COMPONENT ONE

Collecting or analysing the data we need to guide an effective response among men who have sex with men

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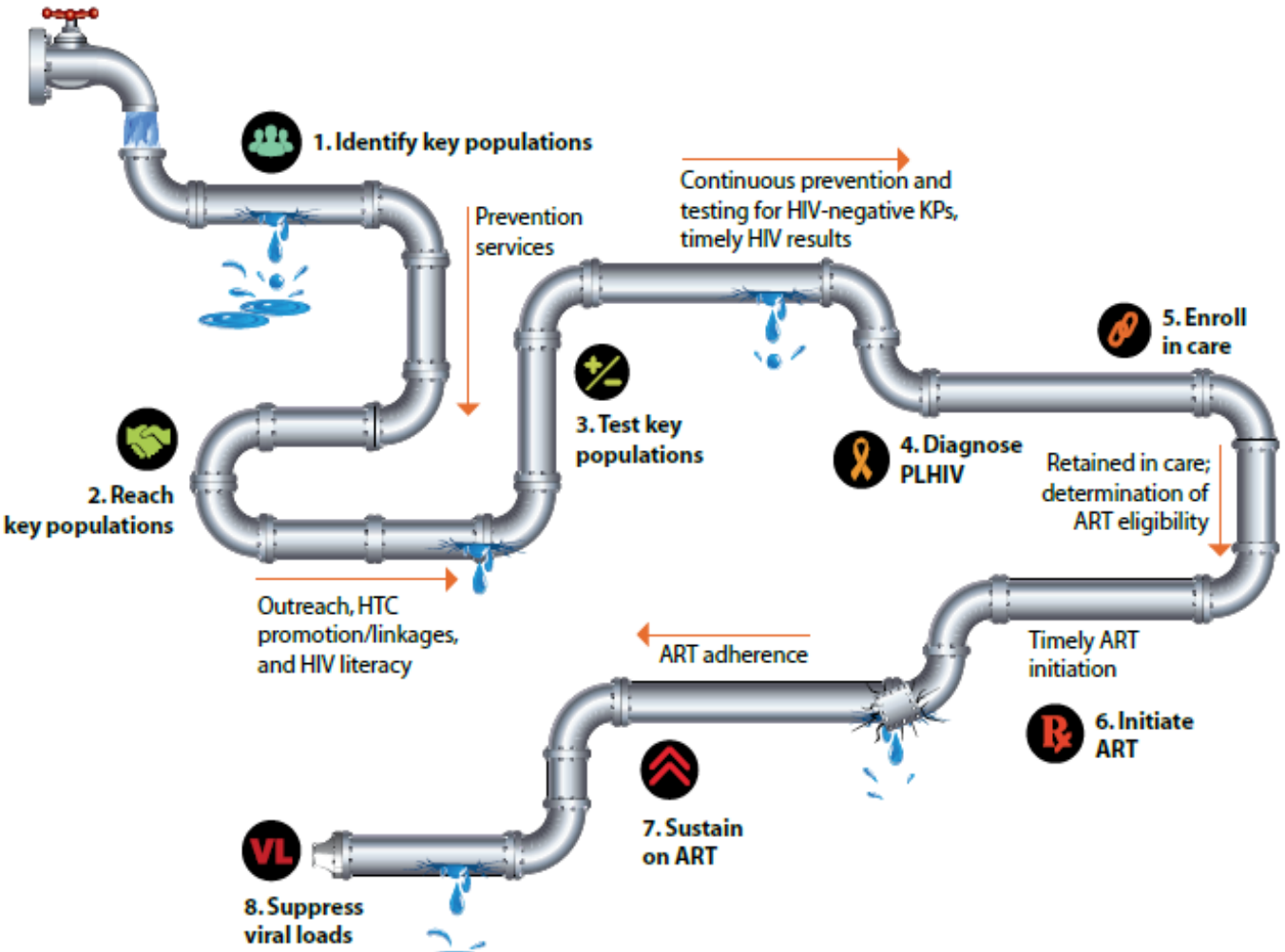
UNAIDS

Cascade of HIV Services

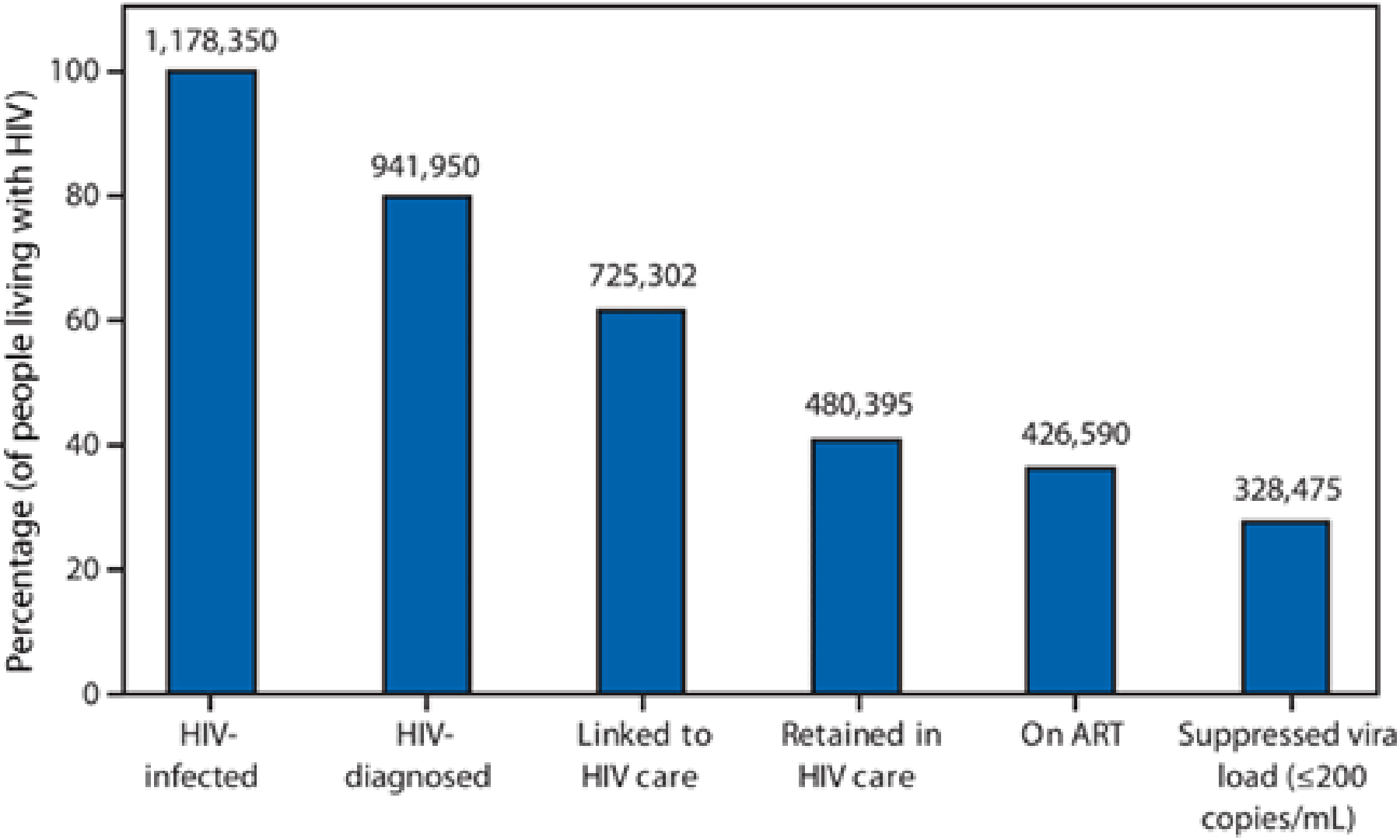
- Tool for diagnosing, monitoring, evaluating and prioritising HIV responses among MSM
- Seven levels:
  1. Total # of MSM in need of HIV services
  2. Estimated proportion living with HIV (prevalence)
  3. Proportion of (2) who have been diagnosed (tested)
  4. Proportion of (3) who have made contact with HIV services
  5. Proportion of (4) who has initiated ART
  6. Proportion of (5) who is adherent to ART
  7. Proportion of (6) who reached viral suppression

HIV service cascade: a 'leaking



Note: KPs = Key Populations, HTC = HIV Testing and Counseling, ART = Antiretroviral Therapy, PLHIV = persons living with HIV. Source: USAID/FHI 360, PEPFAR and Linkages, HIV Cascade Framework for Key Populations. Washington DC, FHI 360, 2015.

Example


Percentage (of people living with HIV)
100
80
60
40
20
0
1,178,350
941,950
725,302
480,395
426,590
328,475
HIV-infected
HIV-diagnosed
Linked to HIV care
Retained in HIV care
On ART
Suppressed viral load (≤200 copies/mL)

Plenary group exercise

- Is there agreement about the baseline parameters of the HIV service cascade? Prepare a cascade for your country/city, based on the best data you have:
  - Size estimation of MSM in need of services
  - Estimated prevalence of HIV in MSM population
  - Estimated number/% that is reached by services
  - Estimated number/% that is tested
  - Estimated number/% testing positive and referred to pre-ART services
  - Estimated number/% enrolled in ART services
  - Estimated number/% adherent to ART
  - Estimated number/% that is virally suppressed

Discussion: Barriers to HIV services

- Do we know the most important reasons why there is 'leakage' between the different levels of the HIV service cascade?
  - Actual or imagined stigma and discrimination?
  - Fear of disclosure? (two levels)
  - Fear of actual or imagined treatment costs?
  - Inconvenient opening hours or location?
  - Fear of test results or of side effects of ARV drugs?
  - Too much bureaucracy, too many referrals?

Who/where unreached MSM?

- Who are we reaching? (often the easiest to reach)
- Need to link to other networks of risk (sex work, drug use, underground party-scene, illegal saunas or clubs, internet-based sex networks)
- ‘Mapping’ needs to be an ongoing exercise, continuously linked in to program operations

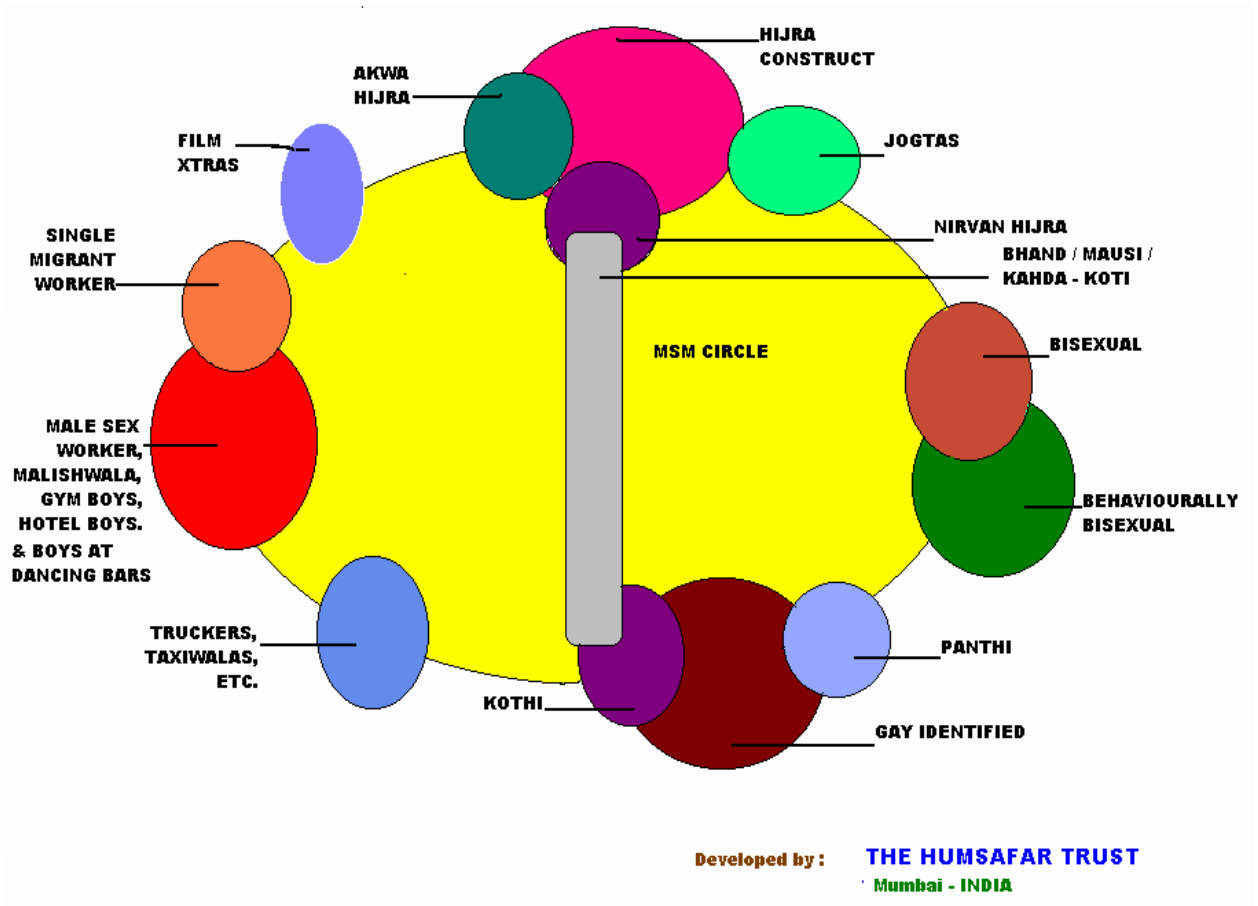
The need for ‘deeper’ knowledge about MSM

- Notions of sexual orientation, love, desire, lust, identity, community, family, fate, hope, destiny, illness, disease, death, karma, friendship, submission, power, violence, romance…. These all influence what we do or not do when we have sex (or when we “seek health”!)
- Our current paradigm reduces these complex and multi-faceted realities to behavioral acts by rational individuals, derived of context
- HIV prevention messages hardly discuss social, emotional aspects of sex, focus mostly on factual knowledge transmission
- HIV prevention and treatment remains dominated by Western bio-medical thought

The need to ground HIV services in local cultures and societies…

- Peer education, counseling, community based responses: all based on Western gay experience towards individual behavior change
- Not much attention for society/culture/family/ religion/other structural factors influencing life of MSM in this country
- Different sense of identity/community/sexual cultures that need to be understood
- Any services and programs have to be grounded in social/ethnographic research

Example: Humsafar Trust, India



Plenary group exercise (optional)

- Please list, similar to Humsafar Trust, a list of settings / circumstances / identities / contexts in which male-male sex happens in your country/city

Group exercise

- Please fill out Checklist One, to assess the extent to which there is sufficient HIV data and related information and knowledge to inform a comprehensive HIV service response for MSM in your country/city