

In Our Own Words

Preferences, Values, and Perspectives on HIV Prevention and Treatment: A Civil Society Consultation with MSM & Transgender People

Commissioned by the World Health Organization (WHO)

December 2010



The Global Forum on MSM & HIV
Working worldwide against HIV for the health
and human rights of men who have sex with men

The Global Forum on MSM and HIV (MSMGF) is an expanding network of AIDS organizations, MSM networks, and advocates committed to ensuring robust coverage of and equitable access to effective HIV prevention, care, treatment, and support services tailored to the needs of gay men and other MSM. Guided by a Steering Committee of 20 members from 17 countries situated mainly in the Global South, and with administrative and fiscal support from AIDS Project Los Angeles (APLA), the MSMGF works to promote MSM health and human rights worldwide through advocacy, information exchange, knowledge production, networking, and capacity building.

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International Human Rights Day

Where after all do universal human rights begin? In small places, close to home - so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person: The neighborhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman, and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world.

Eleanor Roosevelt
Remarks at the United Nations, March 27, 1958

Each year, International Human Rights Day offers an opportunity to reflect on the state of global rights. More than 60 years after their creation, have we moved forward in fulfilling the vision of individuals “born free and equal in dignity and rights”?

For advocates and allies in the HIV community, the human right to health may resonate most strongly on this day – described in the Declaration of Alma Ata as “*a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity*”.

Yet equal health for all is not possible when places close to home judge, stigmatize, and fundamentally contradict the universal dignity of all – places that discriminate on the basis of sexual orientation and gender identity. Over the past year, the world has witnessed egregious attacks on the rights of men who have sex with men and transgender people, from legislation introduced in Uganda to enact the death penalty for homosexual acts, to extra judicial killings in Iraq, Latin America and elsewhere. Rampant stigma and homophobia continue to inflict countless instances of hurt and suffering in the daily lives of millions of people worldwide, the culmination of which violates “social wellbeing” writ large. The recent coverage of a spate of suicides among gay teens in the United States is but one example.

The following report explores in detail the experiences of men who have sex with men and transgender people around the globe, whose ability to access the most basic prevention and treatment services for HIV and other sexually transmitted infections is challenged by social, legal, and health delivery systems that violate their inherent dignity and equality as fellow human beings.

The testimonies contained in the report were collected by the Global Forum on MSM & HIV in the late summer of 2010, via interviews with 39 self-identified gay, bisexual, or transgender men and women from 27 different countries.

The information reveals just how far we have yet to go toward achieving universal human rights - and why human rights must be a fundamental pillar of any effective global response to AIDS.

The Global Forum on MSM & HIV
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ABOUT THIS REPORT

The World Health Organization (WHO) is developing guidelines for delivering an evidence-based essential package of interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) among men who have sex with men (MSM) and transgender people in the health sector in low- and middle-income countries. The WHO formed a Guidelines Advisory Work Group, which developed initial draft recommendations focused on condom and lubricant use, HIV testing and counseling, linking HIV testing and counseling with access to care and treatment, STI management, or programs for prevention and treatment of HIV and STIs, including a suite of individual, group, and community level behavioral, substance abuse prevention, and mental health interventions. As a global partner to the WHO on the development of prevention and treatment guidelines, the Global Forum on MSM and HIV (MSMGF) systematically solicited civil society input from MSM advocates through its ties to regional and country-level networks as part of the guidelines development process. The MSMGF compiled input it collected and submitted to the WHO Advisory Work Group. This report is based on findings gathered and reported to the WHO.

SPECIAL ACKNOWLEDGEMENTS

The MSMGF would like to thank the World Health Organization and members of the Guidelines Advisory Work Group for their support and guidance throughout the project, especially Drs. Ying-Ru Lo, Carlos F. Cáceres, and Elie Akl. We would also like to express our heartfelt appreciation to each of the participants who shared so bravely and generously and from whom we learned a great deal.

BACKGROUND

Men who have sex with men (MSM) are 19 times more likely to be infected with HIV than the general population in low- and middle-income countries.¹ Prevalence among MSM is higher than that of the general population in nearly every country reliably collecting HIV and AIDS surveillance data. For example, compared with HIV prevalence in the adult general population, research conducted as early as 2002 suggested that infection levels among MSM in Latin America were seven times higher in Honduras, 10 times higher in Guatemala and Panama, 22 times higher in El Salvador and 38 times higher in Nicaragua (Soto et al., 2007).² This is a pattern that repeats itself in Africa, Asia, Eastern Europe and the Caribbean.

MSM also face wide-spread and ongoing human rights abuses and discrimination globally.³ As of May 2010, 76 countries had criminal penalties for same-sex acts between consenting adults. Criminalization of and violence towards sexual minorities cause social dislocation, influence transnational migration, and fuel human rights abuses, heightening the risk for HIV transmission and driving those most at need away from prevention, care, treatment, and support services.

The MSMGF recently conducted a global online survey to assess availability of and access to STI and HIV testing and prevention services among MSM across eight regions. There were 5,355 participants total who were each conveniently recruited from various MSM and transgender regional listservs and through word of mouth. Twenty-three percent were living with HIV, 73 percent were HIV negative and 4 percent did not know their HIV status. Fourteen percent of respondents were from North America, 11 percent from Central/South America and the Caribbean, 5 percent from Europe, 1 percent from the Middle East, 35 percent from East/Central Asia, 24 percent South/Southeast Asia and the Pacific Islands, 7 percent from Australia and New Zealand, and 4 percent from Africa.

Table I (below) presents the overall percentages of participants reporting that interventions were: easily accessible, available but hard or close to impossible to access, not available, and never heard of the intervention or strategy.

¹ Baral S. Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000-2006: A Systematic Review. *Public Library of Science (PLoS) Medicine*. 2007; 4(12): e339. doi:10.1371/journal.pmed.0040339.

² Soto RJ, Ghee A, Nunez CA, et al. Sentinel surveillance of sexually transmitted infection/HIV and risk behaviors in vulnerable populations in five Central American countries. *Journal of Acquired Immune Deficiency Syndrome*. 2007, 46:101-111.

³ Ottosson D. State-sponsored homophobia: a world survey of laws prohibiting same-sex activity between consenting adults. International Lesbian and Gay Association Web site. http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2010.pdf. Accessed on September 10, 2010.

Table I – STI/HIV Testing and Prevention Service Accessibility and Availability among MSM

<i>Interventions/Strategies</i>	Easily Accessible	Available but hard or close to impossible to access	Not Available	Never heard of this
	%			
STI testing (n=2767)	51	30	13	6
STI treatment (n=2749)	44	34	14	8
HIV counseling (n=2774)	48	34	12	6
HIV testing (n=2735)	43	30	16	11
HIV treatment (n=2736)	30	36	18	16
Free or low cost medical care (n=2743)	26	38	20	16
Free condoms (n=2764)	39	36	17	8
Free water-based lubricant (n=2756)	26	35	25	14
HIV education materials (n=2734)	34	41	16	9
Behavioral interventions (n=2734)	28	38	17	17
Comprehensive sex education (n=2728)	24	46	19	11
Mental health services (n=2742)	28	42	17	13
Substance abuse treatment (n=2728)	24	38	19	19
Media campaigns to reduce HIV (n=2738)	33	42	15	10
Media campaigns to reduce homophobia (n=2745)	12	35	30	23
Circumcision (n=2738)	51	25	13	12
Information about serosorting (n=2729)	10	25	16	49

There were critical differences in access to basic HIV and STI prevention and screening services. In general, MSM from Australia, North America, and Europe reported greater access to HIV prevention than men from low and middle income countries. In addition, men from low and middle income countries reported higher levels and harsher forms of discrimination, which may affect the availability, accessibility, and acceptability of HIV and STI-related services.

PROCEDURES

Project Team

A project team was formed in July 2010 and recruitment began on 28 August 2010. Project recruitment was targeted for specific characteristics (up to 96 MSM & transgender advocates from 6 regions). Participants were recruited through the MSMGF online database, partnering organizations and networks.

The MSMGF developed a verbal consent script that was appropriate for anonymous interviews. An interview guide was developed to lead with a broad question on how MSM and transgender persons manage their sexual health needs in the participant's country. This was followed with questions on specific prevention and treatment strategies, and probes for each including: personal experience; accessibility in respective setting; perceptions of effectiveness; distribution, challenges & stigma; other interventions; and intervention priorities. Interviews lasted an average of 60 minutes.

Interview Protocol

An interview protocol was developed by the project team to ensure uniformity of interviews. Project team members participated in a one-day training, which included practice interviews and observations of interview techniques. Weekly project team meetings were conducted to debrief interviews that took place the week before. The team also used weekly meetings to troubleshoot telecommunication and other logistical problems that might have occurred as well as to discuss themes emerging across interviews. Principle issues and themes discussed by interview participants were documented in meeting notes.

Interviews

Interviews were conducted between August 23, 2010 and September 8, 2010. Thirty-nine interviews were conducted with MSM and transgender advocates from across six regions, representing 27 countries: Antigua, Argentina, Armenia, Bahamas, Barbados, Canada, Chile, China, Columbia, Curacao, Guyana, India, Jamaica, Kazakhstan, Kyrgyzstan, Macedonia, Malaysia, Nigeria, Papua New Guinea, Poland, Russia, St. Lucia, Sweden, Trinidad & Tobago, Uganda, USA, and Zambia (See Table 2).

Table 2 – Completed Interviews by Region and HIV Status among MSM and Transgender People

	Africa	Asia	The Caribbean	E. Europe/ C. Asia	Latin America	Global North
HIV + Transgender	-	-	-	-	1	-
HIV - Transgender	-	1	3	2	-	4
HIV+ MSM	1	3	4	3	1	1
HIV- MSM	2	1	4	5	-	1

Not reflected in Table 2 were two participants who did not share their HIV status – a transgender woman from Asia and a gay man from Eastern Europe/Central Asia.

SUMMARY OF PRELIMINARY FINDINGS

Overall, interviews revealed no opposition to recommendations per se regarding: condom and lubricant use, HIV testing and counseling, linking HIV testing and counseling with access to care and treatment, STI management, or programs for prevention and treatment of HIV and STIs. However, there were 3 critical caveats regarding implementation of and access to HIV and STI prevention, testing and treatment, expressed universally by nearly all participants and across every region:

- 1) It was repeatedly noted that, in as much as some of these strategies might already exist or could be helpful if they were initiated, they would serve too few individuals who need them if barriers such as stigma, violence, and homo- and trans-phobia remain unaddressed (especially among physicians and other health care providers).
- 2) There was strong support for integration of services that could provide a comprehensive and more holistic approach to the prevention and treatment of STIs and HIV.
- 3) Although both MSM and transgender people commonly shared experiences of sexual oppression and human rights violations, many MSM and all transgender people interviewed also described the particularly intense stigmatization and repression of transgender people, and articulated the dire need to address transgender sexual health concerns separately from those of MSM.

Serosorting and circumcision were not recognized as prevention strategies in most regions and were not seen as viable options for future consideration. Among participants who had seen literature on circumcision as an HIV prevention strategy, there was a sense of the data being incomplete or unconvincing, especially when applied to MSM and transgender people. Nonetheless, some MSM were open to further information about circumcision.

Within the three principle issues listed above, themes related to sexual health emerged revealing common experiences and recommendations across regions, sexual identity, and HIV serostatus. Below are descriptions of these themes with illustrative comments from participants. This is followed by participants' observations regarding the specific strategies that may be included in the WHO guidelines.

PRINCIPLE ISSUES

Barriers to Access

Participants noted many barriers to accessing prevention, screening and treatment services for HIV and STIs. The project team organized these barriers into five major themes: 1) homophobia, transphobia, and discrimination; 2) stigma associated with HIV; 3) criminalization and policy; 4) insensitivity or lack of awareness among health care providers; and 5) safety.

Individually and collectively, these barriers foster a meta-message to MSM, transgender people and their providers that sexual minorities are despised individuals who are unworthy of care. Relevant to the WHO guidelines, there is consensus that homophobia and transphobia create an environment of fear through stigma, discrimination and violence, presenting significant barriers to STI/HIV prevention and treatment services at nearly every step of the care-seeking process. According to interviewees, many sexual minorities do not feel comfortable accessing services at all; if they do seek out services, many do not truthfully disclose their sexual risk factors due to fear of negative consequences. Even if one chooses to engage the health sector and accurately communicate risk factors, he or she may still face nurses or doctors who have inaccurate information about sexual minority risk factors or openly disparage their lifestyle or identity. Several MSM and transgender respondents noted that *“as bad as it is for gay men, it is worse for transgender people.”*

Stigma associated with HIV was described as especially problematic when it originated from physicians and other health providers. Participants had experiences that ranged from obvious negative attitudes towards people living with HIV to medical neglect from health sector workers. HIV stigma creates barriers to accessing services by engendering an environment of shame, fear and rejection that in turn leads to a silencing of sexual health care needs.

Integrated Holistic Services

Participants voiced a strong need for integration of services in the context of comprehensive health care that includes STI/HIV prevention and treatment. This principle issue was seen as a public health responsibility, and access to comprehensive care for all, including MSM and transgender people, was understood as a basic human right. Within this principle issue were four important themes as described by participants: 1) integration of services; 2) comprehensiveness of care; 3) safety; and 4) community involvement/engagement.

Transgender-specific Concerns

While many issues that were discussed during the interviews were common to both MSM and transgender people, respondents also repeatedly pointed out the need to specifically address the sexual health and wellness needs of transgender people as different from those of gay men and other MSM. There was consensus among transgender people (and among MSM who spontaneously brought up transgender sexual health concerns) that: 1) a discussion about sex, sexuality and the bodies of transgender people is a prerequisite for the initiation of any prevention interventions or HIV/STI health care with a transgender person; and 2) recommendations and guidelines about

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transgender sexual health must include consultations with transgender people. Participants provided examples of the lack of sensitivity and training among many providers, as well as the numerous ways the health sector, legal system, and policy environment enable continued oppression of transgender people, rendering existing sexual health services irrelevant or inaccessible. The project team organized transgender specific concerns within three main themes: 1) violence and discrimination specific to transgender people; 2) transgender bodies, sex and sexuality; and 3) other health concerns, including hormone therapies, mental health counseling, and sex reassignment surgery.

The project team organized principle issues identified by participants into a table, which outlines themes under each issue and illustrates them with examples or quotes taken directly from interviews. Table 3 (below) also provides implications for each of the themes outlined.

Table 3 - Principle Issues and Themes among MSM and Transgender Interviewees and Their Public Health Implications

Principle Issues	Themes	Example	Implications
Barriers to access	Homophobia and transphobia	<p>Yesterday an MSM was beaten badly in the public square. I myself was knifed 6 times for being a visible gay figure. People are expelled from university, refused medical care, refused at restaurants. It's worse for transgender persons.</p> <p>Most gay men do not access government health clinics for HIV/STI services because of stigma and discrimination; they don't feel welcome.</p> <p>Many people are not getting services – others are hiding in heterosexual relationships.</p> <p>When parents find out someone is gay, they throw them out of the house. It is hard for MSM to get and keep jobs because of discrimination. As a result, food and homelessness are huge problems for MSM. Even if there are free meds, people can't take the medicine if they don't have food.</p>	A climate of fear, threats and humiliation undermine public health efforts to reach MSM and transgender people.
	HIV stigma	<p>Healthcare workers in the hospital may not wake you up to give you your medication simply based on your HIV status.</p> <p>There is still stigma – you can see it in the body language and funny facial expressions of doctors.</p> <p>People who are HIV+ are scared to come out about their status. Most families are not accepting – of HIV, of transgender persons, of sex work.</p> <p>When someone is sick with AIDS in the hospital, the in-patient staff spreads the news so fast that even the out-patients come in almost immediately to see what an HIV-positive person looks like.</p>	MSM and transgender people living with HIV are subjected to double stigma resulting in substandard care and lack of social support.
	Criminalization and repressive policies	<p>Since HIV transmission is criminalized in Canada, people don't get tested for HIV.</p> <p>If people identify as gay, they will be imprisoned. I've had the police come to my work place because they were trying to extort money out of a co-worker. Someone told them he was a gay man. The Drug Enforcers has searched his home – that's the arm of the government used when they want to frighten or threaten people.</p> <p>Anti-trafficking policies are another case in point. Sex workers go underground. How do you reach transgender sex workers if they are hiding out of fear?</p> <p>It is not easy for transgender sex workers since oftentimes they are subject to both Sharia Law and the secular penal law.</p> <p>The hoops you have to go through to get your gender recognized are ridiculous. There is no anti discrimination protection at the Federal level.</p>	Criminal law in many countries is contradictory to public health goals, driving MSM and transgender people away from services.
	Insensitivity, lack of awareness among providers	<p>Access itself to government hospital services is there but the attitudes of the health care providers is a problem...there are difficulties transgender persons face when their legal identification documents list their sex at birth – often prompting health care personnel to push male-to-female transgender persons, for example, to the men's section of the clinic.</p> <p>Most MSM do not want to go for treatment for HIV because confidentiality is broken so often by doctors, nurses and hospital staff. It's worse with sexual minorities – they will disclose openly who is MSM and who is HIV positive. Most people will just keep things to themselves until they are too weak and sick to go on without care.</p> <p>Family planning doesn't even talk about sex – they are not comfortable dealing with these issues. Providers are also still scared of HIV.</p>	There is an urgent need to train health care professionals and staff, including doctors and nurses on the needs of MSM and transgender people; training programs must include sensitization on sex, sexuality, gender identity, and HIV.
	Safety	<p>Safety is a problem. This climate leads to fear of seeking medical treatment, or, when it is sought, MSM do not tell their sexual orientation to their primary care providers. It is worse for transgender people – primary care providers will not even receive them.</p> <p>As a physician, I travel about 200 miles outside of Kampala after organizing a discrete meeting at a safe space for individuals who might benefit from medical information and care.</p> <p>People know that they can get support at our office, but the neighbours beat our clients when they come around. We try to leave our offices to reach people at cruising spots as well, but homophobes know these venues too. It is a challenge to keep outreach workers motivated when they are harassed so frequently.</p>	Safety concerns inhibit the ability to self-identify, seek services and discuss sexual health and behaviors with providers. Services must be provided under safe conditions, including protection from violence and prosecution.

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Table 3 - Principle Issues and Themes among MSM and Transgender Interviewees and Their Public Health Implications (cont.)

Principle Issues	Themes	Example	Implications
Integrated, holistic services	Integration of services	<i>Transgender people have a lot of difficulty accessing health services in general. They often have to go to separate places to get their different needs met. Broader, more integrated and non-gendered approaches are best for trans people. Health care personnel should work together.</i>	STI and HIV-related programs should be integrated with each other and other health care services in order to ensure consistency of and increase access to prevention, screening, and treatment.
	Comprehensive, Holistic care	<i>We don't often think about comprehensive health. We should be screening for anal cancer among gay men. We need a comprehensive package. We should go beyond this, beyond HIV to include services that address hormone therapies, sex change surgery, and psycho-social support, including therapy. Access to health means that all of these things are related. MSM and transgender people want to be honest with a health provider about what they need including our practical needs, access to lube and condoms, access to psychosocial support. People want to be honest about who they are.</i>	There is a need for comprehensive care that views sexual health as a core component of an individual's overall health.
	Community led or engaged	<i>The MSM Program Coordinator at the National AIDS Center has told me, "We work only with gay people. If someone has sex with a man, he's gay." We have a lot of problems with definitions. We need to train them, but they refuse to work with us. The best strategy is to involve transgender people first. WHO has to change its strategy to listening. You can't expect what works in Thailand is going to work in Malaysia. It takes 2-3 years to build up rapport and relationships necessary to reach and serve the community. Listening and engaging communities for listening sessions are a good first step. If you don't consult with transgender people, your efforts to reach and work with this community will fail...Transgender people are willing to help – just listen!</i>	Development of strategies and interventions must include the meaningful involvement of MSM and transgender people if services are to be relevant, applicable, and acceptable.

Table 3 - Principle Issues and Themes among MSM and Transgender Interviewees and Their Public Health Implications (cont.)

Principle Issues	Themes	Example	Implications
Transgender specific concerns	Violence, discrimination	<p><i>Rape and sexual harassment is common place, especially for transgender sex workers. My friend was raped. When she reported it to the police, their response was, 'how could you be raped, you're a man.'</i></p> <p><i>Transgender sex workers are beaten up all the time. There have been acid attacks and stabbings. There is also verbal violence and sexual harassment. Transgender people have a very difficult time bringing this up. At one point, they thought that by cutting off our hair, they would make us stop having sex.</i></p> <p><i>The government of Malaysia recently introduced a health card system, as a way to monitor and promote the easy access/utilization of health services. The card system benefits on the ministry of health – it doesn't benefit transgender people or sex workers, especially when the ministry of health is known to work with police, violating our rights.</i></p>	Violence against transgender persons must be addressed at all levels if services are to be accessible at the policy, legal, provider, public health, and societal levels.
	Terminology, body, sex and sexuality	<p><i>Doctors look amazed that these (trans) kinds of people really exist. They don't have the basic knowledge on the human body.</i></p> <p><i>You have to start by talking about bodies more generally and establishing what words are OK or not. Some trans guys feel more comfortable with colloquial terms and others feel comfortable with more clinical terms.</i></p> <p><i>It feels like a lot of assumptions are made about the kinds of sex trans persons have or don't have. Because I am a trans man, many providers assume I am not having penetrative sex, and thus am not at risk for HIV. Doctors aren't comfortable talking about sex or sexuality.</i></p> <p><i>When we (LGBT) have better understanding of our bodies and sexuality, we take better care of ourselves. By understanding ourselves and sexuality and how important these things are, people will find their way to prevention.</i></p>	It is essential that health care providers are educated in and sensitized to issues of terminology, body, transition, sex and sexuality specific to transgender people to provide appropriate health care and tailored prevention messages.
	Other health concerns	<p><i>When most people talk about the sexual health needs of transgender people, seldom are issues concerning hormones and sexual reassignment surgery discussed or included. In addition, the ongoing mental health and counselling needs of transgender people are ignored or altogether omitted.</i></p> <p><i>Judging from what other NGOs do, they mostly focus on MSM. They do not have contact with transgender people.</i></p> <p><i>I would be pretty reluctant accessing the public health system because I would not trust them to be trans knowledgeable.</i></p>	There is a lack of awareness and neglect regarding the full spectrum of transgender health needs that must specifically be addressed before appropriate HIV-related services can be provided.

THEMES SPECIFIC TO HIV AND STI PREVENTION AND TREATMENT STRATEGIES

Participants offered their views about specific HIV and STI prevention and treatment strategies that are likely to be included in the WHO final recommendations and guidelines. Their perspectives offer insights into MSM and transgender values and preferences on a range of interventions. This section highlights the main themes that emerged from our interviews in relation to the following prevention and treatment strategies: 1) condoms and lubricants; 2) HIV testing and counseling; 3) prevention and treatment programs; 4) serosorting; and 5) circumcision – illustrated by quotes from MSM and transgender interview participants.

Condoms and Lubricants

MSM believe condoms are useful for prevention and many advocate their distribution. However, interviewees cautioned us about risks involved with condom distribution programs as they have become signifiers for sexual orientation and HIV status and therefore stigmatizing in some countries. Stigma associated with getting or carrying condoms could result in ridicule or harm. In this regard, many participants pressed for condom availability and distribution approaches that are integrated with other services and campaigns as a strategy for de-stigmatizing homosexuality and HIV.

Transgender people also support condom use, but unless doctors, nurses and other health sector providers are educated and sensitized about transgender bodies and sexuality, discussions about condoms may be irrelevant or inappropriately managed.

Condoms are used as evidence against transgender sex workers – if you are carrying condoms, you are doing something immoral. Transgender people are scared to carry condoms because doing so might bring about legal charges against them. Transgender people use and would like to carry condoms – but are scared to.

They haven't acknowledged the fact that transmen do not have the anatomy to use a condom but they still have other kinds of safe sex. Using a condom does not include everyone in the category of women or men.

Men who accept themselves as gay men have an easier time using condoms. Men living double lives won't use condoms for fear that their wives would suspect that they are cheating. Also, in Curacao, condoms are associated with gay men – some men won't use them.

Transgender people are also sex workers. Sex workers here are also using drugs. It is difficult to have discussions about basic things like condoms without addressing all of these issues.

MSM do pick up free condoms, but because many MSM have no jobs and no family support due to discrimination, they sell the free condoms they get to sex workers and use the money to buy food.

HIV Testing and Counseling

Participants provided examples of ways to make HIV testing and counseling services more effective for sexual minorities and called for education of doctors, nurses and other health sector providers. Training should address the sexual health concerns of MSM and transgender people, sensitivity to sexual orientation and gender identity issues, and respect for confidentiality. Several participants commented that testing is sometimes offered without pre and post test counseling, bypassing the opportunity to provide prevention information, support and referral to care and treatment services for those testing positive. Where pre and post test counseling is provided, individuals sometimes avoid it because of fear of discrimination and breaches in confidentiality.

I understand counselling to be client-centered and facilitative, allowing people to come to their own choices. That's an ideal, but it's not what most people are getting access to. People go in and get told what they should do and what they shouldn't do, and what their level of risk is. But I can't imagine that many people are asking about what the specific risk factors are for sexual minorities.

I think that doctors should be educated more. I have heard of cases where people get the result by phone. They are all alone hearing the result and that should not happen.

Gay men and other MSM should not go to the main clinic; they should go get tested with a leader or worker who they can trust.

Pre-post counseling services are almost never provided. Testing is compulsory in Malaysia for sex workers and drug users. HIV and STI testing is present, but people belonging to highly impacted communities are scared to access these services for fear of discrimination.

The main reason so many MSM don't get tested is because they fear their test results will be leaked by the clinic staff. Staff are especially careless about spreading the information of MSM and HIV positive people.

I haven't been tested for HIV or STIs. Most transgender people don't like to get tested because they're afraid of the doctors' attitudes. The doctors don't know how to deal with transgender needs and they don't like transgender people.

When a doctor sees that I'm a transman, he assumes that I do not need an HIV test without even asking about the kind of sex I have. It doesn't occur to him that I might not be straight, that I might have penetrative sex with another man. Doctors make recommendations without realizing the full range of sex that transgender people have.

A lot of gay men get HIV and STI tests at local labs without a doctor's prescription or referral, even though these tests should only be done with a doctor's approval. It makes it easier for gay men to get tested without the pre and post counseling sessions... I do not know what would happen or how it would be handled if a gay man tested positive for HIV or STI under this process. Gay men can get HIV and STI treatment at the government clinics, but do not feel comfortable accessing these services because of stigma.

Prevention and Treatment Programs

Participants across most regions struggle with managing their sexual health needs, including seeking treatment for STIs. Many participants described experiences with doctors, nurses and other health sector professional who were insensitive to their sexual practices, made incorrect assumptions about their sexuality, or reprimanded them for their lifestyle. Some providers made attempts to change the sexuality or gender identity of the participant who was seeking services. This led some participants to avoid testing and treatment for STIs and HIV altogether, or to find treatment in more clandestine ways. Participants reiterated the notion that prevention and treatment are least stigmatizing when integrated and provided within general health sectors but only under conditions where providers and staff are educated and sensitized to their needs.

If there is not enabling environment, what do you expect – even if you offer the services, transgender people won't show up.

We need messages for trans guys, gender queer, trans women. A lot of people say I am gender queer. Prevention messages should include all members of the trans community.

Straight transmen do not have a basic idea of having safe sex with women. This impression comes from thinking you can only get STIs from vaginal intercourse involving a penis.

There are two LGBT organizations that provide services that are not seen in general public, they provide STI/HIV consultation and blood test. If you need treatment for HIV, you can go to an AIDS clinic, but if you need treatment for STIs, it is very expensive. For example, it costs 800 rubles for Hep B or C or syphilis tests alone. If you do not have money, you must spend all your abilities to take money for treatment.

I was tested for an STI once... It was a good doctor, the results came fast, negative. We did not discuss sexual preference. The doctor assumed I was straight.

There is no guided program to facilitate gay men's sexual health. Individuals figure it out themselves beginning with exploring sexuality, sexual orientation, lifestyle, and moral values.

By understanding ourselves and sexuality and how important these things are, people will find their way to prevention.

It's easy to provide information to sex workers and transgender people. But difficult to have individuals carry out guidelines when policy and the legal environment are contrary to public health goals.

Serosorting

Serosorting was not recognized as a prevention strategy by any participants. For some the construct of serosorting did not exist. For others, it led to conversations about the conditions under which MSM and transgender people do or do not disclose. Safety, stigma and discrimination concerns contributed to non-disclosure of HIV status for many.

Serosorting is not itself a sufficient HIV prevention strategy.

In discussions about sex, people don't really disclose their status. There is a big party scene here. Those discussions don't happen in Malaysia.

When guys find out you're positive, they don't want to have sex with you even with a condom. They want nothing to do with you.

Circumcision

In regard to circumcision as an HIV prevention strategy, participants raised questions about: relevance of circumcision in different cultural settings; adequacy of circumcision to protect from infection; and relevance to transgender people. Some felt the focus should be on education regarding sexual health rather than circumcision. The only exception to this was from a physician we interviewed, who said he believes everyone should be circumcised.

I have heard different opinions about that. Personally, I don't think it adds protection - at least of any significance.

I don't think we should encourage persons to think that if I am circumcised you have less chance of being infected. I don't think it should be pushed. Condom use and abstinence which has been the mantra I think should still be used.

Honestly, I don't see it as a solution for prevention. You have to give education. Once educated, people will take care of themselves.

If I had my way, I would get all those boys and cut them.

I cannot tell if it is good, I learned on the internet about this but it is not proved, I need to learn more, but now I do not know.

CONCLUSIONS

Individually and collectively, the five barriers to access – homophobia/transphobia, HIV-related stigma, criminalization/repressive policies, provider insensitivity, and safety - contribute to a sustained message to MSM and transgender people that they are criminals who are disparaged and unworthy of care. This message is reinforced by laws and policies that enable their providers, the social and the health care sectors to ignore the sexual health care needs of these communities. As a result, necessary health seeking and disclosure of sexual concerns to providers are inhibited. This limits appropriate treatment and counseling regarding risk factors and tailored prevention information that could reduce future risk. Direct health care services are often rendered irrelevant and prevention interventions are undermined. Importantly, safety concerns limit individuals' use of services and condoms despite their eagerness to do so. In conclusion, the voices of MSM and transgender people globally suggest that prevention and treatment strategies for HIV and STIs would be more effective, accessible and acceptable if these services are offered within health care systems that are comprehensive, safe, and sensitive to the diversity of sexual health needs of MSM and transgender people.