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“The Time Has Come”

Annex:

Reaching out to female partners of men who have sex with men

Training module for health care providers to address intimate partner transmission of HIV

Training Module Facilitator's Guide

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Annex:
**Reaching out to female partners of men who have
sex with men**

Training module for health care providers to
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Acknowledgements

"The Time Has Come" – Annex: Reaching out to female partners of men who have sex with men is a training module for health care providers to address intimate partner transmission of HIV between men who have sex with men (MSM) and their female partners in Asia and the Pacific. It looks at the types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals.

This training module is an annex to the regional training package developed by the United Nations Development Programme (UNDP) and the World Health Organization (WHO) in 2013, titled *"The Time Has Come" – Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific*. The regional training package aims to reduce stigma in health care settings and to enhance HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific.

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The contents of this training module and the regional training package can be downloaded at: <http://asia-pacific.undp.org/> and <http://aidsdatahub.org/>

Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral treatment
ARV	antiretrovirals
BCC	behaviour change communication
CHTC	couples HIV testing and counselling
HIV	human immunodeficiency virus
IPT	intimate partner transmission (of HIV)
MCH	maternal and child health
MSM	men who have sex with men
M&E	monitoring and evaluation
NGO	non-governmental organization
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
VCCT	voluntary and confidential counselling and testing
WHO	World Health Organization

Top recommended resources

1. *"The Time Has Come" – Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific.* UNDP, WHO, 2013. http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/the-time-has-come/
2. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.* WHO, 2014. <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
3. *Preventing intimate partner transmission of HIV. Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia.* UNDP, UNICEF, UNAIDS, 2015. http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2015-preventing-hiv-transmission-in-intimate-partner-relationships-executive-summary.pdf
4. *A report on addressing the SRH needs of MSM and their female partners using existing SRH facilities and/or working in collaboration with existing organizations. Documentation of models that have worked and replicable strategies.* UNDP, 2012. http://www.in.undp.org/content/dam/india/docs/HIV_and_development/a-report-on-addressing-the-srh-needs-of-msm-and-their-female-par.pdf
5. *Women partners of men who have sex with men (MSM) in India [India 'MSM Situation Paper' series; Technical Brief 2].* Chakrapani, V., Boyce, P., and Dhanikachalam, D. 2011. http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/Technical%20Brief-2_WomenPartners_MSM.PDF
6. *Pehchan Training Curriculum: MSM, Transgender and Hijra Community Systems Strengthening. Curriculum Guide.* India HIV/AIDS Alliance, 2013. http://www.allianceindia.org/wp-content/uploads/2014/09/2014_AllianceIndia_Pehchan-Training-Curriculum-MSM-Transgender-and-Hijra-Community-Systems-Strengthening-Complete-Set-of-Modules-PDF-8-MB.pdf
7. *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach.* WHO, 2012. http://whqlibdoc.who.int/publications/2012/9789241501972_eng.pdf
8. *Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach.* WHO, 2011. http://www.who.int/hiv/pub/populations/msm_guidance_2010/en/
9. *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV.* WHO, 2012. http://www.who.int/hiv/pub/guidance_prep/en/
10. *Male involvement in the prevention of mother-to-child transmission of HIV.* WHO, 2012. http://apps.who.int/iris/bitstream/10665/70917/3/9789241503679_eng.pdf
11. *HIV/SRHR Integration for Men who have Sex with Men and Transgender People.* India HIV/AIDS Alliance, 2012. https://indiahivaidallsiance.files.wordpress.com/2012/07/ai_srhrintegration_msmtg_web-euflag2.pdf

Key terminology

Intimate partner transmission of HIV

For the purposes of this training, intimate partner transmission focuses on the sexual transmission of HIV within an intimate partner relationship, which does not include transmission via sharing needles. The term 'intimate partner transmission' is used rather than 'spousal transmission' because intimate partners are not necessarily married.¹

Intimate partner relationships in the context of men who have sex with men (MSM) in Asia

The term 'MSM' often masks complex sexual identities, interests and practices. Evidence also suggests that substantially different HIV prevention challenges are posed by men who have sex only with other men, compared to men who have sex with men and women.² These two groups are unlikely to respond to the same prevention messages and advice. Many factors influence and shape the way intimacy and sex between men are expressed, and there is no simple way to categorize the intimate partner relationships of same-sex practising men,³ especially considering the diverse range of cultural and ethnic backgrounds, religious beliefs and traditions among MSM living in Asia.

The focus of this training module is on those MSM who have a female partner. For the purpose of this training, a female partner can be a wife through legal or common-law marriage or a regular female partner in the context of a dating relationship. Generally, a 'dating relationship' is defined as a romantic or intimate social relationship between two individuals. Factors that characterize a dating relationship can include the length of the relationship, the nature of the relationship, and the frequency of interaction between the two individuals. In this training module, a dating relationship does not include casual sexual encounters (i.e. where this is no expectation of an actual relationship) or transactional sexual relationships.

Serodiscordant couples

HIV serodiscordant couples, in which one partner is HIV-positive and the other is HIV-negative, are increasingly recognized as a priority for HIV prevention in Asian countries. Using the World Health Organization (WHO) definition, 'couple' in this context refers to two persons in an ongoing sexual relationship; each of these persons is referred to as a 'partner' in the relationship. How individuals define their relationships varies considerably according to cultural and social contexts.⁴ When it comes to HIV programming for serodiscordant couples, WHO

1 'HIV transmission in intimate partner relationships' describes the transmission of HIV to people from their regular partners who inject drugs and/or have sex with other people, including with sex workers. *UNAIDS Terminology Guidelines*, UNAIDS, 2011.

2 *Global Best Practices: Effective Approaches to Inform SBCC Programming and Reduce HIV Risk for Sex Workers and MSM in Jamaica and The Bahamas*. C-Change/USAID, 2011.

3 Ibid.

4 *Guidance on couples HIV testing and counselling – including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach*. WHO, 2012.

recommends that policymakers and programmers should not prescribe the definition of couples who can benefit from HIV interventions.⁵

Issues around key terms and definitions

Serodiscordant couples: The term 'serodiscordant couple' or 'serodiscordant relationship' is often associated with the image of a monogamous heterosexual couple where one partner is living with HIV and the other partner is not. Yet, in HIV epidemics in Asian contexts, there exists a range of serodiscordant relationships that place an HIV-uninfected individual at risk of HIV infection from a partner who is living with HIV. These include relationships that are with members of the opposite sex or same sex in which one, both, or none of the partners are currently a member of a key population group.

Intimate partner transmission of HIV: Even in countries that analyse and report on intimate partner transmission of HIV, this type of relationship may be defined using different parameters. Some countries refer to 'spousal transmission', which usually denotes male-to-female HIV transmission in marital relationships. Other countries in the region refer to transmission within 'stable heterosexual partnerships', which encompasses a broader definition than marital relationships. National-level data collection tools such as behavioural surveys often use different terms to describe an intimate partner relationship, including 'married', 'spouse', 'regular partner', 'living with', 'stable relationship' and 'long-term partner'. Furthermore, many tools assume that a person has only one such partner. For youth, including young men who have sex with men, these ways of characterizing intimate sexual relationships can be even more problematic because the definition of an intimate partner – and the patterns of unsafe sex associated with such partnerships – are often different from that of the adult population.

5 Ibid. For instance, the principle for couples HIV testing and counselling (CHTC) should be that any persons who are in a sexual relationship and wish to test together and mutually disclose their results should be supported to receive this intervention. Health workers should support the decisions of partners to test together, irrespective of the length or stability of their relationship, and policymakers and implementers should ensure that services are inclusive and non-judgemental in order to maximize the uptake and impact of such interventions.

Training overview

Background

High levels of intimate partner transmission of HIV are characteristic of long-running, concentrated epidemics in Asia. Although data from the region shows substantial male-to-female intimate partner transmission rates, there is also some evidence of HIV transmission from women to their male partners. Yet few HIV prevention programmes with key populations, including men who have sex with men, integrate or include components to address this issue; fewer still have been able to demonstrate working with intimate partners.

Whatever their organizational affiliation, health workers are critical to reducing levels of intimate partner transmission of HIV. As health care providers, they have a crucial role in helping MSM protect both themselves and their sexual partners from HIV infection. In health care settings, it is important to pay attention to not just what is said or not said, but how it is said. The conversations and actions that take place impacts on whether MSM patients get tested, treated and retain care, and whether they feel empowered to ensure their intimate partners are also reached with the necessary information and services.

This training aims to impart practical knowledge and skills to health workers across Asia. Evidence indicates that substantially different HIV prevention challenges are posed by men who have sex only with other men, compared to men who have sex with men and women. These two groups are unlikely to respond to the same prevention messages and advice. This training module focuses specifically on reaching out to the female partners of MSM. As such, the module builds on the existing training package for health care providers developed by UNDP and the World Health Organization (WHO) in 2013. The UNDP/WHO regional training package, entitled *"The Time Has Come"*, aims to reduce stigma in health care settings and to enhance HIV, sexually transmitted infections (STI) and other sexual health services for MSM and transgender people in Asia and the Pacific. More information about this comprehensive training package is available on the dedicated "The Time Has Come" website: <http://www.thetimehascome.info/>

The change we hope to see

The change we hope to see is that participants will come away from the training with new ideas and practical strategies for addressing intimate partner transmission of HIV in their existing work with patients and clients, particularly those working with MSM. They will gain insights on how to reach the female partners/spouses of MSM with information, services and referrals. Importantly, they will better understand how this can be achieved in a way that protects and promotes an individual's right to voluntary and informed consent, non-discrimination, privacy and confidentiality.

Intended audience

The primary audience of this training module includes health care providers working with MSM and health care workers that are likely to come into contact with female partners of MSM; for example, staff at antenatal care (ANC) and family planning clinics. Health care providers include those who work in clinical settings (such as doctors, nurses and counsellors working in hospitals, clinics and health centres) as well as those who work in community settings (such as outreach and drop-in centre workers and lay counsellors). They may include health workers from the public health sector, health services run by non-governmental organizations (NGOs) or private sector providers.







Participants' knowledge level

The course content has been designed specifically for individuals who already have an understanding of, or experience in, health service provision for MSM. This is not limited to hospital staff (medical doctors and nurses) but includes other health professionals such as community health and outreach workers and counsellors. It is also relevant for health care workers that work in settings that may be accessed by female partners of MSM, either directly or through referrals.

It is strongly recommended that health care providers who participate in this training module have already completed the regional UNDP/WHO training package *"The Time Has Come" – Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific*.

Module outline: Reaching out to female partners of men who have sex with men

Key learning outcomes, points on the process, timing and guidance for this module.

	<p>KEY LEARNING OUTCOMES</p> <p>Participants will understand</p> <ol style="list-style-type: none"> 1. Why reaching out to intimate partners is an important issue for health care workers to address when working with MSM patients and clients. 2. The types of HIV risks and vulnerabilities that MSM experience in their intimate partner relationships and how this affects their ability to adopt protective behaviours. 3. The types of services that can be provided to MSM patients and/or their female partners. 4. The types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals.
	<p>PROCESS</p> <p>This training module is structured around a presentation that includes time for plenary and group discussion as well as opportunities for group work in the form of case study scenarios.</p>
	<p>TIME</p> <p>One day (9:00am–5:15pm)</p>
	<p>SLIDES</p> <p>The presentation contains 18 PowerPoint slides. The key learning outcomes are addressed in the order presented. Handouts accompany several of these slides, where indicated. If reliable internet connection is available, video clips complement parts of the training.</p>
	<p>SESSION GUIDANCE</p> <p>The session is based around a presentation. Since the slides are accompanied by this manual, the facilitator is not required to have technical knowledge of intimate partner transmission of HIV. However, the facilitator is required to be able to run through the presentation and to facilitate discussion and/or provide clarification based on the information provided in this manual. The set of resources to complete this session effectively includes:</p> <ol style="list-style-type: none"> a) Handouts to accompany the session (provided in the Annexes). b) Technical equipment to show the PowerPoint presentation (e.g. overhead projector/laptop/internet connection). c) Additional video resources (taken from YouTube) to complement parts of the training, where a reliable internet connection is available. These resources are indicated in the manual with the following sign: 

Timing

Time	Session/slide
9:00–9:30am	Welcome/Opening slide Housekeeping Introduction ice-breaker
9:30–10:20am	At the end of the training you will... The time has come... to get started! Handouts Definitions and terminology Map showing levels of IPT in Asia
10:20–10:40am	Morning tea
10:40am–12:20pm	Why is IPT an issue for MSM? Why does reaching out to the female partners of MSM matter? Factors that affect sexual risk behaviour and decision-making among MSM Respecting patient rights and eliminating stigma and discrimination in health care settings
12:20–1:20pm	Lunch
1:20–3:25pm	Reaching out to female partners of MSM Case study scenarios: reaching out to the female partners of MSM
3:25–3:45pm	Afternoon tea
3:45–5:00pm	Case study scenarios (continued) The importance of an enabling environment Supportive HIV treatment policies and guidelines
5:00–5:15pm	Training evaluation form

Materials required

- PowerPoint slides
- Computer
- Screen
- Overhead projector
- Handouts for each participant (see Annexes) – including copy of training agenda
- A folder for participants to put the handouts in
- Flipcharts (paper and pens) – including one at the front of the room
- Table number (placed on each table)
- Notepads and pens for participants

Preparation

If possible, set up the room for the whole day to minimize the need to move tables and chairs around during the sessions. It is recommended that participants be seated in groups around small (preferably round) tables. Ideally, the room set-up needs to include an open space to be used for breakout group work (such as the case study scenario session). If the room is quite small, it is advisable to make use of an outside space where this is possible. Flipcharts should be placed in the corners of the room in preparation for group work. One flipchart should be left at the front of the room for the facilitator(s) to use when needed.

Gender-sensitive facilitation

The facilitator's role is not only to impart knowledge, but also to create an environment conducive to discussion and sharing of experiences. This means acknowledging and encouraging different opinions and viewpoints to be expressed. In a training environment, often a few men or women are vocal while others are reluctant to speak out, especially in plenary discussions. Often in a mixed group, women are less inclined to express their opinion, share their experience and ask questions. The facilitator should create space for the more shy participants to express themselves so that all participants feel equally empowered to speak up and be understood.

Training module facilitator's guide

WELCOME/OPENING (SLIDE 1)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Ensure the welcome slide is on the screen as participants enter the room.

This welcome/opening slide is an opportunity to introduce participants to the topic of the training module.

Allow approximately 5 minutes for this slide.

WHAT TO DO

1. Introduce yourself to the group.
2. Ask participants to take their seats if they have not already done so.
3. Welcome participants to the training and introduce the subject of the training module.

WHAT TO SAY

- Follow WHAT TO DO above.
- “Welcome, everyone, to this UNDP-WHO training...”
- When introducing the module, explain that this is a day-long training focused on a specific aspect of the participants’ work with MSM. Explain that the topic of the training is working with MSM who have female partners (including wives) and how to reach these partners with information, services and referrals.
- Before moving onto slide 2 (“Housekeeping”), tell participants “Before we get to know each other better, let’s get some of the logistics and administrative issues out of the way...”

HOUSEKEEPING (SLIDE 2)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 5 minutes for this slide.

WHAT TO DO

1. Tell participants where the toilets and fire exits are. Describe any other health and safety issues.
2. Ask participants to ensure their mobile phones are switched off or put on ‘silent’ mode for the duration of the training session.
3. Highlight and discuss any other necessary administration issues in this section of the training.

WHAT TO SAY

- Follow WHAT TO DO above.

INTRODUCTION ICE-BREAKER (SLIDE 3)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 20 minutes for this exercise.

WHAT TO DO

1. Engage in an ice-breaker exercise with participants.
2. Ask participants to form a circle, facing inwards, towards the centre. Go around the circle and ask participants to introduce themselves, providing their name, where they're from, and the organization they work for.
3. Once the round of introductions is complete, have the group shuffle up close, shoulder to shoulder and close their eyes. When ready, ask participants to carefully reach out and clasp hands (any hands) with people in the circle. As the facilitator, keep your eyes open and check that each hand is joined to only one other hand, and that there is a healthy amount of intermingling. When you're satisfied they're ready, ask the group to open their eyes and start untangling the knot without letting go of each other's hands. Eventually the group will untangle into a perfect circle, maybe with a breakaway smaller circle.
4. Once the group is untangled and the participants' eyes are open, explain the message behind the ice-breaker and how it relates to the topic of the training. "This ice-breaker showed us that reaching out to others may seem hard at first – see how we were all tangled up to begin with – but once we can see exactly what needs to be done, we can work in partnership with one another for a better outcome. The exercise also reminds us that it's easier to reach out to others when you can identify exactly who it is you're trying to reach, and you know where and how to find them. This is an important theme of today's training as we will be exploring how we – as health care workers – can reach out to the partners of MSM, specifically those MSM who have female partners including wives."
5. Get everyone to clap and congratulate themselves for a job well done.
6. Thank participants and ask them to return to their seats.

Caution: This is a physical activity so ensure that participants are physically able and willing to take part.

WHAT TO SAY

- Follow WHAT TO DO above.
- No dialogue or resources are required for the presentation of this slide as the action is focused around the group ice-breaker exercise.

AT THE END OF THE TRAINING YOU WILL... (SLIDE 4)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 10 minutes for this exercise.

WHAT TO DO

1. Display the slide on the screen and read out the slide title.
2. Step through each learning objective in the slide consecutively and explain in more detail if required or if any participant asks questions.
3. Explain the overall flow of the training.

WHAT TO SAY

- "You are here today because you already work with MSM or because you may be working with their sexual partners, including any regular female partners – or even wives – that they may have. This training builds on your existing efforts with these populations, whether you work in a hospital, clinic, or as an outreach health worker in the community."
- "Over the course of today, we will be looking specifically at the intimate partner relationships of MSM, with a focus on reaching any female partners with information, services and referrals as part of the health sector response to preventing intimate partner transmission of HIV."
- Refer participants to handout #1, the training agenda showing the structure and timing of the training session.
- Explain the overall flow of the training by saying: "The emphasis for today's training module is on practical learning. While PowerPoint slides will be used to explain information, there will be lots of opportunity for interactive discussion, as well as group activities including case studies and role-play."
- "At the end of this training, you will have a deeper understanding of:
- Why reaching out to intimate partners is an important issue for health care workers to address when working with MSM patients and clients.
- The types of HIV risks and vulnerabilities that MSM experience in their intimate partner relationships and how this affects their ability to adopt protective behaviours.
- The types of services that can be provided to MSM patients and/or their female partners.
- The types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals."

THE TIME HAS COME... TO GET STARTED! (SLIDE 5)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 20 minutes to go through both slides 5 and 6.

WHAT TO DO

1. Display the slide on the screen and read out the slide title.
2. Ask participants to describe their expectations for the training.
3. Familiarize participants with the handouts and resources that are available on the tables in front of them.
4. Introduce the next slide, which will clarify key terminology and definitions used in the training.

WHAT TO SAY

- “As the slide says, the time has come for us to get started. In the next few minutes, we will be discussing our expectations for the training. You’ll get to familiarize yourself with some of the handouts and resources, and I will be introducing some of the key terms and definitions we’ll be using during the course of the day.”
- Ask the group to describe their own expectations for the training (i.e. what they expect to learn and hope to take away from the training). Depending on the size of the group, this can either be done in a plenary format which is a less time-consuming option, or if the group is larger, you can give each table of participants a piece of flipchart paper so that they can write down their expectations collectively and then invite one person from each group to give feedback on behalf of their table. The participants’ expectations should be collectively written down and set to one side for the facilitator to refer back to at the end of the training (see slide 20).
- After the expectations exercise, you should move onto the resources accompanying the training module.
- “A common expectation from a training is the hope of coming away with new skills and knowledge. To help fulfil this expectation, we have put together a selection of handouts and resources which can be found [on the table/in the folder] in front of you. Some of these will be referred to during the training and others are supplementary resources for you to take away and read in your own time. To ensure you have all of these resources, please open your handouts folder and check that each of the handouts is included. If there are any missing please raise your hand to let me know.”
- Click on the next slide (Slide 6) that shows all the handouts. Ensure extra copies of each handout are available so that you can distribute them if any are missing. Do not spend more than five minutes on this task.
 - Handout #1: Training agenda
 - Handout #2: Definitions and terminology
 - Handout #3: Copy of the PPT presentation
 - Handout #4: Infographic (map) showing levels of IPT in Asia

- Handout #5: Venn diagram showing factors that shape the sexual risk behaviour of MSM and their choices about contraception with intimate partners
- Handout #6: Good practice examples from the region
- Handout #7: Case study scenarios: reaching out to female partners of MSM
- Handout #8: Supportive HIV treatment policies and guidelines
- Handout #9: Training evaluation form
- Handout #10: List of recommended resources

Note: It is recommended that the handouts and resources are made available to participants to take away electronically on a USB flash drive.

- Once participants have been made aware of the handouts on the table in front of them, go back to the previous slide and point them to the last bullet point: “Definitions”.
- “Before we delve deeper into this issue of intimate partners of MSM, let’s first look at what we mean by ‘intimate partner transmission of HIV’ and ‘female partner’ in the context of MSM relationships.”
- Move on to “Definitions and terminology” (Slide 7)

HANDOUTS (SLIDE 6)

1 2 3 4 5 **6** 7 8 9 10 11 12 13 14 15 16 17 18

WHAT TO DO

1. Leave the slide up on the screen while participants check their handouts folder (no more than a couple of minutes)
2. Once participants have had a chance to check and familiarize themselves with their handouts folder, go back to the previous slide and continue with the next bullet point (‘Definitions’)

WHAT TO SAY

- See relevant bullet point under WHAT TO SAY on the previous slide (slide 5).

DEFINITIONS AND TERMINOLOGY (SLIDE 7)

1 2 3 4 5 6 **7** 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 10 minutes for this slide.

The handout titled “Definitions and terminology” accompanies the presentation of this slide (see Annexes).

WHAT TO DO

1. Explain that this is the definition of ‘intimate partner transmission of HIV’ – or IPT for short – that will be used in today’s training.

2. Move on to the blue text box on the slide that describes some of the challenges and complexities when looking at the issue of IPT in the context of MSM.
3. Read out the bullet points [shown as a ✓] and ask participants if they have any questions or need clarifications about the information on the slide.
4. Remind participants that today's training will also be looking at intimate partners in a 'serodiscordant couple'.
5. Ask participants to raise their hands if they are familiar with the term 'serodiscordant couple'. If one or more participants raises their hands, ask one of these participants to explain the term. If nobody raises their hand, provide participants with the correct response [i.e. a HIV serodiscordant couple is a couple where one partner is HIV-positive and the other is HIV-negative].
6. Remind participants that organizations such as UNAIDS and WHO recommend that health care workers should not be prescriptive in their definition of 'couples' who can benefit from HIV interventions, for example, by not limiting HIV-related services to only married or heterosexual couples.
7. Remind participants that their folders/packs should contain a handout of key terms and definitions relevant to this training.

Note: the 'Key terminology' section on pages 6 and 7 of this manual provides additional background on these two terms. This may be helpful when responding to participant questions.

WHAT TO SAY

- Follow WHAT TO DO above.

MAP SHOWING LEVELS OF IPT IN ASIA (SLIDE 8)

1 2 3 4 5 6 7 **8** 9 10 11 12 13 14 15 16 17 18

Allow approximately 10 minutes for this slide.

Infographic handout (map) accompanies the presentation of this slide.

WHAT TO DO

1. Display the slide on the screen.
2. Remind participants that they have a copy of this infographic in their handouts.
3. Explain what this map shows about long-running concentrated epidemics in Asia and epidemic trends regarding HIV transmission from key populations to their intimate partners.
4. Ask participants if they have any questions or need clarifications about the infographic.
5. Explain the data sources, if requested.

WHAT TO SAY

- “High levels of intimate partner transmission of HIV have become a common feature of long-running, concentrated epidemics in Asia, with new infections occurring primarily in key populations and among their immediate sexual partners. If we take a closer look at the map, we can see that in a number of countries, around one-third of new adult HIV infections are attributable to intimate partner transmission of HIV – or IPT for short.”
- “In Asian countries with mature epidemics, we see that IPT is occurring between men who are from, or once belonged to, a key population group and their regular female partners (often their wives) – for example, men who inject drugs or former injecting drug users and their female partners or wives, clients of sex workers or former clients of sex workers and their female partners or wives, and men who have sex with men and their regular female partners or – if they are married – wives.”
- “Finally, before we stop for the morning tea break, it is important to remind ourselves that not all cases of IPT in Asia are from men to women, or from husbands to wives. In parts of the region, there is also some evidence of HIV transmission from women to their regular male partners. However, in today’s training we are looking specifically at IPT in the context of MSM.”
- Explain that participants now have a 20-minute tea break. Ensure that participants return to their seats promptly.
- If participants ask questions about the infographic, explain that the data presented is based on country self-reporting and refers to estimates produced over recent years, from 2009 (India) up to 2014 (Thailand). The infographic itself is taken from the UNDP, UNICEF, UNAIDS report (2015) *Preventing HIV transmission in Intimate Partner Relationships: Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*. The data sources are:
 - a. Cambodia: National Centre for HIV/AIDS, Dermatology, and STDs and partners (2011), *HIV Estimation and Projection 2011, Cambodia* (Phnom Penh).
 - b. India: UNAIDS (2009), *HIV Transmission in Intimate Partner Relationships in India* (New Delhi).
 - c. Indonesia: Indonesian National AIDS Commission (2013) 2011 UN General Assembly Political Declaration on HIV and AIDS: Mid-Term Review Report of the ‘Ten Targets’ in Indonesia (Jakarta).
 - d. Myanmar: National AIDS Programme, Myanmar/Strategic Information and M&E Working Group (2012), *HIV Estimates and Projections Asian Epidemic Model Myanmar 2010–2015* (Yangon).
 - e. Thailand: <http://www.aidszeroportal.org>.

MORNING TEA BREAK (20 MINUTES)

WHY IS IPT AN ISSUE FOR MSM? (SLIDE 9)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 20 minutes for this slide, which includes approximately 10 minutes for plenary discussion.

As the facilitator, you will need to summarize participant feedback to the plenary in the form of bullet points on a flipchart, which should be located close to you, ideally in a position where as many participants as possible can see the flipchart paper.

WHAT TO DO

1. Display the slide on the screen and read out the slide title.
2. Follow the dialogue guide below.
3. Lead a plenary discussion by asking participants to share reasons why they think an MSM might have a regular female partner or wife.

WHAT TO SAY

- “The previous slide demonstrated why intimate partner transmission of HIV – or IPT for short – is a serious issue for many countries in the region. The data we saw reminds us of the importance of health care workers addressing IPT within their HIV-related work with patients and clients. The rest of this training looks at a specific aspect of IPT; that is, HIV transmission within the intimate partner relationships of MSM. Specifically, we are addressing HIV transmission between those MSM who have female partners, including wives.”
- “As we can see from this slide, MSM across the region often have partners – both male and female – of all types. Sometimes these partners are casual or commercial (involved in sex work); in other cases, they may have regular or intimate partners and at times they may be seeing multiple partners that fall into each of these types of relationships.”
- “What this shows is that there is no simple way to categorize the intimate partner relationships of MSM. This is perhaps not surprising when you also take into account the diverse range of cultural and ethnic backgrounds, religious beliefs and traditions among MSM living in Asia.”
- “The statistics we see on the slide present the estimated percentage of MSM who report having sex with women in different parts of Asia. This tells us that across the region, being an MSM does not rule out sex with women or even traditional marriage.”

Note: data on the estimated percentage of MSM who report having sex with women is taken from the following publication: WHO Regional Office for South-East Asia (SEARO) (2010), *HIV/AIDS among Men Who Have Sex with Men and Transgender Populations South-East Asia: The Current Situation and National Responses* (New Delhi).

- Lead a plenary discussion by asking participants why they think some MSM may also have regular female partners or wives. Invite participants to share their ideas with the plenary.
- Write participant responses on a flipchart at the front of the room. Depending on the answers given, try and group participant responses into three categories: (1) reasons due to

individual choice/behaviour; (2) reasons due to family/social factors; (3) reasons due to the broader environment such as laws and policies. Examples of likely responses could include:

- There are men who are attracted to both men and women (bisexual).
 - Some MSM may want to have a wife, and may also want to have children.
 - MSM often experience low self-esteem and feelings of shame because of the social stigma attached to being an MSM. As a result, an MSM may have relationships with women – or enter into marriage – because he wishes to be accepted by others.
 - MSM can feel there is expectation or pressure from their families or among the wider community to get married and have children.
 - Some MSM feel they cannot openly have a sexual relationship with another man because of the social stigma and discrimination attached to same-sex relationships.
 - Same-sex intercourse could be criminalized in their country and the MSM fears prosecution if he is revealed to be an MSM, so he also has relationships with women or gets married.
- Thank participants for sharing their ideas and explain that, as a group, we will be returning to this flipchart later on in the training.

WHY DOES REACHING OUT TO THE FEMALE PARTNERS OF MSM MATTER? (SLIDE 10)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 10 minutes for this slide.

WHAT TO DO

1. Display the slide on the screen and read out the slide title.
2. Step through each of the bullet points [shown as a ✓]
3. Invite participants to add any other benefits they can identify, as health professionals, of reaching out to the female partners of MSM. If additional benefits are identified by participants, write these up on flipchart paper so that the text is visible to those in the room.

WHAT TO SAY

- Follow WHAT TO DO above.

FACTORS THAT AFFECT SEXUAL RISK BEHAVIOUR AND DECISION-MAKING AMONG MSM: PART 1 (SLIDE 11)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately one hour to go through both Slides 11 and 12. This includes time for the viewing of a YouTube clip during Slide 11 if a reliable internet connection is available, and plenary discussion (approximately 30 minutes) during Slide 12.

A handout of the Venn diagram shown on the PowerPoint accompanies Slide 11 (see Annexes).

WHAT TO DO

1. Display the slide on the screen.
2. Follow the dialogue guide below.
3. Remind participants that they have a copy of the Venn diagram in their handouts folder.

WHAT TO SAY

- “To date, efforts to address intimate partner transmission of HIV have often focused on the vulnerabilities of female partners and wives. There has been less attention paid by policymakers and HIV programmers to understanding HIV risk and vulnerability among men from key populations – including MSM – and how this affects their sexual decision-making and behaviour with intimate partners.”
- “If countries are to reduce levels of IPT, those of us working in HIV prevention need to better understand that men’s HIV risk, like that of women, can be increased as a result of different factors. We can’t reach out to the female partners who may be at greater risk of HIV infection, if we don’t first have an understanding as to the reasons why men from key populations – including MSM – find it difficult to adopt behaviours that protect both themselves and their intimate partners from HIV.”
- “Many factors influence and shape the way intimacy and sex between men are expressed, and there is no simple way to define the intimate partnerships of MSM.”
- “But we can deepen our understanding of the different types of factors that can influence decision-making and sexual risk behaviours of MSM within their intimate partner relationships.”
- Remind participants that they have a copy of the Venn diagram shown on the PowerPoint slide in their handouts.
- “Behavioural factors refer to the individual behaviours of MSM.” Invite one of the participants to read out the bullet points in the pink text box. After they have read out the seven bullet points, alert participants to the asterisk (*) next to ‘engagement in commercial sex’. Explain that this is because although commercial sex work by itself is not a risk factor for HIV, condom use that varies between types of partners, unsafe sexual behaviours, and inconsistent condom use increases vulnerability to STIs, including HIV.”
- “Moving to the left, we come to social factors. These refer to the social contexts, cultures and communities in which MSM live.” Invite another participant to read out each of the bullet points in the light blue text box.

- “Finally, we arrive at structural factors which we see in the darker blue box. These refer to the laws, policies, economic conditions and social inequalities that directly or indirectly affect the choices and behaviours of MSM.” Invite a third participant to read out each of the four bullet points.
- “Do any of these sound familiar? Let’s go back and look at the flipchart from earlier [note: this refers to Slide 9] when we discussed some of the reasons why an MSM might have a female partner or wife.”
- Referring back to the answers on the flipchart from Slide 9, invite participants to identify which of their explanations and reasons might relate to social factors. Which might relate to individual or behavioural factors? And which, if any, could be categorized as structural factors?
- “So, coming back to our Venn diagram, can anyone tell me what this area in the middle means? What do you think ‘overlapping risk factors’ refers to?” Invite participants to share their ideas.


FACTORS THAT AFFECT SEXUAL RISK BEHAVIOUR AND DECISION-MAKING AMONG MSM: PART 2 (SLIDE 12)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

WHAT TO DO

1. This slide continues on from the previous slide so there is no need for a separate introduction.
2. Follow the dialogue guide below.

WHAT TO SAY

- Continue the discussion from the previous slide as follows: “As you’ve just correctly identified, behavioural, social and structural factors do not exist in isolation from one another but often overlap to increase HIV risk and vulnerability within the intimate partner relationships of MSM. For example, the social environment in which MSM live can have a strong influence on behavioural factors such as low or inconsistent condom use with intimate partners.”
- “In Asia, MSM often experience pressure from their families to take a female partner, marry and have children and this makes it harder for them to adopt protective behaviours – including consistent condom use with their wives or girlfriends.”
- **An additional resource (YouTube clip)** can be used to supplement this point if you have access to reliable internet. This short clip available on YouTube helps to visually illustrate the messages on this slide:
 -  *What it’s like to be gay in China*
 - Web-link: <https://www.youtube.com/watch?v=PVfeLeTKeJA>
 - Recommended viewing is footage from 1:27–2:57 minutes.
 - This clip reinforces the social pressure that MSM in parts of Asia face to have a female partner, marry and have children.

- “Research from our region and globally also indicates that we experience different HIV prevention challenges when working with men who have sex only with other men, compared to men who have sex with men and women, and that these two groups are unlikely to respond to the same prevention messages and advice.”
- “For example, if we take a closer look at this quote from an NGO health service provider from India, we can see that married MSM face particular challenges within their intimate partner relationships. Depending on how comfortable they feel within a health care setting, MSM patients may find it difficult to disclose certain aspects about their life and behaviours. For example, in this quote, even though the patient was visiting an MSM-friendly clinic for STI testing and treatment, he still did not disclose to his health care provider that he was married.”
- Lead a 15-minute plenary discussion among participants to help them understand the reasons why this patient did not disclose his marital status to his health care provider. Ensure the discussion covers the following possible reasons:
 - The health care worker never asked him if he had a female partner or was married.
 - Fear of stigma or discrimination (the MSM felt he might be judged badly if he revealed he was married).
 - Concern about patient confidentiality (the MSM might have worried that the health care worker would tell others about the fact he had a female partner or wife).
 - The patient did not think this piece of information was relevant to disclose to his health care provider.

The following activity is an excerpt from the India HIV/AIDS Alliance module on ‘MSM with Female Partners.’ This module is part of the Pehchan Training Curriculum Guide: MSM, Transgender and Hijra Community Systems Strengthening (2013). UNDP and WHO thank the India HIV/AIDS Alliance for their kind permission to reproduce part of this module in the section below.

As part of this ongoing plenary discussion, use the following statements to elicit the opinions of participants:

- An MSM who has a wife and a boyfriend is cheating on the boyfriend.
- An MSM cannot have both a wife and a boyfriend – he should choose one or the other.
- An MSM cannot be bisexual.
- Does an MSM have the right to make his female partner unhappy?
- MSM have no right to marry.
- Encourage an open and honest discussion on these issues. Bring out different opinions by letting participants debate these statements, and gently point out where they are making value judgements about another’s behaviour and thoughts. Try and keep the discussion to no more than 15 minutes. Conclude the discussion by reminding participants (especially those who provide counselling) that regardless of their own personal views, they must have a non-judgemental attitude when dealing with MSM patients or clients who have female partners.

RESPECTING PATIENT RIGHTS AND ELIMINATING STIGMA AND DISCRIMINATION IN HEALTH CARE SETTINGS (SLIDE 13)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 10 minutes to introduce this slide, before breaking for lunch.

WHAT TO DO

1. Display the slide on the screen.
2. Follow the dialogue guide.

WHAT TO SAY

- Lead into this slide by saying: "We've just discussed the importance of ensuring that our attitudes as health care workers are respectful and non-judgemental when working with MSM who have female partners. Another issue that comes up when looking at approaches to reach intimate partners is the need for health care workers to strike a balance between responsibility to the individual patient – in this case the MSM patient – and the protection of others – in today's training, this is the female partner/spouse."
- "National HIV responses in Asia advocate for public health approaches that balance the rights of individuals and society at large, while at the same time balancing the right to confidentiality of individuals with the right to health and life of their partners."
- "So...what does this mean for MSM programming and specifically, for health care workers who want to reach out to their intimate partners with information and services?"
- "To start with, this requires that the human rights and dignity of MSM – including those who are HIV-positive – are not violated within health care settings. Their rights to voluntary and informed consent, privacy and confidentiality need to be respected by health care workers. This is especially important because, as we've already discussed, MSM are already stigmatized and marginalized within most societies. This makes it harder for them to access and use health services. For those living with HIV, they face the double stigma of being both HIV-positive and a man who has sex with other men."
- "If MSM patients fear their rights will be violated by health care workers, this makes them less likely to access services for themselves and far less likely to encourage their sexual partners to access sexual reproductive health (SRH), STI or HIV services. This includes bringing in their partners for couples HIV testing and counselling or mediated disclosure if they believe they are or are found to be HIV-positive."
- Explain to participants that after lunch they will be exploring different scenarios in which information and services can be provided to MSM and their female partners in a non-discriminatory, non-judgemental and respectful way.
- Wrap up this session by thanking participants for their attention throughout the morning. Before breaking for lunch, explain to participants where the lunch will be served and remind them that the afternoon session will start promptly in one hour's time. It is advisable to remind participants 10 minutes before the end of lunch that the afternoon session will start shortly and that they should start making their way back to the room.

LUNCH BREAK (1 HOUR)

Depending on the energy levels in the room and any time constraints, consider a quick five-minute ice-breaker straight after lunch to get participants energized for the afternoon session. An example of a quick and easy energizer is provided below:

- *Once back at their tables, ask participants to stand up and take a step back from their seats so that they are not standing too close to the next person. Make sure that the person leading the energizer (most likely the facilitator) is visible to all participants (i.e. standing at the front of the room). The person leading the energizer should choose an item of food that was served at lunch and spell out each letter of the word with their body, instructing participants to follow. Examples might include spelling out the word coconut or aloo (potatoes). This energizer gets participants moving on the spot and engaged before proceeding with the start of the afternoon session. Once participants have spelt out the word, they should be asked to sit back down so that the facilitator can continue with the training session.*

REACHING OUT TO FEMALE PARTNERS OF MSM: PART 1 (SLIDE 14)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 45 minutes for this activity, including 15 minutes for group discussion, 10 minutes for group feedback, and approximately 10 minutes for a plenary discussion afterwards.

A supplementary handout accompanies this slide (titled 'Types of services that can be provided to MSM clients and/or their female partners'). This handout should not be included in participants' handout folders but should be circulated by the facilitator after the rapporteurs from each group have been presented and before the plenary discussion.

WHAT TO DO

1. Display the slide on the screen.
2. Follow the dialogue guide below.

WHAT TO SAY

- Welcome participants back from lunch.
- Depending on time constraints, consider a quick five-minute energizer (see above).
- Begin the session by saying, "We concluded our morning session by looking at the importance of respecting patient rights when reaching out to MSM, as well as their intimate partners with HIV-related information, referrals and services. In a moment, we will look at real-life examples of how components to address IPT have been added or integrated into HIV prevention programmes with MSM."

- “But before we do this, let’s start by thinking about the kind of services health care providers could offer as part of efforts to prevent STIs, including HIV, among MSM and their female partners.”
- Divide participants into two groups. Ask participants to move into their groups, ensuring each group is located in different parts of the room and has access to a flipchart and pens.
- Ensure participants can see the slide and the two questions shown.
- Ask each group to discuss their respective question.
 - Group 1: What are the kinds of services that health care workers could provide to MSM with female partners to help prevent intimate partner transmission of HIV?
 - Group 2: What are the kinds of services that health care workers could provide to the female partners of MSM to help prevent intimate partner transmission of HIV?

Note: Health care providers include providers from the public health sector, NGO-run health services and/or private sector providers.
- Give participants 15 minutes to discuss their question and request that they appoint a rapporteur to report back to the plenary afterwards. Explain that each group will only have 5 minutes to present their response to the question and any key issues that emerged from their discussion.
- At the end of the 15-minute discussion period, ask participants to return to their seats.
- Ask the rapporteur from each group to report back to the plenary. Remind each group that they have a maximum of 5 minutes to present their response.
- After both rapporteurs have presented, circulate the supplementary handout that accompanies this slide (see Annexes). Explain that this handout captures the group discussions and that the list, while comprehensive, does not include every service that could be provided; participants should feel free to note down any additional services they have identified during the discussion.
- During the two presentations and the approximately 10-minute plenary discussion that follows, ensure that the following points are covered:
 - The range of services, referrals and linkages that health care providers can provide to MSM clients and their female partners is extensive (see table below).
 - It is unfeasible to suggest that every health care provider could or should offer all of these services, but this does underscore the importance of creating a strong network of referrals and linkages between and among health care providers and other social services.
 - The type of service offered depends on the type of health care provider and health setting. For example, an NGO-run MSM-friendly Drop-In Centre (DIC) may not offer services for female partners. However, the DIC may have established linkages with a local family planning clinic, enabling their MSM clients to be referred to the clinic along with their female partners. Another example would be an ART clinic which may not provide SRH services. However, the use of high-quality and systematic referrals could help to ensure a strong chain of HIV/SRH integrated services for MSM patients and their female partners. For example, where the female partner is unaware of their partner’s risk behaviour or HIV status, SRH clinics/facilities offer a key entry point for integrating voluntary and confidential counselling and testing (VCCT) with STI and family planning/SRH services.

- Although a health care workers' primary ethical and professional duty is to their patients, the legal environment has an impact on how services are delivered to MSM patients and their female partners. For example, in a criminalized environment (e.g. where same-sex sexual activity is criminalized and/or where HIV transmission and exposure is criminalized), health care providers often find it difficult to reach MSM and their sexual partners to deliver prevention materials, diagnosis and treatment, counselling and other services. In this type of climate, services for MSM are more likely to be provided through health services led by NGOs or community-based organizations (CBOs) and outreach workers than through mainstream public health facilities.

Types of services health care workers could provide to MSM with female partners	Types of services health care workers could provide to female partners of MSM
<ul style="list-style-type: none"> • Providing information and advice to MSM about sexual risk-taking, HIV, STIs and risk reduction counselling. • Condom negotiation skills (e.g. emphasizing the positive role of condoms with sexual partners in enhancing pleasure and sexual well-being, as well as protecting the client's health and that of his female partner) • Providing advice and support to increase client confidence and oral communication skills when discussing sexual matters with their female partners, including negotiation of safer sex methods. • Providing commodities such as free male and female condoms. • Referral to CBOs working with MSM for psychosocial support (including support on how to manage relationships with their female partners). • Referral to local family planning/SRH clinics for the MSM client and/or their female partner. • Referral to local sexual health clinics/services for the MSM client (for sexual health check-up including STI/HIV testing). • Providing information and advice on women-friendly/women-focused sexual health clinics for the client's female partner. • Counselling and support to HIV-positive MSM to help them through the disclosure process to their female partners. • Couples HIV counselling and testing. • Conception counselling for serodiscordant couples and antenatal care and follow-up. • Re-testing for HIV-negative MSM. 	<ul style="list-style-type: none"> • Referral to women-friendly services, including SRH and family planning services. • Counselling/education on SRH issues through the use of female counsellors/female health care workers/female peer educators. • Family planning services (either directly or through linkages and referrals), including contraceptive services and counselling. • Providing information and advice on communicating about sexual health and family planning to their male partner, including negotiating safer sex and condom use. • Referral to CBOs working on women's health and/or women's empowerment issues, particularly in the area of life-skills education. • VCCT (and if the female partner is found to be HIV-positive, referral to appropriate services and if negative given appropriate counselling). • Couples HIV testing and counselling. • Access to post-exposure prophylaxis (PEP) for female partners in a serodiscordant relationship with an HIV-positive MSM partner. • Access to pre-exposure prophylaxis (PrEP) for female partners in a serodiscordant relationship who wish to become pregnant. • Counselling services to help female partners who have found out their partner is an MSM and/or referrals to appropriate support groups. • Support and referral to protective services for domestic abuse/intimate partner violence where this is suspected by the health care worker. • Conception counselling for serodiscordant couples and antenatal care and follow-up. • PMTCT for pregnant female partners who are HIV-positive. • Re-testing for HIV-negative female partners in serodiscordant relationships.

REACHING OUT TO FEMALE PARTNERS OF MSM: PART 2 (SLIDE 14 CONTINUED)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 20 minutes for this activity, including 10 minutes to read handout #6 and 10 minutes for discussion (by tables/groups).

The handout titled 'Good practice examples from the region' accompanies this activity (see Annexes).

WHAT TO DO

1. Continue to leave Slide 14 displayed on the screen.
2. Follow the dialogue guide below.

WHAT TO SAY

- Refer participants to handout #6 in their folders ('Good practice examples from the region').
- Introduce the activity by saying "This handout provides a brief overview of some of the strategies and partnerships that health care providers in different parts of Asia have been using to reach out to the intimate female partners of MSM."
- Ask participants to read through the handout individually. Explain they have 10 minutes to do this.
- Explain to participants that once they've read the handout, they have a further 10 minutes to discuss briefly in their tables/groups whether any elements of the good practices cited could be introduced into their own work or whether there is anything in the good practices that they could replicate or build on in their day-to-day work with clients.
- Ask participants to bring their table/group discussion to an end after 10 minutes.
- Wrap up this session by saying "Building on these good practice examples, we are now going to explore case study scenarios to help think through how we might go about addressing the issue of IPT in different types of situations we may face as health care workers."

CASE STUDY SCENARIOS: REACHING OUT TO FEMALE PARTNERS OF MSM (SLIDE 15)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 1 hour for this exercise, including 5 minutes to explain the learning exercise, 30 minutes for group work, 15 minutes for report back and 10 minutes for plenary discussion. Handouts of the two case study scenarios accompany this slide (see Annexes).

The case study scenarios are adapted from the India HIV/AIDS Alliance module on 'MSM with Female Partners'. This module is part of the *Pehchan Training Curriculum Guide: MSM, Transgender and Hijra Community Systems Strengthening* (2013). UNDP and WHO thank the India HIV/AIDS Alliance for their kind permission to reproduce part of this module for this learning session.

WHAT TO DO

1. Introduce this learning exercise by saying: "The case study scenarios we are about to look at will help you to think through the types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals."
2. Explain that this group exercise will take just under 1 hour with 30 minutes allocated for group work, 15 minutes for report back and a further 10 minutes for plenary discussion. Notify participants that they will be taking their afternoon tea break after the group discussion (i.e. at the end of the 30 minutes). This should give them an additional incentive to keep to the timing.
3. Ask participants to pull out the handout in their folders marked 'Case study scenarios: reaching out to female partners of MSM'.
4. Number off participants – 1 and 2 – and ask them to move into their two groups, positioned in different parts of the room. They should take the handout of the case study scenarios with them.
5. Explain that Group 1 will be looking at *Case Study 1* and Group 2 will be reviewing *Case Study 2*.
6. Notify participants that they have 30 minutes to complete their respective case study scenarios.
7. Explain to participants that the first 7–8 minutes should be allocated for the group to read through the case study and to appoint a timekeeper, note-taker and a rapporteur who will report back to the plenary afterwards. The remaining time should be spent discussing and preparing the group's response to the case study questions (which can be found at the end of the scenario description). Ask each group to summarize their responses on flipchart paper which can be used as a helpful prompt for the rapporteur when they report back to the plenary.
8. Notify participants at the 25-minute mark that they have 5 minutes left.
9. At the end of the 30 minutes, ask each group to wrap up their discussion.
10. Explain that participants now have a 20-minute afternoon tea break. Ensure that participants return to their seats promptly at the end of the tea break.

WHAT TO SAY

- Follow WHAT TO DO above.

If the session is running over time, there is the option of asking participants to have their afternoon tea during their case study discussion. This would help to make up time and ensure the training finishes on schedule.

AFTERNOON TEA BREAK (20 MINUTES)

CASE STUDY SCENARIOS: REACHING OUT TO FEMALE PARTNERS OF MSM CONTINUED (SLIDE 15 CONTINUED)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 30 minutes for this activity.

WHAT TO DO

1. Welcome participants back from their group discussion and tea break.
2. Ask participants to move their chairs so that they are rearranged in a U-shape. The rapporteurs from Groups 1 and 2 should stand at the front of the U-shape so that they and their accompanying flipchart are visible to all participants. This seating arrangement will also facilitate the plenary group discussion afterwards and ensure a more relaxed, informal flow to this part of the session.
3. Before the first group reports back, remind participants that their presentation to the plenary should be no more than 7 minutes long. Explain to participants that there will be time for a short plenary discussion including any questions or clarification after both presentations have been made.
4. Starting with Group 1, ask the rapporteur to report back on their response to the case study scenario questions followed by Group 2.
5. After Group 2 has presented its feedback, thank both rapporteurs for presenting on behalf of their groups and proceed with moderating a short plenary discussion focused on any questions or clarifications, important issues or insights that participants learned from this exercise. Allow approximately 10 minutes for the plenary discussion.
6. Wrap up the discussion by acknowledging that there is no single overarching strategy for reaching out to MSM and their female partners. The patient's situation and health care setting may vary in each case and this will influence the type of approach and advice offered by the health care worker. Reiterate how the case study scenarios have shown there are various approaches that can be taken within health care settings to help reach MSM and their female partners with services, without disclosure of marital status and/or sexuality. Remind participants that whether or not to disclose HIV status is an individual's choice and the role of the health care provider is only to help their patient consider the pros and cons of disclosure and to support the individual in dealing with the consequence of their decision regarding disclosure. Highlight once again the importance of non-judgemental attitudes and confidentiality when dealing with MSM who have female partners.

WHAT TO SAY

- Follow WHAT TO DO above.

THE IMPORTANCE OF AN ENABLING ENVIRONMENT (SLIDE 16)


1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 20 minutes for this slide, including time for a short plenary discussion (maximum 10 minutes) and the viewing of a YouTube clip if a reliable internet connection is available.

WHAT TO DO

1. Display the slide and read out the slide title.
2. Follow the dialogue guide below.

WHAT TO SAY

- “In the last few sessions we've looked at ways to create a more supportive environment within health care settings for our MSM clients and their female partners so that we can reach them with HIV-related information, services and referrals.”
- “But even if we are able to act in a way that reduces fears among our MSM patients about rights violations or discrimination in health care settings, the legal and policy environment can still make it difficult for us to reach MSM and their sexual partners with HIV prevention, treatment and care services.”
- Invite a participant to read out the quote on the slide from a married MSM about his fears of disclosing his HIV status and his fear of disclosing his high-risk sexual behaviour as an MSM. Then ask the plenary the following question: “This quote is from 2011. Can anyone in the room tell me why this married MSM from India would have even more reason to fear disclosing his HIV status to his wife today?... The correct answer is that in 2013, India recriminalized homosexuality.”
- “This reminds us why reforming laws and reviewing health care policies can make it easier for MSM – as well as their sexual partners – to access health services AND to adopt behaviours that can protect themselves and their partners from STIs, including HIV.”
- This would be an opportunity to show the YouTube clip (see additional resource below) to illustrate how punitive laws and policies can undermine the effectiveness of HIV programmes and services for MSM populations.
- In the plenary, facilitate a short discussion (maximum 10 minutes) around how the absence of an enabling environment (whether because of punitive laws and/or strict conservative religious and social traditions) makes it harder for health care workers to reach the MSM population. Ask participants to share their experiences, including any effective strategies that they have used themselves, of reaching out to the MSM population when faced with a punitive legal environment and/or social intolerance towards this population.
- **An additional resource (YouTube clip)** can be used to supplement this slide if you have access to reliable internet. The video clip is:
 -  *High Level Policy Consultation on HIV Non-Disclosure, Exposure and Transmission, Oslo, Norway*

- Web-link: <https://www.youtube.com/watch?v=PSN64dpdFqI>
- Recommended viewing is footage from 2:13–4:04 minutes.
- *Video clip courtesy of POZ YouTube channel:* "The person speaking in this clip is Robert Suttle, a young MSM from the State of Louisiana in the USA and an advocate against HIV criminalization. You can see UNAIDS Executive Director Michel Sidibé sitting next to Robert, on his right. After a contentious relationship broke up, Robert's former partner filed criminal charges against him for not having disclosed his HIV status when they first met. Robert was not accused of transmitting HIV or of lying about his HIV status. But he was still prosecuted under a Louisiana law that effectively requires people with HIV to disclose their status prior to sexual contact, regardless of whether there was any chance of HIV transmission. The clip serves as a reminder as to why criminalization of same-sex sexual conduct and criminalization of HIV transmission and exposure discourages MSM from getting tested and treated for STIs, including HIV, and reluctant to disclose to health care workers any behaviours which may be placing them – and their intimate partners – at greater risk of HIV infection."

SUPPORTIVE HIV TREATMENT POLICIES AND GUIDELINES (SLIDE 17)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Allow approximately 25 minutes for this slide. A handout accompanies this slide (see Annexes).

A hard copy of the 2012 WHO Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach should be made available on each table. If this is not feasible then a hard copy of this publication should be held up at the front of the room for participants to see. A copy of this guidance can be downloaded and printed at http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf

WHAT TO DO

1. Display the slide on the screen.
2. Follow the dialogue guide below.

WHAT TO SAY

- Introduce this slide by saying "Supportive HIV treatment policies and guidelines can also help to create a more enabling environment for MSM and their female partners."
- Explain that one way to ensure this is to ensure services for serodiscordant couples do not discriminate based on marital status or sexual orientation. This includes services such as
- couples counselling, ARV treatment and PrEP.
- Point participants to a hard copy (either by holding up a copy of the publication at the front of the room and/or by pointing to available copies on their tables) of the 2012 WHO *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for public health approach*.

- Explain that in this publication, WHO recommends that policymakers and health care providers are not prescriptive in the definition of 'serodiscordant couples' who can benefit from HIV treatment, care and support services. For example, a HIV-positive man in a relationship with a HIV-negative man should not be excluded from services for serodiscordant couples just because of his sexual orientation. Likewise, marital status should not affect whether or not a MSM with a female partner can access services for serodiscordant couples.
- "In May 2015, the Ministry of Health in Viet Nam issued an updated ARV treatment guideline which strengthened efforts to prevent HIV transmission between key populations and their intimate sexual partners. Key features of this guideline are shown on the slide."
- "As we can see, the Government of Viet Nam has been proactive in implementing WHO guidelines by ensuring any HIV-positive person in a serodiscordant relationship can access ARV treatment, regardless of their CD4 count. This includes MSM who are in serodiscordant relationships irrespective of the sex of their partner (male or female) or whether the couple is married, living together or living separately."
- Remind participants that there is a handout in their folders which provides some relevant excerpts from the WHO guidance on ARV-related prevention for serodiscordant couples (2012).
- Ask participants how familiar they are with their own national ARV treatment guidelines for serodiscordant couples and whether they think these guidelines support or hinder efforts to reach the female partners of HIV-positive MSM with information and services. Depending on time constraints, limit the discussion to a maximum of 15 minutes.

TRAINING EVALUATION FORM (SLIDE 18)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 **18**

Allow approximately 15 minutes for the introduction and completion of the training evaluation form. The training evaluation form is provided in the Annexes to this manual. As the facilitator, please ensure completed evaluation forms are submitted to UNDP Bangkok Regional Hub.

WHAT TO DO

1. Display the slide on the screen.
2. Follow the dialogue guide below.
3. Remind participants of the handout on 'Top recommended resources' and encourage them to make use of them.
4. Ensure all participants have a contact email they can use should they have any follow-up questions on the training.
5. Ensure all participants have a copy of the training evaluation form in front of them [a copy of this form is provided in the Annexes].
6. Ensure all participants stay in the room to complete the form.
7. Collect the completed training evaluation form from each participant.
8. Wrap up the training by thanking participants for their contributions and concentration and lead participants in a round of applause for their efforts.

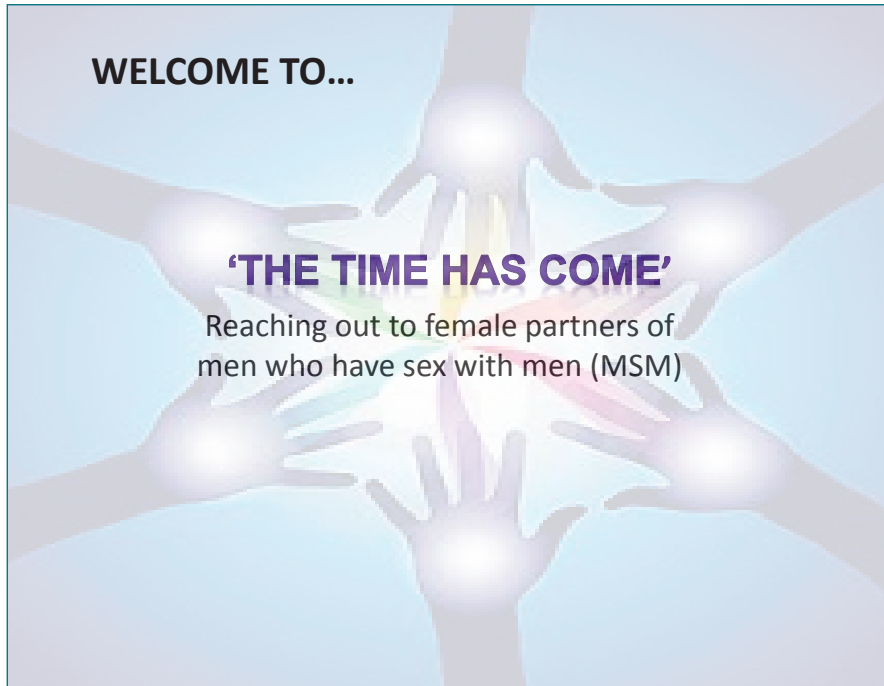
WHAT TO SAY

- “As we now move towards the closing of today’s training, I would like to remind you all of the resources we have put together for you to take away. In your handouts, you will see a list of top recommended resources [hold up this handout in front of the participants]. This list contains a number of documents that provide more information about today’s training topic as well as additional guidance on how to put what you’ve learnt into practice when you go back to your workplace.”
- If USB flash drives are provided, remind participants that electronic copies of these resources along with all of the day’s training materials are available on these devices.
- “After today, if you have any follow-up questions about this training or about any of the materials we have shared, then please contact UNDP Bangkok Regional Hub in the first instance.”
- “And now the time has almost come to say goodbye. But before we do, we ask that you complete the training evaluation form that can be found in your handout folders. This is a short form that should not take more than five minutes to complete. It is important that you complete this form so that we can ensure the training is as useful as possible to health care workers and to build on and improve aspects of the course for future participants.”
- After collecting all of the completed training evaluation forms, thank the participants for their contributions and concentration throughout the training and lead them in a round of applause for their efforts.

END OF TRAINING MODULE

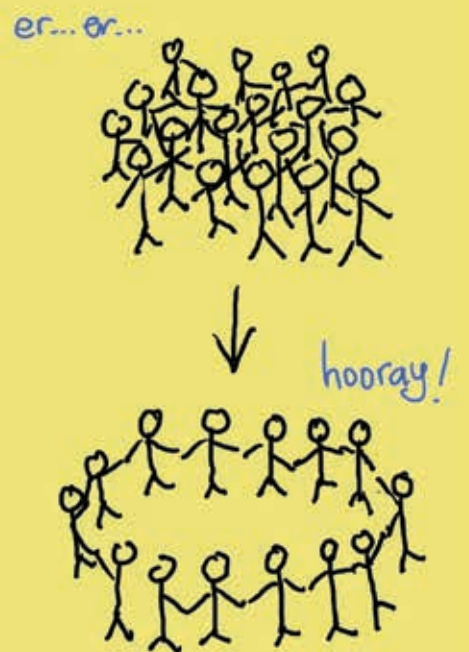
Presentation slides

For accompanying talking points, please refer to the Training Module Facilitator's Guide.





Introduction ice-breaker



At the end of the training you will...

...have a deeper understanding of:

1. Why reaching out to intimate partners is an important issue for health care workers to address when working with MSM patients and clients.
2. The types of HIV risks and vulnerabilities that MSM experience in their intimate partner relationships and how this affects their ability to adopt protective behaviours.
3. The types of services that can be provided to MSM patients and/or their female partners.
4. The types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals.

5

The Time Has Come... to get started!

- Expectations
- Handouts and resources
- Definitions



6

Handouts

1. Training agenda
2. Definitions and terminology
3. Copy of the PPT presentation
4. Infographic (map) showing levels of IPT in Asia
5. Venn diagram showing factors that shape the sexual risk behaviour of MSM and their choices about contraception with intimate partners
6. Good practice examples from the region
7. Case study scenarios: reaching out to female partners of MSM
8. Supportive HIV treatment policies and guidelines
9. Training evaluation form
10. List of recommended resources

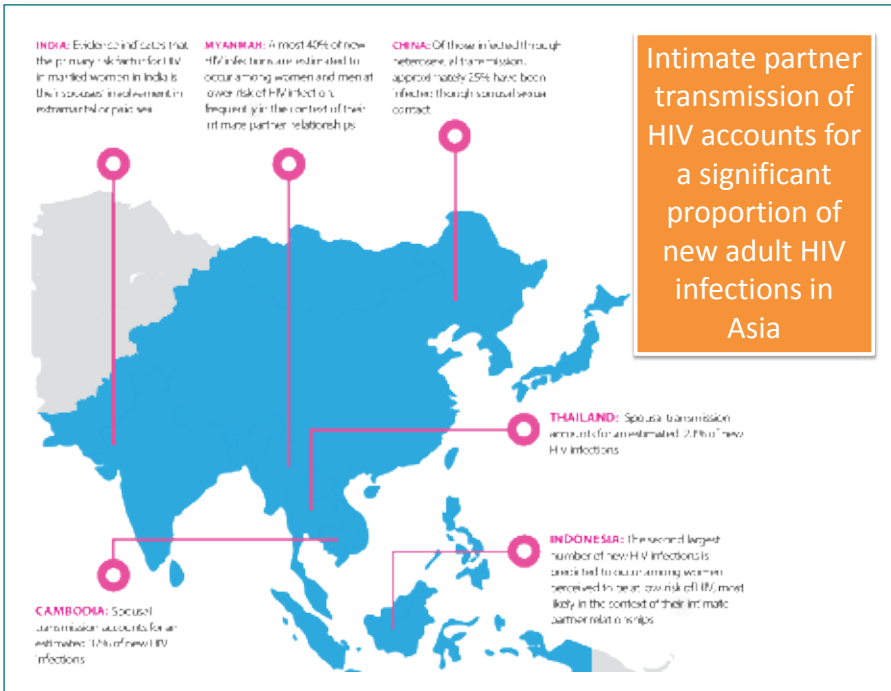
Definitions and terminology

Intimate partner transmission of HIV (IPT)

In today's training, intimate partner transmission focuses on the sexual transmission of HIV within an intimate partner relationship, which doesn't include transmission via sharing needles. An intimate partner relationship includes marriage or a dating relationship.

Intimate partner relationships in the context of men who have sex with men (MSM)

- ✓ The term 'MSM' often masks complex sexual identities, interests and practices.
- ✓ Many factors influence the way intimacy and sex between men are expressed
- ✓ There is no simple way to categorize the intimate partner relationships of same-sex practising men.
- ✓ The focus of this training module is on those MSM who have a female intimate partner.
- ✓ A 'female intimate partner' can be a wife through legal or common-law marriage or a regular female partner in the context of a dating relationship. In this training module, a dating relationship does not include casual sexual encounters (i.e. where this is no expectation of an actual relationship) or commercial sex.



Why is intimate partner transmission of HIV an issue for MSM?

➤ A substantial proportion of MSM and male sex workers in the region have high numbers of male and female partners of all types.

➤ There is no simple way to categorize the intimate partner relationships of MSM.

% of MSM who report having sex with women:

- 12.6–69.6% in parts of India
- 22.3% in Thailand
- 93.6% in Timor-Leste

➤ Being an MSM does not rule out sex with women or traditional marriage in many parts of Asia.
➤ Not only do many MSM have female sex partners but a significant number are married or have regular female partners.

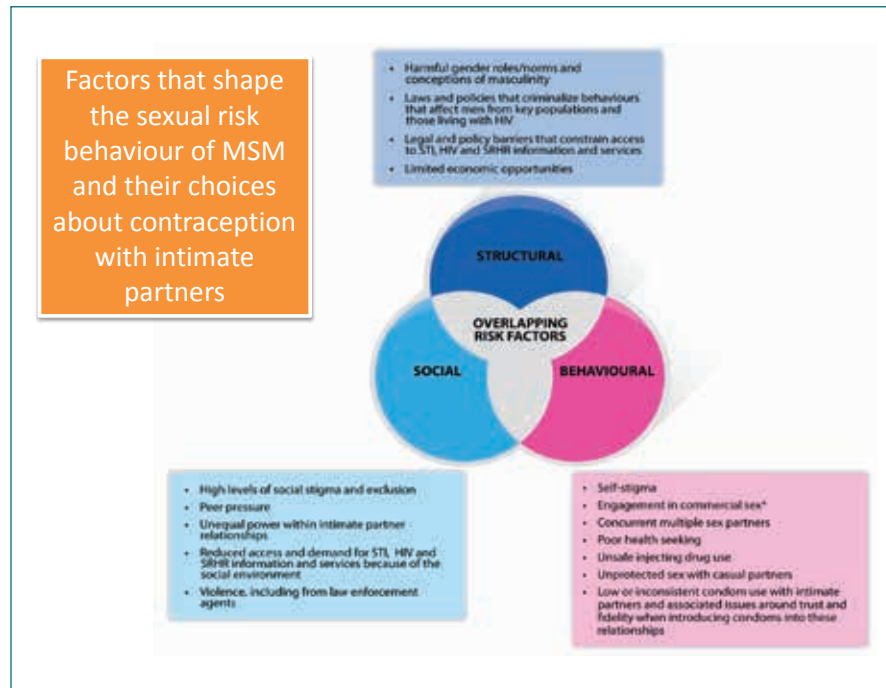


Why does reaching out to female intimate partners of MSM matter?

Health care workers who address the issue of intimate partner transmission of HIV with their MSM patients and clients can:

- ✓ Help to avert new adult HIV infections.
- ✓ Help MSM to protect both themselves *and their intimate sexual partners* from HIV infection.
- ✓ Reach the intimate partners and spouses of MSM with HIV information and services – individuals who would otherwise be difficult to reach, especially where resources for HIV prevention are limited.
- ✓ Help to prevent vertical transmission (PMTCT), especially among women who are perceived to be at low risk of HIV infection.





- Structural factors such as traditional gender roles mean MSM often experience strong pressure from their families to marry and have children.
- This can make it harder for MSM to adopt protective behaviours, including consistent condom use with their sexual partners, including spouses/female partners.
- As health care workers, we experience different HIV prevention challenges when working with men who have sex *only* with other men, compared to men who have sex with men *and* women.
- These two groups of MSM are unlikely to respond to the same HIV prevention messages and advice.

An MSM sought STI treatment but he did not reveal his marital status to his doctor. Even after completing the full course of treatment, he got the symptoms again because his wife had also got infected but she had not been treated. So it is a major area that needs to be addressed.

NGO SERVICE PROVIDER, BHUBANESWAR, INDIA CITED IN CHAKRAPANI ET AL. (2011).

Respecting patient rights and eliminating stigma and discrimination in health care settings

As health care workers, we face the challenge of striking a balance between responsibility to the individual patient – in this case the MSM patient – and the protection of others – in today's training this is their female partner/wife.

In order to uphold the human rights and dignity of our MSM patients we need to:

- ✓ Be non-judgemental when working with MSM patients who have female partners/wives.
- ✓ Respect the right of the MSM patient to voluntary and informed consent.
- ✓ Respect the right of the MSM patient to privacy and confidentiality.

(A doctor) asked me... 'Where did you go and get this disease?' I did not want to tell him that I am a kothi (MSM). I told him, 'I went to a place near Chennai once. I had sex with a woman there.' Then he asked, 'Is your wife with you?' I said, 'Yes.' Immediately he said, 'You should have done all this with your wife. Otherwise HIV would not have come'... Imagine what would have happened had I told him that I have sex with men?

INTERVIEW WITH A HIV-POSITIVE KOTHI FROM CHENNAI, INDIA. CITED IN CHAKRAPANI ET AL. (2011).

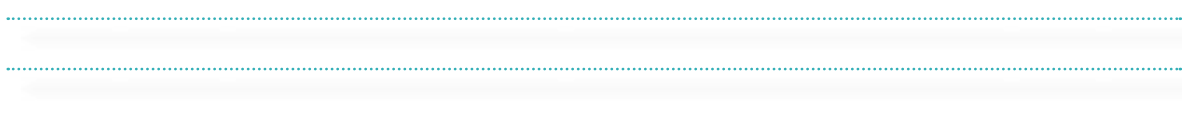


Reaching out to female intimate partners of MSM

Group 1: What types of services can health care workers provide to MSM with female intimate partners?

Group 2: What types of services can health care workers provide to the female intimate partners of MSM?

Each group has 15 minutes to discuss their question. A rapporteur should be appointed to present the group's response to the plenary at the end of the 15 minutes. The rapporteur has a maximum of 5 minutes to present the group's response and any key issues that emerged from the discussion. It is recommended that the types of services are listed on the flipchart provided to help the rapporteur when reporting back.



Case study scenarios: reaching out to the female intimate partners of MSM

CASE STUDY GUIDELINES:

- Approximately 1 hour is allocated for this learning exercise: 30 minutes for group work, 15 minutes for report back (a maximum of 7 minutes per group) and a further 10 minutes for plenary discussion.
- Each group has 30 minutes to complete their respective case study scenarios.
- It is recommended that the first 7–8 minutes should be allocated for group members to read through the case study and to appoint a timekeeper, note-taker and rapporteur who will report back to the plenary.
- The remaining time should be spent discussing and preparing the group's response to the case study questions (which can be found at the end of the scenario description).
- Each group should summarize their responses on flipchart paper for the rapporteur to refer to when reporting back to the plenary.
- The rapporteur has a maximum allotted time of 7 minutes to present their group's response to the plenary, including any key issues and points from the discussion.



The importance of an enabling environment

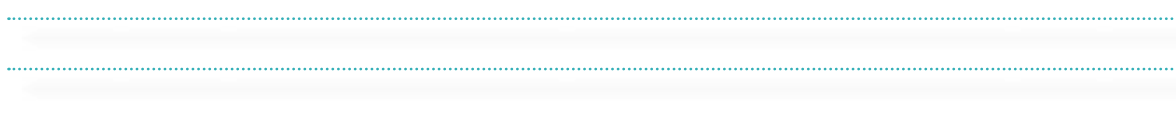
Several countries in Asia have laws that criminalize HIV exposure and transmission. Yet, studies show these laws do not have beneficial public health outcomes. Instead, such laws can make it harder for health care workers to reach MSM and their sexual partners.

For MSM who are living with HIV, these laws can make them more fearful of disclosing their status to intimate sexual partners, and reluctant to take part in testing or treatment programmes.

A punitive legal environment (including laws that criminalize same-sex sexual activity) can also make it harder for MSM, including those living with HIV, to access a range of health and social services. It can also make it harder for MSM to adopt protective behaviours and negotiate safer sex with their female partners.

"If I tell her [my wife] that I have [HIV] infection but do not know how I got [it], then she will question, 'How is it possible to get infection without your knowledge? Have you gone to someone else?' We can live with the label of a womaniser, but it is not easy to live with the label of a man who is after other men."

MARRIED MSM FROM PUDUKKOTTAI, INDIA.
CITED IN CHAKRAPANI ET AL. [2011].



Supportive HIV treatment policies and guidelines

Preventing IPT means ensuring that services for serodiscordant couples do not discriminate based on marital status or sexual orientation. This includes services such as:

- Couples HIV testing and counselling
- ARV treatment
- PrEP

Viet Nam Updated ARV Treatment Guideline (2015)


- Immediate ARV treatment regardless of CD4 count to key populations, including MSM
- Immediate ARV treatment to people with HIV-negative primary (regular/intimate) partner (not limited to married or cohabiting couples or heterosexual couples)
- The guideline is in line with World Health Organization (WHO) recommendations.

A valuable resource for health care workers working with MSM and/or their intimate partners: WHO's *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach* (2012)



Training Evaluation Form

The Time Has Come...
...for your feedback



Any questions about this training? Contact [insert relevant name] @undp.org



Annexes (handouts)

Handout #1: Training agenda

Time	Session/slide
9:00–9:30am	Welcome/Opening slide Housekeeping Introduction ice-breaker
9:30–10:20am	At the end of the training you will... The time has come... to get started! Handouts Definitions and Terminology Map showing levels of IPT in Asia
10:20–10:40am	Morning tea
10:40am–12:20pm	Why is IPT an issue for MSM? Why does reaching out to the female partners of MSM matter? Factors that affect sexual risk behaviour and decision-making among MSM Respecting patient rights and eliminating stigma and discrimination in health care settings
12:20–1:20pm	Lunch
1:20–3:25pm	Reaching out to female partners of MSM Case study scenarios: reaching out to the female partners of MSM
3:25–3:45pm	Afternoon tea
3:45–5:00pm	Case study scenarios (continued) The importance of an enabling environment Supportive HIV treatment policies and guidelines
5:00–5:15pm	Training evaluation form

Handout #2: Definitions and terminology

Intimate partner transmission of HIV

For the purposes of this training, intimate partner transmission focuses on the sexual transmission of HIV within an intimate partner relationship. Transmission via sharing needles is not included. The term 'intimate partner transmission' is used rather than 'spousal transmission' because intimate partners are not necessarily married.¹

Intimate partner relationships in the context of men who have sex with men (MSM) in Asia

The term 'MSM' often masks complex sexual identities, interests and practices. Evidence also suggests that substantially different HIV prevention challenges are posed by men who have sex only with other men, compared to men who have sex with men and women.² These two groups are unlikely to respond to the same prevention messages and advice. Many factors influence and shape the way intimacy and sex between men are expressed, and there is no simple way to categorize the intimate partner relationships of same-sex practising men,³ especially considering the diverse range of cultural and ethnic backgrounds, religious beliefs and traditions among MSM living in Asia.

The focus of this training module is on those MSM who have a female partner. For the purpose of this training, a female partner can be a wife through legal or common-law marriage or a regular female partner in the context of a dating relationship. Generally, a 'dating relationship' is defined as a romantic or intimate social relationship between two individuals. Factors that characterize a dating relationship can include the length of the relationship, the nature of the relationship, and the frequency of interaction between the two individuals. In this training module, a dating relationship does not include casual sexual encounters (i.e. where there is no expectation of an actual relationship) or transactional sexual relationships.

Serodiscordant couples

HIV serodiscordant couples, in which one partner is HIV-positive and the other is HIV-negative, are increasingly recognized as a priority for HIV prevention in Asian countries. Using the World Health Organization (WHO) definition, 'couple' in this context refers to two persons in an ongoing sexual relationship; each of these persons is referred to as a 'partner' in the relationship. How individuals define their relationships varies considerably according to cultural and social contexts.⁴ When it comes to HIV programming for serodiscordant couples, WHO recommends that policymakers and programmers should not prescribe the definition of couples who can benefit from HIV interventions.⁵

1 'HIV transmission in intimate partner relationships' describes the transmission of HIV to people from their regular partners who inject drugs and/or have sex with other people, including with sex workers. *UNAIDS Terminology Guidelines*, UNAIDS, 2011.

2 *Global Best Practices: Effective Approaches to Inform SBCC Programming and Reduce HIV Risk for Sex Workers and MSM in Jamaica and The Bahamas*. C-Change/USAID, 2011.

3 Ibid.

4 *Guidance on couples HIV testing and counselling – including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach*. WHO, 2012.

5 Ibid. For instance, the principle for couples HIV testing and counselling (CHTC) should be that any persons who are in a sexual relationship and wish to test together and mutually disclose their results should be supported to receive this intervention. Health workers should support the decisions of partners to test together, irrespective of the length or stability of their relationship, and policymakers and implementers should ensure that services are inclusive and non-judgemental in order to maximize the uptake and impact of such interventions.

Handout #3: Presentation

WELCOME TO...

'THE TIME HAS COME'

Reaching out to female partners of men who have sex with men (MSM)

Housekeeping

Welcome to all

- Toilets
- Fire exits/emergencies
- Mobile phones
- Other administrative issues

Introduction ice-breaker

At the end of the training you will...

...have a deeper understanding of:

1. Why reaching out to intimate partners is an important issue for health care workers to address when working with MSM patients and clients.
2. The types of HIV risks and vulnerabilities that MSM experience in their intimate partner relationships and how this affects their ability to adopt protective behaviours.
3. The types of services that can be provided to MSM patients and/or their female partners.
4. The types of approaches and strategies that could be used in different health care settings to reach MSM as well as their female partners with information, services and referrals.

The Time Has Come... to get started!

- Expectations
- Handouts and resources
- Definitions

Handouts

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Definitions and terminology

Intimate partner transmission of HIV (IPT)

In today's training, intimate partner transmission focuses on the sexual transmission of HIV within an intimate partner relationship, which doesn't include transmission via sharing needles. An intimate partner relationship includes marriage or a dating relationship.

Intimate partner relationships in the context of men who have sex with men (MSM)

- ✓ The term 'MSM' often masks complex sexual identities, interests and practices.
- ✓ Many factors influence the way intimacy and sex between men are expressed
- ✓ There is no simple way to categorize the intimate partner relationships of same-sex practising men.
- ✓ The focus of this training module is on those MSM who have a female intimate partner.
- ✓ A 'female intimate partner' can be a wife through legal or common-law marriage or a regular female partner in the context of a dating relationship. In this training module, a dating relationship does not include casual sexual encounters (i.e. where this is no expectation of an actual relationship) or commercial sex.

Intimate partner transmission of HIV accounts for a significant proportion of new adult HIV infections in Asia

CHINA: HIV is the leading cause of death in China. In 2010, there were 80,000 new HIV infections in China.

THAILAND: Thailand has the highest number of HIV infections in the world. In 2010, there were 100,000 new HIV infections in Thailand.

VIETNAM: Vietnam has the highest number of HIV infections in the world. In 2010, there were 100,000 new HIV infections in Vietnam.

CAMBODIA: Cambodia has the highest number of HIV infections in the world. In 2010, there were 100,000 new HIV infections in Cambodia.

Why is intimate partner transmission of HIV an issue for MSM?

➤ A substantial proportion of MSM and male sex workers in the region have high numbers of male and female partners of all types.

% of MSM who report having sex with women:

- 12.6–69.6% in parts of India
- 22.3% in Thailand
- 93.6% in Timor-Leste

➤ There is no simple way to categorize the intimate partner relationships of MSM.

➤ Being an MSM does not rule out sex with women or traditional marriage in many parts of Asia.

➤ Not only do many MSM have female sex partners but a significant number are married or have regular female partners.

Why does reaching out to female intimate partners of MSM matter?

Health care workers who address the issue of intimate partner transmission of HIV with their MSM patients and clients can:

- ✓ Help to avert new adult HIV infections.
- ✓ Help MSM to protect both themselves *and their intimate sexual partners* from HIV infection.
- ✓ Reach the intimate partners and spouses of MSM with HIV information and services – individuals who would otherwise be difficult to reach, especially where resources for HIV prevention are limited.
- ✓ Help to prevent vertical transmission (PMTCT), especially among women who are perceived to be at low risk of HIV infection.

Factors that shape the sexual risk behaviour of MSM and their choices about contraception with intimate partners



➤ Structural factors such as traditional gender roles mean MSM often experience strong pressure from their families to marry and have children.

➤ This can make it harder for MSM to adopt protective behaviours, including consistent condom use with their sexual partners, including spouses/female partners.

➤ As health care workers, we experience different HIV prevention challenges when working with men who have sex only with other men, compared to men who have sex with men *and* women.

➤ These two groups of MSM are unlikely to respond to the same HIV prevention messages and advice.

An MSM sought STI treatment but he did not reveal his marital status to his doctor. Even after treatment, he got the symptoms again because his wife had also not been treated. So it is a major area that needs to be addressed.

NGO SERVICE PROVIDER, BHUBANESHWAR, INDIA CITED IN CHAKRAPANI ET AL. (2011)

Respecting patient rights and eliminating stigma and discrimination in health care settings

As health care workers, we face the challenge of striking a balance between responsibility to the individual patient – in this case the MSM patient – and the protection of others – in today's training this is their female partner/wife.

In order to uphold the human rights and dignity of our MSM patients we need to:

- ✓ Be non-judgemental when working with MSM patients who have female partners/wives.
- ✓ Respect the right of the MSM patient to voluntary and informed consent.
- ✓ Respect the right of the MSM patient to privacy and confidentiality.

(A doctor) asked me... "Where did you go and get this disease?" I did not want to tell him that I am a MSM. I told him, "I went to a place near..." He said, "I had sex with a woman there." Then he asked, "to your wife with you?" I said, "Yes, immediately he said, 'You should have done all this with your wife. Otherwise HIV would not have come...' (Imagine what would have happened) had I told him that I have sex with men!"

INTERVIEW WITH A MSM PATIENT WITH HIV IN CHENNAI, INDIA. CITED IN CHAKRAPANI ET AL. (2011).

Reaching out to female intimate partners of MSM

Group 1: What types of services can health care workers provide to MSM with female intimate partners?

Group 2: What types of services can health care workers provide to the female intimate partners of MSM?

Each group has 15 minutes to discuss their question. A rapporteur should be appointed to present the group's response to the plenary at the end of the 15 minutes. The rapporteur has a maximum of 5 minutes to present the group's response and any key issues that emerged from the discussion. It is recommended that the types of services are listed on the flipchart provided to help the rapporteur when reporting back.

Case study scenarios: reaching out to the female intimate partners of MSM

CASE STUDY GUIDELINES:

- Approximately 1 hour is allocated for this learning exercise: 30 minutes for group work, 15 minutes for report back (a maximum of 7 minutes per group) and a further 10 minutes for plenary discussion.
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- Each group should summarize their responses on flipchart paper for the rapporteur to refer to when reporting back to the plenary.
- The rapporteur has a maximum allotted time of 7 minutes to present their group's response to the plenary, including any key issues and points from the discussion.

The importance of an enabling environment

Several countries in Asia have laws that criminalize HIV exposure and transmission. Yet, studies show these laws do not have beneficial public health outcomes. Instead, such laws can make it harder for health care workers to reach MSM and their sexual partners.

For MSM who are living with HIV, these laws can make them more fearful of disclosing their status to intimate sexual partners, and reluctant to take part in testing or treatment programmes.

A punitive legal environment (including laws that criminalize same-sex sexual activity) can also make it harder for MSM, including those living with HIV, to access a range of health and social services. It can also make it harder for MSM to adopt protective behaviours and negotiate safer sex with their female partners.

"If I tell her [my wife] that I have [HIV] infection but do not know how I got [it], then she will question, 'How is it possible to get infection without your knowledge? Have you gone to someone else?' We can live with the label of a womaniser, but it is not easy to live with the label of a man who is after other men."

MARRIED MSM FROM PUDUKKOTTAI, INDIA. CITED IN CHAKRAPANI ET AL. (2011).

Supportive HIV treatment policies and guidelines

Preventing IPT means ensuring that services for serodiscordant couples do not discriminate based on marital status or sexual orientation. This includes services such as:

- Couples HIV testing and counselling
- ARV treatment
- PrEP

A valuable resource for health care workers working with MSM and/or their intimate partners: WHO's *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach* (2012)

Viet Nam Updated ARV Treatment Guideline (2015)

- Immediate ARV treatment regardless of CD4 count to key populations, including MSM
- Immediate ARV treatment to people with HIV-negative primary (regular/intimate) partner (not limited to married or cohabiting couples or heterosexual couples)
- The guideline is in line with World Health Organization (WHO) recommendations.

Training Evaluation Form

The Time Has Come...
...for your feedback



Any questions about this training? Contact [insert relevant name] @undp.org

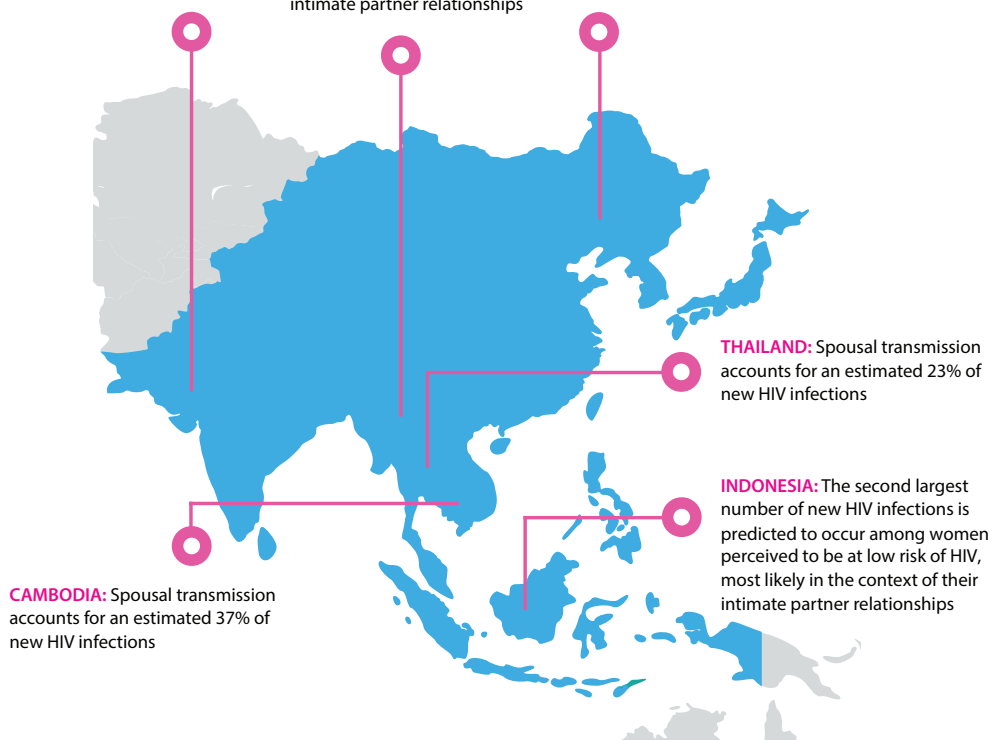
Handout #4: Infographic showing levels of intimate partner transmission of HIV in Asia

Epidemic modeling shows that countries in the region with mature, concentrated epidemics have high levels of intimate partner transmission of **HIV**

INDIA: Evidence indicates that the primary risk factor for HIV in married women in India is their spouses' involvement in extramarital or paid sex

MYANMAR: Almost 40% of new HIV infections are estimated to occur among women and men at lower risk of HIV infection, frequently in the context of their intimate partner relationships

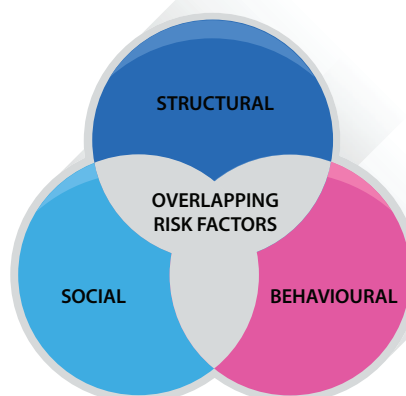
CHINA: Of those infected through heterosexual transmission, approximately 25% have been infected through spousal sexual contact



Source: *Preventing intimate partner transmission of HIV. Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia.* UNDP, UNICEF, UNAIDS, 2015.

Handout #5: Venn diagram showing factors that shape the sexual risk behaviour of MSM and their choices about contraception with intimate partners

- Harmful gender roles/norms and conceptions of masculinity
- Laws and policies that criminalize behaviours that affect men from key populations and those living with HIV
- Legal and policy barriers that constrain access to STI, HIV and SRHR information and services
- Limited economic opportunities



- High levels of social stigma and exclusion
- Peer pressure
- Unequal power within intimate partner relationships
- Reduced access and demand for STI, HIV and SRHR information and services because of the social environment
- Violence, including from law enforcement agents

- Self-stigma
- Engagement in commercial sex
- Concurrent multiple sex partners
- Poor health seeking
- Unsafe injecting drug use
- Unprotected sex with casual partners
- Low or inconsistent condom use with intimate partners and associated issues around trust and fidelity when introducing condoms into these relationships

Source: *Preventing intimate partner transmission of HIV. Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*. UNDP, UNICEF, UNAIDS, 2015.

Supplementary handout for Slide 14: Types of services that can be provided to MSM and/or their female partners

Note: The facilitator should not circulate this handout until after participants have completed the group exercise.

Types of services health care workers could provide to MSM with female partners

- Providing information and advice to MSM about sexual risk-taking, HIV, STIs and risk reduction counselling.
- Condom negotiation skills (e.g. emphasizing the positive role of condoms with sexual partners in enhancing pleasure and sexual well-being, as well as protecting the client's health and that of his female partner)
- Providing advice and support to increase client confidence and oral communication skills when discussing sexual matters with their female partners, including negotiation of safer sex methods.
- Providing commodities such as free male and female condoms.
- Referral to CBOs working with MSM for psychosocial support (including support on how to manage relationships with their female partners).
- Referral to local family planning/SRH clinics for the MSM client and/or their female partner.
- Referral to local sexual health clinics/ services for the MSM client (for sexual health check-ups including STI/HIV testing).
- Providing information and advice on women-friendly/women-focused sexual health clinics for the client's female partner.
- Counselling and support to HIV-positive MSM to help them through the disclosure process to their female partners.
- Couples HIV counselling and testing.
- Conception counselling for serodiscordant couples and antenatal care and follow-up.
- Re-testing for HIV-negative MSM.

Types of services health care workers could provide to female partners of MSM

- Referral to women-friendly services, including SRH and family planning services.
- Counselling/education on SRH issues through the use of female counsellors/ female health care workers/female peer educators.
- Family planning services (either directly or through linkages and referrals), including contraceptive services and counselling.
- Providing information and advice on communicating about sexual health and family planning to their male partner, including negotiating safer sex and condom use.
- Referral to CBOs working on women's health and/or women's empowerment issues, particularly in the area of life-skills education.
- VCCT (and if the female partner is found to be HIV-positive, referral to appropriate services and if negative given appropriate counselling)
- Couples HIV testing and counselling
- Access to post-exposure prophylaxis (PEP) for female partners in a serodiscordant relationship with an HIV-positive MSM partner.
- Access to pre-exposure prophylaxis (PrEP) for female partners in a serodiscordant relationship who wish to become pregnant.
- Counselling services to help female partners who have found out their partner is an MSM and/or referrals to appropriate support groups.

Types of services health care workers could provide to MSM with female partners

Types of services health care workers could provide to female partners of MSM

- Support and referral to protective services for domestic abuse/intimate partner violence where this is suspected by the health care worker.
 - Conception counselling for serodiscordant couples and antenatal care and follow-up.
 - PMTCT for pregnant female partners who are HIV-positive.
 - Re-testing for HIV-negative female partners in serodiscordant relationships.
-

Handout #6: Good practice examples from the region

Programming approach: Training and support for health care workers and counsellors to provide HIV and SRH services and referrals to MSM clients and their female partners

What it involves: Working with service providers to develop innovative and effective ways to reach out to the intimate partners of MSM while also respecting the patients' right to confidentiality. This approach encourages health care facilities and community service providers to view service provision and outreach to female partners of MSM as part of their mandate. This includes offering training and support to service providers and counsellors working with MSM so that they are better equipped to meet the needs of their MSM patient related to HIV and sexual and reproductive health (SRH), including within the context of an intimate partner relationship.

Programme examples from the region: In Cambodia, the Chhouk Sar clinics in Phnom Penh cater to the specific needs of key populations including MSM. Health care workers at these NGO-run clinics are trained to understand and respond to the different circumstances and health needs of key populations, based on their gender, sexual orientation and age, and to treat each patient respectfully. Working closely with the Ministry of Health, service provision includes STIs/HIV/ART services as well as counselling and referral mechanisms to SRH and psychosocial support services. As part of this, MSM clients are referred to sexual health services and are supported to take along their sexual partners, including any female partners. In India, the Mumbai-based CBO, the Humsafar Trust, has networked with government hospitals and family planning clinics to sensitize staff to the specific SRH needs of MSM and their female partners, including wives. Because the clinics run by the Humsafar Trust cater to the needs of MSM and transgender clients only, staff work with government hospitals to support MSM in referring their female partners for health services. This includes establishing linkages with the maternal health clinics as well as organizations providing SRH services and support primarily for women (e.g. the Mumbai branch of the Family Planning Association of India). These referral mechanisms facilitate service provision to female partners even if the partner/wife is unaware of the sexual identity and behaviours of their MSM partner. Training and sensitization of health care officials has helped to ensure these referral mechanisms protect and promote the health and human rights of both the MSM client and their female partner.

Summary of results and lessons learned: Engaging female partners of MSM in service provision can be challenging, but these examples show how strategies to prevent IPT can successfully balance the right to confidentiality of individuals with the right to the health and life of their intimate partners. An essential first step in reaching female partners of MSM is to sensitize health care providers to the specific needs of these groups of MSM. This includes the range of health and psychosocial support needs (including SRH/family planning) of MSM patients with female partners/wives. Without such training and support, service providers may be less likely or feel ill-equipped to address issues around IPT. Assessments of the Chhouk Sar and Humsafar Trust clinics found that strong referral networks and linkages between community service providers and government-run health care facilities were critical in meeting the HIV and SRH needs of MSM and their female partners. These partnerships appear to be most effective when staff from both health care facilities and community providers receive

appropriate training and sensitization. This includes training on sexual and relationship counselling as well as mediated disclosure for HIV-positive MSM. This type of sensitization is important because one of the key challenges identified by health workers is convincing their MSM clients to undergo regular testing and to come back with their sexual partners if they are diagnosed with an STI or HIV.

Potential application: The Chhouk Sar and Humsafar Trust clinics offer examples of how community service providers can partner with public health facilities to sensitize staff about the specific health needs of MSM who have female partners or are married. This should build on what already exists, rather than starting from scratch. For instance, community health/outreach workers working with MSM can provide training to SRH providers on the HIV-related needs of their MSM clients while health care workers at SRH or maternal health clinics can sensitize community providers on the different types of SRH services available for men and their female partners, and the most appropriate way to access them.

Handout #7: Case study scenarios: reaching out to female partners of MSM

CASE STUDY GUIDELINES:

- Approximately 1 hour is allocated for this learning exercise: 30 minutes for group work, 15 minutes for report back (a maximum 7 minutes per group) and a further 10 minutes for plenary discussion.
- Each group has 30 minutes to complete their respective case study scenarios.
- It is recommended that the first 7–8 minutes should be allocated for group members to read through the case study and to appoint a timekeeper, note-taker and rapporteur who will report back to the plenary.
- The remaining time should be spent discussing and preparing the group's response to the case study questions (which can be found at the end of the scenario description).
- Each group should summarize their responses on flipchart paper for the rapporteur to refer to when reporting back to the plenary.
- The rapporteur has a maximum allotted time of 7 minutes to present their group's response to the plenary, including any key issues and points from the discussion.

These case study scenarios are adapted from the India HIV/AIDS Alliance *Pehchan Training Curriculum Guide: MSM, Transgender and Hijra Community Systems Strengthening* (2013). UNDP and WHO thank the India HIV/AIDS Alliance for their kind permission to reproduce part of this guide for this learning session.

Case Study 1:

Ashok recently got married and is happy in his marriage. He likes his wife a lot. After one month of marriage, he finds out that one of his ex-boyfriends has tested positive for HIV. Although he is worried, he is also scared to get himself tested. He has stopped having sex with his wife because he doesn't want to infect her. His wife, however, wants a child and doesn't understand why Ashok is avoiding her. This situation leads to tension in their lives. Ashok approaches a local community-based organization for counselling.

Questions:

- What arguments could the counsellor use to persuade Ashok to go for HIV testing?
- If he does agree to get tested, and it turns out he is HIV-negative, how should he take care of himself, his wife and other partners from infection?
- If he gets tested and the results show he is HIV-positive, should he disclose his HIV status to his wife?
- How can he do so without talking about his sexuality?
- Should the client lie to his female partner if he thinks that is the only way to expose her to testing and treatment for HIV?
- If Ashok discovers he is HIV-positive, what options can the couple explore regarding having children?

Case Study 2:

A female health care worker at a sexual and reproductive health (SRH) clinic is trained to provide education and counselling on family planning. Recently the clinic has established a partnership with a local MSM-friendly Drop-In Centre (DIC). The DIC has been referring MSM clients with female partners to the SRH clinic. A MSM arrives at the SRH clinic with his wife. The health care worker is aware that the male client has been referred by the DIC, but it appears that the wife is unaware of her husband's sexual orientation. The couple ask the female health care worker for advice on family planning and reproductive health.

Questions:

- What type of information and services might the SRH clinic offer to the MSM and his wife?
- As an MSM, does the male client's behaviour create any additional risks for his wife?
- What words of advice or suggestions could the health care worker use to promote the use of condoms within the couple's relationship?
- What arguments could the health care worker use to persuade the couple to receive VCCT (Voluntary Confidential Counselling and Testing) services for STI and HIV?
- How should the health care worker handle any questions from the wife about why the couple should access VCCT without engendering the MSM patient's right to confidentiality?

Handout #8: Supportive HIV treatment policies and guidelines

Excerpts from the World Health Organization's *Guidance on Couples HIV Testing and Counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach* (2012).

How individuals define their relationships varies considerably according to cultural and social context. WHO guidelines recommend that health care providers and policymakers are not prescriptive in the definition of couples who can benefit from these interventions. Rather, the principle should be that any persons who are in a sexual relationship and wish to test together and mutually disclose their results should be supported to receive couples HIV testing and counselling (CHTC). Health workers should support the decisions of partners to test together irrespective of the length or stability of their relationship, and policymakers and implementers should assure that services are inclusive and non-judgemental in order to maximize the uptake and impact of these beneficial interventions.

People in couples who test together and mutually disclose their HIV status are more likely than those testing alone to adopt behaviour to protect their partner. In addition, in a serodiscordant couple the provision of ART to the positive partner can significantly decrease the risk of transmission to the negative partner, or potentially the provision of antiretrovirals (ARVs) to the negative partner – called pre-exposure prophylaxis (PrEP) – can help to prevent HIV transmission. Another potential benefit of couples testing together and sharing their results is that they can support each other, if one or both partners are HIV-positive, to access and adhere to ART as well as interventions for the prevention of mother-to-child transmission (PMTCT) of HIV.

Individual HIV testing and counselling and couples HIV testing and counselling compared

Individual HTC	Couples HTC
Individual learns only his/her own HIV status.	Individuals learn their own HIV status and the status of their partner.
Individual assumes burden of disclosing to partner.	Mutual disclosure is immediate.
Couple has to deal with issues of tension and blame on their own.	Counsellor can help ease tension and diffuse blame.
Only one partner hears the information.	Partners hear information together, enhancing likelihood of shared understanding.
Counselling messages take into account only one partner's status; individuals may wrongly assume that their partner's status is the same as their own.	Counselling messages are tailored, based on the test results of both partners.
Counselling is not present to facilitate the couple's discussion about difficult issues.	Counsellor creates a safe environment and can help couples talk through difficult issues that they may not have discussed before.
Prevention, treatment and care decisions are more likely to be made in isolation.	Prevention, treatment and care decisions can be made together.
Individual bears burden of getting family members, children tested.	Decisions about family or child testing, as well as family planning, can be made together.

Handout #9: Training evaluation form

Reasons for participating:

1. What were your main reasons for taking part in this training? Please tick as many as apply.

- To improve your skills or knowledge
- You were asked to take part by your employer
- The topic is relevant to your job
- Other, please specify

Please rate your skills:

2. Understanding the health needs of MSM with female partners (1 = No skills, 5 = Very good skills)

- | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | 1 | 2 | 3 | 4 | 5 |
| Before the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| After the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Awareness of the types of services that can be offered to MSM with female partners (1 = No skills, 5 = Very good skills)

- | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | 1 | 2 | 3 | 4 | 5 |
| Before the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| After the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Awareness of the types of services that can be offered to female partners of MSM (1 = No skills, 5 = Very good skills)

- | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | 1 | 2 | 3 | 4 | 5 |
| Before the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| After the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. Knowledge of strategies and approaches to help MSM and their female partners without disclosure of marital status and/or sexuality (1 = No skills, 5 = Very good skills)

- | | | | | | |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | 1 | 2 | 3 | 4 | 5 |
| Before the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| After the training: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. If you have any further comments about how the training helped you develop skills or knowledge in these areas, please add them in the box below.

Relevance of the training:

7. How relevant were the following sessions from today's training for your job role (1 = Not relevant, 5 = Very relevant)

	1	2	3	4	5
Understanding MSM risk behaviour and decision-making:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient rights, stigma and discrimination:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching female partners of MSM (case study scenarios):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enabling environment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. If you have any further comments about the relevance of the training, please add them here.

Application of learning:

9. How confident do you feel about applying what you've learnt today in your job role? (1 = Not confident, 5 = Very confident)

Rating 1 2 3 4 5

10. How often do you expect to be able to apply what you've learnt today in your job role? (1 = Not at all, 5 = Very often)

Rating 1 2 3 4 5

11. What resources (e.g. additional training, financial resources and documents such as guidance documents and revised guidelines) might you need to help you use what you've learnt today in your job?

Training content:

12. Did you find the amount of content in the training useful? (1= Not useful, 5 = Very useful)

Rating 1 2 3 4 5

13. Did you find the content of the training accessible? (1= Too difficult, 5 = Too easy)

Rating 1 2 3 4 5

14. Were there other topics or issues you think should have been included in the training?
If yes, please explain in the box below. If no, please move on to the next question.

Training methods:

15. How useful did you find the following in helping you to learn? (1 = Not useful, 5 = Very useful)

	1	2	3	4	5
Facilitator(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PowerPoints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group/plenary discussions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Case study scenarios	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. If you have any further comments about the training methods, please add them here.

About the trainer:

17. Please rate your trainer(s) in the following areas (1 = Very poor, 5 = Very good)

	1	2	3	4	5
Knowledge of the subject	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creating interest in the subject	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relating the training to your job role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responding to questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Facilities:

18. Please rate the following aspects of the training facilities (1 = Very poor, 5 = Very good)

	1	2	3	4	5
Room/venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IT facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Handout #10: List of recommended resources

1. *'The Time Has Come' Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific*. UNDP, WHO, 2013. http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/the-time-has-come/
2. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. WHO, 2014. <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>
3. *Preventing intimate partner transmission of HIV. Evidence, strategies and approaches for addressing concentrated HIV epidemics in Asia*. UNDP, UNICEF, UNAIDS, 2015. http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2015-preventing-hiv-transmission-in-intimate-partner-relationships-executive-summary.pdf
4. *A report on addressing the SRH needs of MSM and their female partners using existing SRH facilities and/or working in collaboration with existing organizations. Documentation of models that have worked and replicable strategies*. UNDP, 2012. http://www.in.undp.org/content/dam/india/docs/HIV_and_development/a-report-on-addressing-the-srh-needs-of-msm-and-their-female-par.pdf
5. *Women partners of men who have sex with men (MSM) in India [India 'MSM Situation Paper' series; Technical Brief 2]*. Chakrapani, V., Boyce, P., and Dhanikachalam, D., 2011. http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/Technical%20Brief-2_WomenPartners_MSM.PDF
6. *Pehchan Training Curriculum: MSM, Transgender and Hijra Community Systems Strengthening. Curriculum Guide*. India HIV/AIDS Alliance, 2013. http://www.allianceindia.org/wp-content/uploads/2014/09/2014_AllianceIndia_Pehchan-Training-Curriculum-MSM-Transgender-and-Hijra-Community-Systems-Strengthening-Complete-Set-of-Modules-PDF-8-MB.pdf
7. *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach*. WHO, 2012. http://whqlibdoc.who.int/publications/2012/9789241501972_eng.pdf
8. *Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach*. WHO, 2011. http://www.who.int/hiv/pub/populations/msm_guidance_2010/en/
9. *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV*. WHO, 2012. http://www.who.int/hiv/pub/guidance_prep/en/
10. *Male involvement in the prevention of mother-to-child transmission of HIV*. WHO, 2012. http://apps.who.int/iris/bitstream/10665/70917/3/9789241503679_eng.pdf
11. *HIV/SRHR Integration for Men who have Sex with Men and Transgender People*. India HIV/AIDS Alliance, 2012. https://indiahivaidalliance.files.wordpress.com/2012/07/ai_srhrintegration_msmtg_web-euflag2.pdf



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