are most vulnerable to HIV infection. Available at: [http://whqlibdoc.who.int/trs/WHO\\_TRS\\_938\\_eng.pdf](http://whqlibdoc.who.int/trs/WHO_TRS_938_eng.pdf)

**Global consultation on the health services response to the prevention and care of HIV/AIDS among young people.** (2003) UNAIDS, WHO, UNFPA and YouthNet. English. Type of document: Consultation report. Target audience: Policy-makers, programme planners and managers. Implementation focus: Global, national. The report reviews the evidence on the effectiveness of a number of interventions delivered through a range of different service providers. It covers information and counselling; use and distribution of condoms for sexually active young people; STI treatment and care; harm reduction; and measures to decrease HIV transmission by PWID, as well as access to HIV testing, care and support. Available at: <http://whqlibdoc.who.int/publications/2004/9241591323.pdf>

**Adolescent-friendly health services: an agenda for change.** (2002) WHO. English. Type of document: Policy brief, advocacy. Target audience: Policy-makers, programme planners and managers. Implementation focus: National and subnational. This publication is intended for policy-makers and programme managers in both low- and middle-income countries, as well as decision-makers in international organizations supporting public health initiatives in these countries. It makes a compelling case for concerted action to improve the quality—and especially the friendliness—of health services for adolescents. It also highlights the critical role that adolescents themselves can play, in conjunction with committed adults, to contribute to their own health and well-being. Available at: [http://whqlibdoc.who.int/hq/2003/WHO\\_FCH\\_CAH\\_02.14.pdf](http://whqlibdoc.who.int/hq/2003/WHO_FCH_CAH_02.14.pdf)

## Chapter 3: Sexual health

### *Detecting and managing sexually transmitted infections*

**Global strategy for the prevention and control of sexually transmitted infections, 2006–2015: breaking the chain of transmission.** (2007) WHO. English, Arabic, Chinese, Russian. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers. Implementation focus: Global, national. The Global strategy for the prevention and control of STIs contains technical and advocacy components. It provides a framework to guide an accelerated global response to prevent and control STIs. It also discusses opportunities for interfacing and integrating with HIV and sexual and reproductive health programmes. Available at: [http://whqlibdoc.who.int/publications/2007/9789241563475\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241563475_eng.pdf)

**Guidelines for the management of sexually transmitted infections.** (2003) WHO. English, French, Portuguese, Spanish. Type of document: Programme planning and management; operational guidelines. Target audience: Programme managers. Implementation focus: National. This guideline presents treatment recommendations for the comprehensive management of patients with STIs in the broader context of control, prevention and care programmes for STIs and HIV. It covers both the syndromic approach to STI management and the diagnostic treatment of specific STIs. Available at: <http://www.who.int/entity/hiv/pub/sti/en/STIGuidelines2003.pdf>

**Periodic presumptive treatment for sexually transmitted infections: experience from the field and recommendations for research.** (2008) WHO. English. Type of document: Operational guidelines. Target audience: Programme managers, clinicians. Implementation focus: National. This publication summarizes

the deliberations of the technical consultation on current knowledge of periodic presumptive treatment and experiences to date with interventions, including the conditions that seem to be most favourable for these interventions to work well. Further research is clearly needed in this field – including research using possible modelling with current field data. The publication also formulates and presents recommendations for research, as well as guidelines for people carrying out programmes with periodic presumptive treatment.

Available at: <http://www.who.int/reproductive-health/publications/ppt/ppt.pdf>

**IUSTI Asia Pacific Branch clinical guidelines for sexual health care of men who have sex with men** (2006) IUSTI. English. Type of document: Normative guidelines; operational guidelines. Target audience: Programme managers, clinicians, health-care workers. Implementation focus: This guideline assists health professionals including Clinicians and HIV counsellors who work in hospital outpatient departments, sexually transmitted infection (STI) clinics, non-government organizations, or private clinics; HIV counsellors and other health care workers, especially doctors, nurses and counsellors who care for MSM; and pharmacists, general hospital staff and traditional healers in Asia and the Pacific in providing health care services for MSM:

Available at: [http://www.iusti.org/sti-information/pdf/IUSTI\\_AP\\_MSM\\_Nov\\_2006.pdf](http://www.iusti.org/sti-information/pdf/IUSTI_AP_MSM_Nov_2006.pdf)

**WHO Training modules for the syndromic management of sexually transmitted infections.** (2007)

WHO. English, French, Spanish. Type of document: Training programme. Target audience: Programme managers, clinicians, health-care workers. Implementation focus: This training programme, comprising seven modules plus a trainers' guide aims to equip all relevant clinicians and service providers with the skills needed to manage STIs using the syndromic management approach. Available at: <http://www.who.int/reproductivehealth/publications/rtis/9789241593407/en/index.html>

### ***Enabling people to know HIV status***

**UNAIDS/WHO policy statement on HIV testing** (2004) UNAIDS and WHO. English. Type of document: Policy statement. Target audience: Policy-makers, programme managers. Implementation focus: Global, national. This policy statement outlines the “3Cs” principles of HIV testing (confidentiality, counselling and consent), and contains a description of the four types of HIV testing: client-initiated; diagnostic testing; recommendation of HIV testing by health-care providers; and mandatory HIV screening. Available at: <http://www.who.int/hiv/pub/vct/en/hivtestingpolicy04.pdf>

**Opening up the HIV/AIDS epidemic: guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting.** (2000) UNAIDS. English, French. Type of document: Normative guidelines; operational guidelines. Target audience: Programme managers, clinicians, health-care workers. Implementation focus: This publication is a follow-up to the Technical Consultation on Notification, Confidentiality and HIV/AIDS in Windhoek, and the International Consultation on HIV Reporting and Disclosure (Geneva), and proposes that vital and effective steps towards opening up the HIV/AIDS epidemic involve the encouragement of beneficial disclosure, ethical partner counselling and the appropriate use of HIV case-reporting. Available at: [http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp\\_en.pdf](http://data.unaids.org/Publications/IRC-pub05/JC488-OpenUp_en.pdf)

### ***Voluntary counselling and testing (VCT)***

**WHO HIV testing and counselling (TC) toolkit.** WHO. English. Type of document: Toolkit. Target audience: Programme managers and implementers and their partners in the public and private sectors, including NGOs, CBOs and FBOs. Implementation focus: The toolkit provides references offering practical guidance on the processes of planning and implementing testing and counselling services in resource-limited settings. Available at: <http://www.who.int/hiv/topics/vct/toolkit/en/index.html>

**WHO SEARO. Targeted VCT intervention – men who have sex with men (MSM).** WHO. English. Type of document: Training toolkit. Target audience: Clinicians, health-care workers. Implementation focus: This toolkit assists in training to appreciate the need to adapt VCT to the specific needs of MSM and to explore the barriers to VCT for MSM. Available at: [http://www.searo.who.int/LinkFiles/Training\\_Materials\\_voluntary-module3-4.pdf](http://www.searo.who.int/LinkFiles/Training_Materials_voluntary-module3-4.pdf)

### ***Provider-initiated HIV testing and counselling (PITC)***

**Guidance on provider-initiated HIV testing and counselling in health facilities.** (2007) WHO and UNAIDS. English, Russian. Type of document: Normative guidelines; operational guidelines. Target audience: Programme managers, policy-makers, health-care providers. Implementation focus: National, district, facility. This guide summarizes a wealth of evidence that PITC can increase uptake of HIV testing, improve access to health services for PLHIV, and may create new opportunities for HIV prevention. It provides guidance and recommendations related to testing and counselling in different settings: low-level, concentrated and generalized HIV epidemics. Available at: [http://whqlibdoc.who.int/publications/2007/9789241595568\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)

**WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children.** (2007) WHO. English. Type of document: Normative guidelines, operational guidelines. Target audience: Programme managers, policy-makers, health-care providers. Implementation focus: National, district, facility. The publication outlines revisions that WHO made to case definitions for surveillance of HIV, and the clinical and immunological classification of HIV. It is designed to assist in the clinical management of HIV, especially where there is limited laboratory capacity. In this classification, the clinical staging of HIV-related disease for adults and children, and the simplified immunological classification are harmonized to a universal four-stage system. Available at: <http://www.who.int/hiv/pub/guidelines/HIVstaging150307.pdf>

**Recommendations for human immunodeficiency virus (HIV) screening in tuberculosis (TB) clinics.** (2008) CDC. English. Type of document: Fact sheet. Target audience: Programme managers, policy-makers, health-care providers. Implementation focus: Recommendations for HIV screening for all TB patients after the patient is notified that testing will be performed, unless the patient declines (i.e., opt-out screening). Routine HIV testing is also recommended for persons suspected of having TB disease and contacts to TB patients. Persons at high risk for HIV infection should be screened for HIV at least annually. Prevention counseling and separate written consent for HIV testing should no longer be required. Available at: <http://www.cdc.gov/tb/publications/factsheets/testing/HIVscreening.htm>

### ***Counselling***

**Basic counselling guidelines for ARV programmes** (2005) WHO. English. Type of document: Training manual. Target audience: Clinicians, health-care providers. Implementation focus: This documents highlights the importance of treating mental health disorders of PLWA from a humanitarian, public health and economic perspectives and gives practical guidelines in counselling issues, techniques and processes. Available at: [http://whqlibdoc.who.int/publications/2005/9241593067\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593067_eng.pdf)

### ***Female partners***

**WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities.** (2007). English, Russian. Type of document: Normative guidelines; operational guidelines. Target audience: Programme managers, policy-makers, health-care providers. Implementation focus: National, district, facility. This guide summarizes a wealth of evidence that PITC can increase the uptake of HIV testing, improve access to health services for PLHIV, and may create new opportunities for HIV prevention. It provides guidance and recommendations on testing and counselling in different settings: low-level, concentrated and generalized HIV epidemics. Available at: [http://whqlibdoc.who.int/publications/2007/9789241595568\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)

## Chapter 4: Access to care, support and treatment

### ***Continuum of care***

**WHO SEARO. Continuum of care. Fact sheet on HIV/AIDS for nurses and midwives.** (2002) WHO. English. Type of document: Chapter within the Fact Sheet booklet. Target audience: Nurses. Guidelines on the principles and components of a continuum of HIV care. Implementation focus: National, regional. Available at: [http://www.searo.who.int/LinkFiles/Publications\\_FactSheet-HIV-AIDSNurses.pdf](http://www.searo.who.int/LinkFiles/Publications_FactSheet-HIV-AIDSNurses.pdf)

**FHI. Scaling up the continuum of care: a new toolkit for implementers working in the Asia-Pacific Region.** (2007) FHI Type of document: Toolkit. Target audience: Governments and partners. Implementation focus: National, regional. [http://www.fhi.org/en/HIVAIDS/pub/res\\_CoC\\_toolkit.htm](http://www.fhi.org/en/HIVAIDS/pub/res_CoC_toolkit.htm)

### ***Co-trimoxazole prophylaxis***

**Guidelines on co-trimoxazole prophylaxis for HIV-related infections among children, adolescents and adults: recommendations for a public health approach.** (2006) WHO Department of HIV/AIDS. Gilks C, Vitoria M. English, French. Type of document: Normative guidelines. Target audience: Clinicians, national and regional health programme managers. Implementation focus: National, regional. Available at: [http://whqlibdoc.who.int/publications/2006/9789241594707\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9789241594707_eng.pdf)

### ***Isoniazid preventive treatment (IPT)***

Three I's Meeting: intensified case finding (ICF), isoniazid preventive therapy (IPT) and TB infection control (IC) for people living with HIV. (2008) WHO. English. Type of document: Infrastructure and logistic. Target audience: National programmers and their partners. Implementation focus: National, regional. Available at: [http://www.who.int/hiv/pub/meetingreports/WHO\\_3Is\\_meeting\\_report.pdf](http://www.who.int/hiv/pub/meetingreports/WHO_3Is_meeting_report.pdf)

Isoniazid preventive therapy (IPT) for people living with HIV WHO. English. Type of document: Working group consensus statement. Target audience: National program managers. Implementation focus: National, regional. Available at: [http://www.stoptb.org/wg/tb\\_hiv/assets/documents/IPT%20Consensus%20Statement%20TB%20HIV%20Core%20Group.pdf](http://www.stoptb.org/wg/tb_hiv/assets/documents/IPT%20Consensus%20Statement%20TB%20HIV%20Core%20Group.pdf)

### ***Treatment preparedness and adherence support***

**Adherence to long-term therapies: evidence for action.** (2003) WHO. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Clinicians, health programme managers, policy-makers. Implementation focus: National, regional. This review of the published literature discusses the definitions, measurements, epidemiology, economics and interventions applied to nine chronic conditions including HIV/AIDS, hypertension, tobacco smoking, and tuberculosis. It provides a concise summary of the consequences of poor treatment adherence, both for health and economics, and discusses the options available for improving adherence. Available at: [http://www.who.int/chp/knowledge/publications/adherence\\_introduction.pdf](http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf)  
[http://www.who.int/hiv/pub/prev\\_care/lttherapies/en/](http://www.who.int/hiv/pub/prev_care/lttherapies/en/)

### ***Antiretroviral therapy***

**WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children.** (2007) WHO. English. Type of document: Normative guidelines, operational guidelines. Target audience: Programme managers, policy-makers, health-

care providers. Implementation focus: National, district, facility. This publication outlines revisions that WHO made to case definitions for surveillance of HIV, and the clinical and immunological classification of HIV. It is designed to assist in the clinical management of HIV, especially where there is limited laboratory capacity. In this classification, the clinical staging of HIV-related disease for adults and children, and the simplified immunological classification are harmonized to a universal four-stage system. Available at: <http://www.who.int/hiv/pub/guidelines/HIVstaging150307.pdf>

**Rapid advice. Antiretroviral therapy for HIV infection in adults and adolescents.** 2009 revision.

Type of document: Normative guidelines, operational guidelines. Target audience: Programme managers, policy-makers, health-care providers. Implementation focus: National, health facilities.

This publication is the most recent guidelines for the prescription of antiretroviral therapy for those at need. It is very updated and innovative and has raised the pattern for the initiation of ARV. [http://www.who.int/hiv/pub/arv/rapid\\_advice\\_art.pdf](http://www.who.int/hiv/pub/arv/rapid_advice_art.pdf)

**HIV drug interactions** (2009) University of Liverpool. Type of document: Interactive website with a wide range of medications to assess possible drug–drug interactions between ART and other commonly used medications. Target audience: Clinicians. Available at: <http://www.hiv-druginteractions.org/>

**IMAI–IMCI chronic HIV care with ARV therapy and prevention: interim guidelines for health workers at health centre or district hospital outpatient clinic.** (2007) WHO. English, French. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Health centre or outpatient care, district hospital. This simplified operational guideline is based on WHO normative guidelines, and serves both as a learning and job aid. It addresses children, adolescents and adults, and effectively integrates HIV prevention, care and treatment, and promotes broader uptake of preventive interventions essential for HIV control. It includes patient education, prevention for HIV-positive persons, clinical staging, prophylaxis (INH, co-trimoxazole, fluconazole), preparation for ART, clinical monitoring, special considerations for ART for pregnant women and children, treatment adherence support, and data collection based on a simple treatment card. Clinical content is offered using IMAI–IMCI basic chronic HIV care/ART clinical training, integrated PMTCT training and the reproductive choice/family planning short course. Available at: [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

**Prioritizing second-line antiretroviral drugs for adults and adolescents: a public health approach. Report of a WHO working group meeting, Geneva, Switzerland, 21–22 May 2007.** (2007) WHO.

English. Type of document: Normative guidelines evidence, policy and advocacy. Target audience: Programme managers, policy-makers, clinicians. Implementation focus: National, facility. This report provides guidance for national HIV/AIDS programmes on options for simplified second-line regimens that countries can choose based on programme efficiencies and costs. It highlights the need for prioritizing drugs for use in second-line regimens, including protease inhibitors, and nucleoside and nucleotide reverse transcriptase inhibitors. Available at: [http://www.who.int/hiv/pub/meetingreports/Second\\_Line\\_Antiretroviral.pdf](http://www.who.int/hiv/pub/meetingreports/Second_Line_Antiretroviral.pdf)

**Prequalification programme: a United Nations Programme managed by WHO** (WHO website). WHO. English.

This website provides access to the list of WHO-prequalified ARV products, and the procedures that enable manufacturers to prequalify them. It also provides information on medicines prequalified by WHO, assessment reports, and procedures. Type of document: WHO website with linked detail. Target audience: Agencies involved in procurement of medicines. Implementation focus: National, regional. Available at: <http://healthtech.who.int/>

**HIV/AIDS treatment and care: clinical protocol for the WHO European Region.** (2007) WHO-EURO, Eramova I, Matic S, Munz M. English, Russian. Type of document: Normative guidelines. Target audience: Programme managers, policy-makers, clinicians. Implementation focus: Regional, facility. This publication contains 13 treatment and care protocols that have been specifically developed for the entire WHO European Region. The protocols represent a comprehensive and evidence-based tool that offers clear and specific guidance on diagnosing and managing a wide range of HIV/AIDS health-related issues for adults, adolescents and children. These issues arise during ART; managing OIs; TB; hepatitis; injecting drug use; sexual and reproductive health; PMTCT; immunizations;

palliative care; and PEP. Check for future updates at [www.euro.who.int/aids](http://www.euro.who.int/aids)  
Available at: <http://www.euro.who.int/document/e90840.pdf>

**WHO consultation on ART failure in the context of a public health approach: 2008 meeting report.** (2009) WHO. English. Type of document: Meeting report. Target audience: National programme managers. Implementation focus: National. Available at: [http://www.who.int/hiv/pub/arv/art\\_meeting\\_art\\_fail.pdf](http://www.who.int/hiv/pub/arv/art_meeting_art_fail.pdf)

### ***Prevention, surveillance and monitoring of HIV drug resistance***

**HIV drug resistance (WHO webpage).** WHO. English. Type of document: Webpage with links. Target audience: Clinicians, policy-makers, national and regional programme managers. Implementation focus: National, regional. Available at: <http://www.who.int/hiv/drugresistance/>

### ***Managing opportunistic disease and co-morbidities***

**IMCI chart booklet for high HIV settings.** (2007) WHO. English. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Facility. The modified IMCI chart booklet for high HIV settings addresses common childhood illnesses (including pneumonia, malaria, diarrhoea and severe malnutrition), as well as identifying and managing HIV-related conditions. It has guidelines on HIV-exposed and -infected infants and children, including infant-feeding, immunization, co-trimoxazole prophylaxis and nutritional support. General information is provided on ARVs for children, treatment adherence, and side-effects of these drugs. The IMCI chart booklet is a companion to the IMAI guideline modules for adults and adolescents. Available at: [http://whqlibdoc.who.int/publications/2006/9789241594370.cb\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9789241594370.cb_eng.pdf)

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** (2008) WHO. English. Type of document: Normative guidelines; programme planning and management. Target audience: National and regional programme managers, NGOs providing HIV-care services, policy-makers, service providers. Implementation focus: Global, national. This guideline contains global technical, evidence-based recommendations for prevention and care interventions, other than ART, which PLHIV in resource-constrained settings should expect as part of their health-care services. The guideline promotes expansion of interventions for HIV prevention, and non-ART care and treatment for adults and adolescents living with HIV. It focuses on preventing illness and OIs. Preventing HIV transmission is seen as an integral part of care and treatment services. Implementation can be adapted for countries with different epidemiology and capacities. Available at: [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Global action plan for the prevention and control of pneumonia (GAPP): report of an informal consultation.** (2007) WHO and UNICEF. English. Type of document: Meeting report. Target audience: MoH, technical experts, health-care providers. Implementation focus: Childhood pneumonia. Available at: [http://whqlibdoc.who.int/publications/2008/9789241596336\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241596336_eng.pdf)

### ***Nutritional care and support***

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** (2008) WHO. English. Type of document: Normative guidelines; programme planning and management. Target audience: National and regional programme managers, NGOs providing HIV-care services, policy-makers, service providers. Implementation focus: Global, national. This guideline contains global technical, evidence-based recommendations for prevention and care interventions, other than ART, which PLHIV in resource-constrained settings should expect as part of their health-care services. The guideline promotes expansion of interventions for HIV prevention, and non-ART care and treatment for adults and adolescents living with HIV. It focuses on preventing illness and OIs. Preventing HIV transmission is seen as an integral part of care

and treatment services. Implementation can be adapted for countries with different epidemiology and capacities. Available at: [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Nutrient requirements for people living with HIV/AIDS (2004) WHO.** English, French. Type of document: Guidelines based on a technical consultation to review evidence and recommendations, and identify research priorities related to nutrition and HIV. Target audience: Clinicians and community workers. Implementation focus: National, regional. Available at: <http://www.who.int/nutrition/publications/hivaids/9241591196/en/>

**Integrating nutrition and food assistance into HIV care and treatment programmes: operational guidance (draft).** (2008) WHO and World Food Programme (WFP). English. Target audience: National bodies, implementing NGOs, and WHO and WFP country staff. Implementation focus: National, facility. As part of a comprehensive response to treatment, care, and support for PLHIV, food and nutrition programmes are being developed and implemented in many countries. Following on the World Health Assembly Resolution 57.14, WHO and WFP are working together to assist countries in integrating food and nutritional support into national HIV programmes and are also developing related strategies. This document is a first step towards addressing requests made by countries for tools and guidance on how to design and implement food and nutritional support for PLHIV. Available at: [http://www.who.int/hiv/topics/arv/who\\_wfp\\_nutrition.pdf](http://www.who.int/hiv/topics/arv/who_wfp_nutrition.pdf)

**WHO Executive Board EB116/12 116th Session 12 May 2005: nutrition and HIV/AIDS.** (2005) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Policy-makers, national programme managers. Implementation focus: Global, national. This paper reports a 2005 WHO consultation on nutrition and HIV/AIDS for eastern and southern Africa. It reviews the evidence and provides recommendations on integrating nutrition into the essential package of care, treatment and support for PLHIV. Available at: [http://www.who.int/gb/ebwha/pdf\\_files/EB116/BI116\\_12-en.pdf](http://www.who.int/gb/ebwha/pdf_files/EB116/BI116_12-en.pdf)

### **Managing diarrhoea**

**Implementing the new recommendations on the clinical management of diarrhoea: guidelines for policy makers and programme managers.** (2006) WHO. English. Type of document: This manual provides policy makers and programme managers with the information they need to introduce and/or scale up a national decision to introduce the new ORS formulation and zinc supplementation as part of the clinical management of diarrhoeal diseases. Target audience: Policy-makers, programme managers. Implementation focus: National, regional. Available at: [http://whqlibdoc.who.int/publications/2006/9241594217\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9241594217_eng.pdf)

### **Managing HIV-related conditions**

**IMAI-IMCI chronic HIV care with ARV therapy and prevention: Interim guidelines for health workers at health centre or district hospital outpatient clinic.** (2007) WHO. English, French. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Health centre or outpatient care, district hospital. This simplified operational guideline is based on WHO normative guidelines, and serves both as a learning and job aid. It addresses children, adolescents and adults, and effectively integrates HIV prevention, care and treatment, and promotes broader uptake of preventive interventions essential for HIV control. It includes patient education, prevention for HIV-positive persons, clinical staging, prophylaxis (INH, co-trimoxazole, fluconazole), preparation for ART, clinical monitoring, special considerations for ART for pregnant women and children, treatment adherence support, and data collection based on a simple treatment card. Clinical content is offered using the IMAI-IMCI basic chronic HIV care/ART clinical training, integrated PMTCT training and the reproductive choice/family planning short course. Available at: [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

**IMAI acute care.** (2005) WHO. English, French. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Facility. This simplified, operational guideline is based on WHO normative guidelines and serves both as a



learning and job aid for acute care, integrated with HIV prevention for adolescents and adults. It uses the same format as the IMCI chart booklet, and presents a syndromic approach (with limited essential laboratory testing) to the most common adult illnesses including most OIs. Clear instructions are provided about patients who can be managed at the first-level facility and those who require referral to the district hospital, or assessment by a more senior clinician. Acute care also includes PITC and case finding for TB. Several training courses are available to teach its content, e.g. OI management and STI/genitourinary problems.  
Available at: [http://www.who.int/hiv/pub/imai/en/acutecarerev2\\_e.pdf](http://www.who.int/hiv/pub/imai/en/acutecarerev2_e.pdf)

**IMCI chart booklet for high HIV settings.** (2007) WHO. English. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Facility. The modified IMCI chart booklet for high HIV settings addresses common childhood illnesses (including pneumonia, malaria, diarrhoea and severe malnutrition), as well as identifying and managing HIV-related conditions. It has guidelines on HIV-exposed and -infected infants and children, including infant-feeding, immunization, co-trimoxazole prophylaxis and nutritional support. General information is provided on ARVs for children, treatment adherence, and side-effects of these drugs. The IMCI chart booklet is a companion to the IMAI guideline modules for adults and adolescents. Available at: [http://whqlibdoc.who.int/publications/2006/9789241594370.cb\\_eng.pdf](http://whqlibdoc.who.int/publications/2006/9789241594370.cb_eng.pdf)

**Policy for prevention of oral manifestations in HIV/AIDS: the approach of the WHO Global Oral Health Programme.** (2006) Peterson PE. English. Type of document: Evidence, policy and advocacy. Target audience: Dental health workers, policy-makers. Implementation focus: Global. This paper provides background information about the HIV epidemic and key recommendations about the oral health response to HIV. It also addresses capacity building and strengthening the prevention of HIV-related oral disease. Available at: <http://adr.iadrjournals.org/cgi/reprint/19/1/17.pdf>

**HIV-related opportunistic diseases** (1998) WHO. English. Type of document: Technical update on opportunistic diseases in HIV and their management. Target audience: Clinicians. Implementation focus: Global. Available at: [http://whqlibdoc.who.int/unaid/1998/a61273\\_eng.pdf](http://whqlibdoc.who.int/unaid/1998/a61273_eng.pdf)

**Malaria and HIV interactions and their implications for public health policy.** (2005) WHO. English, French. Type of document: Evidence, policy and advocacy; programme planning and management. Target audience: Policy-makers, programme planners, implementers. Implementation focus: National, regional. This report from a joint technical consultation provides recommendations to improve planning and implementation of programmes against HIV and malaria. There are many synergies and interactions between these two epidemics among children and during pregnancy, particularly in resource-constrained settings. Available at: <http://whqlibdoc.who.int/publications/2005/9241593350.pdf>

## **Palliative care**

**Palliative care: symptom management and end-of-life care.** (2006) WHO. English. Type of document: Guideline. Target audience: Clinic and community health care workers. Implementation focus: Facility and community. Available at: English: <http://www.who.int/hiv/pub/imai/genericpalliativecare082004.pdf>.

**WHO's pain ladder (web page).** WHO. English. Type of document: Guideline. Target audience: Clinicians. Implementation focus: Facility and community. Available at: <http://www.who.int/cancer/palliative/painladder/en/index.html>

**Caregiver booklet: symptom management and end of life care (draft).** (2006) WHO. English. Type of document: Guideline. Target audience: Home-based caregivers of PLHIV, PLHIV, primary care health workers. Implementation focus: Facility and community. This booklet is designed for use by health workers to educate family members and other caregivers, and is then given to them to use as a reference at home for home-based care of serious long-term illness and people who may be close to the end of their lives. It covers preventing problems, managing common symptoms, when to seek health care, as well as special advice on psychosocial

support. It also supports the extension of care from the health facility to the home. The booklet is focused on PLHIV, but it can also be used for HIV-negative patients with other chronic health problems. Available at: <http://www.who.int/hiv/pub/imai/patient/en/index.html>

**Restoring hope: decent care in the midst of HIV/AIDS.** (2008) WHO, T. Karpf et al. English. Type of document: Community approach to treatment, care and prevention services. Target audience: Programme managers and planners, policy-makers, implementers; NGOs; health-care workers; public and private employers; donor representatives, technical working groups, trainers. Implementation focus: Global, regional, local and within the community. “Decent care” is a concept adapted from the world of work, and builds on the philosophical and spiritual traditions of dignity, respect and integrity. The authors represent a wide variety of faiths and cultural traditions from around the world. Each brings his or her unique background to bear upon the experience of HIV. They go beyond mere speculation on decency, and instead focus on personal journeys of the heart. For health systems developers and health services providers, this publication is a call to re-examine assumptions about what care is and how it should be practised. The writers make the case for thinking clearly and critically, and urge PLHIV to become full partners in designing and implementing their own care, and for caregivers to accept them in this role. That is the critical challenge of decent care. Available at: <http://www.palgrave.com/products/title.aspx?PID=323603>

### **Transgender health**

**HIV/AIDS and the transgendered person** (2007) CDC USA Type of document: Information outline. Target audience: Health care workers. Implementation focus: Facility and community. Introductory document addressing HIV in transgendered persons with additional resources. Available at: <http://www.cdc.gov/lgbthealth/pdf/FS-Transgender-06192007.pdf>

**The World Professional Association for Transgender Health’s standards of care, 6th edition** (2001) World Professional Association for Transgender Health Type of document: Guidelines. Target audience: Clinicians Implementation focus: National, regional. This document addresses the psychiatric, psychological, medical, and surgical management of gender identity disorders. Available at: [http://www.wpath.org/publications\\_standards.cfm](http://www.wpath.org/publications_standards.cfm)

**Transgender HIV/AIDS health services. Best Practice guidelines.** Type of document: Guideline. Target audience: Health and social services. Implementation focus: Facility and community. This document aims to improve the understanding and delivery of service to HIV affected transgendered persons. Available at: <http://www.careacttarget.org/library/tgguidelines.pdf>

**Protocols for hormonal reassignment of gender.** Tom Waddell Health Center, San Francisco Department of Public Health. Type of document: Guidelines. Target audience: Clinicians. Implementation focus: Clinic, facility and community. This detailed client focused document comprehensively addresses hormonal and related therapies in reassignment of gender. Available at: <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>

## **4. 4 Mental health**

**Psychiatric care in anti-retroviral (ARV) therapy (for second level care): Module 3 WHO mental health and HIV/AIDS series.** (2005) WHO. English. Type of document: Operational guidelines. Target audience: District clinicians, medical and clinical officers. Implementation focus: National, district. This publication is part of a WHO series of five modules aimed at different levels of the district clinical team dealing with ARV programmes, and covers issues around the fact that HIV and mental disorders frequently coexist, and one disease may affect the presentation and progression of the other, as well as response and adherence to treatment. The modules cover organization and systems support, basic counselling, psychosocial support groups, and psychotherapeutic interventions. This module on psychiatric care guides the clinician through screening for a mental disorder, its classification, and guidelines for both therapeutic and psychological management of mental

disorders in HIV-infected individuals. The module is being updated and will be included in the IMAI manual for district clinicians in low-resource, high HIV prevalence settings, currently in development.

Available at: [http://whqlibdoc.who.int/publications/2005/9241593083\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593083_eng.pdf)

**Psychosocial support groups in anti-retroviral (ARV) therapy programmes: Module 4 in the WHO mental health and HIV/AIDS series.** (2005) WHO. English. Type of document: Operational guidelines. Target audience: Counsellors and nurses. Implementation focus: National, district.

This is Module 4 of a WHO series of five modules that are aimed at different levels of the district clinical team, and deal with ARV programmes. The modules make the case that HIV and mental disorders frequently coexist, and that good counselling on adherence is essential for treatment. They cover organization and systems support, basic counselling, psychiatric care, psychotherapeutic interventions. This fourth module deals with psychosocial support groups. Available at: Series 1: [http://whqlibdoc.who.int/publications/2005/9241593040\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593040_eng.pdf)

Series 2: [http://whqlibdoc.who.int/publications/2005/9241593067\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593067_eng.pdf)

Series 3: [http://whqlibdoc.who.int/publications/2005/9241593083\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593083_eng.pdf)

Series 4: [http://whqlibdoc.who.int/publications/2005/9241593105\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593105_eng.pdf)

Series 5: [http://whqlibdoc.who.int/publications/2005/9241593091\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593091_eng.pdf)

**IMAI-IMCI chronic HIV care with ARV therapy and prevention: interim guidelines for health workers at health centre or district hospital outpatient clinic.** (2007) WHO. English, French. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Health centre or outpatient care, district hospital. This simplified operational guideline is based on WHO normative guidelines, and serves both as a learning and job aid. It addresses children, adolescents and adults, and effectively integrates HIV prevention, care and treatment, and promotes broader uptake of preventive interventions essential for HIV control. It includes patient education, prevention for HIV-positive persons, clinical staging, prophylaxis (INH, co-trimoxazole, fluconazole), preparation for ART, clinical monitoring, special considerations for ART for pregnant women and children, treatment adherence support, and data collection based on a simple treatment card. Clinical content is offered using the IMAI-IMCI basic chronic HIV care/ART clinical training, integrated PMTCT training and the reproductive choice/family planning short course. Available at: [http://www.who.int/hiv/pub/imai/Chronic\\_HIV\\_Care7.05.07.pdf](http://www.who.int/hiv/pub/imai/Chronic_HIV_Care7.05.07.pdf)

## 4. 5 Vaccinations

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** (2008) WHO. English. Type of document: Normative guidelines; programme planning and management. Target audience: National and regional programme managers, NGOs providing HIV-care services, policy-makers, service providers. Implementation focus: Global, national. This guideline contains global technical, evidence-based recommendations for prevention and care interventions other than ART, which PLHIV in resource-constrained settings should expect as part of their health-care services. The guideline promotes expansion of interventions for HIV prevention, and non-ART care and treatment for adults and adolescents living with HIV. It focuses on preventing illness and OIs. Preventing HIV transmission is seen as an integral part of care and treatment services. Implementation can be adapted for countries with different epidemiology and capacities. Available at: [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Hepatitis A vaccination** (2003) WHO English Type of document: Guideline. Target audience: Clinicians, policy makers. Implementation focus: National, regional, community. Available at: [www.who.int/vaccines/en/hepatitisa.shtml](http://www.who.int/vaccines/en/hepatitisa.shtml)

**Hepatitis A vaccination** (2009) CDC English Type of document: Guideline. Target audience: Clinicians, policy makers. Implementation focus: National, regional, community. Available at: <http://www.cdc.gov/hepatitis/HAV/HAVfaq.htm#vaccine>

**Hepatitis B vaccination** (2009) WHO English Type of document: Guideline. Target audience: Clinicians, policy makers. Implementation focus: National, regional, community. Available at: <http://www.who.int/mediacentre/>

factsheets/fs204/en/

**Hepatitis B vaccination** (2009) CDC English Type of document: Guideline. Target audience: Clinicians, policy makers. Implementation focus: National, regional, community. Available at: <http://www.cdc.gov/hepatitis/HBV/HBVfaq.htm#recctbl>

**Vaccine-preventable diseases, vaccines and vaccination.** (2005) WHO. English. Type of document: Guideline. Target audience: Clinicians. Implementation focus: National, regional, community. Available at: [http://whqlibdoc.who.int/publications/2005/9241580364\\_chap6.pdf](http://whqlibdoc.who.int/publications/2005/9241580364_chap6.pdf)

## 4.6 Coinfections (TB and hepatitis)

### 4.6.1 Tuberculosis

**A guide to monitoring and evaluation for collaborative TB/HIV activities: field test version.** (2004) WHO. English, Russian. Type of document: Monitoring, evaluation and quality assurance. Target audience: Policy-makers, programme managers. Implementation focus: National. This guide has been developed to assist in managing TB and HIV/AIDS programmes that are implementing or planning to implement collaborative TB/HIV activities. It will facilitate collection of standardized data, and help in interpreting and disseminating data for programme improvement. Available at: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.342.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.342.pdf)

**Essential prevention and care interventions for adults and adolescents living with HIV in resource-limited settings.** (2008) WHO. English. Type of document: Normative guidelines; programme planning and management. Target audience: National and regional programme managers, NGOs providing HIV-care services, policy-makers, service providers. Implementation focus: Global, national. This guideline contains global, technical, evidence-based recommendations for prevention and care interventions other than ART, which PLHIV in resource-constrained settings should expect as part of their health-care services. The guideline promotes expansion of interventions for HIV prevention, and non-ART care and treatment for adults and adolescents living with HIV. It focuses on preventing illness and OIs. Preventing HIV transmission is seen as an integral part of care and treatment services. Implementation can be adapted for countries with different epidemiology and capacities. Available at: [http://www.who.int/hiv/pub/prev\\_care/OMS\\_EPP\\_AFF\\_en.pdf](http://www.who.int/hiv/pub/prev_care/OMS_EPP_AFF_en.pdf)

**Guidelines for the prevention of tuberculosis in health care facilities in resource-limited settings.** (1999) WHO, Granich R et al. and the United States Department of Health and Human Services. English, Russian, Spanish. Type of document: Operational guidelines. Target audience: District programme managers, health-care workers. Implementation focus: District, facility. These guidelines provide discussion and recommendations for the district and referral level based upon three levels of infection control: administrative, environmental, and personal respiratory protection. Available at: [http://whqlibdoc.who.int/hq/1999/WHO\\_TB\\_99.269.pdf](http://whqlibdoc.who.int/hq/1999/WHO_TB_99.269.pdf)

**The global plan to Stop TB, 2006–2015.** (2006) WHO. English, French, Spanish, Arabic. Type of document: Evidence, policy and advocacy. Target audience: Programme managers, policy-makers. Implementation focus: Global, national. The plan provides a consensus view of what the Stop TB Partnership can achieve by 2015 by implementing the Stop TB strategy. Strategic directions for achieving targets and the working group plans of key partnerships are detailed in conjunction with an outline of the global and regional scenarios for TB control. Available at: <http://www.stoptb.org/globalplan/assets/documents/GlobalPlanFinal.pdf>

**Tuberculosis care with TB–HIV co-management: Integrated Management of Adolescent and Adult Illness (IMAI).** (2007) WHO. English. Type of document: Operational guidelines. Target audience: Health-care workers: primary health workers at health centre and outpatient of district hospital. Implementation focus: Health centre or outpatient facility, district hospital. This simplified operational guideline is based on WHO normative guidelines, and serves both as a learning and job aid. The new guideline module is fully integrated with other IMAI guideline modules, and addresses the diagnosis and treatment of TB disease in both HIV-positive and HIV-negative patients for first-level facility health workers. Guidelines for diagnosis of smear-negative patients according to the

latest normative guideline are included. The publication also offers clear guidelines for HIV testing in TB patients, as well as specific recommendations for co-management of TB–HIV including ART. Available at: [http://whqlibdoc.who.int/publications/2007/9789241595452\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595452_eng.pdf) Facilitator's guide: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_fac.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_fac.pdf) Participant's manual: [http://www.who.int/hiv/pub/imai/primary/tbhiv\\_comgt\\_partman.pdf](http://www.who.int/hiv/pub/imai/primary/tbhiv_comgt_partman.pdf)

#### 4.6.2 Viral hepatitis

**HIV/AIDS treatment and care for injecting drug users: clinical protocol for the WHO European Region.** (2007) WHO-EURO, Eramova I, Matic S, Munz M. English, Russian. Type of document: Normative guidelines. Target audience: Programme managers, policy-makers, clinicians. Implementation focus: Regional, facility. This publication contains 13 treatment and care protocols that have been specifically developed for the entire WHO European Region. The protocols represent a comprehensive and evidence-based tool that offers clear and specific guidance on diagnosing and managing a wide range of HIV/AIDS health-related issues in adults, adolescents and children. These issues arise during ART, managing OIs, TB, hepatitis, injecting drug use, sexual and reproductive health, PMTCT, immunizations, palliative care, and PEP. Check for future updates at [www.euro.who.int/aids](http://www.euro.who.int/aids). Available at: <http://www.euro.who.int/document/e90840.pdf>

**Management of hepatitis C and HIV coinfection: clinical protocol for the WHO European region.** WHO-EURO. English. Type of document: Clinical management protocol. Target audience: Clinicians. Implementation focus: National, regional. Comprehensive guidelines for HCV diagnosis and management. Available at: [http://www.euro.who.int/document/SHA/e90840\\_chapter\\_6.pdf](http://www.euro.who.int/document/SHA/e90840_chapter_6.pdf)

**Hepatitis B. (2009)** WHO. English. Type of document: Web page. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: [http://www.who.int/immunization\\_delivery/new\\_vaccines/hepb/en/index.html](http://www.who.int/immunization_delivery/new_vaccines/hepb/en/index.html)

**Hepatitis B factsheet.** (2009) WHO. English. Type of document: Factsheet. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: <http://www.who.int/mediacentre/factsheets/fs204/en/>

**Hepatitis B. (2009)** WHO-WPRO. English. Type of document: Web page with links. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: [http://www.wpro.who.int/health\\_topics/hepatitis\\_b/](http://www.wpro.who.int/health_topics/hepatitis_b/)

**Hepatitis C factsheet.** (2009 under revision) WHO. English. Type of document: Web page. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: [http://www.who.int/immunization/topics/hepatitis\\_c/en/index.html](http://www.who.int/immunization/topics/hepatitis_c/en/index.html)

**Hepatitis C.** (2009) CDC. English. Type of document: Factsheets and guidelines with links. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: <http://www.cdc.gov/hepatitis/HCV/index.htm>

**WHO EURO hepatitis website.** 2009. WHO-EURO. English. Type of document: Web page. Target audience: Health care workers. Implementation focus: Clinic, facility. Available at: [http://www.euro.who.int/aids/hepatitis/20070621\\_1](http://www.euro.who.int/aids/hepatitis/20070621_1)

#### 4.7 Substance use

**Management of substance abuse** (2009) WHO. English. Type of document: Web page. Target audience: Clinicians, policy makers. Implementation focus: Regional, facility. This website contains information pertaining to psychoactive substance use and abuse, and also information about the World Health Organization's projects and activities in the areas of substance use and substance dependence. Available at: [http://www.who.int/substance\\_abuse/en/](http://www.who.int/substance_abuse/en/)

**Treatment approaches for drug addiction.** (NIDA) Type of document: Factsheet. Target audience: Clinicians

Implementation focus: Clinic, facility. This document covers research findings on effective treatment approaches for substance abuse and addiction. [http://www.nida.nih.gov/PDF/InfoFacts/IF\\_Treatment\\_Approaches\\_2009\\_to\\_NIDA\\_92209.pdf](http://www.nida.nih.gov/PDF/InfoFacts/IF_Treatment_Approaches_2009_to_NIDA_92209.pdf)

**Operational guidance for the management of opioid dependence.** (WHO SEARO) Type of document: Guideline Target audience: Clinicians Implementation focus: Facility, clinic. The comprehensive guidelines provide a frame work for evidence based management of opioid dependence in South-East Asia. [http://www.searo.who.int/LinkFiles/Publications\\_guidelines\\_management\\_opioid\\_\\_in\\_SEAR.pdf](http://www.searo.who.int/LinkFiles/Publications_guidelines_management_opioid__in_SEAR.pdf)

**Comprehensive management of substance abuse.** (NIH US) Type of document: Guidelines. Target audience: Clinicians. Implementation focus: Clinic, facility. Case management based guidelines for substance abuse treatment providers. <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A49769>

**Drug abuse and addiction. Signs, symptoms and help for drug problems.** Type of document: Web page fact sheet. Target audience: Clinicians, general population. Implementation focus: Clinic, facility, individual. This site has general information on substance abuse and multiple related links. [http://www.helpguide.org/mental/drug\\_substance\\_abuse\\_addiction\\_signs\\_effects\\_treatment.htm](http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm)

**Over the influence: the harm reduction guide to managing drugs and alcohol.** Type of document: Web page Target audience: Clinicians, general population. Implementation focus: Clinic, facility, individual. Description of the text and link to Drug Policy Alliance Network. <http://www.drugpolicy.org/library/bookstore/denning0204.cfm>

## 4.8 Laboratory issues

**Consultation on technical and operational recommendations for clinical laboratory testing harmonization and standardization: helping to expand sustainable quality testing to improve the care and treatment of people infected with and affected by HIV/AIDS, TB, and Malaria. (22–24 January 2008 Maputo, Mozambique).** (2008) WHO, WHO-AFRO, US CDC and American Society for Clinical Pathology. English. Type of document: Consultation report Target audience: Policy makers, laboratory service providers. Implementation focus: National, regional. A detailed summary from a consensus aimed at strengthening laboratory capacity in resource limited settings. Available at: [http://www.who.int/diagnostics\\_laboratory/3by5/Maputo\\_Meeting\\_Report\\_7\\_7\\_08.pdf](http://www.who.int/diagnostics_laboratory/3by5/Maputo_Meeting_Report_7_7_08.pdf)

**Summary of WHO recommendations for clinical investigations by level of health care facility.** (2007) WHO. English. Type of document: Guideline. Target audience: Clinicians. Implementation focus: National, regional, facility. A concise summary of health care level based recommended investigations. Available at: <http://www.who.int/hiv/amds/WHOLabRecommendationBylevelFinal.pdf>

### 4.8.1 Laboratory services for HIV diagnosis

**Guidelines for assuring the accuracy and reliability of HIV rapid testing: applying a quality system approach.** (2005) WHO and CDC. English. Type of document: Evidence, policy and advocacy; operational guidelines. Target audience: Programme managers and planners, policy-makers, testing personnel. Implementation focus: National, district, facility. This document establishes guidelines for applying the quality systems that are essential for HIV rapid testing. It is intended to help all people involved in policy development, planning and implementing HIV rapid testing. The guide covers organization and management, personnel, equipment, purchasing and inventory, process controls, records and information management, as well as offering guidance on implementation. Available at: [http://whqlibdoc.who.int/publications/2005/9241593563\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9241593563_eng.pdf)

**Overview of HIV rapid test training package. US CDC and WHO.** English. Type of document: Guideline . Target audience: Laboratory personnel, programme managers Implementation focus: Facility, clinic. This document

summarises an HIV rapid test training curriculum. Available at: <http://wwwn.cdc.gov/dls/ila/hivtraining/Overview.pdf>

**HIV rapid test training: framework for a systematic roll-out.WHO and US CDC.** English.Type of document: Guideline.Target audience: Policy makers, programme managers. Implementation focus: National, regional. This document summarises recommendations for a systematic roll-out of HIV rapid testing Available at: <http://wwwn.cdc.gov/dls/ila/hivtraining/Framework.pdf>

**HIV testing in the WHO Western Pacific Region.** Type of document: Target audience: Program managers and health professionals. Implementation focus: National. Available at: <http://www.wpro.who.int/internet/resources.ashx/HSI/docs/HIV+testing+in+the+Western+Pacific+Region.pdf>

## Chapter 5: Strategic information

### **MSM population size estimation**

**Estimation of the size of high risk groups and HIV prevalence in high risk groups in concentrated epidemics (2009).** English.Type of document: Meeting of Experts Report.Target audience: Programme managers, researchers, strategic information personnel. Implementation focus: National (country programme level), regional or local. This document presents the major methods available for estimating the size of populations at high risk for HIV, and outlines the strengths and weaknesses of each method. It also explores how best to choose the right method for a given country situation and subpopulation. Available at: [http://www.epidem.org/Publications/Amsterdam%20Report\\_July%202009.pdf](http://www.epidem.org/Publications/Amsterdam%20Report_July%202009.pdf)

**Estimating the number of men who have sex with men in low and middle income countries. (2006)** Caceres CF et al. Sexually Transmitted Infections, 2006, 82 (Suppl 3):iii3–iii9.Type of document: Peer reviewed journal article.Target audience: Programme managers, researchers. Implementation focus: Global, national. An analysis of published and unpublished surveillance and research data on the prevalence of same-sex sexual activity among male adults, including male-to-female TG and sex workers, in low- and middle-income countries. Available at: [http://sti.bmj.com/cgi/content/abstract/82/suppl\\_3/iii3](http://sti.bmj.com/cgi/content/abstract/82/suppl_3/iii3)

**Epidemiology of male same-sex behaviour and associated sexual health indicators in low- and middle-income countries: 2003–2007 estimates. (2008)** Caceres CF et al. Sexually Transmitted Infections, 2008, 84 (Suppl 1): i49–i56. English.Type of document: Peer reviewed journal article.Target audience: Programme managers, researchers. Implementation focus: Global, national. A systematic review of published and unpublished data on the prevalence of male-to-male sex in the total male population, data on the prevalence of heterosexual activity and unions among MSM, and data on associated sexual health indicators. Available at: [http://sti.bmj.com/cgi/reprint/84/Suppl\\_1/i49](http://sti.bmj.com/cgi/reprint/84/Suppl_1/i49)

### **Surveillance for HIV, AIDS and STIs and related behaviours**

**Guidelines for second generation HIV surveillance: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2000. (A revised version will be available at some point in 2010)** English. Type of document: Normative guidelines.Target audience: Programme managers, researchers, and strategic information personnel. Implementation focus: National (country programme level), regional or local. This very practical document helps to design and implement second generation HIV surveillance enhancing the quality of data available in countries or regions, to enlighten the development of the proper response.A new version, updated and with more outstanding good case studies is to be published at some point of 2010. <http://www.who>

int/hiv/pub/surveillance/en/cds\_edc\_2000\_5.pdf

**Guidelines on protecting the confidentiality and security of HIV information: proceedings from a workshop**, May 2006. Interim guidelines. (2006) UNAIDS. English. Type of document: Workshop proceedings and interim guidelines. Target audience: Policy-makers, national programme managers. Implementation focus: National. Available at: [http://data.unaids.org/pub/manual/2007/confidentiality\\_security\\_interim\\_guidelines\\_15may2007\\_en.pdf](http://data.unaids.org/pub/manual/2007/confidentiality_security_interim_guidelines_15may2007_en.pdf)

**Guidelines for measuring national HIV prevalence in population-based surveys**. (2005) WHO and UNAIDS. English. Type of document: Normative guidelines. Target audience: Programme managers, researchers. Implementation focus: National (country programme level). These guidelines assist surveillance officers and programme managers involved in HIV/AIDS surveillance activities in planning and conducting population-based HIV prevalence surveys. The publication also provides guidelines on how to analyse and reconcile national population-based survey results with those obtained from sentinel surveillance, in order to produce an estimate of HIV prevalence in a country. Available at: <http://www.who.int/hiv/pub/surveillance/guidelinesmeasuringpopulation.pdf>

**The pre-surveillance assessment: guidelines for planning serosurveillance of HIV, prevalence of sexually transmitted infections and the behavioural components of second generation surveillance of HIV**. (2005) WHO, UNAIDS and Family Health International. English. Type of document: Normative guidelines. Target audience: Programme managers, researchers. Implementation focus: National (country programme level). This publication describes how a pre-surveillance assessment is needed for initial and subsequent rounds of HIV surveillance to ensure that data needs and data gaps are identified and addressed. It provides an overview of pre-surveillance assessment to address the questions needed to plan for surveillance, while taking into account the local epidemiological situation. The publication focuses on periodic HIV serosurveys and both behavioural and STI surveys. Available at: <http://www.who.int/hiv/pub/surveillance/psaguidelines.pdf>

**Guidelines for effective use of data from HIV surveillance systems**. (2004) WHO, UNAIDS, Family Health International and European Commission. English, Spanish. Type of document: Normative guidelines. Target audience: Programme managers, researchers. Implementation focus: National (country programme level). This publication addresses the question of using data collected through second generation HIV surveillance systems. It discusses three areas of data use: programme planning, programme monitoring, and evaluation and advocacy. It also offers examples of how data can be used effectively in these contexts. Available at: English: <http://www.who.int/hiv/strategic/surveillance/en/useofdata.pdf>

**HIV surveillance training modules, WHO Regional Office for South-East Asia**. (2007) WHO-SEARO. English. Type of document: Training modules: District level surveillance officers. Implementation focus: National (district level). Available at: Module 1: Overview of the HIV epidemic with an introduction to public health surveillance [http://www.searo.who.int/LinkFiles/Publications\\_Module-1.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-1.pdf)  
Module 2: HIV clinical staging and case reporting [http://www.searo.who.int/LinkFiles/Publications\\_Module-2.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-2.pdf)  
Module 3: HIV serosurveillance [http://www.searo.who.int/LinkFiles/Publications\\_Module-3.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-3.pdf)  
Module 4: Surveillance for sexually transmitted infections [http://www.searo.who.int/LinkFiles/Publications\\_Module-4.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-4.pdf)  
Module 5: Surveillance of HIV risk behaviours [http://www.searo.who.int/LinkFiles/Publications\\_Module-5.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-5.pdf)  
Module 6: Surveillance of populations at high risk for HIV transmission [http://www.searo.who.int/LinkFiles/Publications\\_Module-6.pdf](http://www.searo.who.int/LinkFiles/Publications_Module-6.pdf)  
Facilitator training guide for HIV surveillance [http://www.searo.who.int/LinkFiles/Publications\\_facilitator.pdf](http://www.searo.who.int/LinkFiles/Publications_facilitator.pdf)

## Research

**Global consultation on MSM and HIV/AIDS research**. (2008) amFAR. English. Type of document: Report of a global consultation. Target audience: Researchers, programme managers. Implementation focus: Global, national. Report of a global consultation process and a separate meeting to consider a wide range of research priorities



on MSM and HIV/AIDS, including epidemiology and surveillance, biomedical interventions, behavioural sciences, social sciences, and human rights and policy. Available at: [http://www.amfar.org/uploadedFiles/Articles/Articles/Around\\_The\\_World/MSM/Global%20Consultation%20on%20MSM-FINAL.pdf?n=6150](http://www.amfar.org/uploadedFiles/Articles/Articles/Around_The_World/MSM/Global%20Consultation%20on%20MSM-FINAL.pdf?n=6150)

## **Operations research**

**Guide to operational research in programs supported by the Global Fund.** (2007) WHO and GFATM. English. Type of document: Monitoring, evaluation and quality assurance. Target audience: Programme managers, programme planners, policy-makers, researchers. Implementation focus: National. This document describes the value of, and approaches to operational research in the context of Global Fund-supported programmes, including a description of the process and practical examples. Available at: [http://www.who.int/hiv/pub/epidemiology/SIR\\_operational\\_research\\_brochure.pdf](http://www.who.int/hiv/pub/epidemiology/SIR_operational_research_brochure.pdf)

**Framework for operations and implementation research in health and disease control programmes.** (2007) WHO, GFATM, UNAIDS, USAID, TDR and World Bank. English. Type of document: Monitoring, evaluation and quality assurance. Target audience: Programme managers, programme planners, policy-makers, researchers. Implementation focus: National. This document was developed by WHO, Global Fund and other partners. It explains the definitions and scope of operational research, describes the steps needed to include operational research in Global Fund grant applications, and provides case studies of operational research activities from the field. Available at: <http://www.theglobalfund.org/documents/me/FrameworkForOperationsResearch.pdf>

**HIV testing, treatment, and prevention: generic tools for operational research.** (2009) WHO. English. Type of document: Tools for operational research. Target audience: Programme managers, researchers. Implementation focus: National. This document provides generic tools to assist data collection on key topics including adherence to ARVs, prevention of transmission by those under treatment, stigma, and testing for HIV. Available at: [http://www.who.int/hiv/pub/operational/or\\_generic\\_tools.pdf](http://www.who.int/hiv/pub/operational/or_generic_tools.pdf)

## **Monitoring and evaluation**

**Monitoring and reporting on the health sector's response towards universal access to HIV/AIDS treatment, prevention, care and support 2009–2101. WHO framework for global monitoring and reporting.** (2009) WHO. English. Type of document: M&E framework. Target audience: National programme managers. Implementation focus: Global and national. This framework contains a set of core indicators to monitor progress in the health sector towards universal access to HIV prevention, treatment and care by 2010. Available at: [http://www.who.int/hiv/universalaccess2010/hiv\\_me\\_framework\\_2009-10.pdf](http://www.who.int/hiv/universalaccess2010/hiv_me_framework_2009-10.pdf)

**A framework for monitoring and evaluating HIV prevention programmes for most-at-risk populations.** (2008) UNAIDS, English. Type of document: Guidelines. Target audience: Programme managers, researchers. Implementation focus: National and subnational (country programme level). This document provides an overview of M&E methods and approaches for most-at-risk populations. Available at: [http://data.unaids.org/pub/Manual/2007/JC1519\\_me\\_Framework\\_en.pdf](http://data.unaids.org/pub/Manual/2007/JC1519_me_Framework_en.pdf) Behaviour change and HIV prevention: (re)considerations for the 21st century. (2008) Global HIV Prevention Working Group. English, French, Spanish, Russian. Type of document: Evidence-based review of HIV behaviour change strategies. Target audience: Programme managers and implementers. Implementation focus: National and subnational (country programme level). The report surveys what is known about the effectiveness of behaviour change strategies, what still needs to be learnt, and what needs to be done to advance such efforts. Available at: [http://www.globalhivprevention.org/pdfs/PWG\\_behavior%20report\\_FINAL.pdf](http://www.globalhivprevention.org/pdfs/PWG_behavior%20report_FINAL.pdf)

## **Using strategic information effectively for programme improvement**

**HIV triangulation resource guide: synthesis of results from multiple sources for evaluation and**

**decision-making.** (2009) The Global Fund, WHO, UNAIDS. English. Type of document: Guidelines. Target audience: Programme managers and monitoring and evaluation staff. Implementation focus: National. Available at: [http://www.who.int/hiv/pub/surveillance/hiv\\_trianguation\\_guide.pdf](http://www.who.int/hiv/pub/surveillance/hiv_trianguation_guide.pdf)

**Guidelines for effective use of data from HIV surveillance systems.** (2004) UNAIDS Working Group on Global HIV/AIDS/STI surveillance. English. Type of document: Guidelines. Target audience: Programme managers and surveillance staff. Implementation focus: National. Available at: <http://www.who.int/hiv/strategic/surveillance/en/useofdata.pdf>

**Male to male sex and HIV/AIDS in Asia. MAP Report** (2005) Type of document: Evidence-based advocacy. Target audience: Programme managers. Implementation focus: Regional and national. Available at: [http://www.mapnetwork.org/docs/MAP\\_&M%20Book\\_04July05\\_en.pdf](http://www.mapnetwork.org/docs/MAP_&M%20Book_04July05_en.pdf)

### **Situation analysis**

**Rapid assessment and response: adaptation guide on HIV and men who have sex with men (MSM-RAR).** (2004) WHO. English. Type of document: Programme planning: assessment. Target audience: Policy-makers, programme managers, researchers. Implementation focus: National (country programme level). This document provides guidance on how to conduct a rapid assessment and response focusing on lifestyles, behaviours and HIV/AIDS concerns. It outlines a series of simple and practical activities across a variety of settings that may be used to explore the circumstances, experiences and needs of MSM. It is designed to be used either in conjunction with the WHO Rapid Assessment and Response Technical Guide (TG-RAR), or as an independent resource. Available at: [http://www.who.int/entity/hiv/pub/prev\\_care/en/msmrar.pdf](http://www.who.int/entity/hiv/pub/prev_care/en/msmrar.pdf)

### **Setting targets**

**Setting national targets for moving towards universal access: operational guidance.** (2006) UNAIDS. English. Type of document: Monitoring, evaluation and quality assurance. Target audience: Programme managers, programme planners, policy-makers. Implementation focus: National. This document offers operational guidance to countries to set targets for scaling up towards universal access to prevention, treatment, care and support services. Available at: [http://data.unaids.org/pub/Guidelines/2006/20061006\\_report\\_universal\\_access\\_targets\\_guidelines\\_en.pdf](http://data.unaids.org/pub/Guidelines/2006/20061006_report_universal_access_targets_guidelines_en.pdf)

**Considerations for countries to set their own national targets for HIV prevention, treatment and care.** (2006) UNAIDS. English. Type of document: Normative guidelines. Target audience: Programme managers, researchers. Implementation focus: National (country programme level). This publication describes the key considerations for countries to set their own national targets for HIV prevention, treatment and care. It provides guidance to help countries define and prioritize their efforts in order to come as close as possible to universal access by 2010. Available at: [http://data.unaids.org/pub/Report/2006/Considerations\\_for\\_target\\_setting\\_April2006.pdf](http://data.unaids.org/pub/Report/2006/Considerations_for_target_setting_April2006.pdf)

**Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.** (2007) WHO, UNODC and UNAIDS. English. Type of document: Monitoring, evaluation and quality assurance. Target audience: Programme managers, programme planners, policy-makers. Implementation focus: National. This document provides technical guidance to countries for setting national targets for scaling-up towards universal access to HIV prevention, treatment and care for IDUs. It includes a framework and process to set national targets, a comprehensive package of core interventions for IDUs, a set of indicators and indicative targets (or “benchmarks”) to be used to set programmatic objectives, and to monitor and evaluate HIV interventions for IDUs. It includes examples of data sources and indicative targets. Available at: <http://www.who.int/hiv/idu/TechnicalGuideTargetSettingApril08.pdf>

## Data quality

**Routine data quality assessment tool (RDQA): guidelines for implementation (Draft).** (2008) Global Fund, WHO, UNAIDS and USAID. English. Type of document: Tool. Target audience: Monitoring and evaluation staff. Implementation focus: National. Available at: <http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/RDQA%20Guidelines-Draft%207.30.08.pdf>

## Chapter 6: Leadership and governance

### Strengthening and expanding health systems

#### Integration and linkage of health services

**Integrated health services: what and why?** (2008) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Programme managers, policy-makers. Implementation focus: National. This WHO technical and policy brief describes integration of services, including a discussion of definitions, rationale and key considerations. This complex issue is simplified in the paper by breaking it down into a series of practical questions about who does what at what levels of a health system. Available at: [http://www.who.int/healthsystems/service\\_delivery\\_techbrief1.pdf](http://www.who.int/healthsystems/service_delivery_techbrief1.pdf)

**Interim policy on collaborative TB/HIV activities.** (2004) WHO. English, French, Russian, Spanish. Type of document: HIV treatment and care. The interim policy on collaborative TB/HIV activities provides the type of activities and the circumstances in which they need to be implemented. The Global TB/HIV Working Group has been forging a collaboration between the HIV/AIDS and TB control programmes, nurturing the evidence-base and promoting experience sharing for providing optimal patient-centred prevention and care for HIV-infected TB patients. Available at: [http://whqlibdoc.who.int/hq/2004/WHO\\_HTM\\_TB\\_2004.330\\_eng.pdf](http://whqlibdoc.who.int/hq/2004/WHO_HTM_TB_2004.330_eng.pdf)

**Reproductive Health Matters: ensuring the sexual and reproductive health of people living with HIV: policies, Programs and Health Services. Reproductive Health Matters, 2007, 15 (Suppl 1): 1–135.** (2007) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Programme managers, policy-makers. Implementation focus: this journal publication addresses the reproductive health rights and needs of HIV-positive women and men, their partners, children and families. Available at: <http://www.who.int/reproductivehealth/publications/rtis/rhmatters/en/print.html>

**Redefining AIDS in Asia – crafting an effective response: report of the Commission of AIDS in Asia** (2008) UNAIDS. English. Type of document: Report. Target audience: Policy makers, programme managers, clinicians, health-care workers. Implementation focus: This publication is a review of the report of the Commission of AIDS in Asia which reviewed over 5,000 papers; commissioned almost 30 new studies in a range of areas; engaged more than 30 specialists to examine and propose new and innovative ways to address the epidemics in Asia; surveyed over 600 members from community-based organizations and other members of civil society; and staged two sub-regional workshops and five country missions, listening to testimonies on the HIV situation and response from Government and civil society representatives. Available at: [http://data.unaids.org/pub/Report/2008/20080326\\_report\\_commission\\_aids\\_en.pdf](http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf)

#### Demand and access

**Preparing for treatment programme (WHO website).** WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Policy makers, programme managers, clinicians, health-care workers. Implementation focus: This programme sets out WHO's policy position on GIPA and treatment access. WHO

recognizes that engaging PLHIV is essential in order to achieve the goals of the WHO/UNAIDS “3 by 5” Initiative. These groups need to know the facts about HIV and AIDS, and how to treat and manage side-effects (treatment literacy) for themselves and for the support of others in their community. They need to be able to advocate for treatment and participate in public policy decisions related to HIV and AIDS (advocacy), and to develop a social movement that engages with and complements the public health system (community mobilization). Available at: <http://www.who.int/3by5/partners/ptp/en/>

**Missing the target #5: improving AIDS drug access and advancing health care for all.** ITPC. English. Type of document: Evidence, policy and advocacy. Target audience: Policy makers, programme managers, clinicians, health-care workers. Implementation focus: This link provides access to the website of the International Treatment Preparedness Coalition, which is a community group that supports scaling up HIV treatment and other HIV services, and advocates for universal access to treatment. The website contains documents and publications that help AIDS activists to become aware of global developments and the importance of PLHIV being able to gain access to treatment. Available at: <http://www.aidstreatmentaccess.org/itpc5th.pdf>

**Service delivery model on access to care and antiretroviral therapy for people living with HIV/AIDS.** (2004) International Federation of Red Cross and Red Crescent Societies. English. Type of document: Service delivery model. Target audience: Policy makers, programme managers, clinicians, health-care workers. Implementation focus: This guide provides a comprehensive service delivery model for the provision of ART in collaboration between governments NGOs and other partnerships. Available at: [http://www.ifrc.org/cgi/pdf\\_pubshealth.pl?service-delivery-en.pdf](http://www.ifrc.org/cgi/pdf_pubshealth.pl?service-delivery-en.pdf)

## **Health workforce**

**Tools for planning and developing human resources for HIV/AIDS and other health services.** (2006) WHO and MSH. English. Type of document: Operational guidelines. Target audience: Programme managers, programme planners, policy-makers. Implementation focus: Global, regional, national, district. This manual provides useful information on forecasting human resource needs to adequately train and supply a sufficiently large workforce. Among other things, it covers: an analytical framework and method to update health workforce policy; rapid assessment of human resource management needs; the impact of HIV and AIDS on human resources; as well as a model for estimating workforce needs for ART; and other priority health services. A spreadsheet application helps to estimate the size of the necessary health workforce. Available at: [http://www.who.int/hrh/tools/tools\\_planning\\_hr\\_hiv-aids.pdf](http://www.who.int/hrh/tools/tools_planning_hr_hiv-aids.pdf)

**Joint ILO/WHO guidelines on health services and HIV/AIDS.** (2005) WHO and ILO. Arabic, Chinese, English, French, Spanish, Russian, Indonesian, Vietnamese. Type of document: Operational guidelines; programme planning and management. Target audience: Programme managers, policy-makers. Implementation focus: National, district, facility. This WHO and ILO operational guidance is aimed at assisting health services in building their capacity to provide their workers with a safe, healthy and decent working environment. This is seen as the most effective way to reduce transmission of HIV and other blood borne pathogens, and to improve the delivery of care to patients. Available at: [http://whqlibdoc.who.int/publications/2005/9221175537\\_eng.pdf](http://whqlibdoc.who.int/publications/2005/9221175537_eng.pdf)

**Task-shifting: treat, train and retain. Global recommendations and guidelines.** (2008) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Policy-makers, programme managers, programme planners. Implementation focus: Global. This publication covers WHO’s recommendations on task-shifting as part of a solution to the global health workforce crisis within the response to HIV/AIDS. Available at: <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>

**IMAI-IMCI task-shifting implementation support brochure.** (2008) WHO. English. Type of document: Brochure. Target audience: Clinicians, health-care workers. Implementation focus: Tool for HIV prevention, care and treatment. Available at: [http://www.who.int/hiv/pub/imai/IMAI\\_IMCI\\_taskshifting\\_brochure.pdf](http://www.who.int/hiv/pub/imai/IMAI_IMCI_taskshifting_brochure.pdf)

## Financing

**Costing guidelines for HIV/AIDS intervention strategies.** (2004) UNAIDS and ADB. English.

Type of document: Programme planning and management. Target audience: Programme managers, policy-makers. Implementation focus: National. This tool helps to estimate resource needs for health sector scale-up and strategic planning. The booklet provides assistance and guidance in costing for selected HIV/AIDS interventions to planners and programme managers at country level. It provides a scheme for rapid costing assessments (RCAs) including a spreadsheet (INPUT) for generating local data on unit costs. Available at: [http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines\\_en.pdf](http://data.unaids.org/publications/IRC-pub06/JC997-Costing-Guidelines_en.pdf)

**Achieving universal health coverage: developing the health financing system.** (2005) WHO. English.

Type of document: Evidence, policy and advocacy. Target audience: Programme managers, policy-makers. Implementation focus: National. This technical and policy brief covers the development of a health financing system for achieving universal health coverage. The roles of prepayment and reduced reliance on out-of-pocket payments and user fees are discussed. Available at: [http://www.who.int/health\\_financing/documents/pb\\_e\\_05\\_1-universal\\_coverage.pdf](http://www.who.int/health_financing/documents/pb_e_05_1-universal_coverage.pdf)

**WHO discussion paper: the practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care.** (2005) WHO. English.

Type of document: Evidence, policy and advocacy; programme planning and management. Target audience: Programme managers, policy-makers. Implementation focus: National, district. This evidence and policy paper covers the practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. It argues that free HIV treatment and care at the point of service delivery is necessary for universal access. Available at: <http://www.who.int/hiv/pub/advocacy/promotingfreeaccess.pdf>

## Leadership and governance

**The Global Fund country coordinating mechanisms (CCMs) website.** TGF. English.

Type of document: Website Target audience: Policy-makers, programme managers, programme planners. Implementation focus: Country coordinating mechanisms are central to the Global Fund's commitment to local ownership and participatory decision-making. These country-level partnerships develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval, they oversee progress during implementation. Country coordinating mechanisms include representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions, private businesses, and people living with the diseases. The Fund's website offers guidance on its operation. Available at: <http://www.theglobalfund.org/en/apply/mechanisms/>

**“Three Ones“ key principles: coordination of national responses to HIV/AIDS: guiding principles for national authorities and their partners.** (2004) UNAIDS. English.

Type of document: Normative guidelines; programme planning and management; monitoring, evaluation and quality assurance. Target audience: Policy-makers, programme managers, programme planners. Implementation focus: Global, regional, national. This policy note states that there has been a marked shift in the global response to the complex AIDS crisis, adding that national responses are broader and stronger, and have improved access to financial resources and commodities. It provides details on the “Three Ones” principle that aims to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management. The principle includes: One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; One National AIDS Coordinating Authority with a broad-based multisectoral mandate; One agreed country-level Monitoring and Evaluation System. Available at: [http://data.unaids.org/UNA-docs/Three-Ones\\_KeyPrinciples\\_en.pdf](http://data.unaids.org/UNA-docs/Three-Ones_KeyPrinciples_en.pdf)

**WHO's global health sector strategy for HIV/AIDS 2003–2007.** WHO. English.

Type of document: Normative guidelines. Target audience: Policy-makers, programme managers, programme planners. Implementation focus: Global, regional, national. This guideline defines the health sector's role within a multisectoral HIV response, and provides a checklist for what leaders might wish to achieve with their efforts.

Available at: [http://www.who.int/hiv/pub/advocacy/GHSS\\_E.pdf](http://www.who.int/hiv/pub/advocacy/GHSS_E.pdf)

**International guidelines on HIV/AIDS and human rights: 2006 consolidated version.** (2006) UNAIDS and UNHCR. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: Global, regional, national. These guidelines provide technical guidance on putting into operation a rights-based approach to HIV/AIDS. Available at: [http://whqlibdoc.who.int/unaid/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/unaid/2006/9211541689_eng.pdf)

**The Sydney Declaration: good research drives good policy and programming – a call to scale up research.** (2007) I.A. Society. English. Type of document: Report. Target audience: Policy-makers, programme managers, programme planners. Implementation focus: This document outlines the importance of research driving good policy and planning. Available at: <http://www.iasociety.org/Default.aspx?pagelid=63>

### ***Involving MSM and TG***

**The greater involvement of people living with HIV (GIPA): UNAIDS policy brief.** (2007) UNAIDS. English. Type of document: Evidence, policy and advocacy; normative guidelines; programme planning and management; monitoring, evaluation and quality assurance. Target audience: Policy-makers, programme managers and planners. Implementation focus: Global, regional, national. This UNAIDS publication urges everyone involved in the AIDS response to ensure that PLHIV have the scope and practical support to achieve a greater and more meaningful involvement in the response to the epidemic. It sets out the GIPA Principle which aims to realize the rights and responsibilities of PLHIV, including their right to self-determination and participation in decision-making processes that affect their lives. This Principle was formalized at the 1994 Paris AIDS Summit when 42 countries agreed to “support a greater involvement of people living with HIV at all levels, and to stimulate the creation of supportive political, legal and social environments”. Available at: [http://data.unaids.org/pub/BriefingNote/2007/JC1299\\_Policy\\_Brief\\_GIPA.pdf](http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf)

**Healthy alliances in HIV prevention.** <http://www.library.nhs.uk/publichealth/ViewResource.aspx?resID=323705>

### ***Involving civil society***

**Scaling up effective partnerships: a guide to working with faith-based organisations in the response to HIV and AIDS.** (2006) Church World Service, Ecumenical Advocacy Alliance, UNAIDS, Norwegian Church Aid and World Conference of Religions for Peace. English. Type of document: Operational guidelines. Target audience: Programme managers and planners, policy-makers. Implementation focus: Global, regional, national. This is a toolkit on how to improve collaboration between government and faith-based organizations. It provides background information and case studies, counteracts myths, and offers practical guidance to people who wish to collaborate with faith-based organizations on joint projects related to HIV and AIDS. Available at: <http://www.e-alliance.ch/media/media-6695.pdf>

**Partnership work: the health service–community interface for the prevention, care and treatment of HIV/AIDS.** (2002) WHO. English. Type of document: Evidence, policy and advocacy. Target audience: Programme managers, programme planners, policy-makers, PLHIV, lay counsellors, nurses, clinical officers, implementers, NGOs, health workers, public and private employers, donor representatives. Implementation focus: Global, national, district. This publication identifies three strategies to strengthen the interface between health services and communities in HIV/AIDS work, including strengthening the capacity of the health-care system to interact with communities, capacity of communities to interact with the health services, and processes and methodologies for change. Within these categories, several mechanisms are identified that could enhance the interface between health services and communities. Available at: [http://www.who.int/hiv/pub/prev\\_care/en/37564\\_OMS\\_interieur.pdf](http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf)

**Universal access targets and civil society organizations: a briefing for civil society organizations.**

(2006) UNAIDS. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: This briefing has been produced by UNAIDS specifically for civil society organizations interested in finding out more about the planning, setting and monitoring of Universal Access targets to guide national AIDS work from now until 2010. It highlights suggestions for engaging with this process and in addition to civil society organizations it is also being circulated to UN and government staff with responsibility for encouraging greater civil society engagement in AIDS work. Available at: [http://www.unaids.org/unaidresources/images/Partnerships/061126\\_CSTargetsetting\\_en.pdf](http://www.unaids.org/unaidresources/images/Partnerships/061126_CSTargetsetting_en.pdf)

**Scaling up for better health.** (2008) WHO. English, French. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: The sixth issue of the Scaling-up for Better Health (IHP+) update, profiles Mali, summarize IHP+ consultations on engaging Civil Society Organisations, reports back on the first inter-regional meeting of IHP+ partners in Lusaka, reports on planned support for Global Fund's Round 8 implementation of proposals, and the outcome of the first Global Forum on Human Resources for Health. [http://www.who.int/healthsystems/strategy/IHP\\_update6\\_12Mar.pdf](http://www.who.int/healthsystems/strategy/IHP_update6_12Mar.pdf)

**Stigma and discrimination**

**International guidelines on HIV/AIDS and human rights: 2006 consolidated version.** (2006) UNAIDS and UNHCR. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: Global, regional, national. These guidelines provide technical guidance on putting into operation a rights-based approach to HIV/AIDS. Available at: [http://whqlibdoc.who.int/unaidresources/2006/9211541689\\_eng.pdf](http://whqlibdoc.who.int/unaidresources/2006/9211541689_eng.pdf)

**Reducing HIV stigma and discrimination: a critical part of national AIDS programmes.** (2007) UNAIDS. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: This document presents strategies, programme examples and research findings concerning how governments, the UN system, donors and civil society can make the reduction of HIV-related stigma and discrimination central in the national response to AIDS. Available at: [http://data.unaids.org/pub/Report/2008/jc1420-stigmadiscri\\_en.pdf](http://data.unaids.org/pub/Report/2008/jc1420-stigmadiscri_en.pdf)

**Priority interventions: HIV/AIDS prevention, treatment and care in the health sector.** (2009) World Health Organization. English. Type of document: Evidence, policy and advocacy; normative guidelines. Target audience: Policy-makers, programme managers and programme planners. Implementation focus: This is designed to be a 'living' web-based document that will be periodically updated with new recommendations based on the rapidly-evolving experience of health-sector scale up. Available at: [www.who.int/hiv/pub/priorityinterventions/en/](http://www.who.int/hiv/pub/priorityinterventions/en/)

