

**Health Sector  
Models to  
increase access  
to HIV Counseling and  
Testing (HCT)  
among Males who have  
Sex with Males in the  
Philippines**

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## **Acronyms**

ART	Antiretroviral therapy
ASP	AIDS Society of the Philippines
BHW	Barangay health worker
BPO	Business process outsourcing
DoH	Department of Health
FFSW	Freelance female sex worker
FSW	Female sex worker
HAIN	Health Action Information Network
HCT	HIV testing and counseling
IEC	Information, education, communication
IHBSS 2011	2011 Philippine Integrated Behavioral and Serologic Surveillance
KPHR	Key Populations at higher risk
LGU	Local government unit
MSM	Males who have sex with males
NASPCP	National AIDS and STI Prevention and Control Program
NCR	National capital region
NEC	National Epidemiology Center
NGO	Non-governmental organization
OFW	Overseas Filipino worker
PGH	Philippine General Hospital
PLHIV	People living with HIV
PPV	Positive predictive value
PWID	People who inject drugs
QC	Quezon City
RFSW	Registered female sex workers
RHWC	Reproductive Health and Wellness Center (a name adopted by some SHCs)
RITM	Research Institute for Tropical Medicine
SACCL	STD AIDS Cooperative Central Laboratory
SES	Socioeconomic status
SHC	Social Hygiene Clinic
SPMC	Southern Philippines Medical Center
TasP	Treatment as Prevention
TCS	HIV treatment, care and support
TG	Transgender
TLF SHARE COLLECTIVE	The Library Foundation Sexuality, Health and Rights Educators Collective Inc.
WHO	World Health Organization

## **Executive Summary**<sup>1</sup>

Urgent action is needed to control the expanding HIV epidemic in the Philippines. After many years of stable, low level transmission, the number of cases detected has risen an average of 62% in each of the past 5 years; compounded, this is almost a 10-fold increase in the number of cases detected each year. It is clear which population is being affected: in the first half of 2012, 96% of newly identified cases were males and 87% of all newly identified cases were males who have sex with males (MSM). As a result, the HIV prevalence in MSM is now ranging from 2-5% and climbing. Without increased action, it is a distinct likelihood that prevalence will rise to the 15-30% levels seen among MSM in cities such as Bangkok and Phnom Penh, resulting in more than 100,000 new cases nationally.

Much of the HIV response to date has focused on female sex workers (FSWs). The HIV prevalence among female sex workers remains below 1%. The monitoring of FSW by Social Hygiene Clinics (SHCs) has provided easy access to this population. However, this kind of simple link from affected population to health system does not exist for MSM. In this report, we examine this issue. More specifically, we look at access to HIV counseling and testing (HCT), which is the entry point to HIV treatment, care and support (TCS). After determining the current locations and modes of HCT for MSM in the Philippines, we analyse the possibilities for future expansion of access.

Such an expansion could have a major impact on the epidemic. Antiretroviral treatment (ART) reduces HIV transmission by an infected heterosexual individual by as much as 96%. If, as expected, a similar prevention effect holds for MSM, it could counteract the biggest biological driver of the MSM epidemic: the high per-act probability of HIV transmission between MSM. Such a “treatment as prevention” (TasP) strategy would only work, however, if MSM get tested – because testing is a prerequisite to getting onto ART. This expansion of early diagnosis and treatment would also benefit the individual’s chances of survival by four-fold or more. And the process of testing even affects behaviour: it can reduce subsequent unsafe behaviors – by both HIV positive and HIV negative people who were tested – by up to 70%.

To assess current MSM HCT efforts, we examined existing surveillance data (from the 2011 Philippine Integrated Behavioral and Serologic Surveillance (IHBSS 2011)), performed an inventory of services available at SHCs, treatment hubs, and NGOs, and conducted site visits to seven SHCs, two private hospitals, a private clinic, four public hospitals, three private laboratories, six MSM NGOs, and two city health departments. The study was limited to considering HCT among MSM in seven category A (highest priority) cities, including Cebu, Davao, Angeles, and several cities in the national capital region (NCR).

The 2011 IHBSS shows that the MSM population at risk is young (median age of 23; median age at first male-male sex of 16), with a median of four male partners in a year, and only 35% condom use at last male sex. A majority (56%) favors males exclusively, and 6% are married. Most MSM meet partners in gay bars and clubs, workplaces, and on the street; they get information about HIV from friends and, in some locations, TV, radio, and SHCs. Certain subpopulations of MSM (e.g., MSM who favor males exclusively, and those who are overseas Filipino workers or social networkers, or who know many other MSM) have higher risk behaviors but also better access to HIV services. By contrast, married MSM, and MSM who favor females or who know few other MSM, are at lower risk but have poorer access to services. Young MSM, and high income MSM also have lower access to HIV services.

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<sup>1</sup> All figures cited in the Executive Summary are fully referenced, with greater context, in the main text.

HCT throughput for MSM in general is grossly inadequate. Only 15% of MSM have ever had an HIV test, and only 5% were tested in the past year and know their result. Cross-cutting challenges include a complex testing algorithm that requires multiple visits (and thus causes a significant proportion of loss-to-follow-up), almost no access for minors (<18 years old) due to a requirement for parental approval, and frequent stock-outs of rapid test kits. The corresponding solutions could include a revised algorithm (currently under review), a lower age of consent for testing (currently proposed to the legislature), and a greater role for the national Department of Health in conducting demand forecasting for rapid test kits.

A major barrier to HCT is that almost half (47%) of MSM do not know a place to get HCT. This points to a need for greater outreach from health services to MSM populations. Other barriers include low quality services. To be of a high quality, MSM HCT should have a clear and simple pathway for patients to access HCT, be available where and when MSM can access services, and involve MSM staff and volunteers. In addition, MSM HCT should include informative pre-test counseling, supportive post-test counseling, and, for those who need it, a strong link to TCS.

Based on the MSM who are tested, 54% of newly diagnosed MSM PLHIV are detected in NCR, and roughly equal numbers are detected in government hospitals (primarily at 4 sites in NCR), private hospitals, private laboratories, and SHCs. In the first half of 2012, the single site that now identifies the most cases per month is a male-health clinic set up by RITM in Malate; at this site, 21% of all HCT clients have tested as reactive. Among SHCs, HCT (and other services for MSM) are heavily concentrated in category A sites, with Quezon City particularly prominent.

These testing sites are based on a diversity of health delivery models. SHC staff in Quezon City conduct HCT during outreach, with the assistance of MSM peer educators hired using funds from the local government unit (LGU) and the Global Fund for AIDS, TB and Malaria. Davao City SHC staff test at nighttime at the SHC, after MSM are recruited via NGO outreach. CebuPlus, an NGO based in Cebu City, provides MSM peer educators to assist in the SHC, and will now provide both pre-test counseling and blood extraction on their premises, after which the referred blood is tested by the SHC. A government research institution (RITM), an SHC (Quezon City), and an NGO (AIDS Society of the Philippines (ASP)) are establishing stand-alone clinics with predominantly (RITM Malate) or only male health services, either for free (RITM Malate, Quezon City) or fee-for-service (ASP). Makati Medical Center is a private hospital providing HCT for clients who present either to a physician or directly to the laboratory; other, stand-alone private laboratories are notable for providing low-fee HCT. In addition to the involvement with SHCs described above, NGOs are using MSM events and clans to recruit to mass testing, or online chat rooms to recruit to SHC HCT.

This diversity is a strength of the response in the Philippines, and should be embraced. There is no single, perfect model for delivering HCT because sites vary in terms of potential clients, available resources, and the site's experience in providing MSM HCT. With testing rates so low, no models should be abandoned. The real question, however, is which of the models has the greatest potential for future expansion.

Expansion must overcome various challenges. SHCs, for example, are dominated by FSW clients and are therefore associated with sex work and not appealing or welcoming for MSM clients. Private hospitals are costly. Private laboratories have poor or non-existent pre-test and post-test counseling and poor connections to TCS. And public hospitals have significant issues with stigma, lack of confidentiality, and complex and unclear client flows for walk-in HCT.



Solutions to these challenges are as varied as the health sector models. At SHCs, an early step is to designate male-specific times or days, and to advertise the availability of free HIV testing in cinemas, on websites and blogs, and in and around the SHC. But the real increases in MSM clients are unlikely to come unless there are MSM peer educators involved and doing outreach – preferably with HCT being offered at the outreach site. The MSM peer educators can come either from partner NGOs (volunteer or paid) or be employed by the SHC using LGU funds; for sustainability, the latter may be preferable as NGO funding options are currently limited. Either way, these solutions should be very cost-effective because MSM peer educators are low-cost workers with excellent access to the clients who are most likely to be HIV positive.

The opening of an MSM-specific clinic in Malate is an exciting and, thus far, extremely successful initiative. Two additional MSM-specific clinics are planned in NCR; their costs and outputs should be tracked carefully to determine cost effectiveness. Expansion of this model is more likely to come only after SHCs or NGOs have experience with some of the other models described above, and are confident about the existence of substantial demand for their services.

An area that remains under-exploited is partnership between NGOs and private hospitals. Private hospitals can provide high quality, confidential services that are desired by many MSM, and NGOs have the capacity to generate demand for this HCT among MSM. This pathway would be even more promising if the Phil Health insurance package could be expanded to include free HCT and baseline CD4 testing.

Involvement of MSM in delivering services, and outreach to bring HCT beyond traditional healthcare settings, have been essential in many countries to bridge the gap between MSM and the health sector. Wider application of these principles in the Philippines would cost relatively little and could bring enormous benefit for MSM and the country as a whole.

# 1. Introduction

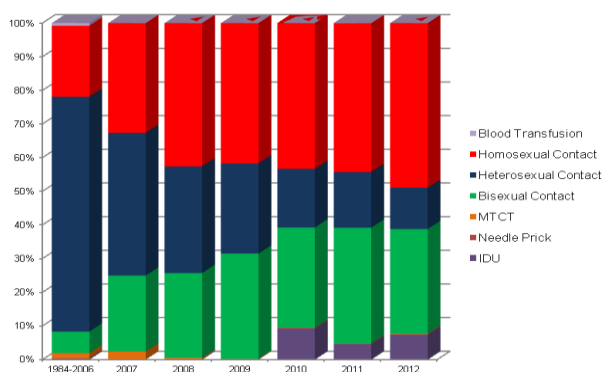
## 1.1 The HIV response in the Philippines: an evolving epidemic and evolving needs

The Philippines is situated at a critical point in its response to HIV/AIDS. After many years of extremely low levels of HIV infection, the past 5 years saw the epidemic emerge in certain key populations at higher risk (KPHR) – with the largest numbers in males who have sex with males (MSM). A prompt and strategically targeted response is needed to avert the HIV crisis brewing in the Philippines.<sup>2</sup>

From 1984 to June 2012, a cumulative total of 9,964 HIV positive cases were documented.<sup>3</sup> Most of these cases were detected recently: from 2007 onwards, the number of cases detected per year has increased by between 48% and 91% every year.<sup>4</sup> Compounded, these increases mean that the cases detected in 2011 reflected a 587% increase over the number detected in 2007. In 2011, the burden of cases detected in that single year boosted the national total to date – the number of all cases detected over the entire history of the epidemic – by 39%. And the trend is continuing. In the first six months of 2012, the numbers detected are 57% higher than the same period in 2011. Thus, there is now a case being detected every 2-3 hours in the Philippines.

These numbers only reflect those being reported tested and reported. Theoretically, such increases could result solely from greater or more targeted HIV counseling and testing (HCT). However, surveillance results and modeling suggest that the estimated total number of cases doubled between 2008 and 2011, and will double again between 2011 and 2015. Indeed, a vast number of people who are infected with HIV still do not access HCT, do not know their HIV status, have no access to treatment services, and are not reported to the Registry.

Figure 1: Proportion of Modes of Transmission of AIDS Cases by Year  
Jan 1984 – Dec 2011 (Source: Philippine HIV and AIDS Registry, Dec 2011)



In addition, the nature of the epidemic has changed. Overall, sexual contact has consistently been the most common mode of HIV transmission, accounting for 92% of all AIDS cases to date, with other modes

<sup>2</sup> Transitional Funding Mechanism Proposal, Republic of the Philippines, March 2012.

<sup>3</sup> National Epidemiology Center, Department of Health, Republic of the Philippines. Philippine HIV and AIDS Registry, June 2012. Available at [http://www.doh.gov.ph/sites/default/files/NEC\\_HIV\\_June-AIDSreg2012.pdf](http://www.doh.gov.ph/sites/default/files/NEC_HIV_June-AIDSreg2012.pdf)

<sup>4</sup> The Philippines is one of only seven countries worldwide where HIV infection rose by more than 25% between 2001 and 2009 (UNAIDS Global Report 2010).

of transmission including: (i) mother-to-child transmission (MTCT; <1%); (ii) blood transfusion (<1%); (iii) injecting drug use (4%), and (iv) needle stick injuries (<1%) (Figure 1). However, there has been a shift in the male:female ratio of new HIV cases (the percentage of males has risen from 64% (1984-2006) to 96% (2012)) and in the mode of transmission. MSM were only 28% of new cases in 1984-2006, but this rose to 78% for 2007-2011 and 87% for the first half of 2012.

These numbers are reflected in changes in prevalence. While the national HIV prevalence remains below one percent of the adult population and a decrease in HIV prevalence among registered female sex workers was noted, significant increase in prevalence was observed in other key at-risk population (Table 1).

**Table 1: HIV prevalence among female sex workers and MSM in 10 sentinel sites, and among PWID in Cebu City, IHBSS, DOH**

KPHR	2007	2009	2011
Female sex workers in Registered Entertainment Establishments (RFSW)	0.0%	0.23%	0.13%
Freelance female sex workers (FFSW)	0.05%	0.54%	0.68%
Males who have sex with males (MSM)	0.30%	1.05%	2.12%
People who inject drugs (PWID) in Cebu	0.40%	0.59%	53.8%

Risk behaviors among KPHR also remain a concern. Only 34% of MSM used a condom at last anal sex with another male (2011 Philippine Integrated Behavioral and Serologic Surveillance (IHBSS 2011)). Changing these behaviors remains challenging in an environment that is not supportive for these KPHR. Based on these changing dynamics, the Department of Health has warned that the total number of HIV cases in the Philippines could reach 35,941 by 2015, with 8,752 needing antiretroviral therapy (ART).<sup>5</sup>

The early response to the epidemic focused primarily on registered female sex workers (RFSW) and, to a lesser extent, freelance female sex workers (FFSW). The Social Hygiene Clinics (SHCs) served as an ideal location for these HIV prevention efforts, which were simply added to existing STI interventions with these groups at SHCs.

However, the new epidemic requires a new response. For the group constituting 87% of new cases – MSM – there is no natural, existing link to health education, health services, and HIV testing and counseling (HCT). How do and can MSM – the most affected population – access HCT and other HIV services in the Philippines? And how can these services be expanded to increase health and decrease HIV incidence in the country? These are the questions addressed by this report.

Below, we review the rationale for prioritizing HCT, and the challenges of doing so among MSM. We then outline quantitative data on MSM demographics and behaviors, and testing capacity and locations, based on IHBSS 2011 and our own inventory of services. Finally, we review the strengths, challenges and opportunities for each HCT delivery model, and close with a list of good practices and some suggestions for prioritization of future actions.

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<sup>5</sup> NEC/DoH: 2012 PLHIV estimates.

## 1.2 HIV epidemiology among MSM: the role of HIV testing and ART

Worldwide, HIV remains predominantly a heterosexually transmitted epidemic. However, in some regions, MSM contribute the greatest number of cases. In Asia, MSM have 19 times the odds of being HIV infected compared with someone in the general adult population.<sup>6</sup> As a result, in a region of relatively low prevalence, HIV prevalence among MSM averages 5.2% in East Asia and 14.7% in South and South-East Asia.<sup>7,8</sup> Emergence of an epidemic among MSM can occur undetected,<sup>9</sup> as in Thailand where the first report in 2003 was of 17.3% prevalence among MSM in Bangkok.<sup>10</sup> Subsequently, this increased further to reach 28.3% in 2005 and 30.8% in 2007.<sup>11</sup>

How and why do such epidemics develop? Frequent, unprotected sex with multiple partners is the ultimate driver, but underlying this are two other important sets of determinants.<sup>12</sup>

First are the structural factors, including legal, policy and socio-cultural conditions that stigmatize MSM; these create conditions that increase the likelihood of more frequent, unsafe sex and decrease the likelihood that MSM will be reached by public health and health system interventions. Evidence for the latter point comes from the situation among black MSM in the United States. Although this population has lower rates of HIV risk behaviors than white MSM in the same area, their HIV prevalence is strikingly higher. Rather, the explanation for the higher prevalence is that black MSM have higher rates of untreated STIs and, if HIV positive, are less likely to know their status and be on ART.<sup>7</sup> This suggests that poor access to HIV/STI-related healthcare – as occurs for MSM in the Philippines – can be a direct driver of HIV epidemiology.

The second underlying set of determinants is biological – primarily the high probability of transmission per act through receptive anal intercourse. (The 1.4% per-act probability for unprotected, receptive anal intercourse is ~18-times greater than the estimated probability for transmission during vaginal intercourse.<sup>13</sup>) Modeling demonstrates that this biological issue is the dominant explanatory factor for the disproportionate disease burden in MSM. If per act transmission probabilities were instead at the level seen for vaginal intercourse, then HIV incidence in MSM would be reduced by 80-98%.<sup>7</sup>

This biological argument suggests that any solution will require – as an important component – a biological intervention. The prime candidate for such an intervention is antiretroviral treatment (ART) of eligible HIV-positive MSM.<sup>7</sup>

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<sup>6</sup> Baral et al. Elevated risk for HIV infection among men who have sex with men in low and middle income countries 2000-2006: a systematic review. *PLoS Med* 2007. 4: e339.

<sup>7</sup> Beyrer et al. Global epidemiology of HIV infection in men who have sex with men. *Lancet* 2012. 380: 367-377.

<sup>8</sup> Van Griensven et al. A review of the epidemiology of HIV infection and prevention responses among MSM in Asia. *AIDS* 2010. 24(suppl 3): S30-S40.

<sup>9</sup> Celentano. Why has the Thai HIV epidemic in men who have sex with men been so silent? *AIDS* 2005. 19: 1931.

<sup>10</sup> Van Griensven et al. Evidence of a previously undocumented epidemic of HIV infection among men who have sex with men in Bangkok, Thailand. *AIDS* 2005. 19: 521-526.

<sup>11</sup> Van Griensven et al. Trends in HIV prevalence, estimated HIV incidence and risk behavior among men who have sex with men in Bangkok, Thailand, 2003 to 2007. *J AIDS* 2010. 53: 234-239.

<sup>12</sup> Sullivan et al. Successes and challenges of HIV prevention in men who have sex with men. *Lancet* 2012. 380: 388-399.

<sup>13</sup> Grulich et al. Probability of HIV transmission through anal intercourse. *Int J Epidemiol* 2010. 39: 1064-1065.

Among heterosexuals, ART reduces transmission by an individual person living with HIV (PLHIV) by 96%.<sup>14</sup> As a result, implementation of ART has the capacity to eliminate<sup>15</sup> or at least halve<sup>16</sup> HIV incidence relative to a scenario lacking ART (debate about the exact extent of the impact are ongoing<sup>17</sup>).

Although such studies are only now being conducted among MSM, it is widely expected that a similar protective effect from ART would result in this population. The first step in taking advantage of such a prevention effect among MSM is to provide opportunities for more MSM to find out their status via HIV testing so that they can then access ART.

### 1.3 More reasons to get tested: health improvements and behavioral prevention

International experience has led to several strong conclusions about HIV prevention. One of these conclusions is that combination prevention is essential: the answer is not one approach or another, but a combination of different strategies – typically behavioral, biomedical, and structural.<sup>18</sup> Although the scope of the current study is restricted to HCT, other prevention modalities such as condom promotion and behavior change communication remain essential. However, an increasing number of prevention strategies involve the healthcare sector,<sup>12</sup> and thus require a linkage between that sector and most at risk populations.

Among the various approaches, identifying PLHIV and getting them onto antiretroviral treatment (ART) has a special prominence. Reaching individuals at risk, and convincing them to get tested, is the gateway to treatment. For the individual, earlier initiation of ART can reduce the risk of death at least four-fold.<sup>19,20</sup> At a societal level, getting more people onto treatment can act as a biological form of prevention, as described above.<sup>14</sup>

In addition, the process of testing itself can have a strong preventive effect. Many of those who test negative will subsequently reduce their number of unsafe sexual encounters,<sup>21,22</sup> presumably because the process of counseling and testing forces them to think through the consequences of HIV infection.

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<sup>14</sup> Cohen et al. Prevention of HIV-1 infection with early antiretroviral therapy. *NEJM* 2011 365:493-505.

<sup>15</sup> Granich et al. Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *Lancet* 2009 373: 48–57.

<sup>16</sup> Eaton et al. HIV Treatment as Prevention: Systematic Comparison of Mathematical Models of the Potential Impact of Antiretroviral Therapy on HIV Incidence in South Africa. *PLoS Med.* 2012 Jul;9(7):e1001245.

<sup>17</sup> Cohen et al. HIV Treatment as Prevention: Debate and Commentary—Will Early Infection Compromise Treatment-as-Prevention Strategies? *Plos Med* 2012. 9: e1001232.

<sup>18</sup> Coates et al. Behavioral strategies to reduce HIV transmission: how to make them work better. *Lancet* 2008 372: 669-684.

<sup>19</sup> Kitahata et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *NEJM* 2009. 360: 1815-1826.

<sup>20</sup> Severe et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *NEJM* 2010 363: 257-263.

<sup>21</sup> Nduba et al. Behaviour change in clients of health centre-based voluntary HIV counselling and testing services in Kenya. *Sex Transm Infect.* 2007 83(7):541-6.

<sup>22</sup> Mola et al. Condom use after voluntary counselling and testing in central Mozambique. *Trop Med Int Health.* 2006 Feb;11(2):176-81.

For those who test positive, there is subsequently an average decrease of 68% in unprotected anal or vaginal intercourse with partners who were not already HIV+.<sup>23</sup>

The reasoning above is directed primarily at policy makers, with explanations about how HIV testing should increase health broadly and reduce eventual health expenditures. For individuals who are considering getting tested, however, there are additional resources that outline why HIV testing is the right decision for the individual.<sup>24</sup> There are many reasons why finding a person's determination of their HIV status "could be one of the most important things [they] do."<sup>24</sup> Amongst these reasons, protection of health – both of the individual and their partner – has proven a compelling inducement to HIV testing in many settings.

#### 1.4 HIV services by and for MSM: global, regional and national responses

MSM represent a group that can be diverse<sup>25</sup> and hard to reach, with behavior change interventions requiring multiple, sustained and interactive interventions.<sup>26</sup> Partnership with MSM is essential<sup>27</sup> but, as with all HIV prevention efforts, the role of government remains key:

"Although some individual communities have responded effectively on their own, all national-level successes [in HIV prevention] have been associated with government (often inter-governmental) leadership and community activism. Such leadership and activism is particularly important for ... populations, such as injecting drug users and men who have sex with men, who continue to face stigma and discrimination and, as a consequence, lack access to prevention services."<sup>28</sup>

Unfortunately, however, insufficient funding and prioritization means that typically <10% of MSM are reached by even basic HIV prevention services,<sup>29,30</sup> and comprehensive clinical care for MSM is rarely available.<sup>31</sup>

In Asia, examples of MSM and transgender-specific interventions have been described.<sup>32</sup> These interventions have, correctly, been focused on large cities, as it is here that MSM are more likely to

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<sup>23</sup> Marks et al. Meta-analysis of high risk behavior in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programs. J AIDS 2005. 39: 446-453.

<sup>24</sup> Such resources include "Top 5 reasons to get HIV tested" (<http://aids.about.com/od/toptenlists/tp/whytest.htm>) and "HIV testing frequently asked questions" under "Why should I take an HIV test" (<http://www.avert.org/hivtesting.htm>).

<sup>25</sup> TREAT Asia. MSM and HIV/AIDS risk in Asia: What is fueling the epidemic among MSM and how can it be stopped? The Foundation for AIDS Research (amfAR), 2006.

<sup>26</sup> Herbst et al. A meta-analytic review of HIV behavioral interventions for reducing sexual risk behavior of Men who have Sex with Men. J AIDS 2005. 39: 228-241.

<sup>27</sup> World Health Organization. Prevention and treatment of HIV and other sexually-transmitted infections among men who have sex with men and transgender people in low- and middle-income countries: Recommendations for a public health approach. WHO, 2011.

<sup>28</sup> Merson et al. The history and challenge of HIV prevention. Lancet 2007. 372: 475-488.

<sup>29</sup> Beyrer. Global prevention of HIV infection for neglected populations: Men who have sex with men. Clin Infec Dis 2010. 50(S3): S108-S113.

<sup>30</sup> Beyrer et al. A call to action for comprehensive HIV services for men who have sex with men. Lancet 2012. 380: 424-438.

<sup>31</sup> Mayer et al. Comprehensive clinical care for men who have sex with men: an integrated approach. Lancet 2012. 380: 378-387.

discover like-minded people and thus their sexual identity, and to have access to larger networks through which HIV can spread rapidly.<sup>7</sup>

In the Philippines, complex identity issues for MSM and transgender people create barriers to behavior change.<sup>33</sup> The country's history of interventions targeting MSM and transgender people has been reviewed,<sup>34</sup> and strategic plans have been outlined for the entire HIV response<sup>35</sup> and for MSM and transgender-related responses.<sup>36</sup> However, more specific strategies for each area of activity remain to be determined.

Barriers to HIV testing in the Philippines among MSM and transgender people have been identified as including: poor health-seeking behaviors of Filipinos in general; lack of awareness of facilities providing HCT; the cost of testing; the process of the test (drawing of blood); the perception that SHCs are for sex workers; the perception that MSM will be stigmatized in SHCs or other health facilities; the perceived lack of confidentiality; and the perception of HIV as being both a cause of further discrimination and a death sentence.<sup>37</sup> Many of these themes also emerged from the current investigation; some potential remedies are proposed.

### **1.5 Acting now**

The changes in the Philippines HIV epidemic are relatively recent, and many of the interventions to address this new reality are themselves both recent and, in some cases, lacking detailed data on impact. However, this is not the time to wait for a perfect evidence base. Due to the underlying biology and sociology, HIV epidemics among MSM can progress very rapidly,<sup>7</sup> as was seen in Thailand.<sup>11</sup> In addition, the prevention goal around HCT has a simple metric – the number of MSM tested – which can be used to monitor any existing or new efforts. A transition to Bangkok-like levels of HIV among MSM could occur in only a few years. The time to act is *now*.

## **2. Objectives of the current assessment**

In a partnership between the Department of Health, through the National Epidemiology Center (NEC) and the National AIDS and STI Prevention and Control Program (NASPCP), and the World Health Organization (WHO), the objective of this work was to assess existing models for MSM access to HIV testing, and thus to HIV treatment care and support (TCS). Specific reference was made to: the overall need; the capacity, strengths and weaknesses of current models in operation; which MSM might fit which models; and opportunities for expansion. There was a focus on practical issues and the feasibility of each model including who implements (ownership) and who would finance, both in the short and long term.

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<sup>32</sup> UNDP/USAID/UNAIDS/AIDS Projects Management Group. Towards universal access: Examples of municipal programming for men who have sex with men and transgender people in six Asian cities. UNDP, 2011.

<sup>33</sup> Health Action Information Network/UNDP. Assessing the risks and vulnerabilities of Filipino Men who have Sex with Men (MSM) and Transgender (TG) people in three cities. HAIN, 2012.

<sup>34</sup> Health Action Information Network. Assessment of HIV programs and interventions targeting MSM and TG. HAIN, 2012.

<sup>35</sup> Philippine National AIDS Council. The 5<sup>th</sup> AIDS medium term plan: 2011-2016 Philippine strategic plan on HIV and AIDS. PNAC, 2011.

<sup>36</sup> Philippine National AIDS Council. The national, comprehensive HIV and AIDS strategic plan for the MSM and TG population, 2012-2016. PNAC, 2012.

<sup>37</sup> Health Action Information Network/UNDP. Assessing the risks and vulnerabilities of Filipino Men who have Sex with Men (MSM) and Transgender (TG) people in three cities. HAIN, 2012.

The assessment deliberately focused on MSM – as the group contributing the most new cases in the Philippines. Transgender issues were discussed but there was insufficient time to explore them in depth. The assessment was also limited to HCT, as it is the entry point to medical care, including ART, for PLHIV. This focus is in line with the division of labor among the UN agencies, with UNDP concentrating on community interventions and prevention activities and WHO concentrating on the health system aspect of the HIV response. Other prevention efforts, such as behaviour change, condom distribution, and NGO capacity building, remain vitally important, but are not included in the scope of this assessment. In addition, this assessment focused on the category A (highest priority) sites for HIV in the Philippines, as there were more interventions to be assessed in these areas. Any recommendations would have to be adapted to other settings.

### **3. Assessment Process**

The assessment process was guided by a regional framework<sup>38</sup> and was consistent with guidelines on rapid assessment and response,<sup>39</sup> and service delivery approaches to HIV testing and counseling.<sup>40</sup>

During the preparation phase, in March 2012, meetings were held with Manila-based organizations including the AIDS Society of the Philippines (ASP), Health Action Information Network (HAIN), NEC, The Library Foundation (TLF SHARE COLLECTIVE), UNAIDS, and UNDP. There were site visits to the Research Institute for Tropical Medicine (RITM)'s male health clinic in Malate and the SHC in Bernardo, Quezon City, a document review, and a consultative meeting convened by NEC.

In early June 2012, NEC coordinated an inventory of services available at SHCs, NGOs, and treatment hubs, and an analysis of the IHBSS 2011 data to see how demographics, risk behaviors, and treatment-seeking behaviors in the Philippines vary by geography and by categories of MSM.

These preparations formed the basis for site visits conducted over two weeks in June-July 2012. The site visits included SHCs (Manila, Quezon City, Makati, Pasay City, Angeles, Mandaue, Davao and Cebu City), private hospitals (Makati Medical Center and Chong Hua Medical Center (Cebu)), a private clinic (Friendly Care Clinic, Mandaluyong), public hospitals (Philippine General Hospital, San Lazaro Hospital, Vicente Sotto Memorial Medical Center (Cebu City), Southern Philippines Medical Center (Davao), and Rafael Lazatin Memorial (Angeles)), private labs (Sims (Manila), Physicians' Diagnostic Services Center, Inc. (Davao), and the lab within Makati Medical Center), a learning group session in Angeles, and outreach testing in Quezon City. In addition, there were further interviews with NASPCP, NGOs (ASP, Bahaghari, Love Yourself, Take the Test, ACHIEVE, and CebuPlus), City Health Officers and City Planning Officers (Quezon City and Cebu City), and Ateneo de Manila University. A full list of sites and interviewees is provided in Table 10.

This study was conducted in the five cities with the highest HIV prevalence among MSM, as determined by the IHBSS 2011 (Table 2). In addition, Makati and Mandaue were included as additional category A cities. Of these seven cities, Quezon City (2.67 million), Manila City (1.65 million) and Davao (1.36 million) have the largest populations, although of course many of the health facilities in these cities

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<sup>38</sup> WHO/UNDP/UNAIDS/Department of Health of Hong Kong/ APCOM. Priority HIV and sexual health interventions in the health sector for men who have sex with men and transgender people in the Asia-Pacific region. WHO, 2010.

<sup>39</sup> World Health Organization. Rapid assessment and response adaptation guide on HIV and Men who have Sex with Men. WHO, 2004.

<sup>40</sup> World Health Organization. Service delivery approaches to HIV testing and counseling (HTC): A strategic HTC programme framework. WHO, 2012.



draw clients from outside their borders. In Cebu, 52% of newly identified cases in 2011 were people who use drugs (PWID; from NEC Form A), but in all other cities the dominant KPHR is MSM.

**Table 2: HIV prevalence and HIV testing by SHCs among MSM in Category A (yellow) and B sites**

City	Estimated HIV Prevalence <sup>41</sup>	Sites for this study	Estimated #MSM <sup>42</sup>	#MSM tested by SHC, Jun 2011- May 2012 <sup>43</sup>	% of the city's MSM population tested in 2011-12 by the city's SHC <sup>44</sup>	Other major testing sites <sup>45</sup>
Quezon City	5.60%	*	22,197	2,334	10.5%	Precision, St Luke's
Cebu	4.70%	*	6,586	440	6.7%	Precision
Manila City	4.20%	*	13,982	909	6.5%	San Lazaro, PGH
Davao	2.70%	*	11,105	645	5.8%	SPMC
Pasay	2.00%	*	3,491	64	1.8%	
Angeles	2.00%	*	2,576	204	7.9%	
Cagayan de Oro	1.90%					
Zamboanga	1.30%					
Mandaluyong	1.00%					
Bacolod	1.00%					
Baguio	1.00%					
Makati	0.70%	*	4,477	399	8.9%	Makati Medical Center
Marikina	0.70%					
Caloocan	0.60%					
Pasig	0.30%					Medical City
Mandaue	0.30%	*	2,704			
Iloilo	0.30%					
General Santos	0.00%					

## 4. Results from quantitative data analysis

### 4.1 *Who is the target audience for MSM interventions?*

There are an estimated 689,529 MSM in the Philippines.<sup>46</sup> Almost 10% of them (68,953) are estimated to live in the seven cities examined in the current study.

MSM populations are diverse, and sampling methodologies will influence the identity of those surveyed. However, the MSM reached during IHBSS 2011 in the Philippines are a population of interest, as they are the types of MSM who are likely to be identified during outreach interventions (see below). The participants in IHBSS 2011 had the characteristics outlined in Table 3.

<sup>41</sup> Based on the testing during IHBSS, 2011

<sup>42</sup> Tayag et al. Philippine Priority Areas for HIV Intervention (PAHI), February 2, 2012.

<sup>43</sup> From the NEC inventory conducted for this study, as reported by SHCs to NEC.

<sup>44</sup> Derived by dividing the previous column by the one before it

<sup>45</sup> Based on the cases reported to the national reference lab and NEC; see Table 4

<sup>46</sup> This is the high NEC estimate used for the latest Spectrum Estimation and Projection Package (EPP) epidemiology estimate; it is equal to 3% of the male population aged 15-49 years old.

**Table 3: Demographics, risk behaviors, and connections to other MSM (IHBSS 2011)**

<b>1) Demographics:</b>	
a) Median age	23 years
b) Median income	9,000 PHP/mo
c) Married	5.6%
d) Have been overseas Filipino workers (OFW) in the past 5 years	3%
e) Taking or injecting hormones in past 12 months (surrogate for transgenders)	1.6%
<b>2) Risk behaviors</b>	
a) Median age at first male-male sex	16 years
b) Paid a male partner for sex in past 12 months	80%
c) # male partners in 12mo, mean	9
d) # male partners in 12mo, median	4
e) Participated in group sex in past 12 months	35%
f) Condom use, last anal sex with male	35%
g) Used drugs in past 12 months	55%
<b>3) Connection to other MSM</b>	
a) Member of social networks	21%
b) Median number of MSM known	20
c) Favor males exclusively	56%

Prevention services, including outreach to promote and provide HCT, should be targeted to the sites where MSM meet to find partners. Three types of sites stand out (IHBSS 2011). First, gay bars and other clubs are meeting sites for 35% and 25% of respondents from Manila and Quezon city, respectively, and for 14-21% of MSM in the other study cities. For Pasay and Angeles, workplaces are important (43% and 27%, respectively, possibly because these cities had a lot of respondents who were based in male entertainment establishments). But for all the other study cities, the street remains the most important site (39-52%). These 3 types of sites are where outreach is needed. Of note, MSM who look for male partners on the street have the lowest condom use (24% at last anal sex) and low HIV testing (3% within the past 12 months), which suggests that this population is a particularly important target.

The majority of transactions for paid sex are also accessible to outreach. Although IHBSS respondents in Manila and Pasay found paid male sex partners equally from friends and cruising sites (34-44% from each), in the other study cities 70-81% of the meetings were at cruising sites.

MSM get information about STIs or HIV primarily from friends (24% nationally; IHBSS), although notable outliers include TV (23% for Manila; 8% or less for other cities), radio (18% for Pasay; 7% or less for other cities) and SHC (31% for Angeles; 10% or less for other cities). This demonstrates that specific initiatives with these mechanisms can be effective.

## 4.2 How do behaviors vary?

IHBSS data were analysed to see if particular categories of MSM had different risks and behaviors. All the figures in the entire section below represent percent deviation, for a particular category, from the mean of the entire IHBSS sample.

Young MSM (<20 year old; 29% of IHBSS sample) are much less likely to have been tested. Relative to the figures for all MSM, they are 51% less likely to be comfortable testing at SHCs, 62% less likely to have had an HIV test and, of those who tested, 40% less likely to have returned to get their HCT result. They are 13% less likely to exclusively favor males, consistent with an evolving sexuality.<sup>47</sup>

Married MSM (6% of total) are safer (23% less likely to have had last sex with a male without a condom; 22% fewer male partners) but they also know 32% fewer MSM and access services less (18% less likely to have been tested for HIV; 33% less likely to have had condoms from an NGO). The same trends occur, and are even more pronounced, for MSM who identified their sexual preference as being for “females”.

MSM living with a partner are 58% less likely to be comfortable testing at SHCs.

MSM with an income below the median are 11% more likely to have had an HIV test, 8% more likely to have had the HIV test at an SHC, and 18% more likely to have visited an SHC in the past year. (For MSM with above median income, the corresponding figures are -6%, -5%, and -10%. Interviews also suggested greater risk behaviors by educated MSM due to their disposable income, whereas the poorer “parloristas” are more marginalized, though IHBSS data did not show a large difference in recent condom use or numbers of partners.) Low income MSM are also more likely to have been reached by SHC (23%) and NGO (56%) prevention services.

Compared to the IHBSS sample mean, OFW have 33% more male partners and know 82% more MSM, but are 137% more likely to have had an HIV test. They are 44% less likely to have had that test at an SHC.

Social networkers have 33% more male partners than is true for the IHBSS sample mean and know 18% more MSM; they are 25% more likely to exclusively favor males. They are 21% more likely to have had an HIV test, but testing is 12% less likely to be at an SHC, which they are 22% less likely to have visited in the past year.

MSM who know less than 20 MSM (the median number of other MSM known) have lower risks (15% less likely to have had last male sex without condom; 33% fewer male partners) but access fewer services (25% less likely to have had an HIV test; 15-36% less likely to have visited an SHC or received prevention services from SHCs or NGOs). They are 17% less likely to favor males exclusively.

If the proxy for risk is the number of male partners and percent having last male sex without condom in the past 12 months, this suggests the typology shown in Figure 1. Based on this typology, there is a population of MSM who have higher risk behaviors but get more HIV testing and more prevention activities targeted to them. They may be more “out” to other MSM but, as professionals, are still hidden in the general population. We have not identified a population that has both high risk and low access to

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<sup>47</sup> In the current analysis of MSM <20 years old, using IHBSS 2011, the % using condom in last anal sex and median # partners was very similar to the average for all MSM; we therefore classified them as “medium risk” . However, IHBSS 2009 indicated several reasons to believe that young MSM may be a higher risk population. Full analysis of IHBSS 2011 on this issue is pending.

services – the worst combination – but there are still populations with markedly poorer than average access to services.

**Figure 1: Typology of MSM risk and access to services**

		Risk		
		High	Medium	Low
Access to services, including HCT	Low		Young MSM; High income MSM	Married MSM; MSM who favor females; MSM who know few other MSM
	High	MSM who favor males; OFW; Social networkers; MSM who know many other MSM	Older MSM; Low income MSM	

### 4.3 *Where do MSM get tested?*

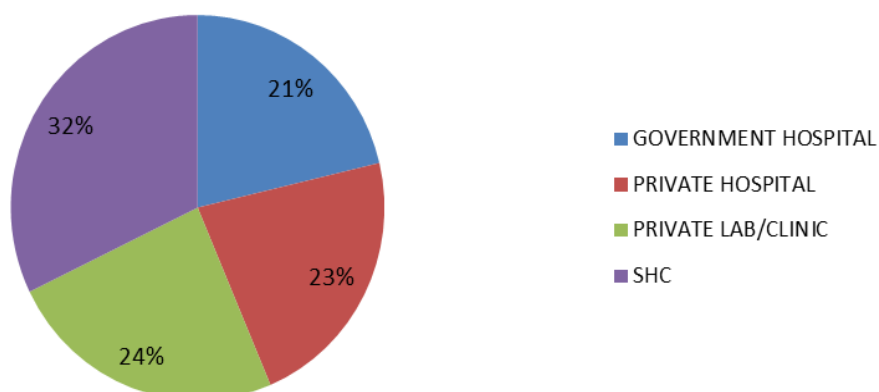
With a population of 94.85 million (2011; World Bank), the Philippines is served by 379 VCT sites, including 23 of the nation’s 120 social hygiene clinics. However, 47% of MSM don’t know a place to get HCT (IHBSS 2011), and testing rates remain low.

Data on the number of tests administered in each site are incomplete, though some data for SHCs are presented in the next section. The most common testing site noted by respondents in the IHBSS 2011 was SHCs (61%), followed by private labs (22%) and “other” (14%). Government hospitals and private hospitals were not named options for this question.

Another way to look at testing location is to look at where PLHIV are newly diagnosed. From 2007-11, 82% of new HIV+ cases were detected in four regions: 54% in the national capital region (NCR); 12% in region IV-A (Cavite to Batangas); 9% in region VII (Cebu); and 7% in region XI (Davao).<sup>3</sup>

As part of this study, we obtained further information on the sites where the 1,960 MSM were newly diagnosed as HIV+ in 2011. Based on this analysis, approximately equal numbers of HIV+ MSM are being detected in each of the four types of facilities (Figure 2). The contrast with the IHBSS result above (61% last tested in SHCs) may be explained by serial testing (see section 6.1), with early tests occurring in SHCs but never being confirmed, after which clients finally make their way to private facilities or the large public sector treatment hubs for HCT that is confirmed.

**Figure 2: % of HIV+ MSM detected in each facility type in 2011**



The individual sites where the most MSM PLHIV were newly diagnosed in 2011 are listed in Table 4. The top 5 sites identified 29% of MSM PLHIV, and the top 10 sites identified 45%.

**Table 4: Sites diagnosing the most MSM as HIV+ in 2011**

Rank	Facility name	# MSM diag HIV+ in 2011, per facility	# MSM diag HIV+ in 2011, cumulative	Percent national total
1	Manila SHC	147	147	8%
2	Cebu SHC	120	267	14%
3	Project 7 SHC Quezon City	119	386	20%
4	Precision Diagnostic Lab QC, Cebu, etc	96	482	25%
5	San Lazaro Hospital / SACCL	92	574	29%
6	Bernardo SHC Quezon City	73	647	33%
7	Research Institute for Tropical Medicine (RITM)	67	714	36%
8	Philippine General Hospital (PGH)	66	780	40%
9	Davao RHC SHC	54	834	43%
10	Makati Medical Center	50	884	45%
11	The Medical City	48	932	48%
12	Southern Philippines Medical Center (SPMC)	37	969	49%
13	St Luke's Medical Center	36	1005	51%
14	Physicians Diagnostic Lab Cebu, Davao	20	1025	52%
15	Lung Center of the Philippines	18	1043	53%
16	Healthway Medical Lab	17	1060	54%

17	Makati SHC	17	1077	55%
18	RITM Satellite	14	1091	56%
19	Manila Doctors Hospital	14	1105	56%
20	Healthstat Diagnostic	13	1118	57%
21	Santo Domingo Diagnostic Lab	12	1130	58%
22	Batasan SHC QC	12	1142	58%
23	Davao Doctors Hospital	11	1153	59%
24	Sims Lab	10	1163	59%
25	Chong Hua Medical Center	9	1172	60%
26	Pasay SHC	7	1179	60%

In 2012, the RITM satellite clinic in Malate has become fully functional in providing outreach and HCT. As a result, it has become probably the leading facility in terms of number of MSM diagnosed per month. The figures for the first 6 months of 2012 are in Table 5.

**Table 5: Number of MSM tested and reactive at RITM Malate satellite clinic in 2012**

Month	No. Tested	No. Reactive	% reactive
January	52	12	23%
February	100	20	20%
March	63	14	22%
April	184	27	15%
May	113	29	26%
June	142	38	27%
<b>TOTAL</b>	654	140	21%

In the inventory sample, ~7% of those tested were found to be HIV+. If this percentage holds up in the remaining sites, this suggests that only ~5% of the MSM who get HCT are guided to or through this process by NGOs.<sup>48</sup> Eleven out of the 16 treatment hubs reported in the inventory; they tested a total of 1135 MSM (~2% of the estimated national total tested).

#### **4.4 Staffing of SHCs, MSM/transgender and PLHIV involvement**

Out of 22 category A cities, 11 SHCs in 9 cities provided staffing details (Table 6). Some (~10%) of their full time staff and many (almost half) of the volunteers are MSM, but few (<3%) are PLHIV (Table 6). The 4 category B and 3 category C SHC who reported their staffing did not identify any MSM, transgender people, MSW or PLHIV staff or volunteers. Of the SHCs in non-priority areas, 8 reported staffing but only one (Santiago) had MSM volunteers.

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<sup>48</sup> This estimate is based on an assumption that the inventory captured the main NGOs involved in providing MSM HCT services. We believe this to be the case.

**Table 6: Number of MSM, transgender, MSW and PLHIV employed in category A SHCs**

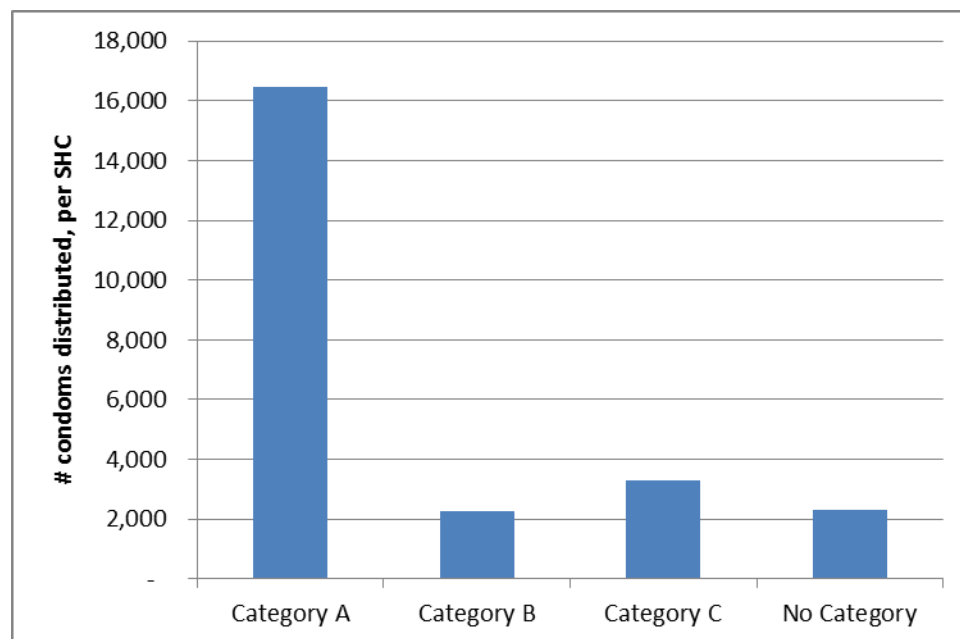
	Total number in 11 SHC in 9 category A cities	Of the total, how many are MSM?	Of the total how many are transgender?	Of the total how many are MSW?	Of the total how many are HIV+?
<b>Full time staff</b>	124	12	3	0	3
<b>Part time staff</b>	20	5	0	0	0
<b>Volunteers</b>	69	32	3	0	2

Similar figures emerged from questions about HIV counselors. In category A cities, 15 of the 106 HIV counselors were MSM, but 11 of these 15 are located in Quezon City. Similarly, Quezon City is responsible for all 3 transgender HIV counselors, and for 3 out of 4 PLHIV counselors. SHCs in category B, C and non-priority areas reported only 2 MSM, 1 transgender and 2 PLHIV out of their 76 counselors.<sup>49</sup> These numbers suggest that SHCs have not reoriented their service models to cater significantly to MSM.

#### 4.5 Services offered by SHCs

Based on the self-reporting for this study, for June 2011-May 2012, category A sites provide far more services per SHC to MSM, transgender people and MSW in terms of condom distribution (Figure 3), outreach, and HIV screening (Figure 4).<sup>50</sup> Note that these data are normalized to figures “per SHC”, so the percentage of SHCs reporting from each category does not influence the result.

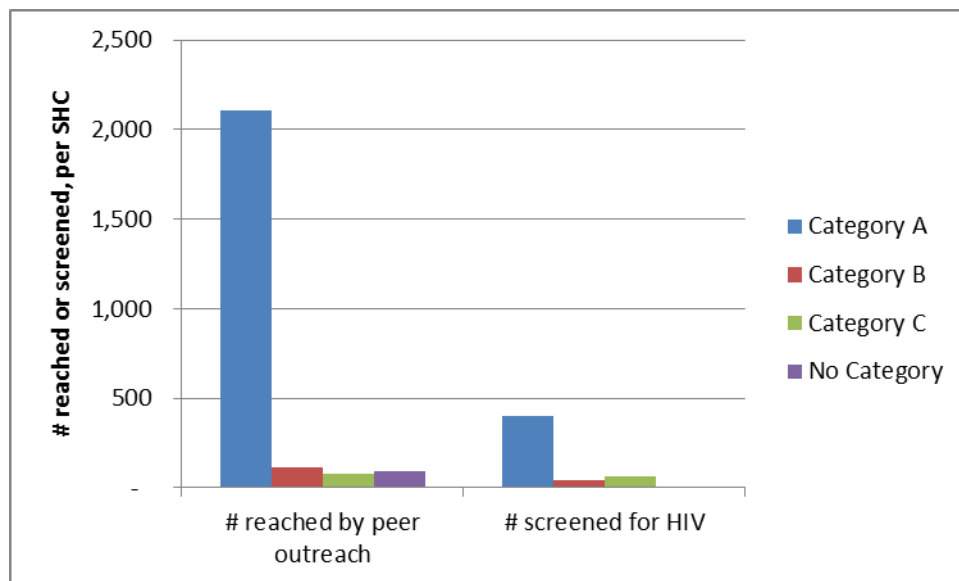
**Figure 3: Number of condoms distributed to MSM/transgender/MSW per SHC, 2011-12**



<sup>49</sup> The exception was Bauang RHWC, but its figures were suspicious as it reported that all four of its counselors were simultaneously MSM, transgender, MSW and PLHIV.

<sup>50</sup> The mean number of MSM being tested at each SHC was 402 (13 category A SHCs), 248 (6 category B SHCs), 66 (3 category C SHCs) and 7 (14 non-priority SHCs).

**Figure 4: Number of MSM/transgender/MSW reached by peer outreach and screened for HIV, per SHC**



In the inventory for the current study, various facility types reported on MSM HCT numbers. Of all the MSM HCT reported by SHCs, 91% was from category A SHCs, including 41% from the 3 SHCs in Quezon City. This is consistent with the IHBSS, in which respondents identified Quezon City as the site with the highest rate of HCT at SHCs and Pasay City the lowest, among the 7 cities studied in the current assessment.<sup>51</sup> Therefore, it appears that HCT in SHCs is concentrated in category A sites and, in particular, in Quezon City.<sup>52</sup>

This concentration of testing may be driven as much by availability of services as by need and epidemiology. In the reported data, there was a similar rate of confirmed HIV+ among those MSM getting their results in the different regions (9% in category A, and 7% in each of categories B, C and non-priority regions). This suggests that even the “lower priority” sites (category B, C and non-priority) are not low prevalence sites *for the subpopulation that is getting HCT*. This points to an apparent need for more widely distributed HCT services for MSM, and would be consistent with reports from SHC staff in Quezon City. They noted that many of their first-time testing clients – particularly those reached by outreach services – were coming from other cities.

#### 4.6 Current throughput of HCT for MSM is insufficient

The IHBSS 2011 results most relevant to HCT are in Table 7. Notably, the percentage of MSM ever tested for HIV is low (15%) and the percentage who were tested in the past year and know their result is even

<sup>51</sup> This is consistent with IHBSS 2011 data, in which Pasay respondents were half as likely to say that they got their last HIV test at the SHC, compared to the national average.

<sup>52</sup> IHBSS 2011 data suggest that Davao also has a higher than average testing rate at its SHC. The percentage of Davao respondents ever having an HIV test was twice the national average and, of those ever tested, the percentage testing in an SHC was 41% higher than the national average. This points to the Davao SHC as a positive model for the Philippines.



lower (5%).<sup>53</sup> This is consistent with our inventory result that, in the cities being studied, only 2-13% of estimated MSM had an HIV test at an SHC in the past year (Table 2).

The throughput of testing is further reduced by loss to follow-up. Based on the IHBSS 2011, only 65% of all MSM being tested received any result. It is not yet clear, on a national level, what percentage of MSM with *reactive* results end up getting their confirmatory (positive or negative) result. Laboratories accounting for approximately one third of new cases reported on this for Jan-Mar 2012. For this group of laboratories, the national average was 81% of reactivities returning for their result. Region VII (Cebu) achieved a 93% return rate whereas region XI (Davao) achieved only 76%.

**Table 7: HIV testing knowledge and practices among MSM (IHBSS 2011)**

Don't know a place to get HIV test	47%
Ever tested for HIV	15%
Had an HIV test in past 12 months and know result	5%
Of those tested, last HIV test was at SHC	60%
Would be comfortable to have an HIV test at SHC	70%
Visited SHC in past 12 months	14%
Received result of most recent HIV test	65%
Had an HIV test in the past 12 months	7%
Of newly identified PLHIV, % asymptomatic (from NEC Form A)	95%

Although a substantial number of people get HCT in the Philippines, the focus of testing volumes may not be on the groups with highest risk. For example, large numbers of OFW undergo employment-related testing even though many of these individuals may be at relatively low risk.<sup>54</sup> A side benefit for this particular group is, certainly, more complete detection. A total of 20% of all PLHIV identified to date have been OFW, even though only 3% of MSM in the IHBSS 2011 were OFW. As the epidemic changes, however, the percentage of OFWs among PLHIV is dropping: only 10% of PLHIV newly identified in 2012 were OFW.

Another example comes from Manila SHC. Due to the local laws in Manila, this SHC does not have FSW as their clientele. The largest number of HIV testing clients in Manila SHC comes from those securing health certificates and from health center / government hospital referrals (Table 8). However, much less than 1% of clients from this source are reactive, compared to 21% of referrals from friends. Thus, it is the latter sources that yield the largest number of reactive cases. The referral source that directs the most people to testing is not always the source of the most reactive cases. SHCs that track this information (like Manila SHC) can concentrate on increasing the referral sources that yield the most reactive cases. For example, Manila SHC actively encourages MSM clients to refer their friends, and advertises on the internet and TV, since friends and internet/TV are the sources that yield the most reactive clients (Table 8).

<sup>53</sup> This result, from IHBSS 2011, is an UNGASS indicator and is therefore reported in: Philippine National AIDS Council. 2012 Global AIDS response progress report.

<sup>54</sup> A concentration of OFW processing in Manila may explain why only 52% of testing in Manila was “voluntary, not required”, whereas this number was 74% nationally (IHBSS 2011).

**Table 8: Referral Source of all clients (not just MSM) who had an HIV test in Manila SHC, 2011**

	# Tested	# Reactive	% reactive	Reactives from this source, as % of all reactives
Voluntary	409	20	5%	11%
NGO	166	21	13%	12%
Private org	26	4	15%	2%
Govt org	133	20	15%	11%
Peer Ed	29	2	7%	1%
Friends	328	69	21%	38%
Internet/TV	356	40	11%	22%
Outreach	74	2	3%	1%
Health certificate	1762	1	0%	1%
Health Center/ Govt hospital	1045	1	0%	1%
<b>TOTAL</b>	<b>4328</b>	<b>180</b>	<b>4%</b>	

## **5. Cross-cutting issues from site visits**

### **5.1 What is needed?**

In the simplest terms, what is needed is easy availability of high quality services for MSM. Availability includes issues such as the total number of service points, their even or otherwise appropriate geographic distribution, and opening hours that coincide with times when clients are able to access those services. There are several elements to the idea of quality – each of which is also simple. The pathway for patients to access testing and get their results should be as short and as clear – and involve as few people – as possible.<sup>55</sup> There should be informative pre-test counseling, supportive post-test counseling, and a strong linkage to treatment for those who test positive. And the entire process should be packaged in a way that is MSM friendly: services should be available where and when MSM can access services (see above); and many of the peer educators and counselors that provide the services should themselves be MSM, including young MSM.<sup>29,30</sup> The barriers created by culture and stigma should not be underestimated; MSM involvement in service delivery is essential to overcome these barriers.

### **5.2 A variety of health sector models**

There are clearly a variety of models for providing services to MSM. Some of the models described in more detail in section 6 are:

- SHC staff conducting testing during outreach, with the assistance of MSM peer educators hired using LGU funds (Quezon City)

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<sup>55</sup> For example, Ateneo University is working with the Friendly Care Clinic in Mandaluyong to shorten and simplify the processing for each HTC client, thus maximizing client confidentiality.

- SHC staff conduct testing at nighttime at the SHC, after MSM are recruited via outreach (Davao)
- NGOs providing MSM peer educators to assist an SHC with activities such as BCC, outreach, pre-test counseling and, in the future, blood extraction (Cebu City)
- An NGO providing both pre-test counseling and blood extraction on their premises, after which the extracted blood is tested by the SHC (Cebu City)
- A government hospital (RITM-Malate Clinic), an SHC (Quezon City-Sundown Clinic), or an NGO (ASP-Icon Clinic) establishing stand-alone clinics with predominantly (RITM Malate) or only (Icon and Sundown) male health services, either for free (RITM Malate, Sundown) or fee-for-service (Icon).
- A private hospital providing HCT for clients who present directly to the laboratory (Makati Medical Center)
- Private laboratories providing low-fee HCT
- NGOs using events and clans to recruit to mass testing, or online chat rooms to recruit to SHC HCT
- An NGO using a website to register clients before tracking and accompanying them through the HCT process at an SHC (Love Yourself)

This diversity is a strength of the response in the Philippines, and should be embraced. There is no single, perfect model for delivering HCT because sites vary in terms of potential clients, available resources, and maturity of the response.

In terms of clients, for example, Cebu includes overlapping populations of PWID and MSM, so interventions for the two must be integrated. Angeles, by contrast, has a huge SW population that swamps any MSM who dare to attend the SHC, so testing during outreach is more important than ever. In general, MSM clients will vary greatly in terms of income, social behaviors, and how comfortable they are with their identity, and therefore what kind of HCT location appeals to them most. The low cost of private laboratories may appeal to many MSM, whereas SHC appeal more to lower socioeconomic status (SES) MSM, and higher SES MSM are reached more by online chatters, blogs, NGOs, and private hospitals. For transgenders, there are some dedicated NGOs (STRAP, COLORS), but most activities appear to be around community organizing and awareness rather than connection to health services.

Resources also vary. Cebu SHC is underfunded but the city is blessed by active NGOs, so the Cebu SHC uses the NGO MSM peer educators (e.g., CebuPlus has 31 trained HIV counselors, of whom 9 are MSM, 3 are transgender persons, 4 are male sex workers, and 6 are PLHIV). In Quezon City, however, there is a sympathetic city health officer and mayor, so the SHC can raise money directly for its own MSM peer educators.

Finally, institutions vary in the maturity of their response. Early on, an SHC is typically associated only with FSW. An SHC might start by establishing certain hours or days for males, and by conducting outreach to generate more MSM clients. If this is successful, an SHC might have a more mixed clientele and thus direct males to come on all days.

Other institutions may evolve from free to paid services. Initially, ASP provided referrals to free services at an SHC. But now ASP feels that there is sufficient demand for testing, and it is therefore establishing a fee-for-service model that has the potential to be self-sustaining. Other NGOs are also expanding on earlier, more limited services. When Cebuplus had limited capacity, they referred outreach clients to the local SHC. But now Cebuplus has a trained phlebotomist and more infrastructure, so they can create a permanent center for collecting and handling specimens for processing by the SHC.

Due to their recent implementation, impact data on many of these models are lacking. However, continued experimentation should be encouraged, with adaptation of service delivery models to suit local needs and the local resources available. Impact evaluations do not need not be complex, as there is a clear output that is desired and can be easily counted (i.e., HCT). For example, NEC could provide MSM NGOs with a very simple reporting format and some guidance on how this can be implemented in a consistent manner.

### 5.3 Common challenges: Stigma; losing clients; reaching minors; and availability of rapid test kits

Several challenges cut across all MSM HCT efforts in the Philippines. The first is stigma. MSM in the Philippines are visible in popular culture, but marginalized in many other ways. Many respondents reported poor attitudes of staff in general services such as outpatient departments (OPDs), labs, and hospital cashiers. There were reports that, to avoid discrimination against PLHIV clients by employers and insurers, physicians must resort to putting everything except “HIV” (e.g., pneumocystis carinii pneumonia (PCP)) on medical records. Reportedly, despite the AIDS Law, people can be dropped from health maintenance organizations (HMOs) just for getting an HIV test, whatever the result. Lack of KPHR-specific skills is a concern even within HCT sites, as most HCT training is reportedly not “target specific” (i.e., it has no messaging or techniques directed specifically to KPHR). Stigma has obvious effects on MSM willingness to access services. Even for those who do get HCT, NGOs stated that most MSM who are reactive cannot tell their family that they are MSM, let alone that they may have HIV.

A simple measure in some hospitals has been to issue an administrative order directing staff to use a code for HIV testing. This limits knowledge about HCT to those who actually need the information (e.g., the cashier doesn’t need to know). The issue of confidentiality and patient privacy in medical care was seen as a broader theme that needs to be addressed more strongly across all disciplines, especially in pre-service training. As these and other initiatives continue, efforts to increase MSM self-reliance (e.g., by Love Yourself) remain an important part of the medical response to HIV. The word “medical” is used here deliberately because, without these efforts, higher rates of loss to follow-up and the inevitable medical consequences become far more likely.

This issue of loss-to-follow-up is a second major challenge. Geographic and demographic details about those who are lost to follow-up are not known, as NEC currently collects the Personal Information Sheet for newly diagnosed individuals (HIV Registry - Form A) only for those who are confirmed positives. However, respondents indicated that a major reason for these losses is the complexity of the testing algorithm. Even sites using rapid tests often ask clients to come back for a result 2-3 days later, as they process the rapid tests in batches. Simple algorithms that minimize patient delays would reduce loss-to-follow-up.

For those clients who receive their reactivity result, there is still a challenge with inconsistent information resulting in varying interpretation by clients. Clients with a reactive result are told a confusing mixture of information – from “more tests are necessary” (the official policy) to “you are reactive” (the more common practice by testing sites, since clients are suspicious as soon as there is no negative result immediately available,<sup>56</sup> and most sites find it only practical to convey this additional

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<sup>56</sup> SHCs, particularly in NCR, reported many instance of MSM “shopping around”: if someone gets a reactive result, they go to another SHC to get another test. In the end, they get multiple tests but never receive a SACCL-confirmed result from any of them.

information). How this news is interpreted is also variable. In one site, MSM described the meaning of “reactive” as ranging from “It would mean I have HIV” to “There would be a chance that I have HIV – maybe 50:50.” Some counselors stress the possibility of having HIV; others stress the possibility of not having HIV. The one consistent message is that clients who are reactive are asked to come back for a third time, 2-3 weeks later, to get the confirmatory Western blot result from the National Reference Laboratory for HIV (NRL-SACCL). The confusion in the earlier messages is likely to be a major reason why many fail to do so. Counselors believe that it is easy for clients to latch onto the uncertainty, to apply wishful thinking that they are still HIV negative, and then to use that interpretation as an excuse not to return for the confirmatory result.

The uncertainty in counseling messages appears to be warranted given that the positive predictive value (PPV) of the rapid tests currently used in the Philippines was reported by healthcare workers to be very variable. According to SACCL data, 10 of the 16 rapid test kits being procured for the Philippines have a specificity of 100% and sensitivity of at least 99.5%, and thus a PPV approaching 100%.<sup>57</sup> The remaining test kits had a specificity of 99.3-99.8%, with 100% sensitivity. These latter figures would imply a PPV from a *single* rapid test of:

- 1-5% if prevalence is 0.01%
- 13-33% if prevalence is 0.1%
- 74-91% if prevalence is 2%.<sup>58</sup>

Such numbers suggest that two distinct policies (i.e., for testing algorithms and counseling messages) may be appropriate for high risk (MSM) versus low risk (ANC and OFW) populations.

Not all rapid tests provide sufficient PPV for a low prevalence setting.<sup>59</sup> Finding combinations of rapid tests that increase the final PPV should be a primary objective of the evaluation of new diagnostic algorithms in the Philippines, which is currently ongoing.<sup>60</sup> Once this is achieved, counselors with MSM clients can be more blunt about the level of concern due to a reactive result and the importance of getting immediate medical supervision by an HIV specialist. The algorithm review should also aim to shorten and simplify the testing protocol. If point of care testing is found to be suitable for the Philippines,<sup>61</sup> this would allow the client to get a result with high confidence in a single visit, rather than requiring clients to come three times. Such algorithms were first used in high prevalence settings but have been adopted in an increasing number of countries.<sup>62,63,64</sup>

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<sup>57</sup> Of note, however, confidence intervals for specificity range as low as 98.8%, which would result in dramatically lower PPV.

<sup>58</sup> These PPVs would increase with a second rapid test.

<sup>59</sup> Pant Pai, et al. Head-to-head comparison of accuracy of a rapid point-of-care HIV test with oral versus whole-blood specimens: a systematic review and meta-analysis. *Lancet Infect Dis* 2012. 12: 373-80.

<sup>60</sup> NRL, Philippines. Review and update of HIV testing algorithms for the Philippines. A consultation conducted by NRL 16-25 August 2011.

<sup>61</sup> This question is not within the scope of the current NASPCP-NEC-WHO study, but should be addressed by the NRL algorithm review.

<sup>62</sup> Marum et al. "What took you so long?" The impact of PEPFAR on the expansion of HIV testing and counseling services in Africa. *J AIDS* 2012. 60 (Suppl 3):S63-9.

<sup>63</sup> Burns et al. Acceptability and feasibility of universal offer of rapid point of care testing for HIV in an acute admissions unit: results of the RAPID project. *Plos ONE* 2012. 7(4):e35212.

<sup>64</sup> Heller, et al. Point-of-care HIV testing at antenatal care and maternity sites: experience in Battambang Province, Cambodia. *Int J STD AIDS* 2011. 22: 742-7.

Another solution to loss-to-follow-up is the start-to-finish tracking used by NGOs such as Love Yourself, which is far more successful than SHCs in getting “real” phone numbers from clients when the clients initially express an interest in HCT. This allows Love Yourself to monitor (and sometimes accompany) these clients through the initial test, receipt of results, and any follow-up testing or referral. However, achieving truly widespread coverage of this intervention may not be realistic. Therefore, a change in the testing algorithm – at least for populations such as MSM who have higher HIV prevalence – holds out greater promise for cross-cutting improvement. The final algorithm must be justifiable on medical and technical grounds, but it may be necessary to move away from practices that are convenient for healthcare workers, and towards practices that are convenient for healthcare clients.

A fourth major challenge is access to HCT for minors – defined as those under the age of 18. The median age of first male sex for MSM in the IHBSS 2011 was 16, so there is a clear rationale and need for HCT among minors.

Based on the AIDS Law, minors need the permission of a guardian to get tested. However, very few are willing to have a discussion with their parents about their sexuality and the reason for wanting HCT. An administrative order says that a social worker can accompany the MSM to HCT, but this is still with a parent in attendance, unless the minor is under the care of the Department of Social Welfare and Development (DSWD). SHCs reported that unaccompanied minors are begging to be tested but are turned away, with SHC staff often worried about losing their license to practice if they test a minor.

Currently, DSWD and UNICEF are attempting to promote legislation that would lower the age of consent for HCT to 15 and/or allow social workers alone to sign off on HCT. If the latter solution is reached, NGOs and SHCs will need to connect minors to social workers.

A final cross-cutting challenge for HCT is the availability of rapid test kits and of HIV-proficient medical technologists. All the demand-generation activities described here will fail if the service cannot ultimately be delivered. Stock-outs of rapid test kits were reported in many settings (both hospitals and SHCs), with lack of financing and lack of demand forecasting identified as the primary drivers of these stock-outs. Although a full analysis of this issue extends beyond the scope of the current project, it is apparent that considerable work is needed on demand forecasting and financing for HIV test kits. The Department of Health at the central level should either lead this effort or determine what actions need to be taken by others. Similarly, the Department of Health will need to think through the numbers and types of personnel needed to implement these tests and whether, given the findings in this report, such staff are currently covering all of the sites where HIV testing is needed. This assessment should include a consideration of whether new staff are needed, or whether existing staff simply need some additional training.

## **6. Feedback from site visits on each specific model**

Based on visits and interviews at various facilities (Table 10), the team collected the observations listed below. These descriptions list the advantages, challenges, good practices, and opportunities for improvement for each facility type in the area of HCT for MSM.

### **6.1 Social Hygiene Clinics (SHCs)**

To date, the response to the HIV epidemic in the Philippines has concentrated primarily on services provided by SHCs. MSM NGOs have directed their clients almost exclusively to SHCs. Although other

avenues are worth pursuing as well (see below), SHCs clearly represent an existing infrastructure to address STIs and HIV, and therefore have an important place in the national response.

The challenges in making SHCs an attractive place for MSM HCT should not, however, be underestimated. Any shift in SHC priorities is clearly happening more slowly than the shift in the HIV epidemic, and most SHCs are still oriented primarily or solely towards FSW. Some have 500 or more FSW clients a day. The association with sex work and the large number of women in a small facility makes for an environment that is not welcoming for men in general, let alone for MSM who are nervous about disclosing their sexual identity and sexual history. Still other SHCs are located in city administration buildings, where there is a high likelihood that SHC clients will be seen by others who are going about their official business. In general, opening hours suit FSW but not individuals (such as many MSM) who have daytime employment, and staff already have a full workload with FSW; these needs do not go away now that there are also MSM clients.

**Figure 5: Most SHCs lack HIV-related materials outside<sup>65</sup>**



Thus, SHC services are not well tailored to MSM needs. SHCs have slightly greater success in reaching poorer MSM (section 4.2), but in general they do little to appeal to MSM clients. Most SHCs don't promote the availability of either HCT or services for MSM, and most MSM are unaware that either is available at SHCs.<sup>66</sup> A typical SHC has no HIV-related posters outside (Figure 5), although there are exceptions (Figure 6). Some SHCs such as Davao have had success by rebranding themselves as Reproductive Health and Wellness Centers and by renovating to eliminate outdoor waiting areas and thus increase confidentiality and comfort for clients.

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<sup>65</sup> This is not an unusual appearance for an SHC. Of note, the "citizen's charter" (in yellow) identifies the SHC's "requirements" as "registered female/male sex worker", which formalizes the association of the SHC with sex work.

<sup>66</sup> 62% of MSM don't know that there are STI services for males at the social hygiene clinic/city health office (2011 IHBSS).

Figure 6: Cebu SHC has extensive HIV-related materials outside the clinic



Even inside SHCs there is often little, if any, indication that HIV testing is available in that clinic, even though such information can be generated very easily (Figure 7) and can direct clients where to make their request for HCT (Figure 8; Davao RHCW). SHCs and other HCT sites that we saw in the Philippines generally lack information materials that promote the many benefits of testing. Fear of testing is common among MSM in the Philippines, so there is a need to communicate positive messages: specifically, that PLHIV – *if they are diagnosed early* – can live long and healthy lives. NGOs and activists indicated that scare tactics around HIV were backfiring, and that positive messaging was required to encourage more testing.

Figure 7: Simple notices can be used to indicate the availability of free HCT





Figure 8: Simple flow charts can advertise free HCT and direct HCT clients where to go



How can these challenges be overcome? SHCs who wish to reach more MSM face several choices. The first is around staffing. Evidence from many settings (and common sense) indicates that MSM are most able to identify where and how MSM clients can be targeted most successfully.<sup>67</sup> And yet, currently, most SHCs have no MSM staff (section 4.5). For those in the right locations, the MSM staffing can be provided by NGOs. This is the solution reached by Cebu SHC since it is facing severe budget cuts in the government health sector and has excellent prospective NGO partners (notably CebuPlus). By contrast, Quezon City SHC had fewer local NGOs and was able to access funding from the local administration. It therefore hired its 20 MSM PE with the LGU budget; it has used these staff to do outreach testing at gay bars and cruising sites.

Both MSM staffing models have questions around sustainability. Threatening the first model, most MSM NGOs in the Philippines currently lack stable sources of funding. Many are relying on true volunteerism (i.e., work for no pay). This has a venerable history from early in the global HIV epidemic, but burn-out and turnover can quickly become a problem, and NGO services may be provided to SHCs “when it is possible” rather than on a reliable schedule. For the second model, SHCs may be subject to budget cuts and programmatic interference when local governments change.

On balance, the LGU-funded approach would seem to be the one with the greatest chance of being consistent and sustainable. But the main message for other SHCs is that they should take advantage of whatever possibilities are available locally – whether that be local NGOs or local funding.

Whichever approach is taken on staffing, the cost-effectiveness is likely to be extremely high. MSM peer educators, and even their MSM supervisors, are paid very small amounts of money (1,000 and 10,000 PHP per month, respectively<sup>68</sup>). Thanks to the efforts of these workers, who have the lowest pay, the SHC is accessing clients with by far the highest likelihood of having HIV.

<sup>67</sup> UNAIDS, Ford Foundation, Chinese Association of STD/AIDS Prevention & Control. Enabling effective voluntary counseling and testing for men who have sex with men: Increasing the role of community-based organizations in scaling up VCT services for MSM in China. UNDP/WHO, 2008.

<sup>68</sup> Indeed, for this work to be sustainable, it may be necessary to increase these allowances, or at least create mechanisms to reimburse for travel and food expenses.

The second choice for SHCs is about which services to offer. The initial, minimal step that SHCs can take is to promote late mornings and late afternoons as times for males to come to SHCs, as typically there are few FSW clients during these times. If there is sufficient demand, such a practice can be expanded so that the SHC designates an entire day as being only for males. In Davao, the SHC does outreach to gay bars and directs those contacted to special night-time clinics at the SHC.<sup>69</sup> Such practices may build and prove demand even further, as in Quezon City and Manila, to the extent that it makes sense to establish a more ambitious, stand-alone male health clinic (see section 6.4).

The facility-based services described above are the easiest, and most familiar, for SHC staff. However, many MSM are either not aware of SHCs as an HCT site for MSM, or they are wary of visiting an SHC to get tested.<sup>70</sup> This is where the extension of SHC hours and, in particular, night-time outreach becomes important. Only this way can SHCs reach clients where and when they socialize.

To undertake such activities, additional staffing (see above), and the money to pay for it, will be needed. Effective and sustainable outreach requires staff who do not have a day job (including a medtech for drawing blood), a van, and MSM who are hired as peer educators. Raising the necessary money may not be easy. SHCs are often politically unpopular (due to the association with sex work), underfunded and understaffed (“one doctor, one nurse and two counselors for a huge city,” according to one SHC). Hospitals, not SHCs, are the health priority for most mayors.

However, as noted above, the low cost and high payoff from such an approach should make a convincing argument. Quezon City, for example, has established its extensive interventions and high MSM testing rates for only 4 million PHP per year, which is ~0.03% of the total city budget.

The City Health Officer (CHO) is the natural person to lead the advocacy for more funds. They can use both a carrot (the opportunity to become a best practice example) and a stick (steps are required to avoid becoming an HIV hotspot, especially for those relying on income from tourists or entertainment (e.g., Quezon City and Angeles)). The CHO will need to be creative about how to present his or her case, since the benefits of prevention efforts can be difficult to quantify.

Fourteen steps that SHCs can take are listed in section 9; the categories of actions include creating a space and time for clients other than FSW, establishing a simple and confidential client flow, and creating direct links from the SHC to MSM clients. Each of these strategies has been implemented in at least some SHCs and was reported to increase HCT for MSM. Further strategies are presented in the next section on outreach.

## **6.2 Testing during outreach**

Outreach efforts link health providers directly to their target population. For HCT, there are two distinct approaches: testing at outreach sites; and outreach to recruit people for testing at SHCs.

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<sup>69</sup> Although this Davao model results in greater confidentiality than with HCT at an outreach site (see below), it is also more challenging to recruit clients in this way, as many who agree to come for HCT do not, in fact, show up at the SHC.

<sup>70</sup> CebuPlus described examples where clients refused to get out of the car, and NGO volunteers had to request Cebu SHC staff to come out of the clinic so that they could draw blood from the client in the car.

Quezon City SHC was the only site that we visited in the Philippines that is conducting testing at outreach sites (the first approach), although some other Global Fund sites also have this activity.<sup>71</sup> In partnership with peer educators from the AIDS Society of the Philippines, these monthly outreach sessions involve a group of ~12 staff (peer educators, counselors, and a medical technician). They position themselves, plus tables and chairs, in a parking lot next to a gay bar (Figure 9). Sometimes, but not always, they have a van where the blood is drawn. Peer educators spread out to recruit MSM from a nearby mall and from the street, where there are many MSM socializing outside two gay bars.

**Figure 9: Preparations for outreach HCT by Quezon City SHC**



For the client, the testing process is simple. Clients receive individual pre-test counseling, with the assistance of a flip chart.<sup>72</sup> Their blood is then extracted by the medical technologist.<sup>73</sup> Clients are given their result ~15 minutes later, during post-test counseling, with a reactive result being defined as a positive result from two different rapid tests. Those with reactive results are referred to one of the three SHCs within Quezon City to collect their confirmatory result 2-3 weeks later.

This HCT approach has three main challenges. First, the MSM are typically with their friends. Maintaining true confidentiality in such a situation is almost impossible: it is obvious from a person's behavior whether they received a reactive or non-reactive result. Second, many of the MSM are from outside of Quezon City.<sup>74</sup> It is not a simple task to track those who are reactive, and ensure that they

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<sup>71</sup> NASPCP reported the full list of SHC doing mobile HCT as follows: SHC Bernardo, QC; SHC Batasan, QC; Project 7, QC; Cavite City Health Office; SHC Angeles, Zamboanga; Marikina; Makati; and Caloocan. However, some of these sites may target FSW, rather than MSM, during this outreach.

<sup>72</sup> Flip charts that are specific to an MSM audience would be a positive addition to this process.

<sup>73</sup> Previously, the site used only a finger prick, as the rapid tests used at the site require only whole blood from a finger prick. However, this then required those who were reactive to get their blood extracted later, which defeated any attempts at confidentiality because it was obvious to everyone who was reactive. Therefore, current practice is to extract blood from all clients at the outset.

<sup>74</sup> The clients at this site come for the nightlife, not for the HCT. However, one of the reasons that they get HCT, once at the site, is because they do not know of places to get HCT near where they live.

return for their confirmatory result. Third, a particular site may become “saturated”<sup>75</sup> if both the SHC staff and the same MSM return regularly. If this occurs, finding a new site to set up HCT requires some level of cooperation, or at least tolerance, from local businesses.<sup>76</sup>

However, the potential benefits of this HCT approach are enormous. It takes testing to the target population. For example, 45% (2161/4790) of HCT clients in Quezon City in the first half of 2012 were MSM, and staff estimated that 90% of these were tested during outreach. Furthermore, outreach allows SHC staff to reach low-income MSM, high-income MSM or both, depending on the site chosen. Many of the MSM pass on the message: after an initial conversation with a peer educator, they help convince their friends to get tested too. And, in general, having testing on-site creates an instant opportunity to convert theoretical discussion (about HIV) into action (getting a test). The importance of this direct connection has been confirmed in Zimbabwe, where testing on-site was far more efficient than counseling that directed clients to get tested at another place and time (70% vs. 5% uptake of testing, in one cohort).<sup>77</sup>

This may explain the challenges faced by Davao RHWC, which takes this second approach: using community outreach to convince MSM to get tested at the facility. Their reason for doing this is the concern about confidentiality during on-site HCT. But, as a result of the indirect approach, they often don’t get enough MSM clients to justify opening their late night HCT clinic at the RHWC.

A final variant of on-site testing is HCT at special events. NGOs (section 6.3) are typically a key driver of such activities. For example, Take the Test is an NGO that coordinates on-site testing, notably at an annual Holy Week event in collaboration with the Puerto Galera SHC. NGOs also recruit to special events via the use of MSM texting clans (e.g., the SMS for MSM project).

Outreach testing may be the best way to reach MSM, but it obviously suffers from woefully insufficient coverage. Even SHCs that do outreach for FSW are unlikely to have MSM outreach. It is certainly possible for these SHCs to do MSM outreach. During IHBSS, they conduct an activity with important differences from HCT (MSM participate in the surveillance so they are not given counseling nor told the results of their HIV test) but also important similarities (the SHC staff, in collaboration with NEC, must contact MSM in outreach-like settings and convince them to submit to HIV testing). Although these activities should not be confused, it is notable that some SHCs test more MSM during those 3 weeks of IHBSS than during the entire rest of the year. Thus, it is clear that the capacity for outreach exists. Most SHCs, however, lack MSM peer educators, despite their low pay. Even for the fortunate few SHCs who

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<sup>75</sup> From May-Dec 2011, 259 people were tested at monthly offsite testing conducted by ASP in partnership with Quezon City SHC. Of those tested, 32 were reactive (12.4%), of which 23 (72%) collected their confirmatory result at one of the three Quezon City SHCs. This has risen to only 394 people screened for the past year (June 2011-May 2012), as there has been some drop-off in the per-month numbers getting tested. Although there is no formal definition of saturation, this drop in numbers may reflect a certain level of saturation. The SHC did not indicate any particular policy on when they moved to other (non-saturated) sites.

<sup>76</sup> The choice of outreach site requires some thought. Ideally, a diversity of outreach testing sites (e.g., not just bars but also parks and streets) could ensure that both open and more hidden MSM are targeted. In practice, however, some SHCs found that MSM in informal cruising sites tended to disperse during outreach testing for IHBSS, and it was easier to attract participants at fixed sites like beauty parlors.

<sup>77</sup> Corbett et al. HIV incidence during a cluster-randomized trial of two strategies providing voluntary counselling and testing at the workplace, Zimbabwe. *AIDS*. 2007 Feb 19;21(4):483-9.

have MSM peer educators, that low pay can lead to turnover and thus loss of important, skills in convincing, negotiating and counseling. If there is an area that is crying out for more funding, this is it.

### 6.3 NGO outreach and innovations

Probably the most important message of all is that MSM volunteers and staff need to be involved in efforts to increase HCT among MSM. Whether those MSM are engaged by SHCs or NGOs is less important (section 6.1). However, NGOs are not just a potential source of MSM peer educators. It is important to single out NGOs for a number of other innovations that they have contributed, and that are worthy of replication.

ASP has coordinated the involvement of MSM as “chatters”. Peer educators enter MSM chat rooms and use a standard script to engage online users in a dialogue about HIV and HCT. In Oct-Dec 2011, ASP greatly exceeded its (rather modest<sup>78</sup>) targets, with each chat manager reaching an average of 270 MSM in NCR and 5-600 MSM in metro Cebu and Davao. Of the total of 3,344 MSM reached in this period, 1,189 were referred for HCT and 397 were documented as receiving HCT at an SHC. Other NGOs use Facebook and blogs to spread information about HCT and HCT sites. ASP also has peer educators focused on face-to-face behavior change communication (BCC) outreach but it is unclear how many of the MSM who are reached by this BCC go on to get HCT, as this is not a measured outcome. In the IHBSS 2011, of those who obtained HIV information from peer educators and NGOs, 11% had HCT in the past 12 months. This was higher than the average for all MSM, but is still not high enough.

Love Yourself takes the link to HCT considerably further. Visitors to its website can register for a test; an assigned volunteer then tracks the MSM through the entire process to make sure that they have an appointment, reach the appointment, get their results and, if necessary, are guided to Treatment, Care and Support (TCS). In many cases, the volunteer accompanies the MSM to the HCT. Loss to follow-up is very low. SHCs are often plagued by MSM clients giving false contact information to the SHC, but those same clients are more willing to trust an MSM NGO such as Love Yourself with their personal information. Indeed, the Love Yourself process requires correct contact details to initiate the discussion. In addition, Love Yourself extends the reach of SHCs to include mid- and upper-class MSM.

CebuPlus is gradually taking on even more of the SHC process. It started by providing the pre-test counseling. Recently, one of its volunteers became a trained phlebotomist; he will soon be drawing blood so that the client does not have to interact with the SHC at all. CebuPlus has an agreement that the SHC will provide the necessary vials and commodities; all blood samples are transferred to the SHC for the actual testing.

Referrals from NGOs can result in efficient targeting of those at highest risk, as measured by reactivity rates as high as 22% from NGO referrals to Manila SHC. However, capacity remains low. In three years of events, Take the Test has overseen HCT for 463 MSM (44 reactive); and Love Yourself has facilitated testing of 1276 MSM in the past year. At Manila SHC, only 12% of reactivities (of all client types, not just MSM) are from NGO referrals (Table 8), whereas 38% and 22% are walk-ins based on information from friends and internet/TV, respectively. Can NGOs reach high coverage, or is the aim to be catalytic?

NGOs still require the services of a laboratory technician, so any HCT must be in partnership with an SHC or other healthcare provider. The SHC (or other partner) typically needs to feel that they are in charge of such relationships. And the NGO somehow has to derive enough money to support itself.

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<sup>78</sup> 50 MSM per quarter (NCR) or 12 MSM per quarter (Cebu and Davao)

To address these issues, there should be collaboration between the NGOs to map outreach and referral capacity per city to avoid overlap and match supply to demand. NGOs could also explore more formal contracting of their services with SHCs – including compensation for the provision of a certain number of HCT clients. And they could try extending their engagement beyond SHCs to reach some of the other testing sites discussed below.

#### **6.4 MSM specific clinics**

In health systems there is always a tension between providing specialized services (for specific populations and specific diseases) versus mainstreaming of services. Both approaches have their advantages: specialized services can be customized to the client and provided more expertly; but mainstreaming is cheaper and puts services in contact with a greater percentage of the population. For MSM HCT, the presence of extensive stigma, and problems with confidentiality in general facilities results in a much stronger argument for specialized services.

Three specialized facilities exist or are planned for MSM HCT. The “old, experienced” facility is the RITM Satellite clinic in Malate, which started operating in 2011 but really started promoting HCT strongly in 2012. As noted in section 4.3, this facility has detected 140 reactive cases out of 654 clients tested in 2012 (21%). Although a detailed analysis of the cost-benefit of this clinic is still pending, the number of cases detected is striking. Love Yourself has been an essential partner for demand generation, which is always a concern for specialized facilities.

The other two specialized facilities will be opened soon. The Sundown male health clinic, funded by the City Health Office of Quezon City, is near MSM sites and will operate during hours that are more convenient for MSM (3-11pm). This initiative will rely substantially on MSM who are on staff with the City Health Office.

Also in Quezon City is the Icon Clinic, which is being established by ASP. Unlike the other two clinics, it will be a fee-for-service facility, in the belief that many MSM are willing to pay for superior, confidential services, and that the facility can thereby be self-supporting. Tracking the performance and finances of this facility will be very important in order to test these two assertions.

Besides the fees, the other difference between the facilities is that Sundown and Icon are clearly for males – and by implication for MSM – whereas some effort has been taken to “disguise” the RITM Malate clinic by installing two ob/gyn private practitioners in the same clinic building. As with the hiding or open display of HIV posters at SHCs, there are strong differences of opinion about what is the best approach – and the answer probably varies depending on the particular MSM client.

If these existing sites are successful, similar models should be pursued for areas with high case loads and substantial existing experience with MSM outreach.

#### **6.5 Private hospitals**

Private hospitals are seen as a desirable place for healthcare in general and for HIV testing in particular. They are a major source of new cases (Figure 2) and were cited as the “best solution” for increasing access to testing as long as the fee issue (see below) can be overcome. Testing can be simple for the client. In Makati Medical Center, for example, the client can either go to a physician first or they can go directly to the lab counter. And, after paying a fee for the test, clients are reportedly motivated to return for results, whereas return rates after free testing are likely to be more dependent on the quality of counseling.

The main challenge is that the fees of ~1000 PHP limit access. The simplest solution to this would be for HCT to be covered as a free service by Phil Health, including coverage for indigents as many MSM are young and/or students.

Counseling is not a strength of the private hospitals (pre-test counseling is limited in the laboratory, and post-test counseling is often an extra fee leading some clients to skip it). As with SHCs, private hospitals need help accessing MSM – they are used to organizing health drives for disease of the general population, but NGO partnerships would help them to target MSM. To convince the hospital management to pursue such an activity, the NGOs would need to provide some estimate of how many clients could be reached.

### 6.6 Private labs

Private laboratories were also seen by many MSM as a desirable place for HIV testing, with better confidentiality and fewer steps and people involved than in some other venues. Fees for HCT – at 200-300 PHP – are considerably lower than private hospital fees. Individual private physicians in small clinics typically refer their patients to these private labs for testing. Some of the larger labs, such as those that provide services to OFW, take advantage of their high throughput to provide same-day results by ELISA.

The drawbacks of these large laboratories are around quality. Pre-test counseling is generally limited to the client reading the introduction to NEC's Form A (a form meant for data collection, not counseling). Post-test counseling and linkage of positive clients to treatment hubs is also weak; reportedly, many positive clients are lost to follow up.

For the private laboratories, the fate of reactive clients is the most concerning issue. There may be a role for NGOs in providing post-test counseling and continuity of care for clients who are reactive.<sup>79</sup> Provision of this service – either by laboratory staff or a sub-contracted NGO – could be a condition of accreditation.

Many of the labs cater to OFW and are therefore testing a relatively general population with low HIV prevalence. If point of care HIV testing is adopted in the Philippines, an algorithm that works for SHCs or male health clinics may have insufficient positive predictive value for these private laboratories.

### 6.7 Public hospitals

Unlike private hospitals, public hospitals are able to reach lower and middle income people, and they contributed 21% of newly identified PLHIV in 2011. But two thirds of these cases came from just four facilities – all of which are treatment hubs.

In most public hospitals, the prospects for increased access for HCT are minimal. PLHIV presenting with opportunistic infections will likely be recognized and tested, especially in treatment hubs; in these cases, there is an excellent practice of referring the blood, not the patient, to the hospital laboratory. But other potential clients – especially in hospitals that are not treatment hubs – are unlikely to be reached. In the facilities visited, there were no pro-active efforts to offer HIV testing: no outreach; and no advertising even within the hospital. The hospitals routinely run out of rapid test kits for long periods of time; clients are therefore referred to private labs and often lost. There is no optimized procedure for walk-in clients, who would face a complex pathway leading through an intake nurse, a physician, a cashier, and finally a lab tech – all of whom will ask, often in public, about the reason for the visit. This compounds the lack of

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<sup>79</sup> In theory, NGOs might also help with demand generation, but it would be difficult for the labs to pay NGOs for referrals, as the labs compete fiercely on price and customers compare prices.

confidentiality and stigma that were cited by many interviewees as being major issues in the public hospital setting. Furthermore, there are no instructions given on how to navigate the facility to get an HIV test.

Some of these issues suggest relatively simple actions that could be taken to improve the situation. However, in the short term, it seems unlikely that the major increase in HCT and access for MSM will come from initiatives at public hospitals that are not already treatment hubs.

### 6.8 Barangay level outreach and events

Clan and MSM events (beauty contests) were suggested as the best opportunities for reaching MSM at barangay level – for example by SHCs or MSM NGOs. A single clan leader can reach up to 100 MSM, and transgender people are both “out” (visible) and popular, so can be a great resource to organize events. Event organizers must continue to identify new clan leaders, as otherwise the events can get “stuck” in a certain socioeconomic group.

Some respondents wanted barangay health workers (BHWs) to add HIV education and MSM outreach to their other BHW duties; they expressed confidence in the “unofficial knowledge” of BHWs about which local residents are MSM. Many other respondents, however, noted that existing BHWs are older, less understanding of MSM communities, and 95% female. There is a significant danger of existing BHWs exposing and stigmatizing MSM. Finally, these BHWs are connected to health centers and therefore not in a position to support HCT. In the Philippine context, routine HCT is not appropriate for the health center level: there would be insufficient testing volume and so skill level would be low. (Current testing candidates (e.g., TB and STI patients) are referred to SHCs.) Therefore, for MSM outreach, it was suggested that the LGU hire a new cadre of BHWs who are attached to an SHC, are young MSM, and will act as MSM peer educators. SHCs could use existing pay scales and sources of funding (i.e., LGUs) for these BHWs. Cebu is already pursuing this model.

### 6.9 Blood banks

Many MSM don’t know where to go for an HIV test, or fear going to a place like an SHC where they might be identified as seeking HIV/STI services. So they donate blood instead. Some blood banks may even use the HIV testing as a lure for donations.

This has two consequences. First, there is an increased risk to the blood pool. If self-deferment has not worked prior to arriving at the blood bank, screening these MSM out by questionnaire is felt to be ineffective. Second, there is a risk that MSM feel (incorrectly) that after donating they have a clean bill of health. Unknown to many of them, the official policy is that reactive clients are not informed of the result, in order to discourage donation by KPHR.

The resolution to this situation is not clear. Some blood banks feel that non-disclosure of HIV test results is unethical and, despite good knowledge of the official policy, the local practice around disclosure is variable. Whatever decision is reached nationally or locally, there should be clearer information on posters and forms at all blood banks. If the blood bank’s policy remains on the side of non-disclosure, these posters should state that “HIV results will not be given to blood donors” and “If you want an HIV test, here is where to go.”

### 6.10 Workplace

There is a potential to reach large numbers of MSM at call centers and business process outsourcing organizations (BPOs); “most” PLHIV clients at SACCL and an estimated 80% of Chong Hua Medical Center



PLHIV clients come from this industry. This group is high risk: they are socializing in a large group, and they are newly graduated with few responsibilities and more disposable income.

The larger companies pay for peer education, so in theory these activities should be more sustainable. Willingness to undertake HIV activities are, however, variable. In Cebu, only 1 BPO allowed an HIV lecture from the SHC. And, to get acceptance in Manila, HIV had to be packaged with a set of interventions called “healthy lifestyle”. Within this package, it is not clear whether the HIV message will be strong enough to elicit testing. Reportedly, none of the 50 peer educators involved in this initiative have themselves taken up the offer of free HIV testing, which would suggest that they may not encourage others to do so. Finally, taking this approach to scale would require a lot of training.

Given the large scope of the current study, a detailed examination of the workplace intervention was not conducted, and results should be viewed with caution. Results did suggest, however, that the programs should be monitored carefully to ensure that HIV, and HCT, do not get “lost” in the integrated approach. In addition, it may be beneficial to ensure that at least some of the peer educators in this program are themselves MSM.

It may also be possible to find a way to target MSM in BPOs more directly. If NGOs or SHCs can determine how MSM BPO workers socialize and communicate amongst themselves, they can use those methods to deliver HIV testing information. HCT could also be offered as part of voluntary regular check-ups at call centers and BPOs (which is not always done now). Any results need to be kept out of human resource databases, as there are many reports of a lack of confidentiality and discriminatory hiring and employment practices as a result of HIV status.

Besides workplaces, there may be opportunities to promote HCT at colleges, teen centers, and schools. Due to lack of time, these possibilities were not analyzed in the current study.

### 6.11 Jails

A partnership between Cebu SHC and CebuPlus resulted in HCT being offered to men in a local jail. Of the 45 men who volunteered for HCT, 16 were reactive. However, the initiative was halted because the warden was afraid that the newly identified PLHIV would use needle sticks against guards. This problem is somewhat particular to Cebu, with its high density of PWID, and currently has no clear resolution. In other settings, HCT in jails should be offered. The optimum provider of this service (e.g., health professionals within jails, or SHCs doing outreach) was not determined during this study.

## **7. Conclusions**

### 7.1 Strengths of the response and challenges for expanding the HIV response among MSM

The response to the HIV epidemic among MSM in the Philippines has several clear strengths. There are smart and motivated people providing strategic information and research (NEC, HAIN) and evidence-informed advocacy (TLF SHARE COLLECTIVE). Existing interventions draw on international best practices such as peer learning, networked outreach, internet chatting, and connecting risk groups to health services (ASP, CebuPlus, Love Yourself, RITM, Take the Test, TLF SHARE COLLECTIVE). And, in the places where testing interventions are targeted to MSM (such as the RITM Malate clinic and Quezon City outreach), they detect many cases efficiently.

The challenges for the response include the lack of evidence of impact. Due to the recent rise in HIV incidence in MSM, most initiatives are new, and there are no pre- and post-intervention data. In addition, there is insufficient funding due to insufficient high-level attention, and this leads to interventions occurring at a grossly insufficient scale. IHBSS and SHC data document the inadequacy of current reach (section 4.6).

A final challenge is the lack of consensus on what health sector models to expand for MSM HCT. This report aims to overcome this last challenge. The main answer is that there is not, and should not be, one perfect model. This report provides many ideas that have been found useful and that can be adapted locally depending on the resources and organizations available (section 9).

## 7.2 Possible DoH Role

There is also, however, an argument for certain actions at a central level. Some respondents believed that DoH needs to do more about HCT for MSM. DoH is admittedly constrained by the decentralized nature of decision making and health service delivery in the Philippines. Nevertheless, there are activities that fall under the DoH remit. DoH could increase its efforts to:

- Advocate to LGUs for greater funding and activity for MSM HCT. DoH could further provide LGUs with information about the growing epidemic, the value for money from preventive activities such as MSM HCT, and the range of activities that SHCs and other institutions can introduce. This document should help with this advocacy process (e.g., see section 8).
- Develop and disseminate simple patient flow diagrams for HCT in hospitals;
- Disseminate IEC materials more widely;
- Develop IEC materials that emphasize positive prevention over fear; these materials should contain positive messages about getting tested early and living with HIV;
- Host national trainings or workshops where SHCs can see what other SHCs are doing for MSM HCT;
- Elevate Quezon City and/or other sites as a national model so others are inspired to improve;
- Provide numeric testing targets based on past performance and estimated MSM population; tie this to improved procurement forecasting;
- Centralize procurement of kits – or at least the forecasting of demand;
- Ensure all major labs have a list of treatment hubs, support groups and MSM/PLHIV NGOs;
- Develop a standard script and monitoring tool for pre- and post-test counseling;
- Provide increased staffing at regional DoH offices (e.g., Cebu region has 1 technical person to cover several million people for 4 disease areas, including HIV/STI)
- Publicize the identity of high priority areas for HIV so that there is more pressure on these LGUs to take more action.

## 7.3 Prioritizing future actions

Section 9 provides a long list of potential actions. To prioritize these, we come back to the basic principle that MSM workers are needed in order to reach MSM clients. Thus, the first priority should be the hiring of MSM peer educators – either by SHCs using LGU funds, or by NGOs that contract with SHCs, private hospitals, or other institutions. These MSM peer educators should have HCT targets to be met each month.

Second, outreach needs to be increased dramatically with, if possible, HCT available at the outreach site. This prioritization is based on the first observation in this report: that a mechanism exists for connecting FSW and the health system (SHC registration), but no such mechanism exists for connecting MSM and

the health system. Outreach testing can provide such a connection for a population that is marginalized and often hidden.

There was insufficient time and resources to undertake a full costing of the different models. In addition, many of these models are in their earlier stages and some do not have budgets sufficient to sustain them without the use of predominantly free workers (true volunteers). However, for those that do have sustainable budgets, a focus on tracking costs would allow more rigorous comparisons between the various models in the future.<sup>80</sup>

The lists in section 9 are generic. To turn these into a local action plan, a Local AIDS Council will be needed to coordinate the response and to create a credible, consolidated request to the LGU. The Local AIDS Council's existence (including per diems) should be funded by the LGU. Their planning process may be aided by a series of "action grids" outlined for rapid assessment and response.<sup>39</sup> In the first grid, participants outline key findings, the information source, validity, and a proposed general response at individual, community and structural levels. The second grid takes each of these responses and assigns an assessment of priority, relevance, feasibility and acceptability. A third grid outlines objectives, activities, costs and resources, a timeframe, a responsible person or agency, and indicators. This process is best undertaken at the local level.

Without an increase in activities, it is quite likely that HIV prevalence among MSM in the Philippines will jump a further ten-fold: from its current levels to the numbers seen in epidemics in Bangkok, Phnom Penh and elsewhere. However, a combination of activities – central guidance; local planning and funding; and implementation by a wide variety of actors – will make a strong impact on the HIV epidemic among MSM in the Philippines with the potential to save tens of thousands of lives.

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<sup>80</sup> An example of such an analysis is provided in: DFID Viet Nam. Harm reduction needs, costing and analysis. Joint assessment of DFID and World Bank projects. Nossal Institute for Global Health, University of Melbourne, Australia, 2008.

## **8. Annex 1: Advocacy document**

The following text could be adapted for advocacy with different audiences.

### **HIV Testing and Counseling: Action is needed NOW!**

After many years of a stable HIV epidemic in the Philippines, the number of HIV cases detected per year has risen **ten-fold** since 2007. Without prompt and decisive action, another ten-fold rise is possible.

Of the new cases detected this year, 96% have been men and 87% are males who have sex with males (MSM). But only **5%** of MSM are getting HIV counseling and testing (HCT).

HIV prevention, including HCT, can cost a **few hundred pesos** per person – whereas the medical costs for each person with HIV can easily exceed a **million pesos**. Prevention pays for itself many times over.

People who get tested **reduce** their subsequent risk-taking. With more HCT, HIV is **detected early**, those who are infected get on **treatment** – and that treatment **drastically reduces the further spread** of the epidemic.

MSM get HCT in Social Hygiene Clinics, private hospitals, private laboratories, and public hospitals. But MSM are a largely hidden population that is not well connected to the health system, and **half do not know a place to get HCT**. Even among those who know where to go, many fear getting an HIV test. Social Hygiene Clinics are thought to be only for sex workers, private hospitals charge too much, and public hospitals are unwelcoming and not always confidential. The health sector needs to **bridge the gap** between themselves and MSM.

What is needed? **MSM need to be involved in providing services to MSM**. That means that Social Hygiene Clinics should hire MSM peer educators to do **outreach** to places where MSM socialize. **HCT at outreach sites** can and should be done. Social Hygiene Clinics and private hospitals can both **partner with and fund NGOs** to provide MSM peer educators and to create demand for HCT among the MSM community. Once these basics are established, there may be enough demand to justify the establishment of a stand-alone male health clinic.

**None of these initiatives come for free**. More staff members are needed. But these new staff members are peer educators who require **minimal pay** even though they are **extremely effective** at reaching the affected population. Local government units will get a huge benefit in return for spending a relatively small amount of new funding.

**The affected population is known. Model interventions to achieve HCT in MSM are available. Now, these interventions need to be expanded drastically.**

## 9. Annex 2: Summary of good practices

The following list can be distributed to and used by facilities and NGOs. As noted in section 7.3, the particular activities should be customised to the local situation through a process of local planning.

**Table 9: List of good practices for HCT in different settings**

<b>Overarching</b>
In each facility, create a pathway for HCT clients that is short, clear, and involves as few people as possible.
Provide informative pre-test counseling, supportive post-test counseling, and, for those who test positive, a strong linkage to treatment.
Provide services where and when MSM can access them – notably at the sites identified by IHBSS (bars, workplaces, and the street).
Many of the peer educators and counselors that provide the services should themselves be MSM.
Analyze which sources of clients yield the most reactive cases; try to focus demand generation activities on those sources.
In <i>all</i> facilities, use a code for HCT so that cashiers etc do not know what service is being requested.
At national level, choose a combination of rapid tests with high positive predictive value. Once this is achieved, HCT sites can explain the meaning of a reactive result more forcefully, and point of care testing can be considered as an option.
Continue efforts to reduce age of consent for HCT to 15 years.
Improve central demand forecasting for rapid test kits.
LGUs to fund and support Local AIDS Councils; in turn, these councils need to put together a consolidated action plan and request for LGU funds.
<b>SHCs</b>
<b>Create a space and time for clients other than FSW</b>
Promote late mornings and late afternoons as times preferentially for male clients
Institute and promote male-specific days at SHCs
Consider whether FSW services can be reduced from once a week to once every two weeks; if so, this opens up time for other clients including MSM and transgender people
Rename the SHC as a "Reproductive Health and Wellness Center" (RHWC) to broaden the appeal of the facility
Once demand is established and proven, establish a stand-alone male health clinic
<b>Establish a simple and confidential client flow</b>
When clients enter the clinic, provide them with a slip to request services. They can tick a box to get an HIV test, rather than stating this request out loud.
Provide walk-in MSM with a priority ticket for HCT so they don't wait with SW
Renovate. Getting rid of outside waiting areas can increase client confidentiality.
<b>Create direct links from SHC to MSM clients</b>
Request LGU funds to hire MSM as peer educators and HCT counselors – a low cost and very effective strategy for reaching the desired clients. It may be possible to fund some of these new MSM peer educators by classifying them as barangay health workers.
SHC staff – including MSM peer educators – to conduct regular outreach to gay bars and cruising sites, with HCT available on site

Form partnerships with NGOs, who can provide MSM staffing for outreach, refer clients to HCT and accompany them from HCT to TCS. Consider signing a Memorandum of Association (MoA) to formalize expectations. <sup>81</sup>
<b>Use IEC and other demand generation strategies</b>
Take three simple but effective actions to attract more HCT clients: post SHC contact details on websites; ask all HCT clients to refer their friends; and advertise in local cinemas about the HIV situation and how to get tested.
Put up notices or posters in the SHC that advertise the availability of free HIV testing at this clinic, and explain how and where to request it
Introduce IEC that promotes the benefits of testing, including positive lifestyles after diagnosis
<b>Testing during outreach</b>
Negotiate with owners of MSM establishments for permission to set up nearby.
MSM peer educators to actively circulate in the area to recruit clients.
Extract blood from all clients so that attention is not drawn to those who are reactive.
Use flip charts; bring simple partitions to increase privacy.
Offer testing during existing events (e.g., beauty contests; dance parties) and events organized by MSM peer educators.
Use clan leaders to recruit for testing events.
<b>NGO outreach and demand generation</b>
Prioritize systems to track clients. Stay in touch with patients throughout the testing process, accompany them to HCT if requested, and accompany them to TCS if confirmed positive.
Include HCT targets in monitoring framework, even if the NGO's main objective is BCC.
Use MSM volunteers as "chatters;" they direct MSM in chat rooms to HCT.
Offer pre-test counseling in NGO facilities. If a trained NGO staff member exists, also offer blood extraction.
Sign a Memorandum of Association with SHCs, private hospitals, and other HCT sites. If possible, get partners to provide funding in return for the NGO delivering HCT clients.
Collaborate between NGOs to ensure appropriate geographical coverage of outreach.
<b>MSM-specific clinics</b>
Establish the clinic only once there is proven demand and a partnership with effective MSM outreach efforts (led by either NGO or SHC).
Operate during evening hours to increase accessibility for MSM.
Locate the clinic near places where MSM socialize.
Track and document expenses and impact (number tested and reactive) over time; the results will influence future expansion of these models.
<b>Private hospitals</b>
Allow clients to access testing both through a physician and by directly approaching the laboratory
Charge a single HCT fee that includes the consultation required for post-test counseling
Partner with NGOs for demand generation
<b>Private laboratories</b>
Strengthen accreditation process – require better post-test counseling and link to TCS. If necessary, these requirements can be met via a partnership with NGOs.
<b>Public hospitals</b>
Create a simplified referral/client pathway for walk-in HCT.

<sup>81</sup> For example, Cebu SHC and CebuPlus have signed an MoA.

In and around the hospital, advertise the availability of HCT, and give instructions on where to go within the hospital to get HCT.
<b>Blood banks</b>
Decide on an official policy regarding disclosure of HCT results, then put posters in the waiting room that advertise this policy and identify sites where HCT is available.
<b>Workplace</b>
Spread HCT messages through existing MSM networks at BPOs.
If HCT results can be kept out of human resources records, encourage HCT as part of regular check-ups.
<b>Jails</b>
Offer HCT through partnerships with SHCs and NGOs.

## 10. Annex 3: List of interviewees

The list of interviewees consulted appears below.

**Table 10: List of interviewees**

Location	Name	Position
NCR- Manila, Makati City & Quezon City		
Department of Health	Dr. Gerard Belimac	Program Manager, National AIDS and STI Prevention and Control Program (NASPCP)
	Ms. Helen Paano	Project Associate for Prevention NASPCP
	Dr. Genesis Samonte	HIV Surveillance Manager, National Epidemiology Center (NEC)
Health Action Information Network (HAIN)	Ms. Noemi Lewis	UNDP Project Coordinator, HAIN
	Mr. Mikael Navarro	UNDP Project Consultant HAIN
TLF SHARE Collective	Mr. Jonas Bagas	Vice Chair, TLF SHARE Collective
Research Institute for Tropical Medicine (RITM)	Dr. Rossana Ditangco	Head - AIDS Research Group, RITM, and founder of RITM Male Health Clinic
Bernardo Social Hygiene Clinic, Quezon City	Dr. Suzette Encisa	SHC Physician, Bernardo Social Hygiene Clinic, Quezon City
UNAIDS, Philippines	Mr. Zimmbodilion Mosende	M&E Adviser, UNAIDS Philippines
UNICEF, Philippines	Ms. Gudrun Nadoll	HIV and AIDS Specialist
UNDP, Philippines	Mr. Philip Castro	Programme Officer for HIV and AIDS
WHO, Philippines	Dr. Soe Nyunt-U	WHO Representative, Philippines
WHO, Western Pacific Regional Office (WPRO)	Dr. Zhao Pengfei	Technical Officer, HIV Prevention, WHO WPRO
Philippine General Hospital	Dr. Edsel Salvania	Consultant-Philippine General Hospital, SAGIP Unit
	Dr. Allan Tenorio	Attending Physician-Philippine General Hospital, SAGIP Unit
Manila Social Hygiene Clinic	Dr. Diane Mendoza	SHC Physician, Manila SHC
STI/AIDS Central Cooperative Laboratory	Dr. Elizabeth Freda Telan	Unit Head-SACCL
	Dr. Rosario Tactacan-Abrenica	Unit Head-Public Health Division San Lazaro Hospital
	Ms. Susan Leano	Medical Technologist
Philippines National AIDS Council (PNAC) Secretariat	Mr. Glenn Cruz	Member-PNAC Secretariat
	Dr. Juan Lopez	OIC Director, PNAC Secretariat
National Center for Disease Prevention and Control/US Agency for International Development (USAID)	Dr. Yolanda Oliveros	Director IV-National Center for Disease Prevention and Control/ Health Officer-USAID
Makati Medical Center	Dr. Janice Caoili	Member-HACT, Makati Medical Center
	Dr. Carmenchu Echiverri	MMC Consultant, Makati Medical Center
	Dr. Vilma Co	ID Consultant, Section Chief, Makati Medical Center
Makati Social Hygiene Clinic	Ms. Ofie Tolentino	IHBSS Coordinator, Makati SHC
	Ms. Tess Pagcaliwanagan	SHC Nurse, Makati SHC



	Dr. Bernard Sese	SHC Physician, Makati SHC
BAHAGHARI	Mr. Rai Mendoza	Secretary-BAHAGHARI
	Mr. Michael dela Cruz Tan	President-BAHAGHARI
Love Yourself	Mr. Ronnievinn Pagtakhan	President-Love Yourself
Pilipinas Shell	Dr. Jonathan Fontilla	Consultant-Pilipinas SHELL Foundation
ACHIEVE Inc.	Ms. Maria Lourdes S. Marin	Executive Director, ACHIEVE
	Mr. Jeffrey Acaba	Researcher, ACHIEVE
Take the Test	Mr. Ryan Pinili	President, Take the Test
Quezon City Social Hygiene Clinic	Dr. Antoinieta Inumerable	City Health Officer, Quezon City
	Dr. Irene Grafil	SHC Physician, Quezon City SHC
	Mr. John Ardinel	Peer Educator-MSM, Quezon City SHC
	Ms. Nancy Abacan	City Planning and Development Officer, Quezon City
AIDS Society of the Philippines	Dr. Jose Sescon	Executive Director, ASP
	Mr. Bong Yap	Project Coordinator, ASP
Ateneo Study Group	Dr. Isabel Melgar	Professor, Ateneo de Manila
Angeles City, Pampanga		
Angeles City Social Hygiene Clinic	Dr. Verona Guevarra	SHC Physician, Angeles SHC
	Ms. Navalita Valencerina	SHC Nurse, Angeles SHC
	Ms. Rosalinda Velasco	SHC Nurse, Angeles SHC
Angeles City Health Office	Dr. Leonario Santos	City Health Officer, Angeles City
Rafael Lazatin Memorial Center	Dr. Tyrel Tolentino	HACT Chairman, Rafael Lazatin Memorial Center Hospital, Angeles City
NCR- Manila & Pasay City		
	Dr. Marcialiano Cruz	Urologist, East Avenue Medical Center
San Lazaro Hospital	Dr. Roentgene Solante	Medical Specialist-SACCL
	Dr. Lalaine Archangel	Physician-Public Health Division San Lazaro Hospital
SIMS Laboratory	Ms. Maria Fe Hibanada	Laboratory Medical Technologist, Sims Laboratory
Pasay City Social Hygiene Clinic	Dr. Loretta Garcia	SHC Physician, Pasay SHC
	Ms. Marie Pierre Parlade	SHC Nurse, Pasay SHC
	Ms. Gigi Zapanta	SHC Medtech, Pasay SHC
	Mr. Jovena de Guzman	BCC Coordinator, Pasay SHC
	Mr. Nico Jose Santos	Peer Educator-MSM, Pasay SHC
	Mr. Humphrey Goricetta	Consultant
Cebu City & Mandaue City		
Center for Health Development	Dr. Jonathan Neil Erasmo	STI Coordinator-CHD Reg. VII, Cebu
Vicente Sotto Memorial Medical Center	Dr. Abelardo Alera	HACT Chairman, Vicente Soto Hospital, Cebu
	Dr. Chamberlain Agtuca	HACT-member, Vicente Soto Hospital, Cebu
Coalition for the Liberation of the Reassigned Sex (C.O.L.O.R.S)	Ms. Magdalena Robinson	President, COLORS
	Ms. Claire Pareja	Member, COLORS
Mandaue Social Hygiene Clinic	Dr. Debbie Catulong	SHC Physician, Mandaue SHC

Chong Hua Hospital	Dr. Arlene Macabaya	Infectious Doctor, Chonghua Hospital, Cebu
	Ms. Angela Christy Parcon	Medical Technologist, Chonghua Hospital, Cebu
	Ms. April Marie Gacasan	Medical Technologist, Chonghua Hospital, Cebu
Cebu Plus	Mr. Jerson See	President, CebuPlus
Cebu City Health Office	Dr. Stella Minoza Ygon	City Health Officer, Cebu City
	Mr. Alipio Bacalso	City Planning and Development Officer, Cebu City
Cebu City Social Hygiene Clinic	Dr. Ilya Tac-An	SHC Physician, Cebu City SHC
BISDAK Pride	Mr. Simeon Remata	BISDAK- member
University of Southern Philippines Foundation	Dr. Lourdes "Odette" Jereza	Consultant/Professor-University of Southern Philippines Foundation
Davao City		
Southern Philippines Medical Center (SPMC)	Dr. Alicia Layug	HACT Chairman, SPMC
	Ms. Evelyn Arandia	HACT- Social Worker, SPMC
	Ms. Fely Ulangkaya	HACT- Social Worker, SPMC
Center for Health Development	Dr. Bernadette Sabay	STI Coordinator-CHD Davao
Mindanao AIDS Advocates Association Inc.	Ms. Nidgie Tindoc	President, Mindanao AIDS Advocate Association
	Mr. Razz Catipan	Public Information Officer, Mindanao AIDS Advocate Association
	Mr. James Fritz Freire	Spokesperson, Mindanao AIDS Advocate Association
Davao City Reproductive Health and Wellness Center (RHWC)	Dr. Jordana Ramiterre	SHC Physician, Davao RHWC
	Mr. Patrick Albit	BCC Coordinator, Davao RHWC
Physicians' Diagnostic Services Center, Inc.	Medical Technologist	
ALAGAD Mindanao	Ms. Alma Mondragon	Executive Director, Alagad Mindanao
Friendly Care Clinic- Mandaluyong		
Friendly Care Clinic- Mandaluyong	Dr. Jerome Tahil	Clinic Physician/Technical Services & Quality Assurance Officer, Friendly Care Clinic, Mandaluyong
	Dr. Eleazer Lim	Clinic Manager, Friendly Care Clinic, Mandaluyong
	Ms. Evilla "Bell" Pagal	Clinic Counselor, Friendly Care Clinic, Mandaluyong