



# REGIONAL CONSULTATION ON IMPROVING ACCESS TO PREVENTION, CARE AND TREATMENT OF HIV AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE

**MEETING REPORT**  
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# **Regional Consultation on Improving Access To Prevention, Care and Treatment of HIV among Men who have Sex with Men and Transgender People**

## **Meeting Report**



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# ACKNOWLEDGMENTS

This meeting report documents the presentations and discussions made during 'Regional consultation on improving access to prevention, care and treatment of HIV among men who have sex with men and transgender people' held on 21-23 August 2013 in Bangkok, Thailand.

Paul Causey facilitated the meeting while the consultation report was authored by Saurav Jung Thapa.

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# ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
APCOM	Asia Pacific Coalition on Male Sexual Health
APN+	Asia Pacific Network of People Living with HIV and AIDS
APTN	Asia Pacific Transgender Network
ART	antiretroviral treatment
ARV	antiretroviral
ASEAN	Association of South-East Asian Nations
BCC	behaviour change communication
CBO	community-based organization
CCM	Country Coordinating Mechanism (of the GFATM)
CSS	community systems strengthening
FHI 360	Family Health International
GF or GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRADE	Grading of Recommendations Assessment, Development and Evaluation
GWL-INA	Indonesian National Network of Gay, Waria and Lelaki
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
IBBS	integrated bio-behavioural survey
ICD	International Classification of Diseases
ICT	information communication technology
IDU	injecting drug user
IEC	information, education and communication
ISEAN	Insular South East Asia Network
ISEAN-HIVOS	ISEAN-HIVOS Multi-country Global Fund Programme among MSM and Transgender Persons
KP	Key Populations
LGBT	lesbian, gay, bisexual and transgender people
M&E	monitoring and evaluation
MSM	men who have sex with men
MSMGF	Global Forum on Gay and other Men Who Have Sex with Men
MSW	male sex worker
NAC	National AIDS Committee
NGO	non-governmental organization
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
PSI	Populations Services International
SOGI	sexual orientation and gender identity
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDP APRC	United Nations Development Programme, Asia-Pacific Regional Centre
USAID	United States Agency for International Development
VCT	voluntary HIV counselling and testing
WHO SEARO	World Health Organization, South-East Asia Regional Office

# BACKGROUND

WHO South-East Asia Regional Office (SEARO) in partnership with UNDP and UNAIDS jointly convened a “Regional consultation on improving access to prevention, care and treatment of HIV among men who have sex with men and transgender people” in Bangkok, Thailand on August 21-23, 2013, keeping in mind UN Secretary-General Ban Ki-moon's stated commitment to address historical grievances against lesbian, gay, bisexual and transgender (LGBT) people along with the commitment made on this issue by other senior UN leaders such as UNDP Administrator Helen Clark and UN High Commissioner for Human Rights Navanethem Pillay.

HIV has affected men who have sex with men (MSM) and transgender people in much greater proportions than the general population. New or just recognized epidemics amongst MSM and transgender people are identified in Africa, Asia, the Caribbean and South America, with high and rapidly rising rates of HIV transmission reported in Asia and the Pacific.<sup>1</sup>

Projections of the Asian epidemic indicate that close to 50 percent of all new HIV infections occurring annually in Asia will be identified among MSM by 2020, unless intensified HIV prevention measures are scaled-up; an increase from 13 percent in 2008.<sup>2</sup> Sex between men accounts for approximately a third of known HIV transmissions in Asia and the Pacific, although this is likely to be underreported.<sup>3</sup>

Amongst MSM in Asia, the odds of being infected with HIV are 18.7 times higher than that of the general population.<sup>4</sup> Many of these infections are occurring and will continue to occur among young men and young transgender people as well, with most clustering in urban areas of the region. Recent HIV prevalence rates among MSM are reported in South and South-East Asia at 14.7 percent; East Asia at 5.2 percent; Oceania at 4.4 percent; however, in specific urban areas these rates are much higher, e.g., in Bangkok at 30.8 percent. HIV incidence rates among MSM in Thailand and China also reveal rapidly rising rates of HIV infection.<sup>5</sup>

Due to the lack of protective laws, insufficient skills, incomplete knowledge about male sexuality and sexual health and high level of stigma and discrimination, access to HIV prevention, treatment, care and community support services is limited compared with the share of the HIV burden faced by these populations.

Experts now recognize that in order to halt the ongoing transmission of HIV amongst MSM and transgender people, the blocking of access to health care and prevention services, and the failure to fully recognize other basic individual rights, must stop. Access to adequate health services and social support is recognized as a fundamental human right. Yet stigma in health care settings, including homophobia, sexism and transphobic policies and practices, prevent open and welcoming access for MSM and

<sup>1</sup> Beyrer MD, C, et al. A call to action for comprehensive HIV services for men who have sex with men. The Lancet, Volume 380, Issue 9839, Pages 424 - 438, 28 July 2012.

<sup>2</sup> Commission on AIDS in Asia. (2008). Redefining AIDS in Asia: crafting an effective response. New Delhi: Oxford University Press.

<sup>3</sup> APCOM. Addressing the needs of young men who have sex with men (Policy Brief). Bangkok 2012.

<sup>4</sup> Barat 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 (12) e339

<sup>5</sup> Beyrer MD, C, et al. Global epidemiology of HIV infection in men who have sex with men. The Lancet, Volume 380, Issue 9839, Pages 367 - 377, 28 July 2012.

transgender people. The cause is often the negative attitudes of clinicians and support staff together with incomplete or inaccurate knowledge about sexual orientation and gender identity (SOGI).<sup>6,7</sup> In 2011, WHO issued guidelines identifying that significant barriers to the uptake of services included insensitive communication and counselling with MSM and transgender clients and insufficient skills related to male sexual health (particularly lack of knowledge about pharyngeal and ano-rectal conditions).<sup>8</sup>

WHO and UNDP, in partnership with USAID, UNAIDS and the Asia Pacific Coalition on Male Sexual Health (APCOM), have been working together to better understand the legal and human rights aspects and other social determinants of the HIV epidemic, identify priority health sector interventions and propose approaches to address stigma and discrimination that hinder health care seeking.

Following recommendations in the existing regional and recently launched WHO global guidance (2011), UNDP APRC and WHO (SEARO and WPRO) have developed a training package focusing on skills training of health care providers providing HIV/STI related services to MSM and transgender people, and the reduction of stigma in health care settings. UNDP is providing technical assistance to this regional initiative under the ISEAN-HIVOS Multi-Country Global Fund Round 10 grant in four countries of insular South-East Asia: Indonesia, Malaysia, the Philippines and Timor-Leste. The training package references the existing regional and newly launched WHO global guidance, "Men who have sex with men and transgender people: Prevention and treatment of HIV and other sexually transmitted infections: Recommendations for a public health approach",<sup>9</sup> and was jointly developed by UNDP and WHO.

Citing the United Nations Charter and the Universal Declaration of Human Rights, United Nations Secretary-General Ban Ki-moon recently proclaimed that the United Nations would speak out in support of LGBT people, including men who have sex with men. Calling the recent documentation of violence and discrimination directed at LGBT people "disturbing" – because lives are at stake – he ended his talk before the Human Rights Council of the UN in Geneva on 7 March 2012 with a simple but powerful statement: "The time has come."

In line with supporting the implementation of the global guidance, the training package is intended to focus on improving the skills of health care providers and other key personnel, and to reduce stigma in health care settings. This package was based on practical work in Indonesia, Lao PDR, the Philippines and Thailand. The package development also closely follows recommendations contained in the bi-regional report from WHO, "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" (2010), and the UNDP "Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men and Transgender Populations in Asia and the Pacific" (2009).

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<sup>6</sup> UN Human Rights Council, Nineteen Sessions, Agenda Items 2 and 8. Annual Report of the United Nations High Commissioner for Human Rights and Report of the Office of the High Commissioner and Secretary-General. Discriminatory Law and practices and acts of violence against individuals based on their sexual orientation and gender identity (A/HRC/19/41) 17, November 2011

<sup>7</sup> Report of the Asia Pacific Regional Dialogue of the Global Commission on the HIV and the Law. Bangkok, 17 February 2011, UNDP.

<sup>8</sup> WHO (2011). Prevention and Treatment of HIV and other Sexually Transmitted Infections among Men who have sex with men and Transgender people.

<sup>9</sup> "Men who have sex with men and transgender people: Prevention and treatment of HIV and other sexually transmitted infections: Recommendations for a public health approach," accessible at <http://www.hivlawcommission.org/index.php/report>



The development process involved input and guidance from a number of people experienced in the delivery of health services to MSM and transgender people including a regional consultation with 36 informal experts from nine countries in Asia convened with support from UNDP, WHO (SEARO and WPRO) and others. The training package had also been extensively piloted in China, Indonesia, the Philippines and Timor-Leste.

# MEETING RECORDS

## SESSION 1 MEETING OBJECTIVES AND OPENING SESSION

This “Regional consultation on improving access to prevention, care and treatment of HIV among men who have sex with men and transgender people” was convened keeping in mind recent high level United Nations commitments to the rights and health of gender and sexual minorities. Clifton Cortez, UNDP Asia-Pacific Regional Centre Manager, a.i. and HIV Health and Development Practice Team Leader recalled UN Secretary-General Ban Ki-moon’s stated commitment to address historical grievances against LGBT people along with the commitment made on this issue by other senior UN leaders such as UNDP Administrator Helen Clark and UN High Commissioner for Human Rights Navanethem Pillay. Mr. Cortez noted that these groups face immense human rights challenges when seeking HIV services such as stigma and discrimination, denial of care and violence and that many national constitutions guarantee equitable access to quality health services and inclusive social protection programmes as a right of citizenship – and these same rights should be afforded MSM, transgender people and *hijras* without the obstacles they currently face.

In 2012, WHO collaborated with key partners to publish new global guidelines on addressing prevention, care, and treatment of HIV and STIs among MSM and transgender people. The development of regional guidelines laid the foundation for the development of the “Time Has Come” training package for health care providers developed jointly by WHO SEARO/WPRO and UNDP APRC and key community partners.

The objectives of the regional consultation were to:

- ◆ Review the status of HIV prevention, care and treatment for MSM and transgender people in the Asia-Pacific region;
- ◆ Share country experiences on addressing stigma and discrimination against MSM and transgender people in health care settings;
- ◆ Discuss the WHO-UNDP Regional Health Sector Training Package for men who have sex with men and transgender people;
- ◆ Identify opportunities and constraints for implementation at country level; and
- ◆ Chart the way forward

The opportunity afforded by this consultation was also used to share and discuss the USAID/MEASURE monitoring and evaluation and programming guidelines.

In reviewing and discussing these items, the meeting helped participants understand HIV and STIs among MSM and transgender people in the context of the Asia-Pacific region, to share country experiences, and identify opportunities for implementation of the UNDP-WHO training package at the country level.

Midnight Poonkasetwattana, Executive Director of the Asia-Pacific Coalition for Male Sexual Health (APCOM) noted that HIV has affected MSM and transgender people in much greater proportions than the general population. New or just recognized epidemics amongst MSM and transgender people are identified in Africa, Asia, the Caribbean and South America, with high and rapidly rising rates of HIV transmission reported in Asia and the Pacific. A coalition of MSM and transgender community organizations has been working on addressing HIV issues and ICAAP 11 in November 2013 is a good chance to showcase this work and to discuss what needs to be done next. APCOM will ensure MSM and transgender voices are heard at ICAAP through a pre-conference on 17 November that they will host to better prepare delegates for the main conference.

Dr. Yonas Tegegn, WHO representative to Thailand noted that projections of the Asian epidemic indicate that close to 50 percent of all new HIV infections occurring annually in Asia will be identified among MSM by 2020 unless intensified HIV prevention measures are scaled-up; an increase from 13 percent in 2008. Sex between men accounts for approximately a third of known HIV transmissions in Asia and the Pacific, although this is likely to be underreported.

Amongst MSM in Asia, the odds of being infected with HIV are 18.7 times higher than that of the general population. According to Gautam Yadav, YVC board member and member of the UNAIDS Youth Advisory Forum, many of these infections are occurring and will continue to occur among young men, *hijras*<sup>10</sup>, and young transgender people, with most clustering in urban areas of the region. Recent HIV prevalence rates among MSM are reported in South and South-East Asia at 14.7 percent; East Asia at 5.2 percent; Oceania at 4.4 percent; however, in specific urban areas these rates are much higher, e.g., in Bangkok at 30.8 percent. HIV incidence rates among MSM in Thailand and China also reveal rapidly rising rates of HIV infection.

Experts now recognize that in order to halt the ongoing transmission of HIV in MSM and transgender people, the blocking of access to health care and prevention services, and the failure to fully recognize other basic individual rights, must stop. Access to adequate health services and social support is recognized as a fundamental human right. Yet stigma in health care settings, including homophobia, sexism and transphobic policies and practices, prevent open and welcoming access for MSM and transgender people. The cause is often the negative attitudes of clinicians and support staff together with incomplete or inaccurate knowledge about sexual orientation and gender identity. In 2011, WHO issued guidelines identifying that significant barriers to the uptake of services included insensitive communication and counselling with MSM and transgender clients and insufficient skills related to male sexual health (particularly lack of knowledge about pharyngeal and ano-rectal conditions).

WHO and UNDP, in partnership with USAID, UNAIDS and the Asia Pacific Coalition on Male Sexual Health (APCOM), have been working together to better understand the legal and human rights aspects and other social determinants of the HIV epidemic, identify priority health sector interventions and propose approaches to address stigma and discrimination issues.

Following recommendations in the existing regional and recently launched WHO global guidance (2011), WHO (SEARO and WPRO) and UNDP (APRC) have developed a training package focusing on

<sup>10</sup> "*Hijra* in South Asia are understood as separate sex/gender collectivities – neither men nor women. These groupings often function as a cultural minority, with a distinct history, collective living and even special religious roles." Presentation on Transgender Rights by Prof. Douglas Sanders, Asia and Pacific Transgender Network Development Conference, Bangkok, Thailand, December 13-16, 2009

skills training of health care providers providing HIV/STI related services to MSM and transgender people, and the reduction of stigma in health care settings. UNDP is providing technical assistance to this regional initiative under the ISEAN-Hivos Multi-Country Global Fund Round 10 grant in four countries of insular Southeast Asia: Indonesia, Malaysia, the Philippines and Timor-Leste. The training package references the existing regional and newly launched global guidance, “Men who have sex with men and transgender people: Prevention and treatment of HIV and other sexually transmitted infections: Recommendations for a public health approach”, and was jointly developed by UNDP and WHO.

Dr. Tegegn cited the United Nations Charter and the Universal Declaration of Human Rights as documents that protect the rights of all humans including LGBT people. He noted that United Nations Secretary-General Ban Ki-moon recently proclaimed the United Nations would speak out in support of lesbian, gay, bisexual and transgender people, including men who have sex with men. Calling the recent documentation of violence and discrimination directed at LGBT people “disturbing” – because lives are at stake – the Secretary-General ended his talk before the Human Rights Council of the UN in Geneva on 7 March 2012 with a simple but powerful statement: “The Time has Come,” which is the title of the training package this consultation will be discussing.

In line with supporting the implementation of the global guidance, the training package is intended to focus on improving the skills of health care providers and other key personnel, and to reduce stigma in health care settings. This package was based on practical work in Indonesia, Lao PDR, the Philippines and Thailand. The package development also closely follows recommendations contained in the bi-regional report from WHO, “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” (2010), and the UNDP “Developing a Comprehensive Package of Services to Reduce HIV among Men who have Sex with Men and Transgender Populations in Asia and the Pacific” (2009).

The UNDP-led development process involved input and guidance from a number of people experienced in the delivery of health services to MSM and transgender people including a regional consultation with 36 informal experts from nine countries in Asia convened with support from UNDP, WHO (SEARO and WPRO) and others. The training package had also been extensively piloted in China, Indonesia, the Philippines and Timor-Leste. Malaysia is scheduled to hold a pilot training in October 2013.

## **SESSION 2**

### **STATUS OF PREVENTION, CARE AND TREATMENT FOR MSM AND TRANSGENDER PEOPLE**

An overview of the HIV epidemic and STI infections among MSM in the Asia-Pacific region, including the epidemic and response, financing the response, and the legal environment was provided by UNAIDS.<sup>11</sup>

There is ample evidence that MSM and transgender people suffer disproportionately from the HIV epidemic. MSM infection rates in countries and cities in the region are shockingly high – 20 percent in Thailand, 16.7 percent in Vietnam, 31.3 percent in Bangkok, and 17.2 percent in Jakarta. MSM as a

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<sup>11</sup> “Getting to Zero: Data for action,” Dr. Vladanka Andreeva, Strategic Intervention Adviser on Prevention and Treatment, UNAIDS RST, Presentation on August 21, 2013, Bangkok, Thailand.

proportion of all infections are rising rapidly. In low-income countries in the region, only 14 percent of MSM have access to HIV services.

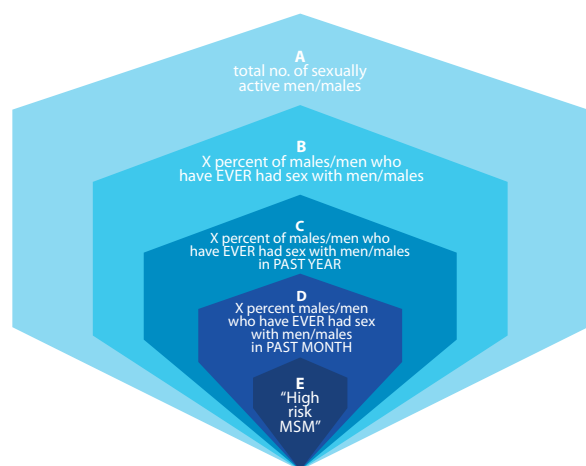
Of the total global AIDS spending of over \$1.3 billion, only less than 1 percent (\$12 million) is targeted specifically towards MSM. Only 26 percent of the total (\$346 million) is earmarked for prevention efforts. Addressing the epidemic among MSM in the Asia-Pacific region is made even more difficult because 18 out of 38 countries criminalize consensual same sex behaviour.

Almost all available data on MSM and transgender people is not disaggregated and for the most part only report on HIV trends among the former. There is an urgent need to get more actionable evidence and data on HIV among transgender people.

Evidence for Treatment as Prevention (TasP) is based on studies of heterosexual cohorts. The applicability of TasP for MSM needs to be further examined.

UNDP APRC presented on “Enabling legal and social environments for effective HIV responses: Maximizing impact of global, regional and national processes.”

Political commitments to addressing the HIV epidemic exist at the global and regional levels starting with the “2011 General Assembly Political Declaration on HIV/AIDS: A Global Commitment to Eliminate HIV/AIDS” in which MSM were recognized as a key target. This needs to be taken up at the national level by developing HIV national strategic plans that promote and protect human rights. Laws and policies that limit access to HIV services should be scrapped and rights based law reforms initiated. Where culture, tradition, religious doctrine and national sovereignty result in violations of human rights and hinder an effective public health response to HIV, they must be challenged.



**Figure 1**  
Presentation on How MSM Population in India was Determined (Ashok Row Kavi, 2013)

The Global Commission on HIV and the Law examined the existing evidence base, convened 7 regional dialogues including in Asia-Pacific, and stated that if “business as usual” continues, there will be 2 million annual HIV infections by 2030. With enhanced legal and policy environments, this can be brought down to approximately 1.2 million new infections.

Ashok Row Kavi of the Humsafar Trust in India made a presentation (see Figure 1) on how target population size estimations have been conducted in Mumbai and what lessons have been learned.

Humsafar Trust saw the need to demonstrate that MSM were an at-risk population for HIV just like FSWs and IDUs. Given the social invisibility of this population, the government was deeply reluctant to identify even a small percentage of male population as MSM as that would have budgetary implications – they would have to set aside more funds to address HIV in MSM and were unwilling and/or unable to do so. After a long process of lobbying and hard work, only 235,000 MSM engaging in the most high risk sexual behaviour were finally accepted as MSM by the government and provided with HIV prevention and treatment support through a Humsafar pilot project. The HIV infection rates among MSM in Mumbai are exponentially higher than the general population, so efforts need to be scaled up substantially.

India is one of the few countries in the region with an actual number of MSM identified; notwithstanding all the flaws in the identification process. It has provided specific HIV interventions with funding in the national budget for this population. It would be useful for other countries in the region to replicate this.

### **SESSION 3**

#### **GUIDANCE FROM GLOBAL AND REGIONAL GUIDELINES**

WHO presented the "Guidelines for the Prevention and Treatment of HIV and STIs among MSM and TG People." This is a clinical and programmatic guidance developed because of the high vulnerability of MSM and transgender people to HIV; MSM are at 19 times higher risk for HIV than the general population and transgender people are at about 49 times higher risk. This is true in both concentrated and generalized epidemics.

Stigma, discrimination and violence impede access to health services for these communities, particularly in the 75 countries that criminalize consensual same sex behaviour between adults.

The WHO guidelines include recommendations on technical issues and good practices as well as prevention of sexual transmission. In instances where there is insufficient evidence, such as male circumcision, the WHO recommends that countries should adopt the guidelines to enable inclusive service provision, to provide evidence based, community-accepted recommendations and to protect human rights and create inclusive environments.

For anti-retroviral therapy, it is recommended that initiation occur earlier at CD4 count less than or equal to 500 for all PLHIV, irrespective of CD4 count for all serodiscordant couples, all pregnant women, all HIV-HBV co-infection with chronic active hepatitis and all HIV TB co-infected. Regarding PrEP, WHO has conditional recommendations.

UNDP APRC gave a detailed overview of "The Time Has Come" training manual, which is designed to train health care providers to be sensitive to the needs of MSM and transgender patients and to reduce stigma in health settings.

Over 200 health care providers were engaged in pilot trainings to improve the manual and assure its relevancy to the region. Primary beneficiaries of the training package will be national and provincial officials overseeing HIV programmes for MSM and transgender people and central health bureaucrats making HIV policy. Next steps for the training package are to implement it in South Asia and Insular Southeast Asia through national trainings. This will be a part of national programmes and 2014 GFATM submissions.



Country experiences from Bhutan, Indonesia and Timor-Leste were shared in panel discussion. In Timor-Leste and Bhutan, meeting participants pointed out, there are no organizations working for MSM and transgender people and the visibility of these groups is very low. Due to conservative religious traditions in Timor-Leste and conservative cultural norms in Bhutan, MSM tend to be very secretive and find it hard to be accepted by society. Doctors and health workers in Bhutan reported little to no levels of interaction with MSM and transgender people; the assumption among them is that homosexuality is a Western thing that is non-existent in traditional societies. Disclosure of non-heterosexual status is often not an option due to the risk of discrimination, ostracism, and even physical harm, in Timor-Leste.

The WHO-UNDP health care training package has already been integrated into the national health care plan of Indonesia. The training has been given to health care and non-health care stakeholders such as police and local authorities involved in taking legal and penal action against MSM and transgender people. This has been achieved despite the fact that Indonesia is a generally conservative Muslim majority country although it does have a secular government.

## **SESSION 4**

### **SUPPORTIVE NATIONAL STRATEGIES AND URBAN RESPONSES**

A panel discussed national strategies and health landscapes of the HIV epidemic among MSM and transgender people in selected Asia-Pacific countries.

In Indonesia, HIV prevalence amongst MSM went from 5.3 percent to 8.4 percent between 2007 and 2011. The national response has been significantly scaled up in response but issues such as condoms generally being available but not appropriate lubricants continue to be common and impede a more effective response.

In India, the government has claimed a reduction of HIV infected MSM from 12 percent to 4 percent but this is likely to be inaccurate based on community-reported new HIV testing results. The current national strategy seeks to reconcile community-based efforts with government efforts, something that has not proven successful in the past.

The first situation analysis of HIV among MSM and transgender people was done in 2006 in the Maldives and the first IBBS with MSM as a key population in 2008. In the last national strategic plan, MSM were identified as a key population but the HIV response among them is difficult as there are no CBO working with MSM and transgender people.

Key populations surveillance in Myanmar among MSM and transgender people, identified HIV prevalence at a shocking 22.3 percent. Stigma and discrimination, religion, and tradition are major obstacles to providing better public health care services for these communities.

Panelists and participants pointed out that the GFATM did include Community Systems Strengthening/human rights strategy with Round 9 funding and urged thinking about how to build on the gains made. For instance, it might be best to integrate services for young MSM into government and community adolescent programmes. The WHO guidance has so far lumped adolescents and adults together but increasingly new guidance is being developed specific to adolescents and youth.

The second panel in this session dealt with "Innovative implementation in urban responses." The HIV Foundation of Thailand noted that encouraging sustainable urban exchanges is important by assisting cities in finding funding. Often, self-help groups are the only ones providing HIV services to positive MSM and transgender people, who are often treated poorly or discriminated against in public health facilities.

A common challenge in providing HIV services to MSM and transgender people across countries such as Bangladesh, Nepal, and Sri Lanka are that stigma and discrimination are normal, limited VCT is available, providing services to hidden populations is difficult, and widespread homophobia complicates the task of reaching those who need services.

Media coverage of MSM and transgender people is overwhelmingly negative because of state-sponsored discrimination including legal prohibition of same sex behaviour, regardless of gender.

Some countries recognize MSM and transgender people as a key population in the national HIV strategy, such as Nepal where the legal environment since a Supreme Court verdict in favour of LGBT people in December 2007 that recognized the rights of those community members.

## **SESSION 5**

### **HIV SITUATION IN THE PHILIPPINES**

The HIV epidemic in the Philippines is concentrated in cities such as Manila, Cebu and Davao. MSM and transgender people have been included in the 2011-2016 national strategic plan on HIV and the government has been directly involved in the response in these populations since 2008. Despite 30 years of the epidemic, the level of awareness about HIV is low. Stigma and discrimination is widespread and affects the ability to provide services.

National guidelines and management protocols on prevention, care, and treatment are urgently needed even though there is little political will to provide HIV funding. As such, the response has been donor driven and dependent on outside sources. The Catholic Church has been a major barrier in the response for promoting HIV service delivery as it has challenged national and provincial government efforts to promote condom distribution and use.

## **SESSION 6**

### **ISSUES AND ACCESS FOR TRANSGENDER PEOPLE AND HIJRAS**

The WHO noted that global guidelines on HIV for sexual minority communities focus very much on MSM. Grouping MSM and transgender people into one category is no longer sufficient for effective response to the current HIV epidemic.

The WHO Civil Society Reference Group on HIV has persuaded the WHO Secretariat to conduct a scoping exercise to document the current state of HIV risk factors and prevalence, including examining the literature on health services and needs, transphobia, and drug use. They will also look at existing guidelines on ART, potential interactions with things such as hormones, PreP, and current guidelines related to sex work and MSM. A final decision on whether to issue global guidelines about transgender people is pending.





After this, a presentation was made on the joint technical brief prepared by WHO, UNAIDS, UNDP, and APTN. Transgender HIV infection rates in the region, where known, are often much higher than that for MSM, such as in Indonesia (41 percent). Having disaggregated data on transgender people's risk factors and HIV trends would be useful for designing better responses. STIs also need to be addressed as they often get ignored and the focus is usually only on HIV. Transgender people are affected by the poor reach of prevention programmes and low condom usage, which varies from 24.5 percent to 85.7 percent in the region.

Hormones and breast implant studies among transgender people are mostly focused on medical processes and less on health effects. Hormone use usually uses contraceptive pills and injections of over the counter drugs with no proper medical support or counselling. Information on hormones is generally obtained from the Internet. Usage starts in transgender people as young as 11 years old, but most start in their early 20s.

While hormones can have positive psychological effects such as feeling good with the physical changes underway, they can also have negative effects such as decreased libido, mood changes, hot flushes, depression, dizziness or migraine headaches. The long-term side effects are unclear and could likely include increased cancer risk. Access to transgender specific health care is very limited and usually delivered by unfriendly service providers. Because of these risks, comprehensive guidance on health care standards for transgender people is needed, especially on hormones usage and surgical procedures intended to modify the body including but not limited to complete gender reassignment.

The challenges faced by transgender people across the region have many similarities. Sexual relationships are often stigmatized and even criminalized by same sex behaviour restrictions when their gender change is not allowed, laws against cross-dressing and by religious practices, such as sharia law in Iran and Malaysia. Transgender people often avoid health care settings because they are often forced to use incorrect hospital wards or clinics, due to lack of understanding of gender issues.

A large number of transgender people must resort to sex work in order to make a living. However, equating transgender status to sex work is neither appropriate nor accurate. The International Classification of Diseases 10 (ICD-10) is under revision and the classification of transgender status as a mental condition is being reviewed. It was noted that transgender status is a medical issue, however, and should be treated as such.

Strategic information on transgender people is sorely lacking. There is a need to empower regional networks to increase national capacity of transgender community organizations and, with support from UNAIDS, a process of recruiting a coordinator for the Asia Pacific Transgender Network is underway.

## **SESSION 7**

### **2013 WORLD HEALTH ORGANIZATION HIV GUIDELINES**

The WHO presented on the evolution of their ART guidelines and how they are moving towards viral load measurement as diagnostics become more available and accessible. The Guidelines are unique as it is the first WHO guidance on when, what and how "to do it". It is not a prescriptive guidance but rather designed to help programme managers prioritize efforts. The 2013 guidelines call for starting ART at a viral load count of 500 or less.

USAID discussed the what, why and how of Treatment as Prevention, or TasP. ART reduces viral load in PLHIV and according to research, people in treatment are 96 percent less likely to transmit HIV to their partners. Community viral load<sup>12</sup> can be brought down to undetectable levels, which may halt the spread of HIV. This also results in huge cost savings over time from reducing the number of people needing treatment.

There is scepticism over TasP because of concerns about accessibility, effectiveness, and toxicity of the drugs, and on whether the model is scalable. There are also concerns over coercion. To implement TasP effectively, we need high rates of testing, strong linkages to care, early ART initiation, adherence and retention. Leaky cascades are a major barrier to the success and effectiveness of TasP and include difficulty in finding HIV positive MSM and transgender people, getting them into treatment and assuring adherence to optimal regimens.

The Ministry of Health in Indonesia has made treatment available to all HIV infected individuals belonging to key populations regardless of CD4 count and has accepted the merits of TasP for key populations. Nevertheless, there remain challenges as few who need testing are actually coming forth. Many of the affected are poor and the cost and logistics are obstacles, such as taking time from work or family obligations and travelling great distances for testing and/or for care. What is needed for KP is convenience – timings suitable to the community, minimize waiting times and same day results and package of interventions that will reduce the number of visits. At the CHAI MSM clinic in Bali, Indonesia, within an hour of an HIV test being done, a CD4 exam, STI exams, and physical exam are conducted and necessary referrals made. It may be better if public health centres were able to serve MSM and transgender populations instead of just having specific facilities for these people. Community responses by themselves will not suffice. TasP is potentially problematic but more studies may help.

A delegate from Nepal stated that his country is an ideal place to undertake TasP as it will address the gaps in provision for testing facilities for MSM, who are mainly served by NGO and CBOs. The national AIDS control authority needs to improve coordination, work more closely with NGO by providing training, and assure better diagnostics. As of May 2013, 12,400 PLHIV on ART and 50 percent of PLHIV in the country needed ART. With the new 2013 WHO guidelines, the number of PLHIV in need of ART increases more than 31 percent (to 18,000).

It was noted that learning across subregions would be useful, particularly in places with similar issues such as Islamic societies. On TasP, WHO said it empathizes with concerns such as those of the Indian government about how adopting TasP now may undermine achievements on treatment provisions for 2015 goals as achievements already made could look less significant if additional goals were set. Concern was also expressed that adopting TasP might shift attention to those capable to manage the cost and logistics of getting treatment away from the poor and vulnerable. WHO does not recommend raising the threshold and adopting TasP unless benefits are clearly demonstrated, such as in serodiscordant couples. WHO reiterated that TasP is not their recommendation yet although some countries are implementing it and they do not discourage it. It was noted that a lot of countries are revising strategic plans to include TasP, especially with regards to key populations.

<sup>12</sup> For a description of community viral load, see this entry from the Lancet (2013): [http://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(12\)70314-6/abstract](http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(12)70314-6/abstract); This concept is also explained in Slide 4 of a presentation made by Aaron Schubert, Regional Team Lead on HIV and TB, USAID RDMA.

## SESSION 8

### REALITIES OF MSM, TRANSGENDER, AND HIJRA LIVING WITH HIV

Throughout the Asia-Pacific region, free treatment is generally available but cost of tests and diagnostics, and of logistics and travel are prohibitive. Stigma and discrimination pose barriers to accessing HIV services. CBOs need to be integrated into the health provision architecture to prevent leaky systems<sup>13</sup> of treatment that may occur if services are only provided by CBOs and ART access points not increased.

Youth Voices Count presented on the key issues faced by young MSM. The impact of internal and external self-stigma is particularly dangerous as young people with low self-esteem often resort to engaging in unprotected sex. Homelessness of young MSM and transgender people can lead to sex work or the need for survival sex. Sexual violence against these groups is frequent but underreported. Drugs and alcohol are used as coping mechanisms, which in turn can lead to risky sexual behaviour and dangerous situations.

What is recommended is expanded use of peer outreach workers at health services, positive portrayals of same sex relations in the media and adoption of anti-bullying policies. Under 18 youth are not allowed to access HIV services in most countries due to age of consent laws. Programmes must be designed specifically to address the needs of this population group.

## SESSION 9

### WORKING GROUP DISCUSSIONS FROM WORLD CAFÉS

Participants in the World Café activity discussed various health services and prevention barriers. They highlighted that stigma around sexual practices among men and around HIV are often a huge barrier to accessing services. Cultural and occupational fears frequently interrupt the delivery of services with institutionalized religion posing a major barrier to promotion of HIV services. For below age of consent patients, we need to find a solution through legal measures or other alternative arrangements. Others discussed strategic information and programming and challenges and concerns such as stigma and discrimination that can affect HIV programme design and management. And some discussed enabling environments including policies, laws, human rights, social justice frameworks and engaging faith leaders. Regarding the modalities of prevention coverage, peer education and outreach were recognized as best practices and therefore need to be expanded and given more resources including ICT tools such as mobile and web-based applications. Legal barriers need to be addressed. If the environment is hostile, adopting measures such as building coalitions and enlisting allies including international organizations may be necessary.

## SESSION 10

### PROGRAMMING FOR RESULTS (M&E)

WHO presented on the technical guidance for countries to set targets for HIV prevention, treatment and care in key populations at country level. This includes normative guidance for MSM (2011) to set targets and measure progress.

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<sup>13</sup> This is explained in Slide 9 of the presentation by Aaron Schubert, Regional Team Lead on HIV and TB, USAID RDMA.

The MSM package includes strategies to strengthen enabling environments and improve health sector programmes. It will provide harmonized guidance on setting targets, references to further reading, and guidance on monitoring the enabling environments. Enabling environments include supportive legislative, policy environments and community empowerment. Overall, the guidance is a simple framework for communities to plan and programme the HIV response in a manner that is evidence-based.

An expert from the University of North Carolina Chapel Hill presented on the MEASURE Evaluation<sup>14</sup> which provides operational guidelines at the national, sub-national, and service delivery levels for M&E of HIV programmes for sex workers, MSM and transgender people. The condoms cascade, which includes regular use, use of appropriate lubricants, and availability/affordability were discussed along with country experiences such as that of the Philippines where they have undertaken size estimates and key informant interviews of providers and customer satisfaction surveys. Critical enablers for good programming include media campaigns to reduce stigma and discrimination and programming that addresses the HIV challenges among MSM and transgender populations.

UNDP discussed how using MEASURE and the UNDP-WHO training toolkit will help with the implementation of Global Fund grants in the Asia-Pacific region. The toolkit will allow for effective monitoring of grant implementation to help illustrate success of intended results.

## **SESSION 11**

### **INNOVATIVE AND SUSTAINABLE FINANCING**

UNAIDS presented on "Investment on AIDS: The Logic." The 2011 UN Political Declaration set concrete targets for 2015 such as reducing sexual transmission of HIV by one-half. Another goal is to include closing the global resource gap by 2015 (amounting to \$24 billion). Low and middle-income countries are on track to reach 15 million people on ART by 2015; 54 percent of eligible PLHIV in these countries, including 44 percent in Asia, are currently on ART.

However, prevention efforts are not going as well. In terms of resources, since 2008 international resources have stayed flat. "Business as usual" will lead to stagnation and better investments are needed to achieve the large gains that are needed. The new Global Fund strategy and funding model builds on country national strategic plans and investment cases but country ownership of costed NSPs is essential. A human rights tool was piloted in Indonesia and has been useful. They have also started work on an MSM investment case.

The National AIDS Management Centre of Thailand presented on the HIV epidemic in their country, which is mature and has some natural decline in incidence. An estimated 500,000 PLHIV are living in Thailand with less than 10,000 new infections annually. Key population behaviour variables are stable. From 2012 to 2016, 41 percent of new infections in Thailand are projected to be among MSM, with 25 percent of all new infections happening in Bangkok. Condom use among MSM needs to be increased from 70 percent to 90 percent to achieve targets. There is a need to change from delivering information to delivering services, with testing as a key intervention. It takes 54,000 tests to detect one case of HIV

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<sup>14</sup> Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People (USAID 2012).

infection in the general population; however, in key affected populations, it takes only 2,800 tests to find one HIV case.

Treating people independent of CD4 counts will save 11,000 lives in Thailand in the next decade, compared to 6,000 lives saved for treating only those with CD4 levels below 350. Questions arise whether countries can pay for this. The workload for health care providers would increase dramatically from about 2,500 patients on ART per year to 25,000 in the first year. TasP would lead to lower future investments although it will be costly in the short term. Behaviour change interventions need to be combined with TasP to control and end the HIV epidemic. Alternative service delivery models are also needed.

It is clear that more money is needed urgently, especially to respond to the urgent need for transgender interventions. HIV prevalence might actually be increasing, as evidenced by the fact that there is no major Indian metropolitan area with an infection rate under 10 percent among MSM and transgender populations, despite the fact that interventions have been focused in urban areas.

Myanmar's HIV rate among MSM and transgender people has been reduced. The Philippines faces a significant gap in funding for its HIV response. Faith-based groups can contribute to the response despite their stated hostility to non-heteronormative sexual behaviour and communities affected are working with Caritas Philippines. As an example, a text message programme has been implemented which helps respondents examine self risk and get directions to the nearest test centre. This scheme has been piloted in Manila.

The U.S. Government has been the largest funder of HIV responses in the world to date. USAID said that any national strategy or pilot programme has to be informed by national experiences and have national ownership.

## **SESSION 12**

### **CONCLUSION AND NEXT STEPS**

This regional consultation was held keeping in mind the commitment of senior United Nations leaders to address historical grievances against LGBT people, especially with regards to access to health services on HIV.

Participants discussed how homophobia and transphobia in health care settings impedes access to critical care and the negative attitudes of health workers can cost lives. The goal of universal health care is not achievable unless MSM and transgender people are included. The WHO and UNDP outlined the measures taken to ensure that MSM and transgender people are not denied care and can access timely and well designed medical care, treatment, and prevention services. WHO presented on the MSM Global Guidelines 2012 and the work they are doing for a possible guidelines for transgender women.

The consultation successfully helped participants understand HIV and STIs in the context of the Asia-Pacific region, to share country experiences, and identify opportunities for implementation at the country level of global and regional guidelines and of the training package developed by UNDP with WHO as part of the ISEAN-HIVOS grant.

Finally, participants discussed the USAID MEASURE guidelines and how it can be used appropriately.

# ANNEX A

# CONCEPT NOTE

## EVENT'S NAME

Regional Consultation on Improving Access to Prevention, Care and Treatment of HIV among Men who Have Sex with Men and Transgender People

## BACKGROUND

Access to a package of health services and social support by men who have sex with men (MSM) is recognized as a fundamental human right. Due to the lack of protective laws, insufficient skills and incomplete knowledge about male sexuality and sexual health, and high level of stigma and discrimination, currently, access to HIV prevention, treatment, care and community support services is limited compared with the share of the HIV burden faced by these populations. In 2011, the Report of the United Nations High Commissioner for Human Rights noted that, "...homophobic, sexist and transphobic practices and attitudes on the part of health-care institutions and personnel may nonetheless deter Lesbian, Gay, Bisexual and Transgender persons (LGBT) persons from seeking services, which in turn has a negative impact on efforts to tackle HIV/AIDS and other health concerns."<sup>15</sup>

In response to the alarming growth in HIV prevalence among MSM and transgender persons, UNDP and WHO in partnership with USAID, UNAIDS and the Asia Pacific Coalition on Male Sexual Health (APCOM) have been working together to better understand the legal and human rights aspects and other social determinates of the epidemic, identify priority health sector interventions and propose approaches to address stigma and discrimination issues.

The Global Commission on HIV and the Law<sup>16</sup> and "Legal, Environments, Human Rights and HIV Responses among MSM and transgender persons in Asia and the Pacific: An Agenda for Action"<sup>17</sup> have documented that stigma in health care settings as a major barrier preventing access to health services, due to negative attitude of care providers, incomplete knowledge about sexual orientation and gender identity (SOGI). Furthermore, WHO has identified insufficient skills regarding male sexual health (pharyngeal and ano-rectal care in particular); insensitive communication and counselling with MSM and transgender clinic clients as significant impediments for the uptake of services provided in health care settings.<sup>18</sup>

Currently, under the ISEAN-HIVOS Global Fund grant, there is a health sector component focusing on skills training of health care providers providing HIV/STI related services to MSM and transgender people, and reduction of stigma in health care settings in four countries including Indonesia, Malaysia, the Philippines and Timor-Leste. UNDP as the TA provider for ISEAN-HIVOS project would work with

<sup>15</sup> UN Human Rights Council, Nineteen Sessions, Agenda Items 2 and 8. Annual Report of the United Nations High Commissioner for Human Rights and Report of the Office of the High Commissioner and Secretary-General. Discriminatory Law and practices and acts of violence against individuals based on their sexual orientation and gender identity (A/HRC/19/41) 17 November 2011.

<sup>16</sup> Report of the Asia Pacific Regional Dialogue of the Global Commission on the HIV and the Law. Bangkok, 17 February 2011. UNDP.

<sup>17</sup> Godwin, J. (2010). Legal Environments, Human Rights, and HIV Responses among MSM and Transgender people in Asia and the Pacific: An Agenda for Action. UNDP.

<sup>18</sup> WHO (2011). Prevention and Treatment of HIV and other Sexually Transmitted Infections among Men who have sex with men and Transgender people

WHO (SEARO and WPRO) to support the implementation of this component, starting with development of a training package with reference to the existing regional and newly launched global guidance "Men who have sex with men and transgender people Prevention and treatment of HIV and other sexually transmitted infections: Recommendations for a public health approach", which was jointly developed by WHO, UNDP, UNAIDS, MSMGF, and GIZ in 2011.

## STRATEGY

To review the draft training package, WHO will convene a 3-day regional informal experts consultation attended by participants with experience on providing HIV and sexual health services for men who have sex with men and transgender persons.

The general objective of the informal consultation is to strengthen the HIV/STI prevention, care and treatment response for MSM and transgender people. The specific objectives are:

- ◆ To review the global guidelines and adapt the same for addressing HIV/STIs in the context of the Asia-Pacific region.
- ◆ Review and discuss the draft regional training package.
- ◆ Share country experiences and provide inputs for finalization of the training package.
- ◆ Develop recommendations for implementation at country level.

## OUTCOME

Improved capacity of health sector practitioners to provide appropriate care to men who have sex with men and transgender persons.

## PARTICIPANTS

WHO will nominate informal experts from the SEARO region who have provided HIV/STI prevention, care and treatment for men who have sex with men and transgender persons.

## PARTNERS

WHO SEARO, UNDP and UNAIDS

## VENUE & DATE

Novotel Ploenchit Hotel, Bangkok, Thailand  
21-23 August 2013



# ANNEX B AGENDA

## DAY 1 WEDNESDAY, 21 AUGUST 2013

### PROGRAMME

TIME	TOPIC	PRESENTER(S)
08.30 – 09.00	Registration (coffee and tea available)	Ruam Rudee Ballroom (9th floor)
<b>I. OPENING REMARKS</b>		
09.00 – 09.30	<p>Opening messages from:</p> <ul style="list-style-type: none"> <li>• CSO representative</li> <li>• WHO SEARO</li> <li>• UNDP</li> <li>• youth community</li> </ul> <p>Recognition of country delegation and others</p>	<p>Mr. Midnight Poonkasetwattana, APCOM Dr Yonas Tegegn, WHO Thailand WR Mr Clifton Cortez, Regional Manager, a.i., UNDP APRC Mr Gautam Yadav, UNAIDS Youth Advisory Forum</p> <p>Participants</p>
<b>II. STATUS OF THE PREVENTION, CARE AND TREATMENT FOR MSM AND TRANSGENDER PEOPLE</b>		
09.00 – 09.30	<p>HIV and STI among MSM and transgender people in Asia Pacific</p> <p>Enabling legal and social environments for effective HIV responses: Maximizing efforts</p> <p>Estimating the size of target populations</p>	<p>Dr Vladanka Andreeva, UNAIDS Regional Support Team, Asia and the Pacific</p> <p>Mr Edmund Settle, UNDP Asia-Pacific Regional Centre</p> <p>Mr Ashok Row Kavi</p>
10.15 – 10.45	Group Photo and Tea Break	
<b>III. GUIDANCE FROM GLOBAL AND REGIONAL GUIDELINES</b>		
10.45 – 12.00	<p>Prevention and Treatment of HIV and Other STIs among MSM and Transgender People (WHO 2011)</p> <p>“The Time has Come” Enhancing HIV, STI and other Sexual Health Services for MSM and Transgender People in Asia and the Pacific: Training Package for Health Providers and Reduction of Stigma in Healthcare Settings (UNDP 2013)</p>	<p>Ms Annette Digna Verster, WHO Geneva</p> <p>Mr Edmund Settle, UNDP Asia-Pacific Regional Centre</p>



TIME	TOPIC	PRESENTER(S)
10.45 – 12.00	Country experiences: Bhutan Indonesia Philippines Timor-Leste	Mr Sonam Wangdi Dr Hellen Dewi Prameswari Dr Ferchito Avelino Sr Rui de Carvalho
12.00 – 13.00	Lunch at The Square – 8th floor	
IV. SUPPORTIVE NATIONAL STRATEGIES AND URBAN RESPONSES Chair: Dr Steve Wignall		
13.00 – 13.45	National strategies and health landscapes India Indonesia Maldives Myanmar	Mr Ashok Row Kavi Mr Ardian Harimurti Prabowo Mr Abdul Hameed Hassan Dr Htun Nyunt Oo
13.45 - 15:00	Innovative implementation in urban responses	Mr Scott Berry, The HIV Foundation Thailand
	City strategies and implementation	Dr Sai Pye, The HIV Foundation Thailand
	Challenges and successes in urban settings: Bangladesh Nepal Philippines Sri Lanka	Dr Md. Saidur Rahman Mr Hiranya Joshi Dr Ferchito Avelino Dr S.A.H. Liyanage
15.00 – 15.30	Tea Break	
V. NATIONAL CHALLENGES – WORLD CAFÉ		
15.30 – 16.30	Chief challenges, issues, opportunities at the national level	Country delegation groupings
17.00 – 17.30	Meeting Secretariat recap	Secretariat members
18.30	Reception at the Ruam Rudee Ballroom	

## ABOUT THE WORLD CAFÉS

The first World Café (above in Day 1) is intended to hear from the participants their own experiences (successes and challenges) at the national programme level. Six tables will each discuss one topic in the table below for 10 minutes, then all move to the next table.

TOPIC – NATIONAL CHALLENGES	FACILITATOR
A. Programme start up and management – including M&E	Ms Annette Digna Verster
B. Strategic information including surveillance	Dr Ferchito Avelino

TOPIC – NATIONAL CHALLENGES	FACILITATOR
C. Enabling environments: Policies, laws, human rights, social justice frameworks and engaging faith leaders.	Mr Jonas Bagas
D. Prevention coverage	Mr Matt Avery
E. Health services access including ARV and STI treatment, i.e., addressing stigma and discrimination in health sectors.	Dr Steve Wignall
F. Structural interventions	Mr Shale Ahmed

Questions for each topic:

- ◆ What were/have been/are the chief challenges in your country?
- ◆ What were the issues that were identified and how were they addressed for the topic?
- ◆ What opportunities were identified or used to help meet the challenges?

The second World Café (Day 2 below) is intended to have the participants identify actions to be taken in their country for improving access to health services for MSM and for transgender people and hijras. Six tables will each discuss one topic in the table below for 10 minutes, then all move to the next table.

TOPIC – Country groups – taking it forward	FACILITATOR
A. HIV testing, counselling and linkages to care	Dr Steve Wignall
B. ARV new guidelines	Ms Annette Digna Verster
C. Create more enabling environments	Mr Jonas Bagas
D. Prevention coverage	Mr Matt Avery
E. Health services access including ARV and STI treatment	Mr Scott Berry
F. Structural interventions	Mr Shale Ahmed

Questions for each topic:

- ◆ What steps are needed in your country to realize success in the topic area?
- ◆ What actions have already or are planned to take?
- ◆ What actions do you see as most needed as “next steps”? Will your country be able to begin those actions? When?

Don't forget, each table will report its “findings” in plenary for each World Café session!

## DAY 2

# THURSDAY, 22 AUGUST 2013

### PROGRAMME

TIME	TOPIC	PRESENTER(S)
VI. ISSUES AND ACCESS FOR TRANSGENDER PEOPLE AND HIJRAS Chair: Prempreeda Pramoj Na Ayutthaya		
09.15 – 11.00	WHO Global plans for transgender guidelines (Draft)	Ms Annette Digna Verster, WHO Geneva
	Regional assessment of HIV, STI and sexual health needs of transgender people (WHO 2012)	Dr Razia Pendse, WHO SEARO
	Stigma and discrimination study amongst transgender people	Dr Abbas Sedaghat, Iran
	Community perspectives: Global, regional and local	Ms Khartini Slamah, APNSW
11.00 – 11.30	Tea Break	
VII. 2013 WHO HIV GUIDELINES – STRATEGIC USE OF ANTIRETROVIRALS (ARV) Chair: Manuel da Quinta, UNAIDS		
11.30 – 12.30	2013 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection (WHO 2013)	Dr Razia Pendse, WHO SEARO
	Treatment as Prevention (TasP)	Mr Aaron Schubert, USAID
	Community experiences Indonesia (TasP)	Dr Steve Wignall
	Thailand (business plan/cost effective analysis) Nepal (country overview)	Dr Petchsri Sirinirund Dr Bal Krishna Subedi
12.30 – 13.30	Lunch at The Square – 8th floor	
VIII. REALITIES OF LIVING WITH HIV AS AN MSM, TRANSGENDER PERSON OR HIJRA Chair: Midnight Poonkasetwattana, APCOM		
13.30 – 15.00	Treatment access for positive MSM and transgender people Information Communication Technology (ICT)	Mr Pathompong (Tom) Serkpookiaw, APN+
	Self-stigma amongst young MSM and transgender people	Mr Gautam Yadav for YVC
	Community experiences Bangladesh India Philippines Thailand	Mr Shale Ahmed Mr Gautam Yadav Mr Jonas Bagas Mr Khun Paeng

TIME	TOPIC	PRESENTER(S)
15.00 – 15.30	Tea Break	
IX. COUNTRY GROUPS – taking it forward		
15.30 – 16.00	World Café report back per table/issue	Table reports from Day One
16.00 – 17.00	Taking it forward – actions to address the issues	World Café (Reporting on Day Three)
17.00 – 17.30	Meeting Secretariat recap	Secretariat members only

## DAY 3 FRIDAY, 23 AUGUST 2013

### PROGRAMME

TIME	TOPIC	PRESENTER(S)
X. PROGRAMMING FOR RESULTS (M&E)		
09.45 - 11.30	Guidance for countries to set targets for HIV prevention, treatment and care for key populations	Ms Annette Digna Verste, WHO Geneva
	Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People (USAID 2012)	Mr William Miller, MEASURE Evaluation/UNC Chapel Hill
11.30 - 12.00	Tea Break (at your convenience)	
XI. INNOVATIVE – AND SUSTAINABLE – FINANCING Chair: Clifton Cortez, UNDP		
12.00 - 12.45	Investment Approach on AIDS (Draft)	Dr Ma. Elena G. Filio-Borromeo , UNAIDS
	Panel discussion: India Indonesia Myanmar USAID	Mr Ashok Row Kavi Dr Hellen Dewi Prameswari Dr Htun Nyunt Oo Mr Aaron Schubert
XII. CLOSING		
12.45	Closing remarks	Mr Steve Kraus, Regional Director, UNAIDS RST, Asia and the Pacific

# ANNEX C

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