USAID
FROM THE AMERICAN PEOPLE

INCREASING ACCESS AND UPTAKE OF HIV TESTING AND COUNSELING AMONG MEN WHO HAVE SEX WITH MEN IN THAILAND

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

MARCH 2011

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

INCREASING ACCESS AND UPTAKE OF HIV TESTING AND COUNSELING AMONG MEN WHO HAVE SEX WITH MEN IN THAILAND

The authors' views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the United States Government.

AIDS Support and Technical Assistance Resources Project

AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. Agency for International Development under contract no. GHH-I-00–07–00059–00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

Acknowledgments
AIDSTAR-One would like to extend appreciation and thanks for support and contributions from the RDMA USG Team, particularly Cameron Wolf, USAID, RDMA Regional HIV/AIDS Technical Advisor; Michelle McConnell, Thailand U.S. Centers for Disease Control; and the HTC Technical Working Group, especially Vincent Wong and Alison Surdo, USAID Washington Office of HIV/AIDS. AIDSTAR-One also wishes to recognize the important contributions from NGOs that shared their time and their stories.

Recommended Citation
Spratt, Kai and Maria Claudia Escobar. 2011. *Increasing Access and Uptake of HIV Testing and Counseling Among Men Who Have Sex with Men in Thailand.* Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Abstract
While Thailand has substantially mitigated its HIV epidemic, it has been less effective in reaching men who have sex with men (MSM), who account for a significant proportion of persons infected with HIV in Thailand. In early 2009, AIDSTAR-One conducted a two-phased scope of work in Thailand addressing issues affecting uptake of HIV testing and counseling (HTC) services for MSM. In Phase 1, AIDSTAR-One conducted a literature review and situation analysis identifying promising programs for MSM in Thailand. In Phase 2, AIDSTAR-One facilitated a two-day stakeholder meeting to review Phase 1 findings and prepare for community-based, same-day HTC for MSM in Thailand. The situation analysis identified that community-based HTC options for MSM are limited and revealed several themes, including that MSM want choices as to where and from whom services are received. AIDSTAR-one proposed three key strategies to provide HTC for MSM in Thailand. Finally, AIDSTAR-One developed a draft monitoring and evaluation plan for implementing a USG-sponsored demonstration project in six provinces on community-based HTC models for MSM.

AIDSTAR-One
John Snow, Inc.
1616 Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: info@aidstar-one.com
Internet: aidstar-one.com

CONTENTS

Acronyms v

Executive Summary vii

Introduction 1

HIV in Thailand: An Overview 1

Promising Programs for Men Who Have Sex with Men in Thailand 2

Situational Analysis of Programs for Men Who Have Sex with Men 7

Summary of Findings 7

Main Themes from Interviews and Observations 11

Models for Community-based, Same-day, Rapid Tesing and Counseling for Men Who Have Sex with Men 13

Key Issues for Implementation 17

Stakeholder Meeting Report 19

Day One Activities 20

Day Two Activities 30

Monitoring and Evaluation Plan for the U.S. Government Testing and Counseling Demonstration Project 41

Proposed Implementation-focused Components Evaluation 43

Appendix 1: AIDSTAR-One Field Visit Itinerary, March 16–April 10, 2009 49

Appendix 2: Stakeholder Meeting: Increasing Access and Uptake of HIV Counseling and Testing Among Men Who Have Sex with Men in Thailand, June 1–2, 2009, Windsor Suite Hotel, Bangkok, Thailand 53

Appendix 3: Stakeholder Meeting List of Participants 55

References 57

ACRONYMS

ART	antiretroviral therapy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
DDC	Ministry of Health Department of Disease Control
ELISA	enzyme-linked immunosorbent assay
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HTC	HIV testing and counseling
IFCE	implementation-focused components evaluation
M&E	monitoring and evaluation
MARP	most-at-risk population
MOPH	Ministry of Public Health
MOU	memorandum of understanding
MSM	men who have sex with men
MSW	male sex worker
NGO	nongovernmental organization
NHSO	National Health Security Office
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PIMAN	Prevention of HIV in Man
PLWH	people living with HIV
PSI	Population Services International
QI	quality improvement
RDMA	Regional Development Mission Asia
RSAT	Rainbow Sky Association of Thailand
S&D	stigma and discrimination
STI	sexually transmitted infection
SWING	Service Workers in Group
TB	tuberculosis
TG	transgender

TRC	Thai Red Cross
TUC	Thailand Ministry of Public Health-U.S. Centers for Disease Control and Prevention Collaboration
UNAIDS	Joint U.N. Programme on HIV/AIDS
UNICEF	U.N. Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. government
WHO	World Health Organization

EXECUTIVE SUMMARY

Although Thailand has made substantial progress in reducing the impact of the HIV epidemic on the general population, the success of its prevention programs has not extended to the population of men who have sex with men (MSM). This group includes male sex workers (MSWs), men who have sex only with men, men who have sex with men and women, and male-to-female transgenders (TGs). In 2007, infections occurring among MSM accounted for a large proportion of all new HIV infections. Research among young Thai males has shown varying percentages (3.3 to 16) reporting same-sex experiences, suggesting that the number of MSM in Thailand may be large (UNGASS 2008; Girault 2008). Studies also indicate that a large proportion of men do not consider themselves exclusively homosexual; therefore, programs designed to reach Thai MSM need to take into account variations in cultural identity and sexual behavior.

From March 16 to April 3, 2009, AIDSTAR-One conducted a two-phase scope of work in Thailand focused on addressing MSM issues and services. The work included:

- *Identifying promising programs for MSM in Thailand:* Conduct a situational analysis of public and private sector organizations supported by the U.S. government (USG) in Bangkok, Pattaya, Chiang Mai, and Khon Kaen that are implementing HIV prevention and care and support programs for MSM.
- *Preparing for community-based, same-day counseling and testing for MSM in Thailand:* Facilitate a stakeholder meeting to review promising programs and practices in HIV testing and counseling (HTC) for MSM; discuss the findings from the situational analysis; propose models for community-based HTC for MSM and analyze the strengths and challenges of these models; and conduct a strategic planning exercise for implementing these HTC models.

In developing tools for the situational analysis in Thailand, AIDSTAR-One reviewed the literature and identified several promising programmatic practices for HTC for MSM:

1. A testing approach that provides HTC services in an environment that is welcoming to and accessible by MSM.
2. Outreach activities that are continuous and that are designed and conducted by peers.
3. HTC services that are delivered respectfully by staff that are sensitive to the specific issues and constraints faced by MSM when accessing services.
4. Training with curricula adapted to MSM issues and concerns.
5. Referrals and linkages that link HTC sites to existing service delivery sites within the facility or to outside sites and facilities.
6. Monitoring and evaluation (M&E) that includes quality assurance for counselors' adherence to the counseling protocol, counseling about status disclosure, and referrals to other services.
7. Government and nongovernmental organization (NGO) collaboration to increase the likelihood of long-term sustainability of HTC services for MSM.

The situational analysis showed that HTC services specifically for MSM are extremely limited. The analysis highlighted several promising programmatic practices currently implemented by USG-supported partners, which could be built on to implement demonstration projects that would introduce same-day, rapid HIV testing. These current practices include the following:

- Peer counselors are available at some sites.
- HTC is offered at sites where other services are available (e.g., sexually transmitted infection [STI] services).
- MSM and TG persons are targeted where they congregate, increasing access to prevention and testing information.
- Popular leaders engage the community to change norms related to high-risk behaviors.
- Public and/or private sector services are linked.
- Government and NGOs collaborate in all provinces.
- Thailand is included in a multi-country research study of community-based HTC that has demonstrated substantial success in increasing uptake of HTC.

Interviews and observations from the situational analysis yielded several common themes:

1. MSM want to choose where to obtain HTC services and from whom services are received.
2. To increase HTC uptake, changes in attitudes about HIV testing are needed.
3. People are less likely to seek HIV testing as long as their knowledge of the effectiveness of antiretroviral therapy (ART) and access to services is low.
4. MSM are not a homogeneous group; program approaches must take into consideration this diversity.
5. Coordination between government services and NGOs will require flexibility to meet the challenges of increasing HTC uptake in the MSM population.
6. Uncertainty about long-term funding threatens program sustainability, although some funding possibilities have been identified.

The situational analysis showed that the NGO and government sectors have enormous potential for, and interest in, finding new ways to increase coverage of HTC services for MSM at the community level. However, key policy and long-term financing issues must be addressed for these services to be sustainable. For the MSM population, having access to same-day, rapid HIV testing would increase uptake of testing, reduce follow-up loss, and lower the cost of seeking HIV testing. In light of these findings, AIDSTAR-One proposes three key strategies that can be adopted individually or in combination to provide HTC for MSM:

- Model 1: Introduce rapid testing into Ministry of Public Health (MOPH) sites currently providing HTC services.

  MOPH sites that primarily provide enzyme-linked immunosorbent assay (ELISA) testing would move to providing rapid testing on-site with same-day test results.

- Model 2: Introduce HTC and rapid testing services at NGO sites.

Currently, only the Thai Red Cross (TRC) and Sisters provides HIV counseling services; however, HIV testing is not available on-site at Sisters. All NGOs would receive appropriate HTC training and would be equipped to provide rapid testing on-site with same-day test results.

- Model 3: Enhance clinical and community collaboration to allow MOPH and NGO staff to collaborate to provide enhanced HTC services.

  MOPH staff could provide rapid HTC services on-site at NGO facilities or locations. Conversely, NGO staff could provide peer services (i.e., counseling and peer support) and rapid testing at the MOPH sites, making them more MSM-friendly. In both cases, providing same-day test results with rapid testing would be the goal.

Following the situational analysis, AIDSTAR-One hosted a two-day stakeholder meeting in Bangkok that included the Thailand MOPH-U.S. Centers for Disease Control and Prevention (CDC) Collaboration (TUC), U.S. Agency for International Development (USAID) implementing partners Pact and FHI, Rainbow Sky Association of Thailand (RSAT), the Ministry of Health Department of Disease Control (DDC), and other Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) Round 8 implementing organizations and provincial partners. The goals of this meeting were to discuss the findings from the AIDSTAR-One situational analysis on promising program practices and the current status of HTC for MSM; develop a detailed understanding of current conditions in each province and the opportunities to introduce community-based, same-day rapid HTC for MSM; and develop action plans at the provincial level for implementing community-based, same-day rapid HTC for MSM, which the USG plans to introduce in six provinces in Thailand.

AIDSTAR-One was asked by USAID/Regional Development Mission Asia (RDMA) to develop a draft M&E plan for rolling out a USG-sponsored demonstration project on community-based HTC models for MSM in six provinces. An implementation-focused components evaluation (IFCE) was proposed that would allow for cross-site comparisons of the extent the models were implemented as designed. In the near future, USAID/RDMA and the CDC will determine which components of the M&E plan will work best for monitoring the rollout of the demonstration HTC sites in their respective provinces.

INTRODUCTION

USAID/RDMA supports a range of community-based programs in Thailand. These programs are focused on increasing knowledge of and access to HIV prevention and care programs among most-at-risk-populations (MARPs). The government of Thailand has recently approved a USAID initiative to implement demonstration projects that will provide same-day, rapid HTC for MSM. This group includes male sex workers (MSWs), MSM, men who have sex with men and women, and male-to-female transgender people (TG). The overall goal of the demonstration projects is to increase access to and uptake of HTC services among MSM and will be implemented and monitored for approximately two years. If the HTC models implemented during the demonstration projects prove successful, similar models could be adapted and scaled up in other provinces with the assistance of GFATM.

AIDSTAR-One is a U.S. President's Emergency Plan for AIDS Relief (PEPFAR)-funded project supporting USG HIV prevention, treatment, and care and support programs. A flexible and rapid mechanism for providing technical assistance and program implementation to the Office of HIV/AIDS and USG country teams, AIDSTAR-One has three primary task areas: 1) technical leadership and knowledge management; 2) improvement of program content, quality, and sustainability of HIV prevention, treatment, and care and support programs; and 3) strategic planning and technical assistance. Using core funds, AIDSTAR-One conducted a two-phase scope of work in Thailand, as described below.

1. *Phase One:* Identifying Promising Programs for MSM in Thailand

   Conduct a situational analysis of the public and private sector organizations supported by USG in Pattaya, Chiang Mai, Bangkok, and Khon Kaen[1] that are implementing HIV prevention and care and support programs for MSM. The analysis sought to determine the potential of these organizations for supporting and/or providing same-day, rapid HTC services for MSM in light of the forthcoming USG-supported HTC demonstration projects.

2. *Phase Two:* Preparing for Community-Based, Same-Day HTC for MSM in Thailand

   Facilitate a stakeholder meeting that included the TUC, USAID implementing partners Pact and FHI, RSAT, the DDC, and other GFATM Round 8 implementing organizations. The goals of this meeting were to review promising programs and practices in HTC for MSM; discuss the findings from the situational analysis; propose models for community-based HTC for MSM and analyze the strengths and challenges of these models; and conduct a strategic planning exercise for implementing these HTC models.

HIV IN THAILAND: AN OVERVIEW

The national government of Thailand was a global leader in successful efforts to reduce the impact of the HIV epidemic in the early 1990s. Core components of the government's strategy included implementing a 100 percent condom use policy targeting brothel-based female sex workers and their

[1] USG also supports projects in Phuket and Chonburi provinces, but these projects were not included in the site visits by USG.

male clients; making ART widely available for pregnant women and their infants for prevention of mother-to-child transmission of HIV; and launching nationwide awareness programs. As a result of these nationally coordinated efforts, HIV prevalence that peaked at 3.4 percent in military conscripts and 2.3 percent in antenatal care clients in the 1990s leveled off at 0.4 percent and 0.8 percent, respectively, in 2006–07. The number of new HIV infections per year decreased from an estimated 143,000 cases in 1991 to an estimated 14,000 cases in 2007, and the decline continues.

Since 2002 ART has been covered under the universal health insurance program that reimburses public and private hospitals for treatment of people living with HIV (PLWH) who are registered in the program (Punpanich, Ungchusak, and Detels 2004; UNGASS 2008). However, the success of Thailand's prevention programs does not extend to other risk groups such as MSM. While HIV prevalence among heterosexuals has remained low at 1.4 percent, it has risen substantially in the MSM population, a group that includes MSWs, MSM, men who have sex with men and women, and male-to-female TGs (UNGASS 2008).

Repeat cross-sectional studies of HIV prevalence among MSM in Bangkok, Chiang Mai, and Phuket found that the number of people with HIV increased rapidly from 2003 to 2005 (van Griensven et al. 2010). Research among young Thai males has shown varying percentages (3.3 to 16 percent) reporting same-sex experiences, suggesting that the number of MSM in Thailand may be large (UNGASS 2008). Studies also indicate that a large proportion of men do not consider themselves exclusively homosexual; therefore, programs designed to reach Thai MSM should develop interventions that respond to the diversity of MSM cultural identity and sexual behavior.

The *National Strategic Plan for Integration of AIDS Prevention and Alleviation 2007–2011*, a recent policy document produced by the AIDS Cluster of the DDC in Thailand, suggests that policy responses to HIV from recent Thailand governments have been inadequate. "Prevention strategies should be developed and improved with the changing epidemiological and behavioral situation in population groups such as youth, discordant couples, sex workers (male and female), clients who visit sex workers, MSM, drug users and ethnic minorities including populations along borders and mobile populations" (Government of Thailand 2007). Recognizing the paucity of programs targeting MSM, the government of Thailand's successful proposal to the GFATM Round 8 outlines a range of prevention programs to be undertaken through government and civil society collaboration beginning July 2009. While these efforts are welcomed, it still remains unclear how to best reach the MSM population and increase demand for and use of HTC services.

High levels of HIV-related stigma and discrimination (S&D) prevent many individuals from accessing HTC and other services. A 2007 report by the World Health Organization (WHO) and the Joint U.N. Programme on HIV/AIDS (UNAIDS) showed that in Thailand, as in other countries in southeast Asia, more than one in four people with HIV have experienced discrimination in health care settings; one-third report breaches in confidentiality about their HIV status; and among those PLWH, 15 percent have been refused medical treatment (WHO 2007). Given the rapid spread of the HIV epidemic among MSM in Thailand, strategies to increase access to and uptake of HTC are urgently needed.

PROMISING PROGRAMS FOR MEN WHO HAVE SEX WITH MEN IN THAILAND

For more than two decades, the USG has supported a broad range of HIV prevention, treatment, and care and support programs. While these programs have reached millions of people infected or

affected by HIV with life-saving services, there have been relatively few rigorous evaluations to determine which interventions, or combination of interventions, are most effective for specific populations at risk for HIV infection. A key objective of this situational analysis is to identify promising practices in HTC services targeting MARPs, specifically MSM in Thailand.

PROMISING PROGRAMMATIC PRACTICES IN HTC FOR MSM

Before conducting the situational analysis in Thailand, AIDSTAR-One technical staff conducted an extensive literature search, which included online searches of the research and program literatures, and performed key informant interviews with experts in HTC to identify promising practices in HTC services. The literature search was global in scope and included clinical trials research from the United States, Europe, and Africa; peer-reviewed qualitative studies; community-based research studies; and project reports from donor-funded programs in the last 10 years. Promising practices related to HTC are summarized in Table 1. Important issues to keep in mind when reviewing the summary include the following:

1. The feasibility of generalizing interventions from research studies to the Thailand situation may be limited because of cultural differences. Program implementation, access, and acceptance are critical issues at the community level if an approach that is effective in one cultural setting is to be successful in another cultural setting. Although adapting a proven intervention may result in a greater chance of success than using a newly developed, untested intervention, rigorous analysis is necessary to evaluate the effectiveness of the intervention (Lyles et al. 2007).
2. Interventions presented in program reports typically have not been well evaluated; as a result, conclusions may be biased.
3. Reports covering many good, community-based programs never make it into the published or grey literature because of language barriers or insufficient funds to adequately document the program results.

The literature review showed that good HTC programs comprise a number of components, not all of which were implemented by every program or research study. These components include the following:

1. *Testing approach.* Because of S&D, it is imperative to offer HTC services in an environment that is welcoming to and accessible by MSM. Peer counselors should be an option, along with health care providers for pre- and post-test counseling; rapid tests with same-day results should be available; and HTC should be available at sites such as STI clinics that already provide services to MSM.
2. *Outreach activities.* Extensive outreach informs communities about HTC services, promotes changes in norms around HIV testing and risk behavior, and provides information on how to access services. Outreach must be continuous and should be designed and conducted by peers who can access social networks and support group norms in favor of HIV testing.
3. *Quality of HTC services.* Services must be delivered respectfully by peers and health provider staff who are sensitive to the specific issues and constraints faced by MSM when trying to access services. Staff must be comfortable discussing risk behaviors.
4. *Training and supervision.* Counselors should be trained using curricula based on national or international standards. Curricula should have sections adapted to address MSM issues and concerns. Supportive supervision is essential to reduce counselor burnout, to address S&D

toward MSM clients, and to make sure that all clients are assured of the Three Cs: consent, confidentiality, and counseling.

5. *Referrals and linkages.* An integrated system of referrals and linkages is a key factor in replicable and sustainable services. Because of S&D, stand-alone MSM HTC services should be avoided; HTC sites should be linked to existing public, private, and NGO health care delivery sites. HTC sites should provide referrals for prevention, treatment, and care and support services either within the facility (e.g., tuberculosis [TB] clinics within hospitals or clinics where HTC is provided) or to outside sites (e.g., facilities providing ART or NGOs providing home-based care services).
6. *M&E.* Output indicators are necessary to assess service quality but are not sufficient by themselves. Routine monitoring should include activity or process/output indicators for counselors' adherence to counseling protocol, counseling about status disclosure, and referrals to other services.
7. *Government and NGO collaboration.* Close collaboration between government HIV programs and NGOs is more likely to result in long-term sustainability of HTC services for MSM, whether those services are provided by NGOs or by the public health sector. Government should earmark resources to support implementation activities, such as peer outreach, and to build the capacity of community-based organizations (CBOs). Partnerships between the public health department, public security department, and NGOs serving MSM should be strengthened so that MSM can access services without being harassed or arrested (i.e., police agree not to arrest men or women carrying condoms on the assumption that this is evidence of engaging in sex work).

Table 1 summarizes the components and activities identified through the literature review and key informant interviews that are used by programs to reach out to MSM and provide high-quality services for MSM. These promising practices informed the development of the tools used for the situational analysis conducted in Thailand.

Table 1. Promising Programmatic Practices in HTC for MSM

1. Testing Approach
• Three Cs are ensured: consent, confidentiality, and counseling (WHO 2007)
• Ongoing counseling, especially couples counseling, is available for PLWH (Ungpakorn and Wilson 2002; USAID 2008)
• HTC is offered at sites providing other services (i.e., STI clinics; UNAIDS/WHO 2004)
• Choice in gender (male, female, or TG) and kind of counselor (health care provider or peer) available if desired by MSM (Christudoss and Pandian 2008; Tareque et al. 2008)
• A variety of options are available, from opt-out to mobile services, especially in rural areas (Population Services International [PSI] 2006a; USAID 2008)
• Services are provided in an environment that is both acceptable and accessible (International HIV/AIDS Alliance 2004)
• Rapid testing is available (CDC 2006)
• HTC is routine only in highly indicative health care settings such as STI and TB clinics (WHO 2007a)

2. Outreach Activities

- To be successful and sustainable, HTC services must be demand driven and integrated into comprehensive prevention and care services. For this to occur, individuals and communities need to be regularly and consistently informed about HIV risk and the availability of HIV testing (International HIV/AIDS Alliance 2004)
- Peers do outreach (Medley et al. 2009; UNAIDS 2006)
- Peer group norms are supportive of HIV testing (Mimiaga et al. 2007)
- Social network strategies are used to reach MSM (Amirkhanian et al. 2003; WHO 2006)
- Ongoing community mobilization is used to emphasize the importance of knowing your HIV status (WHO 2004)
- Bar-based interventions expand beyond high-profile tourist areas and build on resources and experiences within the MSW group (McCamish, Storer, and Carl 2000)
- Public information campaigns explain specifically how early detection can improve treatment success (Gold and Karantzas 2008)
- Men and TGs are targeted where they congregate; stakeholders at these sites learn to increase access to prevention and testing information (Sevelius et al. 2009; UNAIDS 2006)
- Popular leaders work to change norms related to risk behavior (Stall et al. 2000)
- Outreach activities include safer sex information and condom/lubricant distribution (PSI 2006)
- Frequent small group interventions are conducted (Herbst et al. 2005; Sherman et al. 2009)
- MSM develop outreach activities (McCamish, Storer, and Carl 2000)

3. Quality of HTC Services

- Counseling protocol is specifically adapted for MSM (Casey 2009)
- Tailored counseling approaches focus on characteristics that predispose clients to engage in risk behavior (Chesney et al. 2003)
- Quality improvement (QI) protocol is in place (Kamb et al. 1998; USAID 2008)
- Thorough and ongoing preparation and training of counselors is needed to limit counselor turnover (International HIV/AIDS Alliance 2004)
- Short counseling interventions using personalized risk-reduction plans can increase condom use and prevent new STIs; effective counseling can be conducted even in busy public clinics (Kamb et al. 1998)

4. Training and Supervision

- Country curriculum is an adaptation of WHO or CDC curriculum (Casey 2009)
- Resources for supportive supervision are a priority (Islam 2007)
- Staff receive frequent sensitivity training about MSM concerns (WHO 2006)
- Supervisors actively address S&D (WHO 2007)
- Testing protocols and comprehensive procedures in the recruitment, training, supervision, and monitoring of laboratory and counseling staff ensure quality (McCamish, Storer, and Carl 2000)

5. Referrals and Linkages

- Public and/or private sector services are linked (FHI 2007)
- HTC sites provide referrals to prevention and care and support services within their facility (e.g., TB clinics) or to outside sites (e.g., facilities providing ART or home-based care; FHI 2007)
- A mechanism for coordination between organizations in a referral network needs to be established to ensure a coordinated approach across service providers (USAID and MEASURE Evaluation 2009)
- Each organization has someone charged with maintaining a referral network (Stuart, Harkins, and Wigley 2005)
- An integrated system of referrals and linkages is the key to replicable and sustainable services. HTC services are needed to link to existing public, private, and NGO health care delivery sites that cultivate strong community involvement and ownership; stand-alone MSM service sites should be avoided because of S&D (International HIV/AIDS Alliance 2004)
- MSWs and TG sex workers are referred to alternative income projects (Clements-Nolle et al. 2001)

6. M&E

- Data are collected and reviewed routinely in order to improve services (Bertozzi et al. 2008)
- Progress is monitored in implementation of HTC sites, including procedures for obtaining informed consent, ensuring confidentiality, and providing counseling (WHO 2007)

7. Government and NGO Collaboration

- NGOs and the Thai government collaborate closely (WHO 2006)
- National HIV programs and budgets earmark resources to support implementation of HTC activities (such as peer outreach) and build community organization capacity (USAID 2008)
- Public health and public security departments agree to cooperate to increase access to services (e.g., carrying a condom is not evidence of sex work; WHO 2006)

SITUATIONAL ANALYSIS OF PROGRAMS FOR MEN WHO HAVE SEX WITH MEN

From March 16 to April 3, 2009, an AIDSTAR-One team consisting of an M&E consultant and a senior technical advisor visited NGO and government clinics (selected by USG Thailand staff) in Bangkok, Pattaya, Chiang Mai, and Khon Kaen.[2] The goals of the situational analysis were to 1) identify the current HTC modalities available to MSM; 2) observe promising programmatic practices related to HTC currently implemented by organizations serving MSM; 3) identify strategies or models for community-based rapid HIV testing that could be piloted in USG demonstration projects to increase MSM utilization and uptake of HTC services; and 4) determine how program implementation, stigma, health care provider attitudes and practices, communication strategies, and service quality impact MSM use of HTC services.

The situational analysis began with a review of in-country documents such as USG partner reports and presentations. Then, the AIDSTAR-One team, along with USAID/RDMA and/or CDC technical advisors who accompanied the team to most sites, conducted individual or group interviews with six international NGOs, five local NGOs, nine MOPH clinic sites, three private organizations, and USG staff. The team observed two evening NGO outreach activities and conducted one focus group with six MSM at a Bangkok-based NGO. The field visit itinerary and the organizations visited are included in Appendix 1. Most interviews were conducted with one or more informants at the organization's headquarters (e.g., Sisters in Pattaya), in the particular clinic (e.g., Pattayarak), or at the research/academic center (e.g., Royal Institute of Health Sciences).

Interviews lasted 45 to 120 minutes and were conducted in English or in Thai with simultaneous translation. The AIDSTAR-One team reviewed interview notes at the end of each day to identify key themes and content. Follow-up interviews were conducted with several informants to clarify points that came up during the interviews or to examine a particular topic in greater depth.

SUMMARY OF FINDINGS

CURRENT HTC SERVICES

The results of the situational analysis indicate that the current community-based HTC options for MSM are extremely limited. The following is a summary of the findings on HTC services provided by NGOs and the public and private sectors.

[2] USG supports projects in Phuket and Chonburi, but these provinces were not included among the sites visited by USG.

NGO Services

The lead NGO provider of HTC is the TRC. The AIDSTAR-One team visited TRC offices in Bangkok and Chiang Mai. TRC has been conducting research on HIV since 1989. In 1991, TRC established the first anonymous fee-for-service HIV testing site in Bangkok. Over the last decade, 8,000 to 10,000 HIV tests per year have been done, making it the site with the largest volume of voluntary, opt-in HIV testing in Thailand. About 20 percent of TRC clients self-report as MSM. TRC pays peer educators, who are PLWH, in the HIV clinics in Bangkok and Chiang Mai and hosts a PLWH support group called, the "Wednesday Club," the first such group in Thailand where peers provide counseling.

Only one of the five MSM focused-NGO sites visited by the AIDSTAR-One team was providing HTC services. At Sisters, an NGO established in Pattaya in 2003 "for and by male-to-female transgender persons," a TG public health officer provides pre- and post-test counseling and test results four days a week, draws blood for syphilis and HIV testing, transports the blood to a local hospital laboratory for testing, and refers clients for STI services as needed. HIV test results (carried out using ELISA) are usually ready in two days.

Mplus, an NGO that works with MSM, MSWs, and TGs in Chiang Mai, has set up a drop-in center and has conducted peer outreach prevention activities. However, no health-related services were being provided. Some staff and volunteers have been trained in basic counseling by the Provincial Health Office (PHO) but at the time of the situational analysis they were not providing HTC services. The PHO in Chiang Mai plans to establish six MSM-friendly clinics where volunteers from Mplus (and presumably other NGOs) will welcome clients and guide MSM through the clinic process, but will not play a direct role in HTC.

Public Sector Services

HTC is available at most government-operated hospitals and larger health centers. In most cases, ELISA and Western Blot processing is done, but rapid HIV testing for diagnostic purposes is available only in a few of the larger hospitals. Because rapid tests are generally not available, clients at government clinics must return for test results and post-test counseling. On average, results were available in one week. According to informants at public health facilities, returns by MSM for test results ranged from less than 20 percent at Chiang Mai PHO to 80 percent at the Bangkok AIDS, TB, and STD Services Bamrak Clinic.

All USG-supported public health clinic sites visited by the team provided MSM-friendly services, where MSM peers were present to welcome clients and introduce them to the services and clinical staff trained to be sensitive to MSM and their needs. All of these clinic sites had participated over the last five years in special MSM-focused studies that provided a wider range of services than HIV testing. At the conclusion of these studies, without dedicated funds, the additional services ended; however, continued government and NGO collaboration was evident in some provinces. Cross-referrals were being made between NGOs and between NGOs and government clinics. In Pattaya, government staff reported that they partner with the NGO Service Workers in Group (SWING) to conduct outreach at bars and to educate staff and customers about HIV prevention and treatment.

Private Sector Services

Private health care providers and several research projects provide HTC for MSM. Most informants reported that because of confidentiality issues, MSM prefer to go to private clinics for HIV testing, if they can financially afford to, though they were not assured of the quality of counseling and cost could be an issue. At one time in Bangkok, a voucher system was set up whereby NGOs such as

SWING could distribute vouchers during outreach activities. The vouchers allowed clients to use designated private providers who were reimbursed by the government; however, this approach is no longer active.

Other private sector venues for HIV testing include the Prevention of HIV in Man (PIMAN) Center in Chiang Mai. PIMAN is a research project enrolling MSM for a longitudinal pre-exposure prophylaxis trial that employs MSM and TG counselors. The center provides HIV voluntary counseling and testing and screens participants for STIs. The Silom Community Clinic, located in a hospital in Bangkok, is another long-term study site targeting MSM. It provides clinical and community-based care and support, HIV testing, and treatment for STIs.

PROMISING PROGRAMMATIC PRACTICES AND HTC IN THAILAND

Findings from the situational analysis identified several promising programmatic practices currently being implemented by USG-supported partners in Thailand that could be built on to implement demonstration projects introducing same-day, rapid HIV testing. While only one NGO (Sisters) and one private, non–research-focused organization (TRC) are providing HTC for MSM, all of the MOPH sites visited during the situational analysis were attempting to provide MSM-friendly HTC and other services. The following summarizes the promising HTC practices currently implemented for MSM in Thailand.

Testing Approaches

- Ongoing counseling is offered at most MOPH clinics, Sisters, and TRC.
- Peer counselors are available at many sites.
- HTC is offered at sites where other services are available (e.g., STI services).

Outreach

- MSM and TGs are targeted where they congregate, increasing access to prevention and testing information.
- Peers conduct outreach.
- Popular leaders engage the community to change norms related to risk behaviors.
- Outreach activities include safer sex information and condom/lubricant distribution.
- Social network strategies are used to reach MSM.
- NGO staff and volunteers are involved in developing outreach activities.
- Frequent small group interventions are conducted.

Linkages

- Public and/or private sector services are linked.
- HTC sites provide referrals to prevention and care and support services within their facility (e.g., TB clinics) or to outside sites (e.g., facilities providing ART or home-based care).

Government and NGO Collaboration

- Government and NGOs are collaborating in every province.

MAIN THEMES FROM INTERVIEWS AND OBSERVATIONS

Several themes emerged from key informant interviews and observations. The most prevalent themes are outlined as follows:

1. MSM want to choose where to get services and from whom.

   A universal concern among MSM in the choice to seek HTC services is confidentiality. Some informants prefer to have HIV testing at a government facility because if they are seen coming out of a counseling room at an NGO, people may assume that they are infected with HIV. Others prefer having HIV testing at an NGO because the services at public facilities are considered poor quality. Some MSM and TGs have experienced discrimination, such as staff making inappropriate remarks or failing to conduct adequate physical exams because of discomfort interacting with TGs or performing rectal exams. Other informants mentioned that they would like to have support and counseling at NGOs, but prefer to get HIV testing at public clinics. TG informants were unanimous in wanting services available at the NGOs that support them rather than having to use public facilities.

   Regarding who provides the HTC services, one informant said, "Some MSM want only male health care workers to do counseling; others are OK with men or women. We have found that health care workers' attitudes toward MSM are more important than their gender."

2. To increase uptake of HTC by MSM, changes in norms about HIV testing are needed.

   Interviews with many informants indicated an overall reluctance by MSM to get tested for HIV, especially if they feel healthy. This reluctance is linked to several issues:

   - Fear that knowledge of status would result in loss of job, and boyfriend/regular partners
   - Lack of understanding that those who look healthy can be infected with HIV
   - Concern about isolation and rejection by family and peers if their HIV status becomes known
   - HIV is associated with fear and death.

   Several informants said that people are willing to have name-based HIV testing if their risk behavior is not recorded in a government database, as is the case currently. If risk behavior has to be reported to the government, then MSM would prefer the option of going to clinics that offer anonymous testing (such as TRC). However, the current system has a charge for this service (approximately U.S.$8 to U.S.$10), which is prohibitive for low-income MSM.

   NGOs need to address the issue of self-stigma in their efforts to increase uptake of HTC by MSM. Self-stigma, which occurs when people exposed to stigma internalize the stigma, impacts

the willingness of MSM to get tested—whether at an NGO or government site—and to seek treatment in a timely manner. Self-stigma affects the health and well-being of PLWH by eroding the sense of self-worth and human dignity.

3. People are less likely to seek HIV testing as long as knowledge of the effectiveness of ART and access to care are low.

   ART is covered by the National Health Security Office's (NHSO) 30-Baht Scheme, under which a wide range of public health and hospital services are available at a cost of 30 Baht (less than U.S.$1). This information was not well-known to NGO staff and peers interviewed by the AIDSTAR-One team, which was surprising given the likelihood that these groups were the most informed about HIV issues. It is imperative, therefore, that information about the availability of ART for treatment of HIV—as well as the benefits of seeking treatment early—be disseminated more widely. Awareness that ART is covered under the 30-Baht Scheme may encourage more MSM to seek HIV testing before symptoms appear and treatment success is reduced.

4. MSM are not a homogeneous group, and program approaches should reflect this diversity.

   In Thailand, as in other countries in the region, many men do not identify as gay or MSM. Reaching non–gay-identifying MSM is critical because most MSM are not open about their sexual behavior, and many are married or have female partners. TGs may not identify as men or be comfortable with gay-targeted messages or programs. Because it is crucial to reach the entire MSM population with HTC services, multiple strategies must be developed to meet the needs of this diverse group.

5. Coordination between government services and NGOs will require flexibility to find solutions to implementation challenges.

   Integrating peer counselors into public health clinics or locating public health care staff at NGO sites will require organizational flexibility. It will be important to identify advocates within the NGOs and government health services who can work together in the long-term to find innovative ways for implementing new models of enhanced HTC for MSM.

6. Uncertainty about long-term funding threatens program sustainability.

   Most informants recognized that whatever models of community-based, same-day, rapid HIV testing were implemented, program sustainability would be dependent on long-term budget commitments to programs and services for MSM. This support, whether at the NGO level or within the public sector, could come from donors, provincial or municipal governments, or a combination of sources.

MODELS FOR COMMUNITY-BASED, SAME-DAY, RAPID TESTING AND COUNSELING FOR MEN WHO HAVE SEX WITH MEN

The situational analysis showed that the NGO and government sectors have enormous potential for, and interest in, finding new ways to increase uptake of HTC among MSM. For MSM, having access to same-day, rapid HTC would substantially increase the number of people receiving test results, post-test counseling, and referrals to care and support services (Hutchinson et al. 2006; Malonza et al. 2003), as well as lower costs of seeking HIV testing (i.e., eliminating the need to return for testing or results). Since 1992, the government of Thailand has provided fee-for-service HTC services using ELISA in all provincial and district hospitals. Some NGOs, such as TRC and a limited number of private health care providers, also provide HTC services. With the exception of a few Bangkok Municipal Authority hospitals which do HIV rapid testing for diagnostic purposes, HIV rapid testing is not offered in the public sector. In light of the findings of the situational analysis and of the forthcoming USG demonstration projects of HTC for MSM, AIDSTAR-One proposes several models for delivering HIV rapid testing at the community level. Because no one model will work in all locations or for all MSM subgroups (i.e., MSWs, men who have sex only with men, men who have sex with men and women, and TGs), each province could pilot one or more models during the USG-supported demonstration projects. The model or models to pilot should be determined by local stakeholders, based on the particular context and resources of each province. The models include the following:

- Model 1: Introducing rapid testing into MOPH sites currently providing HTC services

  MOPH sites that primarily provide ELISA testing would introduce HIV rapid testing on-site with same-day test results. This approach would ensure that all male clients, whether MSM-identified or "hidden MSM," who use public health clinics will receive their test results.

- Model 2: Introducing counseling and HIV rapid testing services at NGO sites

  Currently, only one NGO (Sisters) provides HIV pre- and post-test counseling, and HIV testing is not available on-site. NGOs would be equipped and staff and/or volunteers would be appropriately trained to provide quality counseling and rapid testing on-site with same-day test results.

- Model 3: Enhancing collaboration between MOPH and NGO staffs in the delivery of HTC services

MOPH and NGO staff could collaborate as a team to provide rapid HIV testing and counseling services on-site at NGO facilities or at locations targeting MSM (drop-in centers, mobile vans, sex worker venues, entertainment districts, and community-outreach activities) and locations and community events targeting non–MSM-identified men (sports venues, pornographic movie theater districts/areas, non–tourist-focused bars, and entertainment districts). Conversely, NGO staff or volunteers could provide peer services (e.g., counseling and peer support) and rapid testing at the MOPH sites, making them more MSM-friendly.

Regardless of the model(s) piloted in each province, a number of structural barriers must be addressed at the national and provincial level. These barriers include the following:

1. *Long-term financing of services through the NHSO and provincial budgeting mechanisms.* HIV testing is not free, although it is currently covered under the 30-Baht Scheme. Other diagnostic and supportive services that are not covered include CD4 and viral load testing. Paying out of pocket for these services is not possible for many poor MSM who, because of S&D, cannot seek financial support from their family. The rationale for being tested for HIV is weakened without the assurance that treatment and care are available. To make HIV treatment and care and support services truly accessible, the NHSO will need to cover these life-saving tests and treatments for MSM (and other PLWH) who are unable to pay the costs.

   If the models piloted during the USG demonstration projects are effective in increasing access to, and uptake of, HIV testing among MSM, the long-term sustainability of those models is dependent on funding by provincial and local governments, assuming GFATM or donor funding to support implementation costs in Thailand ends. With provincial and municipal budgets heavily skewed toward treatment, budgets to support community-based HIV prevention and care and support programs are small. Advocacy with provincial and municipal governments is needed to begin the lengthy process of reallocating sufficient funds to support community-based prevention programs.

2. *Revisions in national policies and procedures.* Current MOPH policies allow only trained laboratory technicians to do rapid HIV testing (for diagnostic purposes) and standard ELISA tests. ELISA testing requires that blood samples be processed in batches. For example, 96 blood samples are needed before a test kit can be processed. This procedure may require that HTC clients return days later to a clinic or hospital to get their test results. While the MOPH is in the process of developing a 3-test rapid testing protocol, chronic staff shortages make it unlikely that trained laboratory staff will be available to process rapid HIV tests at all NGO and public health sites offering rapid tests. Rapid HIV testing is carried out reliably by many different kinds of health care providers and by trained lay counselors in some countries in the southeast region and around the world. Changing the government policy to allow non-laboratory technicians to process rapid HIV tests is critical to increasing access to HIV testing at sites acceptable to MSM.

3. *Creating communities supportive of MSM.* Long-term survival with HIV depends, in part, on early diagnosis and appropriate and supportive treatment. Because of pervasive S&D toward MSM, incorrect information about HIV transmission, prevention, and treatment, and the absence of strong group norms that support early testing, MSM are dying—delay in testing means delay in seeking life-saving treatment. Programs that provide support to MSM in reducing individual vulnerability and sexual risk behaviors must develop innovative peer group and network strategies (as diverse as the MSM population itself) to strengthen the bonds within groups and promote the development of new norms supportive of HTC. At the broader level, government,

business, and community leaders must fulfill their commitment to change the context of violence, S&D, and social exclusion that is the experience of many MSM.

Information gathered from the situational analysis and the two-day stakeholder meeting (see page 19) helped identify several strengths and challenges of Model 3: Enhancing collaboration between MOPH and NGO staffs in the delivery of HTC services (Tables 2 and 3). These strengths and challenges will need to be addressed before the strategies can be implemented.

Table 2. Strengths and Challenges of NGO Staff Providing HTC Services at MOPH Sites

Strengths	Challenges
• Infrastructure is in place • Staff are long-term • Staff have passed minimum counseling standard training • Sites are known to the public • Services are inexpensive (when covered by the 30-Baht Scheme) • NGO staff may be more likely to maintain confidentiality • Potential for one-stop services is provided (internal referrals for STI, ART, opportunistic infection, and support groups) • Model is more sustainable	• Location and standard operating hours may not be convenient • Staffing may not be adequate • Government clinical staff need sensitivity training in order to reduce stigma and discrimination • Referrals need to be tracked to other services • Government and NGO staff may distrust each other

Table 3. Strengths and Challenges of MOPH Staff Providing HTC Services at NGO Sites

Strengths	Challenges
• Sites are seen as safe spaces for MSM • Sites are known to some MSM • Committed staff and volunteers are sensitive to MSM health issues • Hours are more convenient • Services are more accessible (location) • Some staff/volunteers are willing and ready to do counseling and rapid testing • Confidentiality is maintained from government name-based system • People using sites for other services (drop-in center, Internet) may get an HIV test if HTC is easily available	• Space for HTC is limited • Not all MSM will want to identify with established NGO sites • Confidentiality within the MSM community is a concern—S&D are possible • Sustainability depends on long-term donor funding for staff costs, infrastructure, and commodities • QI and supervision are needed • Some government staff may be unwilling to be posted to an NGO site • Providing services has the potential for competition among NGOs • Government and NGO staff may distrust each other • Sites do not provide one-stop services for health needs • Additional funds are needed for additional staff and/or stipends for government staff working evening or weekend hours

KEY ISSUES FOR IMPLEMENTATION

In proposing the models discussed previously, key issues to be addressed at all demonstration sites were identified. These issues include:

1. *Procurement and logistics:* The procurement and supply chain system should be strengthened to avoid stockouts of supplies and test kits.
2. *Policy:* Several policies and policy areas need to be reviewed to increase access to HTC and care and treatment for MSM. These include the following:
    - Which staff are permitted to do HTC
    - How counselors should be selected
    - Hours of operation for sites to accommodate MSM
    - Alternative funding mechanisms to increase access to care and support services for poor MSM, because cost of non–ART-related care is out of reach financially for many MSM
    - The policy whereby people receive care where they reside as opposed to where they are registered. This policy makes it difficult for MSM who have migrated to Bangkok, Pattaya, or other cities to access treatment in these cities.
3. *Laboratory testing:* Several testing policies and regulations need to be addressed:
    - How HIV testing is conducted
    - Utilization of rapid tests
    - Testing algorithms
    - Who may conduct tests
    - Where testing takes place.
4. *Police/harassment:* Because MSM are often victims of police harassment, agreements are needed between security services and health services to ensure that outreach workers in parks, saunas, universities, and other public spaces will not be harassed and that MSM using HTC services will not be targeted. Coordinating activities and conducting educational meetings will help each group learn about the others' needs and concerns, and promote good will through understanding.
5. *Counselor selection and training:* Special attention should be given to selecting, training, and supervising counselors. Individuals with a particular sensitivity to the challenges and concerns of MSM should be given priority in selection.

6. *QI:* An explicit QI plan should be designed and in place from the beginning of implementation of the demonstration projects at all sites. Counselors should have regular refresher trainings, and client perceptions of service quality should be assessed periodically.
7. *Strategies to change norms about HTC:* Demand for HTC is low. The range and coverage of media and other behavior change communication channels, from the Internet to community-based discussion groups about the social network and gender norms that are barriers to HTC uptake, must be greatly expanded and sustained. Awareness must be raised about the availability of ART, coverage of ART under the NHSO 30 Baht Scheme, and access to other HIV-related services.
8. *S&D* Self-stigma among MSM and widespread S&D within health services and the community at-large must be addressed to increase service uptake.

The next section of this report summarizes a two-day stakeholder meeting held in Bangkok June 1 to 2, 2009. The meeting was held to explore in greater detail the findings from the situational analysis, develop potential models to roll-out demonstration projects in each province, and develop strategies to address the key issues for implementing the HTC models.

STAKEHOLDER MEETING REPORT

At the request of USAID/RDMA, a stakeholder meeting was held in Bangkok, Thailand, on June 1 to 2, 2009, with provincial stakeholders from Pattaya, Chiang Mai, Bangkok, Chon Buri, and Khon Khaen, as well as officials from the national MOPH and local international implementing partners. The goals of this meeting included the following:

1. Discuss the findings from the AIDSTAR-One situational analysis on promising programmatic practices and current status of HTC for MSM.
2. Develop a detailed understanding of current conditions in each province and the opportunities to introduce community-based, same-day, rapid HTC for MSM.
3. Develop plans of action at the provincial level for implementing community-based, same-day, rapid HTC for MSM, which USG plans to introduce in six provinces in Thailand.

The goals were accomplished over a two-day period. A detailed agenda for the meeting can be found in Appendix 2.

The meeting was conducted in Thai and English with consecutive translation as needed. Thirty-six participants representing NGOs, Thai national and provincial government officials, and USG staff and implementing partners attended the meeting on June 1. Twenty-five participated on June 2 (see list of participants in Appendix 3). Presentations were made by Dr. Kai Spratt, AIDSTAR-One, and the following presenters:

- Dr. Kathleen Casey, Regional Senior Technical Officer for FHI Thailand, Ph.D.: "UNICEF, WHO, and FHI HIV Counseling Resource Package for the Asia-Pacific: Implications for Training and Counseling in Community-based Settings for MSM"
- Mr. Danai Linchongrat, Director of RSAT: "Mapping of HIV Services and Coordination for Improved Strategic Planning of Global Fund Implementation: Example from Chiang Mai"
- Dr. Anupong Chitvarakorn, Director of DDC, GFATM Round 8 Principal Recipient: "Update on Global Fund Round 8 Budget Issues and Activities"
- Ms. Surang Janyam, Director, SWING: "Experience of Piloting the Gender-Based Violence Screening Tool for MSM in Pattaya"
- Mr. Panus na Nakorn, USAID/RDMA: "Mapping of Services Available for MSM in Each Province."

This section is organized according to the major activities on the agenda. It contains summaries of the discussions, outputs generated by participants during the working sessions of the meeting, and also includes the following:

1. Plenary on promising practices in HTC for MSM

2. Provincial reports on potential models for community-based, same-day, rapid HTC
3. Results of government and NGO discussions on the rationale for rapid testing in Thailand
4. Results on government and NGO discussions for key advocacy messages for HTC in Thailand.

DAY ONE ACTIVITIES

The following is a review of day one activities; several presentations were made:

- **Promising Programmatic Practices to Increase Access to HIV Counseling and Testing Among MSM**, Dr. Kai Spratt, AIDSTAR-One, Technical Advisor

  Summary: The promising programmatic practices table (see Table 1) was presented and discussed with participants.

- **UNICEF, WHO, and FHI HIV Counseling Resource Package for Asia-Pacific: Implications for Training and Counseling in Clinic and Community-based Settings for MSM**, Dr. Kathleen Casey, Senior Technical Office, FHI

  Summary: Dr. Casey presented a summary of the curriculum developed by the U.N. Children's Fund (UNICEF), WHO, and FHI for training health care providers in counseling MSM. The curriculum includes the *HIV Counseling Handbook* for counselor training and as a field reference; the *HIV Counseling Trainer's Manual* in modular form; a 28-item toolkit for HIV counseling that includes low-literacy client education sheets, counsellor education tools, and forms to facilitate casework planning; and training curriculum for counselors developed to recognize the complex psychosocial needs of MSM and TGs.

  The curriculum was developed based on a review of HTC services data from TRC and the Bangkok Municipal Authority, which showed that services were underutilized, counselors were unwelcoming to MSM and TGs, and service hours were inconvenient. The training curriculum's modular structure allows for training to be focused on the learning needs of various types of counselors and clients. The curriculum was piloted in China, Vietnam, India, Bangladesh, Pakistan, and Thailand. Results from the pilots are being incorporated into the curriculum.

- **Findings from AIDSTAR-One Situational Analysis of Thailand**, Dr. Kai Spratt, AIDSTAR-One, Technical Advisor

  Summary: Dr. Spratt presented a summary of the key findings from the situational analysis, including the following: 1) MSM want choices about where they go for services and who provides the services; 2) norms about testing among MSM need to change; 3) awareness about ART is minimal, which contributes to reluctance to be tested for HIV; and 4) flexibility among government and NGO players will be needed to ensure success of community-based HTC for MSM.

  A lively discussion about the pros and cons of HIV testing followed the presentation. While the MOPH staff were very supportive of improving access to services for MSM, it was not clear to some of the MOPH participants why few MSM were seeking HIV testing when there are benefits to knowing one's status, including receiving treatment. One MOPH participant said she felt that if networking and referrals were improved, more people may be willing to get tested. Participants from the NGO sector shared their perspective, saying counselors often do not see

the client's side of things and do not realize the fear and problems MSM have if they are infected with HIV. S&D are still very strong.

Simple things could be changed in health care settings to make it more comfortable for MSM. For example, when registering at the clinic, clients currently must state the reason they have come to the clinic; this information is best shared with the doctor, not in an open waiting room. Other NGO participants expressed concern about the lack of confidentiality and anonymity in the clinic. MSM are already stigmatized in Thai society as "spreaders of the HIV virus," as one NGO staff member commented. Because of stigma, there is fear. MSM do not yet know how to live as PLWH and are not sure how their quality of life will change if they are infected with HIV. One NGO participant said, "Stigma and discrimination is beyond the control of individual counselors; it is within society. We have not yet overcome what society has to say about us."

This discussion led to the topic of communication about HIV to the MSM community and widespread misinformation. Social norms and values about HIV make it difficult for MSM to get complete answers about HIV, and there is a need for social support. One implementing partner participant noted that the availability of care and support after HIV testing is still very limited, and a lot of planning is needed to maintain services after the GFATM award ends. Health care providers discussed the lack of access to training and standardized manuals. One senior MOPH participant summed up the situation with the following: "If we can use the same standards of counseling and HIV testing in the clinic and community, we can work together more strongly."

- **Update from the GFATM Round 8**, Dr. Anupong Chitvarakorn from the DDC, Thai MOPH, principal recipient for the GFATM Round 8 award

  Summary: Dr. Anupong Chitvarakorn reviewed the status of preparation to implement GFATM activities, including supporting social networks, changing social attitudes, and reducing S&D. He noted that there is a general counseling curriculum on HIV testing available from the government but it does not contain any text specific to MSM. He also noted there is funding in the GFATM budget for STIs and for training.

- **Update from National Health Security Office**, Dr. Sorakij Bhakeecheep, Manager, AIDS Office, Bureau of Disease Management, NHSO

  Summary: Of special significance was the participation of Dr. Sorakij Bhakeecheep, who kindly agreed to make a few remarks. He discussed the status of the national health budget and implications for health services and took questions from participants about NHSO support for community-based rapid HTC. This was the first time Dr. Sorakij Bhakeecheep had attended a meeting with NGOs on the issue of counseling and rapid HIV testing for MSM. He noted that many stakeholders are vying for the national health budget, which has been affected by the economic downturn, and that there will be winners and losers in the final budget process. He noted also that health care providers needed more training and incentives to provide better services. Health care providers need more than an increased salary, he emphasized: they wish to advance in their careers and increase their status in the health care system. Unfortunately, it is beyond the NSHO purview to change the current policies in this regard.

  Dr. Sorakij Bhakeecheep agreed with a participant that the burden of data collection is too high and that NSHO is developing a more user-friendly data form that will include only parameters that are reimbursable. He concluded by saying that he is not opposed to peer counselors providing HTC; the important issue is that they are trained appropriately. If peers can become certified, he did not see a problem with them working in MOPH clinics.

- **Provincial Reports on Potential Models for Community-based Same-day Rapid HTC for MARPs**, Dr. Kai Spratt, AIDSTAR-One, Technical Advisor

  Summary: Dr. Kai Spratt made a presentation on the tools and issues that need to be considered for the implementation of HTC models at these demonstration sites. MOPH and NGO participants were divided into groups by province and asked to work together to think about the resources (financial, human resources, NGOs, government staff) available in their province for implementing community-based models of same-day, rapid testing for MSM. Flipcharts with templates of Tables 4 to 10 were given to each province-specific team. They were instructed to brainstorm on the issues, analyze the strengths and weakness of any proposed models, and outline strategies for addressing the implementation challenges. Tables 4 through 10 are taken from the flipcharts filled in by each team; not all topics were covered by all groups.

  First, participants were asked to list the current HTC and service providers in their province, potential new partners these providers could work with, and the model (or models) for HTC service delivery. Next, participants completed a chart summarizing the strengths and challenges of their proposed HTC model(s). Finally, participants summarized the critical issues that would need to be addressed to implement the model(s) and the agencies and organizations with the mandate or responsibility to ensure the model(s) was implemented.

  All text in the following charts is direct Thai to English translation.

  1. Bangkok/Kohn Khaen

     Only one participant from Khon Khaen attended, so he joined the group that included staff from Bangkok municipal government clinics and hospitals. In Bangkok and Khon Khaen, the public sector and a number of private providers currently provide HTC services. In a number of cases they work with NGO partners that promote these services. This group proposed to improve partnerships with MSM-focused NGOs, CBOs, medical facilities, and media to promote use of HTC services. The model proposed by this group involved sending MOPH staff to MSM-focused NGOs where MOPH staff would provide HTC services.

Table 4. Bangkok/Khon Khaen: Current Providers, Potential New Partners, and Models

Current Providers	*Potential New Partners*	*Models*
1. **Government clinics and hospitals** provide testing with results in one week. Key providers include the Bangkok Municipal Authority, MOPH, and some other government organizations. 2. **Private providers** deliver testing with results in one week.	• Lab and technical partners • NGOs: outreach and support groups • Bar owners • Karaoke • Sex establishments • Hospitals (referral for ART) • Press/media • Private organizations • Other government organizations	• Government providers—delivering in-house and mobile services • Working with NGOs to promote services and refer • Referral to government hospitals for ART • Training in counseling from technical partners • Laboratory training from technical partners
Proposed Models for use in this Region:		
• Government providers should continue to deliver current services at MOPH sites • Government-trained NGO staff to provide counseling services • NGO staff work with government medical teams to provide services		

Table 5. Bangkok/Khon Khaen: Strengths and Challenges of Model

Sector	*Strengths*	*Challenges*
Government provider	• Government providers are considered sustainable as they are low-cost and good-quality, one-stop service options • Confidentiality is high • Opportunities are available for staff training	• Clinics hours are not convenient • Wait times can be long • Service providers' attitudes toward MSM may be problematic in some circumstances
CBOs	• Are considered MSM friendly • Have flexible hours and can open outside working hours • Are good for confidentiality	• Need long-term support • Staff need training in service provision • Need good referral networks with government and NGOs • Need resources for clinic facilities, space, and staff

Table 6. Bangkok/Khon Khaen: Critical Issues and Responsible Agencies to Implement Community-based HTC Models

Creating Demand for Testing	***Those Responsible***
There was agreement that a range of strategies and sites should be used to encourage testing among MSM, including: • Outreach strategies and drop-in center promotion • Internet promotion through gay websites • Mass media campaigning for checkups more generally • Targeted media for promoting HTC and STI testing for MSM • Business and bar owner promotion and targeting • Enabling an HTC clinic environment that is confidential, friendly, and has a warm staff that provide high-quality services	Implementers responsible were listed as follows: • NGOs • MOPH • Media partners • Business owners • Clinics and hospital staff and management
Procurement and Logistics	***Those Responsible***
Supply management was raised as a significant issue for ensuring speedy access to test kits as well as condoms and lubricant.	Implementers responsible were listed as follows: • NHSO • GFATM (STI cluster) • USAID • Service providers in hospitals and clinics
Policy	***Those Responsible***
• Policy to support and establish after-hours clinics is required • Policy to support better counseling services for HTC • Documented referral system • Statement in support of testing • Incentives for staff to become HTC counselors • STI policy	Implementers responsible were listed as follows: • MOPH • NHSO
Police/Harassment	***Those Responsible***
• Memorandum of understanding (MOU) with law enforcement • Training of uniformed personnel that includes sensitization to the issues affecting MSM and TG people to facilitate HIV testing	• MOPH • Office of the Prime Minister • Justice Department • Office of Human Rights

Counselor Selection and Training	***Those Responsible***
• National Counselor Training Program	• Office of Mental Health • MOPH • PHO • Hospitals and clinic staff and management • CDC • AIDS Cluster
QI	***Those responsible***
• Refresher training on counselor and service provision in relation to HIV • Lab quality assurance programs and assessment • Service quality assessment and evaluation systems • Client satisfaction surveys with reporting mechanism to stakeholders	• Counseling (same as above/lab CDC) • NSHO • External auditing • Clinic, hospital sites
Behavior Change Communication	***Those Responsible***
• Create demand for testing • Develop an HTC curriculum for outreach staff in CBOs	• FHI and TUC
S&D	***Those Responsible***
• Sensitivity training for service providers • Gender-based violence • Social sensitivity	• TUC and Bangkok AIDS, TB, and STD Services • Office of Human Rights

2. Chiang Mai

Government clinics and hospitals (e.g., Tour Pai Hospital) as well as a range of nongovernment and private providers (e.g., TRC) currently deliver HTC services in Chiang Mai province. NGO partners work to promote these services across MSM communities and networks. Participants proposed to develop an improved network of collaboration between government, NGO, and private organizations to both promote HTC and deliver holistic services across the province.

Table 7. Chiang Mai: Current Providers, Potential New Partners, and Models

Current Providers	***Potential New Partners***	***Models***
1. **Government clinics and hospitals** provide testing with results in one week—key providers include MOPH and some other government organizations. 2. **Private and NGO providers** deliver testing with results in one week including the TRC Anonymous Clinic and the PIMAN Center.	• Thai Network of HIV-Positive People/United Nations • Research Institute • Chiang Mai University	Collaboration between government, CBOs, private orgs, and NGOs Referral and shared service delivery of clients was the goal. • **Government providers** receive client referrals from the range of partners and deliver inpatient, outpatient, and mobile services and then refer out to other referral agencies in the network of services. • **NGOs/CBOs** receive referrals from government providers and deliver outreach, social, education, and support services; and refer to government hospitals, hospital services, and others in the network.
Proposed Models for Chiang Mai:		
• Government providers should continue to deliver current services • CBOs working with government medical teams to provide services at NGOs as well as trained NGO staff providing counseling services • Private and NGO services continue to deliver HTC		

Table 8. Chiang Mai: Strengths and Challenges of the Model

Sector	***Strengths***	***Challenges***
Government provider	• Sustainable service system • Strong management systems • Provides free service to Thai citizens • Good referral systems • Personnel and human resources is a strength of the government provider system • Strong faith and confidence in medical services	• Waiting times for service and results are a problem • Staff numbers are not sufficient to deliver speedy service • Personnel do not have confidence in CBOs • Personnel do not have the skills to ask questions and deal with the answers
Community-based NGOs	• Able to provide services at appropriate and convenient times • Friendly • Fast • Like home • Provide a range of services, not just HTC • Voluntary services are welcoming and supportive • Able to provide services for particular subgroups as required	• Limit on number of clients that can be supported—unmet need • May not be sustainable service systems, given resources • Frequent staff turnover • May not be strong faith and confidence in services provided by the community • One-stop services may not be desirable or easy to establish • Individuals may not wish to disclose in these environments and may not wish to be treated in these environments • NGOs get hit with funding reductions that can affect their capacity to deliver services

Table 9. Chiang Mai: Critical Issues and Responsible Agencies to Implement Community-based HTC Models

<table>
<tr><th>Creating Demand for Testing</th><th>Those Responsible</th></tr>
<tr><td>• Need to create an understanding of the benefits of testing, the convenience of rapid testing, and an understanding that it is safe for people and that the environment of service delivery will be sensitive and supportive
• Outreach is a particularly effective way to promote rapid test HTC services as a new service that MSM can utilize
• A communication strategy should be developed providing a range of different strategies to promote HIV testing
• Target particular subgroups of MSM to get to this information out
• Develop a system of support including social groups, support groups, and referral systems</td><td>Implementers responsible were listed as follows:
• CBOs/NGOs in the particular area
• Government
• Hospital systems
• Service providers in HIV (i.e., provincial AIDS Network)
• Other networks such as radio and television</td></tr>
<tr><th>Procurement and Logistics</th><th>Those Responsible</th></tr>
<tr><td>• Need space to provide services
• Need personnel to provide services
• Equipment ready and available, suitable and up-to-date
• Safety and quality measured/assessed
• Procedures documented and followed
• Group work/group service</td><td>• Medical professional networks and groups in the province of service delivery
• CBO and NGO networks and groups in the province of service delivery
• NGO
• Government
• Hospital systems</td></tr>
<tr><th>Policy</th><th>Those Responsible</th></tr>
<tr><td>• Health services need articulated policies to provide services to MSM
• Provincial policy statement in support of MSM
• Policy for coordination and working together
• Specific laws and regulations
• Exerting pressure where needed
• Opinions/views of policymakers are important</td><td>Implementers responsible were listed as follows:
• CBOs/NGOs
• Government
• International NGOs
• MSM community and groups
• CBOs (e.g., subdistrict administration office/provincial administration office)
• NSHO
• Office of Human Rights</td></tr>
</table>

Police/Harassment	*Those Responsible*
• MOU with law enforcement • Training of uniformed personnel, including sensitization to the issues affecting MSM and TG people to facilitate HIV testing with the goal of changing attitudes • Circle/network of exchange between police and service providers • Coordinate to deliver effective HIV health service in the region—demonstrate to the community cooperative partnership between police and MSM community	• Superintendents in each area • Provincial Public Health Office • Ministry of Social Development and Human Security • Office of Human Rights • NGOs/CBOs
Counselor Selection and Training	***Those Responsible***
• Manage the qualifications for counselors • Manage service standards • High standards and quality of curriculum and study materials for training counselors • Excellent supervision and system of support for counselors as well as ongoing training • Documented procedures for selecting counselors for HTC • Development program for personnel	• Government • Hospital system • AIDS organizations

3. Pattaya/Chonburi

Only one participant from Chonburi was able to attend the meeting and worked with the participants from Pattaya. In both provinces, government clinics and hospitals as well as a number of private providers currently provide HTC services. In a number of cases, they work with NGO partners to promote these services. Participants proposed to strengthen the partnerships between MSM organizations, CBOs, medical facilities, across government, and with media to promote better utilization of HTC services. The participants' model included the continued use of government services along with NGO organizations providing some HTC services, with assistance of government medical staff seconded at MSM-focused NGOs. This group completed only the first exercise on the proposed model.

Table 10. Pattaya/Chon Buri: Current Providers, Potential New Partners, and Models

Current Providers	*Potential New Partners*	*Models*
1. **Government clinics and hospitals** provide testing with results in one week—work closely with Sisters to promote and deliver services. 2. **NGOs** work to promote HTC services. 3. **Private providers** deliver testing with results in one week. 4. **Private health organizations**, such as the Armed Forces Research Institute of Medical Sciences, deliver HTC and STI services.	• PLWH networks • Community and family • Labor division • Human rights organizations and sector • Activity on prevention by CBOs • Bar owners • Pharmacies	• Peer outreach/network • Hotline/website and information, education, and communication programs • Mobile clinic programs—although these tend to have a time limitation • Midnight clinics • Referral to other services

Mr. Panus na Nakorn of USAID/RDMA then remarked on the critical issues summarized by the participants. He noted that when participants return to their province, they may need to revise their list of critical issues and the agencies that are responsible, based on conversations and meetings with colleagues. He recognized that across all the provinces, similar themes emerged from the discussions and that all provinces would have to address these themes in their planning to implement the demonstration projects. He also stressed that participants should be cognizant of the challenges and disadvantages that can be associated with implementation of particular HTC models, and they need to understand how to work to overcome challenges and respond effectively. He remarked that this meeting was a good starting point for learning about and initiating activities related to HTC services for MSM.

DAY TWO ACTIVITIES

The following is a review of day two activities; two key presentations were made:

- **Experience of Piloting the Gender-Based Violence Screening Tool for MSM in Pattaya**, Ms. Surang Janyam, Director, SWING, and Dr. Kai Spratt, Technical Advisor, AIDSTAR-One

  Summary: Dr. Kai Spratt and Ms. Surang Janyam presented an example of good government NGO collaboration in Pattaya. SWING, in collaboration with the PHO and USAID's Health Policy Initiative, developed and pilot tested a tool for public health clinic staff to screen MSM for gender-based violence.

- **Mapping of HIV Services and Coordination for Improved Strategic Planning of Global Fund Implementation: Example from Chiang Mai**, Mr. Danai Linchongrat, Director, RSAT

  Summary: Mr. Danai Linchongrat made a presentation on mapping of HIV services and coordination for improved strategic planning of GFATM implementation. He also discussed the first mapping exercise done in Chiang Mai province. He explained that networks between the PHO and NGOs already existed in Chiang Mai but efforts were underway to strengthen the

networks for better services to be delivered to MSM. The mapping exercise looked at the range of services provided across the province, how to use resources in each province, how well health care providers understood MSM concerns and needs, and the context for MSM services (e.g., do policymakers in the province understand MSM issues? How good is the referral network? Does each member organization in the referral network understand the others' roles?).

In Chiang Mai, services are more developed than in other parts of Thailand. The province is ready to expand MSM services, and all international and local partners are involved in expanding these services. The mapping exercise was guided by four objectives: 1) map the activities of HIV services; 2) find ways for these services to support each other; 3) identify technical capacity-building needs for MSM/TG organizations; and 4) support planning processes. The mapping exercise also helped to identify gaps that need to be filled. The expected outcomes of the mapping exercise are to identify gaps in services; map all NGOs and service providers by service, referral, and training; and identify specific services for MSWs, TGs, and MSM.

Mr. Danai shared that one of the first impressions he had from the mapping exercise was that there was some overlap of implementing partners' activities. One of the next steps, he said, is to initiate talks with partners to divide tasks, get additional details that may have been missed, and gather data on interventions, which will allow the partners to see the entire picture. Minutes will be recorded at all meetings and compared with official minutes, because at times they differ. The spirit of the collaboration approach is not to divide implementers by type (NGOs, private provider, etc.), but by activities. Mapping was done in Bangkok on June 15, in Khon Khaen on June 23, in Udon Thani on June 24, and in Phuket on June 29. Nine more provinces are scheduled to be mapped in the coming months.

Given the issue of HTC service uptake that arose on Day 1 of the meeting, participants were divided into two teams: NGO participants and MOPH participants. They were asked to brainstorm on communication strategies to increase the uptake of HTC services by MSM and to identify the organizations that could support message development and dissemination. The results are presented in Table 11.

Table 11. General Communication Strategies to Increase Uptake of HTC by MSM

Creating Demand for Testing	*Those responsible*
• Develop public relations strategies such as advertisements on relevant websites and peer education • Set key messages for changing attitudes • Provide training on "rapid testing" for MOPH, TUC, PHO, CDC, and Midnight Clinic	Implementers responsible were listed as follows: • NGOs • Government • Peer/community groups • Pharmacies • Education services and schools/premises • Other opportunities (e.g., websites)

Procurement and Logistics	***Those Responsible***
• Promotion by USAID for first three months; Pattaya's role after this	Implementers responsible were listed as follows: • USAID, AIDSTAR-One • GFATM • Government • NGOs • Other agencies
Policy	***Those Responsible***
• Establish a local policymakers forum: "How to Promote Rapid Testing" • Train health care providers in sexuality, gender, and stigma in order to change attitudes and support testing • Train employees in NGOs and local government • Organize a local network to consider how to improve blood testing and blood testing practices	Implementers responsible were listed as follows: • CDC • NGOs • Peers
Police/Harassment	***Those Responsible***
• Meeting • Training • Establish a group or center to monitor violence and harassment toward MSM in the province • Provide a support network for police who are MSM to monitor difficulties in relation to MSM	• Police • Government officers • Government • NGOs • Health • Law enforcement more generally
Counselor Selection and Training	***Those Responsible***
• Develop a national counselor training program • Manage the qualifications for counselors • Manage service standards • Monitor and evaluate the outcomes of counseling activity	• Government • NGOs • USG • GFATM

QI	***Those Responsible***
• Establish a circle/group for sharing learning • Update techniques and methodologies • Provide training/refresher training and retreats • Collect data on service delivery numbers • Set priorities for the service delivery • Establish examination systems for counselors and have them evaluated by persons outside the service system/independent from the system	Not completed.
Behavior Change Communication, Including Media	***Those Responsible***
• Working group to develop information, education, and communication materials • Promotion products for HIV testing • Target particular subgroups of MSM	• Government • NGOs • USG • MSM • Peer/community groups • Places where people assemble/gather
S&D	***Those Responsible***
• Training on S&D reduction for community leaders • Care conferencing • Campaigning and events aimed to raise awareness and reduce stigma	• Community • Government • USG • NGOs • Office of Human Rights
Other Issues	***Those Responsible***
• Budget • Coordinating and managing the work of those responsible	• Community • Government • USG • NGOs • Office of Human Rights

MSM ARE NOT BEING TESTED: WHY?

In the review of findings from the situational analysis, the issue was raised of changing norms among MSM to seek HTC. Government staff from Bangkok expressed concern that MSM were not getting tested but noted that they were not sure why, given the perceived benefits of knowing one's status. A lively two-way dialogue ensued between NGO participants and government staff. NGO participants explained the benefits and risks of getting tested for HIV from the perspective of MSM. The discussion was respectful, with many people asking questions and offering comments. To build on the momentum from this discussion, participants were asked to brainstorm about what kinds of messages they could deliver to PLWH and to people not living with HIV. MOPH staff and NGO staff formed separate groups to develop messages. Each group could arrange messages as they thought appropriate. The MOPH messages are summarized in Table 12; the NGO messages are summarized in Table 13.

Table 12. MOPH Staff Messages for MSM

For Persons not Living with HIV	*For PLWH*
• Free/social security/universal health care system • Can help individuals plan their lives • Can help to reinforce the need to protect oneself from illness and disability • Help for family and partnership planning • Can help to reduce stress and anxiety related to HIV • Can improve psychological health • Can help to support thinking about self-care • Can provide opportunities for career and vocation • Can help to know status after situations where sex is coerced/forced • Prevention and protection	• Can help in partnership and with families to know HIV status • Help to diagnose those living with HIV-related illnesses or symptoms to know they are HIV-positive • Can help in particular professions to know HIV status • Can help in situations of employment in teamwork • Family • Testing for clinical procedures and surgery • Entering provincial government • Can help in serodiscordant relationships to understand risk • To know you have not put yourself at risk • For people who think a lot of about whether they are positive, it can be good to know • Antenatal care

Table 13. Nongovernment Participants Messages for MSM

Benefits of Testing	Concerns About Testing
For the Nation	
Current HTC Programs • Calculate the future treatment needs of the population • Prepare plans for the future care of the population • Economic planning for the future HTC service delivery required • A generally truer and more reliable picture of the epidemic from testing Future Rapid HTC • Patients who receive results can be fairly sure of their accuracy • Can provide a more accurate picture of the status of infection in the country • Can provide a more accurate picture of the human resource needs of HTC work	Current HTC Programs • Financial cost for the Thai government in delivering results and testing • Not enough ART in the country for the estimated number of PLWH • Condition of state services not sufficient to provide the level of care and support needed • Human rights and the usefulness of treatment and care are still not clear in the country Future Rapid HTC • Currently no systems or basis for providing advice and information about rapid HTC • Increased burden on nursing personnel • Not enough health personnel to engage in rapid HTC
For the Community	
Current HTC Programs • Can follow areas of high prevalence for HIV • Can prepare plans for service and activity in the future • Reduce infection rates in the community • Can prepare and plan support services Future Rapid HTC • Can prepare plans for future service and activity • Community is able to prepare and participate in support and education • Reduce infection rates in the community	Current HTC Programs • Responsibility and burden on nursing personnel • Prejudice and discrimination are high • Prevented from the range of choices in education and employment Future Rapid HTC • Difficulties maintaining confidentiality • Prejudice and discrimination among the community may be fostered • Potential reduction in social rights (e.g., prevented from public service exams for employment in the public service, such as local government) • Family difficulties • Loss of income (due to regularly seeking services for treatment and support) • Reduced options for employment and education • Finding medical and support personnel to support MSM may be difficult

Benefits of Testing	Concerns About Testing
For the Individual	
Current HTC Programs • Clearly and surely know the results of your HIV test • Have time to prepare for the result Future Rapid HTC • Can know quickly and be treated quickly • Calculate the cost of treatment and care for opportunistic infections • Calculate the cost of ART • Able to protect others when HIV status is known • Reduce the time of anxiety and not knowing the result of the HIV test • Have time to plan for your life • Reduce the cost of travel	Current HTC Programs • The result takes a long time • Stress and anxiety • Cost is prohibitive for some MSM • Loss of time • Testing can be provided close to sites that provide HIV ART Future Rapid HTC • Fear rejection by partners • Terminated employment • Feeling and emotion in crisis • No time to prepare yourself • No time to prepare your family • No time to adjust in the environment

ADVOCACY AS A STRATEGY TO SUPPORT HTC AND OTHER SERVICES FOR MSM

On Day One, the need for advocacy skills emerged as an unexpected theme. Government and NGO participants could benefit from developing advocacy skills to engage peers in the community and government, to promote their interests, address discriminatory or ineffective policies, and secure long-term funding for MSM services.

On Day Two, AIDSTAR-One and USG participants decided to introduce a short presentation on the basic components of advocacy to the participants and gave them time to begin crafting basic advocacy messages. Dr. Spratt, from AIDSTAR-One, presented basic advocacy principles and skills, followed by a short question-and-answer session. Participants were then divided into groups by NGO or MOPH and asked to brainstorm on advocacy messages for their peers around implementation challenges for community-based, same-day rapid HTC for MSM. The messages developed by each group are presented in Tables 14 and 15.

Table 14. MOPH Participants Key Advocacy Messages

Creating Demand for Testing

- Generally, know early and treat, be prepared
- Provides an opportunity for government services to prepare and be prepared
- HIV testing should be promoted through all parts of society—through communications and through community organizations
- Our services need improvements for PLWH and MSM

Procurement and Logistics

- You are an important part of the service system that can help preserve and improve the system of service
- Providing enough continuous support for quality service delivery
- We are on the same team

Policy

- Evidence-based policy
- Rapid testing will help to prevent HIV more easily and reduce the level of resources required in the response
- Knowing HIV status will help with planning and with knowledge of HIV infection in the country

Police/Harassment

Coordinate, work together, and get support from police to create better health

Counselor Selection and Training

The hospital service is known for its quality of service delivery and needs to improve and maintain that reputation

QI

- QI can reduce the stress and time of service provision
- QI can help to reduce risk and protect from problems that can emerge in providing services

Table 15. NGO Participants Key Advocacy Messages

Creating Demand for Testing

- Know quickly, know for certain, have better health
- Know quickly, treat immediately, have better health, have a longer life
- MSM community can know and understand HIV statistics collectively
- MSM will know what their needs are, services they need quickly and can get conveniently, and will not waste time waiting for services and results

Procurement and Logistics

- More development and modern procedures and systems
- Improved quality of services and systems
- Creating more choices in testing
- Less time to provide services

Policy

- Policy that can provide better and more reliable information
- Can plan for resolution of problems clearly and precisely
- Rapid testing will help to reduce rates of infection
- Reduce the burden of work
- Improve the quality of health and life for the entire country

Police/Harassment

- Have a role to increase understanding among police and other uniformed personnel
- Can maintain and protect health
- Can monitor rates of infection

Counselor Selection and Training

- MSM volunteers better understand the situations of other MSM in the community and can develop strategies for maintaining health and well-being
- Reduce burden and stress of work for current nursing and counseling staff

QI

- Improve the quality systems for evaluating the standards of service delivery
- Involve collaboration from many different parts of the HIV response

Behavior Change Communication, Including Media

- Provide information that increases awareness and understanding that rapid testing will improve the quality of the community and individual; distribute and disseminate this information widely among MSM

UNANSWERED QUESTIONS

Before the meeting adjournment and closing remarks by Dr. Cameron Wolf, several unanswered questions were identified, including the following:

- How can government-based services be engaged to address MSM issues so that services will be improved and sustained in the long-term for MSM?
- What targets should be set for quality of life for MSM?
- What strategies need to be developed or implemented for reaching "hard-to-reach" MSM with HTC services?

The meeting adjourned after two full days spent developing models, outlining strategies to address implementation challenges, drafting messages to change norms around HIV testing, and advocating for broad-based support for MSM-focused, community-based, rapid HIV testing.

MONITORING AND EVALUATION PLAN FOR THE U.S. GOVERNMENT TESTING AND COUNSELING DEMONSTRATION PROJECT

AIDSTAR-One was asked by USAID/RDMA to develop a draft an M&E plan for the roll-out of a USG-sponsored demonstration project on community-based HTC models for MSM. AIDSTAR-One proposes an implementation-focused components evaluation (IFCE; Patton 2007) conducted at the demonstration and pilot sites because:

- Focusing on implementation issues helps in the collection of data that is useful to policymakers in expanding or renewing programs.
- Ideally, the community-based HTC demonstration sites will be implementing some of the identified promising practices that will allow for comparing promising practices components across sites. The unit of analysis will be the components of the program/practice, not the program itself.

The IFCE M&E plan is distinct from the "Core Indicators for MSM services in Thailand" developed by and for USAID/RDMA implementing partners providing prevention, treatment, and care and support services. The Core Indicators are quantitative and track outputs such as the number of new individuals reached, the percentage of MSM who received an HIV test in the last 12 months and know their HIV status, and the number of health promotion materials distributed.

The IFCE indicators are focused on collecting data that answer the following questions:

1. Were the selected model(s) implemented in each province as planned?
2. What issues surfaced during implementation that will need attention in the future?
3. Did the model(s) reach the goals of the province?
4. What changed during the implementation process to address problems that arose? Did these changes improve outcomes?
5. How were program goals and methods adapted to suit the needs and interests of the local staff? In which programs did the staff change to meet the project's requirements?
6. How did the program adapt to meet the needs of the program users?

The indicators in the IFCE plan are *suggested* and are meant to capture information about each component of the HTC models. This evaluation plan is the first step in a process of engagement with in-country stakeholders to clearly define each indicator, as well as to reduce the overall number of indicators, if appropriate. The engagement process will ensure that each component is monitored, each indicator has validity, and the metric for measuring each indicator is Thai-specific and objective.

The IFCE M&E plan includes quantitative and qualitative data that should be collected at all demonstration sites to track the process of implementation, not the outputs of services and other interventions. The IFCE has the following three stages:

1. Effort Evaluation Stage: the first six months of project implementation.
2. Process Evaluation Stage: months 6–18 of the project; data is collected to answer the question, "What is happening and why?"
3. Summative Evaluation Stage: months 19–24 of the project; data is collected to determine if the provinces implementing the HTC models reached the desired goals.

Ideally, the data will be collected and analyzed by an outside organization or research group. Tables 16, 17, and 18 are divided into two sections: quantitative data and qualitative data.

Quantitative data provide indicators that are meant to compliment the Core Indicators and should be collected at the same time as other USG program data or as noted in each table. For example, one Core Indicator is "Number of new individuals reached." To understand which individuals are being reached, the IFCE M&E plan asks implementers to disaggregate the data by MSM, TG, and MSW.

Qualitative data focus on implementation processes that cannot be captured with quantitative data. For example, one of the components of good practices of HTC for MSM (see Table 1) is, "Services are provided in an environment acceptable and accessible" to MSM. To know if services are acceptable, or how they could be improved, open-ended qualitative data would be collected from users of the HTC services (see Table 16). While the amount of qualitative data looks extensive, keep in mind that the overall number of sites in each province will be limited and that not all questions will have to be answered. Which questions are appropriate will depend on the site and the progress each site is making toward implementing the model(s). In total, there will be four qualitative data collection points: months 6, 12, 18, and 22.

It is expected that the data will help to answer the following questions:

- To what extent was/were the model(s) feasible in this province? To what extent was it not feasible? Why?
- How stable and standardized has the implementation of this model been over time?
- To what extent is each of the models amenable to implementation elsewhere? What aspects are situational to the particular province? Which aspects can be generalized?
- What has been learned in implementing this model in this province that might inform similar efforts elsewhere?

In the near future, USAID/RDMA and CDC will determine which components of this M&E plan will work best for monitoring the rollout of the demonstration HTC sites in their respective

provinces. At the request of the USG team, AIDSTAR-One will be available to support those efforts with additional technical and strategic planning assistance as needed.

PROPOSED IMPLEMENTATION-FOCUSED COMPONENTS EVALUATION

Table 16. Effort Evaluation Stage (first six months of demonstration project implementation)

A. Quantitative Data

New indicators should be incorporated into existing service logs, counselor logs, training reports, and quarterly reports. Data will be collected every quarter or per routine for USG programs.

Promising Practices Component	***Indicator***
1. Testing Approach	1. Proportion of individuals who received HTC and received their results from HIV rapid testing disaggregated by MSM, MSW, and TG 2. Number of individuals tested by type and site disaggregated by MSM, MSW, TG, and site (government clinic, NGO, drop-in center) 3. Percentage of counselors at site who are from the same peer group as clients, disaggregated by kind of site (i.e., NGO, MOPH)
2. Outreach	Only Core Indicators used.
3. Quality	1. Number of stockouts of any commodity needed to do HIV counseling and rapid testing per quarter 2. Percentage of sites with a protocol for HIV rapid testing procedures 3. Percentage of sites with a protocol for HIV pre- and post-test counseling
4. Training and Supervision	1. Number of individuals trained to provide counseling disaggregated by NGO, government, and private sector 2. Number of individuals trained to provide rapid HIV testing disaggregated by NGO, government, and private sector 3. Number of HTC supervisors trained 4. Number of counseling observations per supervisor per quarter
5. Linkages and Referrals	1. Percentage of clients who received referral disaggregated by kind of service (prevention, treatment, care and support services) 2. Number of quarterly meetings attended by at least 75 percent of stakeholders in referral network per province

6. M&E	1. Are data on service delivery and usage reviewed every quarter by a supervisor? (Yes/No) 2. Are data on service delivery and usage reviewed every quarter by staff? (Yes/No)
7. Government/NGO collaboration	1. Number of consultative meetings per quarter held between NGO, government, and private sector 2. Number of MOUs or standard operating procedures signed between government, NGO, and private sector 3. Percent increase in government budget dedicated to support NGO outreach and testing services since pilot project started

B. Qualitative Data

Collected at month six through in-depth interviews or as indicated with government/NGO staff and volunteers, and client exit interviews

Promising Practices Component	***Indicator***
1. Testing Approach	1. Clients' satisfaction with HTC experience (exit interviews). 2. Is ongoing supportive counseling available to all clients? (Yes/No) If no, why not?
2. Outreach	1. What kinds of outreach activities are being conducted for MSM, MSW, and TG (e.g., one-on-one, small group sessions, and bar-based sessions? 2. How were outreach workers trained to change norms around HTC? How do norms around testing seem to be changing? If no change, why not? 3. How were MSM involved in developing outreach activities/materials? 4. What are the characteristics of clients using the services? (Are they representative of MSM and TG in this province/town?) 5. What are the target areas for outreach activities? Do the areas extend beyond the high-profile tourist areas? If yes, how was the area targeted? If no, why not? 6. How are public information campaigns explaining the benefit of early detection of HIV in the absence of symptoms? 7. How are activities/outreach activities targeting non–gay-identified MSM?

3. Quality	1. Was the counseling training curriculum adapted to cover the concerns and issues of each MARP? If so, how was this done? If not, why not? 2. Are counselors guiding individuals to develop risk reduction plans? 3. Are the qualifications of staff appropriate? 4. What is the staff-to-client ratio? Is it appropriate for the site? 5. What is the counseling turnover rate? Why is turnover happening? 6. If stockouts are occurring, why is it happening? What steps have been taken to correct the situation? 7. Is there a process (staff meeting, suggestion box) for counselors to provide feedback and express concerns or issues? 8. What actions are being taken to improve quality?
4. Training and Supervision	1. Has staff retained knowledge on HIV testing and protocol (pre-test, immediate post-test comparison; three-month post-test comparison)? 2. After training, was each new counselor mentored by a more experienced counselor? If no, why not? 3. How satisfied are staff/volunteers with the training they received (survey three-month post-training)?
5. Linkages and Referrals	1. Which organizations have agreed to routine communication to keep linkages and the referral network up to date? What have been the factors that have encouraged them to participate in linking services? 2. What/Who is the coordinating body of the referral network? What obstacles or barriers have they encountered with the referral network? 3. Which organizations are missing from the referral network? Why? 4. What criteria are used by counselors to make a referral? 5. How are organizations within the referral network working together to strengthen their coordination? 6. What kind of regular feedback does the HTC site get on referrals made?
6. M&E	1. How is consent being monitored? 2. How is counseling being monitored? 3. How is confidentiality being monitored? 4. How is data used to improve services?
7. Government/NGO Collaboration	What are some examples of government/NGO collaboration?

Table 17. Process Evaluation Stage: What is Happening and Why? (months 6–18)

A. Quantitative Data

The majority of the indicators are the same as those in Table 16. The indicators in bold reflect a change from Table 16 indicators.

Promising Practices Component	***Indicator***
Testing Approach	Same as Effort Evaluation
Outreach	**Number and kind of outreach materials revised**
Quality	Same as Effort Evaluation
Training and Supervision	Same as Effort Evaluation
Linkages and Referrals	Same as Effort Evaluation
M&E	Same as Effort Evaluation
Government/NGO Collaboration	**Percent increase in government budget dedicated to support NGO outreach/testing services (reported annually)**

B. Qualitative Data

Revised indicators are shown in bold. Collected at months 12 and 18 through in-depth interviews with government, NGO, private sector staff and volunteers, and client exit interviews.

Promising Practices Component	***Indicator***
Testing Approach	Same as Effort Evaluation
Outreach	**Have outreach activities/materials been revised? How?** **What is the focus of public information campaigns in the last six months? How are MSM responding to new public information campaigns (if any)?**
Quality	**Question 1. Delete**
Training and Supervision	**Questions 1 and 2 for new staff only**
Linkages and Referrals	**1. Have any organizations dropped out of the referral network? Why?** **Question 3. Delete**
M&E	Same as Effort Evaluation
Government/NGO collaboration	Same as Effort Evaluation

Table 18. Summative Evaluation: Were the goals of the province reached implementing the model(s)? (months 18–24)

A. Quantitative Data

Promising Practices Component	***Indicator***
Testing Approach	Same as Process Evaluation
Outreach	Same as Process Evaluation
Quality	Same as Process Evaluation
Training and Supervision	Same as Process Evaluation
Linkages and Referrals	Same as Process Evaluation
M&E	Same as Process Evaluation
Government/NGO collaboration	Same as Process Evaluation

B. Qualitative Data

Collected at month 22 through in-depth interviews with government, NGO, and private sector staff and volunteers.

Promising Practices Component	***Indicator***
Testing Approach	What were the major challenges in introducing rapid testing with same-day results into this site? What were the major successes?
Outreach	Which have been the most effective outreach activities?
Quality	Which QI efforts have been most successful? Which were the most challenging to implement? Why?
Training and Supervision	What, if anything, about training and supervision should be changed in the future?
Linkages and Referrals	What were the major challenges in maintaining a referral network? What were the major successes?
M&E	Did the data collected at this site change the way services were provided in any way? What changed? What was the process for making those changes?
Government/NGO collaboration	What were the major challenges in maintaining government/NGO collaboration? What were the major successes?

APPENDIX 1

AIDSTAR-ONE FIELD VISIT ITINERARY

MARCH 16–APRIL 10, 2009

Monday, March 16, 2009

9:00–11:30 a.m.	Overview of agenda and objectives Cameron Wolf, USAID/RDMA; USAID/RDMA Conference Room, 3rd Floor, GPF Witthayu Tower A, 3rd floor 93/1 Wireless Road, Bangkok 10330, Thailand

Tuesday, March 17, 2009

9:30 a.m.–12:00 p.m.	Discussion with Pact Thailand at Pact Office
2:00–3:30 p.m.	Discussion with FHI/Sindhorn Building

Wednesday, March 18, 2009

9:30 a.m.–12:00 p.m.	Discussion with Rainbow Sky Association of Thailand USAID/RDMA, Conference Room, 3rd Floor
12:00–1:00 p.m.	Lunch at USAID/RDMA
1:00–4:00 p.m.	MSM coordination meeting, USAID/RDMA Conference Room, 3rd Floor

Thursday, March 19, 2009

10:00 a.m.–1:00 p.m.	Discussion with SWING; CBO for sex workers
2:15–4:00 p.m.	Dr. Praphan, TRC

Friday, March 20, 2009

1:00–4:00 p.m.	M&E harmonized guideline meeting at FHI
7:00–9:00 p.m.	Outreach with SWING (Hotmale club)

Monday, March 23, 2009 (Pattaya Trip)

9:00 a.m.	Meet at Pact
9:15 a.m.	Depart by van for Pattaya
11:00 a.m.–1:00 p.m.	Arrive in Pattaya and lunch

2:30–4:00 p.m.	Site visit to USAID-supported TG drop-in center (Sisters)
7:00–9:00 p.m.	Outreach with SWING/Pattaya

Tuesday, March 24, 2009

9:00 a.m.–12:00 p.m.	Meet with staff at Pattayarak STI Center
1:00–1:30 p.m.	Visit to Pattayarak Hospital Outpatient Clinic and ART Clinic
1:30–2:30 p.m.	Lunch
3:30 p.m.	Depart Pattaya to Suvarnabhumi Airport to Chiang Mai: TG 126; 7:00–8:10 p.m.
	Check-in Le Meridian Hotel Chiang Mai

Wednesday, March 25, 2009

9:00–11:30 a.m.	Meeting with Mplus Staff and volunteers at Mplus Office
12:00–1:00 p.m.	Lunch
1:30–3:30 p.m.	Dr. Kriangsak Jitwatcharanan, CDC-10 clinic
4:00–5:00 p.m.	Meeting at Violet Home drop-in center

Thursday, March 26, 2009

9:00 a.m.–1:30 p.m.	Meeting with Dr. Suwat Chariyaletsak, RIHES, Chiangmai University, 2nd Floor
2:00–3:30 p.m.	Meeting with K. Patcharee Cheewarayakul and K. Warisara, TRC, Chiang Mai
3:45–4:30 p.m.	Meeting with Dr. Surasing Visarutaratna, Chiang Mai Public Health Office
Remark:	Depart for Bangkok Airport by TG 117; 7:15–8:25 p.m.

Friday, March 27, 2009

9:15 a.m.	Depart for DDC office
10:00–11:30 a.m.	Meeting with Dr. Anupong, Principal Recipient for GFATM Round 8, DDC Office
2:00–6:00 p.m.	Team work

Monday, March 30, 2009

9:00 a.m.–2:00 p.m.	Team work, Siri Sathorn Meeting Room
4:00–5:30 p.m.	Dr. Nigoon Jitthai; International Organization for Migration, Thailand

Tuesday, March 31, 2009

10:00–11:30 a.m.	Dr. Kathleen Casey, FHI
1:00–5:00 p.m.	Team work, Siri Sathorn Meeting Room

Wednesday, April 1, 2009

10:00–11:30 a.m.	Meet with Philippe Girault, FHI
2:00–3:30 p.m.	MSM STI Clinic
	Bangkok AIDS, TB, and STD Services 28, Bamrak Clinic, Sathorn Rd, Bangkok
	Depart from Bangkok airport to Khon Kaen (Suvarnabhumi Airport) by TG 046; 6:05–7:00 p.m.
	Check-in Pull Man Rasa Orchid Hotel

Thursday, April 2, 2009

9:00–11:30 a.m.	Meet with chief and staff of Public Health Unit and MReach volunteers, Provincial Health Department, Khon Kaen
12:00–1:00 p.m.	Lunch
1:30–3:30 p.m.	Site visit and discussion with health–center-based HTC for MSM at Srinakarin hospital (CDC-supported site)
	Depart from Khon Kaen to Bangkok (Suvarnabhumi Airport) by TG 047; 7:45–8:40 p.m.

Friday, April 3, 2009

8:30 a.m.	Depart for TUC, MOPH, Nonthaburi
9:30 a.m.–12:00 p.m.	Meeting at TUC: GFATM Round 8 Coordination meeting
12:00–1:00 p.m.	Lunch at TUC
1:00–3:30 p.m.	Continuations of GFATM Round 8 Coordination meeting
4:00–6:00 p.m.	Focus Group at SWING

Saturday, April 4, 2009

	Spratt departs for Cambodia

Sunday, April 5, 2009

	Beal departs for the United States

Friday, April 10, 2009

7:30–9:00p.m.	Debrief USAID team at USAID/RDMA Office (Spratt in person, Beal by phone)

APPENDIX 2

STAKEHOLDER MEETING: INCREASING ACCESS AND UPTAKE OF HIV COUNSELING AND TESTING AMONG MEN WHO HAVE SEX WITH MEN IN THAILAND

JUNE 1–2, 2009, WINDSOR SUITE HOTEL, BANGKOK, THAILAND

Objective: Use findings from the AIDSTAR-One situational analysis to begin strategic planning to implement models for access to community-based HIV rapid testing with same-day results for MSM in four USG provinces in Thailand

Day 1: June 1	**Overview of Tools and Findings for HTC for MARPs**
9:00–9:30 a.m.	Opening Remarks: Dr. Cameron Wolf, USAID/ RDMA; Dr. Michelle McConnell, TUC/CDC
	Plenary for Good and Promising Programmatic Practices Moderators: Chomnad Manopaiboon and Scott Berry
9:30–10:00 a.m.	Dr. Kai Spratt, AIDSTAR-One Technical Advisor "Promising Programmatic Practices to Increase Access to HIV Counseling and Testing Among MSM"
10:00–10:30 a.m.	Dr. Kathleen Casey, Senior Technical Officer, FHI "UNICEF, WHO and FHI HIV Counseling Resource Package for the Asia-Pacific: Implications for Training and Counseling in Community- based Settings for MSM"
10:30–10:45 a.m.	Coffee/tea break
10:45–11:15 a.m.	Dr. Anupong, Director, DDC, MOPH "Update from the Global Fund Round 8: How Will HTC implementation for MSM Be Rolled into GF Activities and Resources?"

11:15 a.m.–12:00 p.m.	Questions and answers
12:00–1:00 p.m.	Lunch break
1:00–2:00 p.m.	Dr. Kai Spratt
	Findings from situational analysis
	Discussion and reality check among participants on findings
	"Potential Models for HIV Testing Among MSM: Strengths and Weaknesses of Models"
2:00–3:15 p.m.	Break-out session: small groups by province to discuss models in context of particular provincial conditions
3:15–3:30 p.m.	Coffee break
3:30–4:30 p.m.	Presentations from each province on potential models
4:30–4:45 p.m.	Wrap-up of Day One and preparation for Day Two
Day 2: June 2	**Coordination and Linkages for Planners**
9:00–9:15 a.m.	Recap Day 1 Process; Scott Berry Moderators: Panus na Nakorn and Kai Spratt
9:15–9:40 a.m.	Dr. Kai Spratt and Khun Surang Janyam, Director of SWING "Example of NGO/Government Collaboration: SWING Gender-based Violence Project with USAID Health Policy Initiative in Pattaya"
9:40–10:30 a.m.	Mr. Danai Linchongrat, Director, RSAT "Mapping of HIV Services and Coordination for Improved Strategic Planning of Global Fund Implementation: Example from Chiang Mai"
10:30–10:45 a.m.	Coffee/tea break
10:45 a.m.–12:00 p.m.	Dr. Kai Spratt
	Tools and Critical Issues
	Small Group: Prioritize the logistical issues for improving HTC that need to be addressed in order to implement models in each province
	Presentations by provincial teams on prioritized issues related to recommended models
12:00–1:00 p.m.	Lunch
1:00–2:00 p.m.	Dr. Kai Spratt Introduction to an Advocacy Communication Model
2:00–3:00 p.m.	Breakout session: Provincial groups work through next steps in their province and draft advocacy messages for different target audiences
3:00–3:15 p.m.	Coffee/tea break
3:15–4:00 p.m.	Individual group presentations on next steps/advocacy (report back from small group exercise)
4:00–4:30 p.m.	Next steps and closing remarks: Dr. Cameron Wolf; Dr. Michelle McConnell

APPENDIX 3

STAKEHOLDER MEETING LIST OF PARTICIPANTS

Satayu Sittikan	AIDSNET
Pongthorn Chanlearn	Mplus
Sirisak Chaited	Mplus
Kreingkral Yodruen	Chiang Mai Provincial Health Office
Warissara Pnrnchayapakul	TRC/Chiang Mai
Danai Linchongrat	RSAT
Surang Janyam	SWING
Chamyong Paengnongyang	SWING
Preecha Khamkhao	SWING
Rattiya Luewichana	Bangrak Hospital
Pornpan Suvarnataja	Clinic #28, Bangkok Department of Health
Suparp Pengpoom	Pattayarak Clinics
Chutima Chomsookprakit	Pact Thailand
Farida Langkafah	Pact Thailand
David Dobrowolski	Director, Pact Thailand
Cameron Wolf	USAID/RDMA
Nithya Mani	USAID/RDMA
Panus na Nakorn	USAID/RMDA
Rawiwan Bunyen	TUC
Angkana Charoenwattanachok	TUC
Anupong Chitvarakorn	DDC/MOPH
Patchara Sirivongrangsan	Bangkok AIDS, TB, and STD Services
Ratree Sirisritreeruk	Bangrak Hospital
Chutchawal Petchor	TUC
Suchada Muktier	TUC

Usanee Kritsanavarin	TUC
Kathleen Casey	FHI
Cristina Garces	FHI
Siroat Jittjang	FHI
Jittinee Khienvichit	FHI
Uraiwan Noiupanya	Bangkok Municipal Authority AIDS Control Division
Narumol Leuhctrrun	Pattaya Clinics
Thissadee Sawangying	Sisters Pattaya
Aranya Ngamwang	FHI
Sorakij Bhakeecheep	NHSO
Celine Daly	FHI
Puripakorn Pakdiratna	Translator
Kai Spratt	AIDSTAR-One
Scott Berry	Consultant

REFERENCES

Amirkhanian, Y. A., J. A. Kelly, E. Kabakchieva, T. L. McAuliffe, and S. Vassileva. 2003. Evaluation of a Social Network HIV Prevention Intervention Program for Young Men Who Have Sex With Men in Russia and Bulgaria. *AIDS Education and Prevention* 15(3):205–20.

Bertozzi, S. M., L. M. Marie, S. Bautista-Arredondo, and A. Coutinho. 2008. Making HIV Prevention Programmes Work. *Lancet* 372:831–44.

Casey, K. 2009. "UNICEF, WHO & FHI HIV Counseling Resource Package for Asia-Pacific: Implications for training and counseling in clinic and community-based settings for MSM." PowerPoint presented at Stakeholder Meeting, Bangkok, Thailand, June 1.

CDC. 2006. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR* 55(RR14):1–17.

Chesney, M. A., B. A. Koblin, P. Barres, et al. 2003. Individually Tailored Intervention for HIV Prevention: Baseline Data from the EXPLORE Study. *American Journal of Public Health* 93(6):933–38.

Christudoss, E., and A. Pandian. 2008. "An Assessment Study of Counseling and Testing Centers." Abstract No. WEPE1057. XVII International AIDS Conference, Mexico City, August 3-8.

Clements-Nolle, C., R. Marx, R. Guzman, and M. Katz. 2001. HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention. *American Journal of Public Health* 91(6):915–31.

FHI. 2007. *Scaling Up the Continuum of Care for People Living with HIV in Asia and the Pacific: A Toolkit for Implementers*. Bangkok, Thailand: FHI.

Girault, P. 2008. "Coverage & Response USAID-Supported MSM Program in Bangkok & Chiang Mai, Thailand." PowerPoint presented at USG MSM Monitoring and Evaluation Meeting, Bangkok, Thailand, August 20, and at Family Health International, Asia Regional Office, Bangkok.

Gold, R. S., and G. Karantzas. 2008. Thought Processes Associated with Reluctance in Gay Men to be Tested for HIV. *International Journal of STD & AIDS* 19(11):775–9.

Government of Thailand. 2007. *National Strategic Plan for Integration of AIDS Prevention and Alleviation 2007–2011*. Bangkok, Thailand: Ministry of Public Health.

Herbst, H. H., R. T. Sherba, N. Crepaz, et al. 2005. A Meta-Analytic Review of HIV Behavioral Interventions for Reducing Sexual Risk Behavior of Men Who Have Sex With Men. *Journal of Acquired Immune Deficiency Syndrome* 39:228–41.

Hutchinson, A. B., B. M. Branson, A. Kim, and P. G. Farnham. 2006. A Meta-analysis of the Effectiveness of Alternative HIV Counseling and Testing Methods to Increase Knowledge of HIV Status. *AIDS* 20(12):1597–604.

International HIV/AIDS Alliance. 2004. *Voluntary Counseling and Testing: Emerging Approaches from Asia and Eastern Europe. Workshop Report*. Brighton, UK: International HIV/AIDS Alliance.

Islam, M., ed. 2007. *Health Systems Assessment Approach: A How-To Manual*. Submitted to USAID in collaboration with Health Systems 20/20, Partners for Health Reform*plus*, Quality Assurance

Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health.

Kamb, M. K., F. Fishbein, J. M. Douglas, et al. 1998. Group Efficacy of Risk-Reduction Counseling to Prevent Human Immunodeficiency Virus and Sexually Transmitted Diseases: A Randomized Controlled Trial. *JAMA* 280(3):1161–7.

Lyles, C. M., L. S. Kay, N. Crepaz, et al. 2007. Best Evidence Interventions: Findings From a Systematic Review of HIV Behavioral Interventions for US Populations at High Risk, 2000–2004. *American Journal of Public Health* 97(1):133–43.

Malonza, I. M., B. A. Richardson, J. K. Kreiss, J. J. Bwayo, and G. C. Stewart. 2003. The Effect of Rapid HIV-1 Testing on Uptake of Perinatal HIV-1 Interventions: A Randomized Clinical Trial. *AIDS* 17(1):113–8.

McCamish, M., G. Storer, and G. Carl. 2000. Refocusing HIV/AIDS Interventions in Thailand: The Case for Male Sex Workers and Other Homosexually Active Men. *Culture, Health & Sexuality* 2(2):167–82.

Medley, A., C. Kennedy, K. O'Reilly, and M. Sweat. 2009. Effectiveness of Peer Education Interventions for HIV Prevention in Developing Countries: A Systematic Review and Meta-Analysis. *AIDS Education and Prevention* 21(3):181–206.

Mimiaga, A., R. H. Goldhammer, F. C. Belanoff, A. M. Tetu, and K. H. Mayer. 2007. Men Who Have Sex With Men: Perceptions About Sexual Risk, HIV and Sexually Transmitted Disease Testing, and Provider Communication. *Sexually Transmitted Diseases* 34(2):113–9.

Patton, M. Q. 2007. *Utilization-Focused Evaluation*, 3rd ed., 201–214. Thousand Oaks, CA: Sage Publications.

PSI. 2006. *AIDSMARK Regional Lessons Learned: Asia*. Washington, DC: PSI.

PSI. 2006a. *Taking It to the Streets: Reaching Truckers, Sex Workers, Rural Populations with Mobile VCT*. Washington, DC: PSI.

Punpanich, W., K. Ungchusak, and R. Detels. 2004. Thailand's Response to the HIV Epidemic: Yesterday, Today and Tomorrow. *AIDS Education and Prevention* 16(Supplement A):119–36.

Sevelius, J. M., O. G. Reznick, S. L. Hart, and S. Schwarcz. 2009. Informing Interventions: The Importance of Contextual Factors in the Prediction of Sexual Risk Behaviors Among Transgender Women. *AIDS Education and Prevention* 21(2):113–27.

Sherman, S. G., C. Sutcliffe, B. Sirojn, C. A. Latkin, A. Aramratanna, and D. D. Celentano. 2009. Evaluation of a Peer Network Intervention Trial Among Young Methamphetamine Users in Chiang Mai, Thailand. *Social Science & Medicine* 68:69–79.

Stall R., R. B. Hays, C. R. Waldo, M. Ekstrand, and W. McFarland. 2000. The Gay '90's: A Review of the Research in the 1990s on Sexual Behavior and HIV Risk Among Men Who Have Sex With Men. *AIDS* 14(Supplement 3):S101-S114.

Stuart, L., J. Harkins, and M. Wigley. 2005. *Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings. Family Health International*. Arlington, VA: FHI.

Tareque G., A. Bari, S. Akhter, K. Bensera, S. A. Bina, and H. O. Rashid. 2008. "Female Counselor in MSM/MSW/TG Project Is Not a Gender Barrier Rather a Breakthrough in the Traditional Framework of Gender Sensitivity in HIV Prevention." Abstract No, THPE0301. XVII International AIDS Conference, Mexico City, August 3-8.

UNAIDS. 2006. *HIV and Men Who Have Sex with Men in Asia and the Pacific: UNAIDS Best Practice Collection*. Geneva: UNAIDS.

UNAIDS/WHO 2004. *UNAIDS/WHO Policy Statement on HIV Testing*. Geneva: WHO. Available at http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Techpolicies/HIVtesting_UNAIDS_policies.asp (accessed December 31, 2008).

UNGASS. 2008. *Thailand UNGASS Country Progress Report: Reporting Period: January 2006–December 2007*. Bangkok, Thailand: UNGASS.

Ungpakorn J. and D. Wilson. 2002. *A Brief Guide to HIV/AIDS Counseling: Manual*. Bangkok, Thailand: AIDS ACCESS Foundation of Thailand. Bangkok, Thailand: UNGASS.

USAID. 2008. *International HIV Counseling and Testing Workshop: Towards Universal Access to HIV Counseling and Testing. Workshop Report*. USAID.

USAID and MEASURE Evaluation. 2009. *Development of a Monitoring Framework for Referral Within a Network of HIV/AIDS Service Providers: Condensed Final Report Based on Four Case Studies*. Available at http://www.phishare.org/files/8971_sr_09_58b.pdf (accessed August 2009)

van Griensven, F., A. Varangrat, W. Wimonsate, et al. 2010. Trends in HIV Prevalence, Estimated HIV Incidence, and Risk Behavior Among Men Who Have Sex With Men in Bangkok, Thailand, 2003-2007. *Journal of AIDS* 53(2):234-9.

WHO. 2004. *Rapid HIV Tests: Guidelines for Use in HIV Testing and Counseling Services in Resource-Constrained Settings*. Geneva: WHO.

WHO. 2006. *HIV and Men Who Have Sex with Men in Asia and the Pacific: UNAIDS Best Practice Collection*. Geneva: WHO.

WHO. 2007. *Scaling Up HIV Testing and Counselling in Asia and the Pacific: Report of a Technical Consultation: Phnom Penh, Cambodia, 4–6 June 2007*. Geneva: WHO.

WHO. 2007a. *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*. Geneva: WHO.

For more information, please visit aidstar-one.com.

AIDSTAR-One

John Snow, Inc.

1616 Fort Myer Drive, 11th Floor

Arlington, VA 22209 USA

Phone: 703-528-7474

Fax: 703-528-7480

Email: info@aidstar-one.com

Internet: aidstar-one.com