



THE FUTURE OF EUROPEAN PREVENTION AMONG MEN WHO HAVE SEX WITH MEN

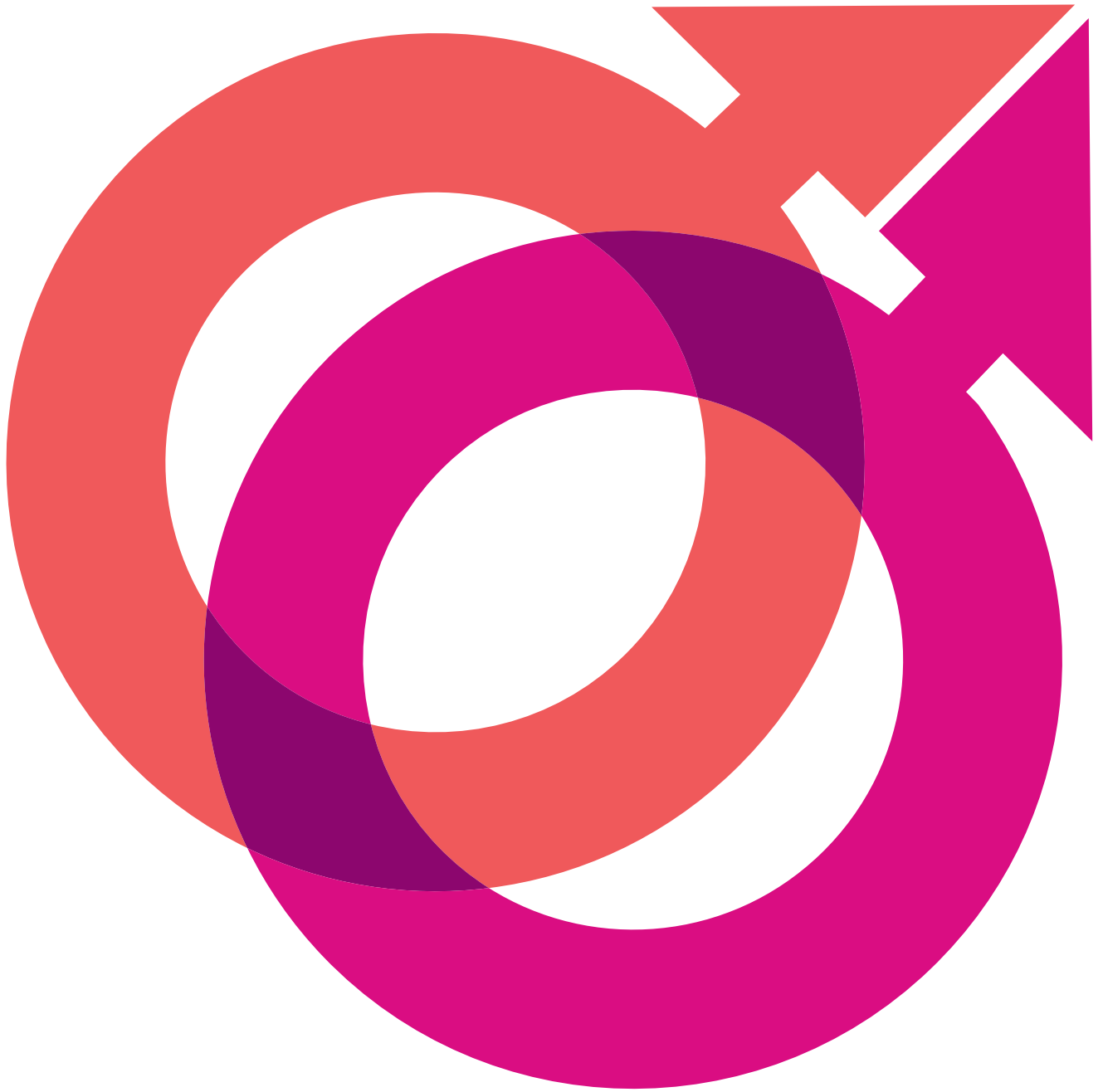
A CONFERENCE REPORT FROM
FEMP 2011 STOCKHOLM 10-11 NOVEMBER



The Future of European Prevention among MSM



Executive
Agency for
Health and
Consumers



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ACKNOWLEDGEMENTS

SMI is grateful to the members of the scientific and organising committees and everyone who gave their input (both work-wise and with valuable ideas) throughout the preparation process for this conference. SMI is also thankful to EAHC/EC, Executive Agency for Health and Consumers, the Swedish International Development Cooperation Agency, the Norwegian Institute for Public Health, and the World Health Organisation Europe for the financial support that made FEMP2011 possible!

Organisers:

Swedish Institute for Communicable Disease Control (SMI) is a government expert agency responsible for monitoring the epidemiological situation for communicable diseases and promoting protection against such diseases.

The Executive Agency for Health and Consumers

(EAHC) has a mandate to implement the EU Health Programme and perform the tasks entrusted to it by the European Commission.

The conference has received funding from the **European Commission** under the Public Health Programme 2008–2013. However, the sole responsibility for the results lies with the author and the European Commission is not responsible for any use that may be made of the information contained therein.

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Article number 2011-15-20
ISBN 978-91-86723-21-7

This title can be ordered from:
Smittskyddsinstitutets beställningsservice
c/o Strömberg, 120 88 Stockholm.
Or from our web store:
Fax: 08-779 96 67,
E-mail: smittskyddsinstitutet@strd.se,
www.smittskyddsinstitutet.se/publikationer

The title is also available for downloading from www.smittskyddsinstitutet.se/publikationer
The website of the Swedish Institute for Communicable Disease Control.

Production: Global Reporting Sweden AB

Text: Aida Burnett-Cargill

Editors: Staffan Hallin, Viveca Urwitz

Text editing: Eamon Somers

Photography: Oskar Kullander and Kina Robberts

Layout: Lisa Jansson

Foreword

Many of the colleagues with whom I have worked over the last two decades share with me a personal and professional dissatisfaction (unease is perhaps a better word) with the increasing numbers of new HIV infections and poor sexual health among gay and bisexual men, as well as concern at the poor state of prevention campaigns that target MSM in Europe – West and East (not to mention Central Asia).

We have noticed a slow but steady increase in the numbers of newly infected gay, bisexual men and other MSM since the turn of the century. Our growing awareness has led us to question whether “we are doing ‘the best thing’ (right things), and if we are; whether “we are doing enough?” In “we” I include all participants: health care systems and public /governmental agencies and funders (national and international), NGOs, the research community and last, but not the least, those with a commercial interest.

We have also taken note of what we believe to be a hidden and under-reported outbreak of HIV in Eastern and central parts of Europe, set against a background of the general low state of human and sexual rights for LGBT people, and poor health promotion and prevention campaigns targeting men who have sex with men.

In the almost thirty years since HIV entered the lives of gay and bisexual men; acting independently in our private lives as well as in our role as prevention professionals; we have managed to change ours and others’ attitudes and behaviours. We used educational campaigns, we invented “safer sex” as a major risk reduction tool, we lobbied governments, we convinced colleagues and initiated behavioural and sociological research. Despite recurring complaints by organisations working with MSM about the lack of funding (often justified), considerable sums of money have been invested in prevention campaigns that target gay communities. Many successful interventions have been carried out.

It was the early 1980s when first reports began to emerge of the then unknown affliction. Thirty years have now passed and the societal, medical, economic and political contexts are totally different. The question is: Have we been at the vanguard of these developments and how they affect the shape of the epidemic among MSM in our prevention efforts? Or have we merely followed the

paths set out during the first two decades of the epidemic, without adapting our strategies to the very different world that has emerged in the meantime?

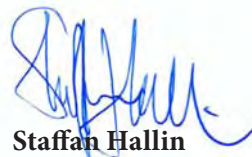
These reflections and this understanding gave birth to the idea of arranging a larger European gathering with the participation of all concerned where these issues could be highlighted and discussed. The opportunity arose in Brussels on the World AIDS Day, December 1st, 2009 during a hearing arranged by ECDC at the European Parliament, and where the Swedish government “tested the waters” to see if there was any interest in a more all-inclusive intervention on a wider pan-European level. There was.

The hearing at the European Parliament coincided with a general meeting of the European MSM Internet Survey project (EMIS), funded by the European Commission/EAHC. This also gave us the opportunity to see if there was an understanding of our ideas and support for our intentions. There was.

And a European conference was in the making...

Judging from the comments made both during and after the conference, for instance by the Swedish Minister of Social Affairs and Mr Massimo Mirandola ([Power Point presentation available in the electronic version](#)), it was a successful arrangement. The sheer number of participants (close to 400) and the countries they represented (37) made the conference the largest ever pan-European gathering to look at MSM issues. A lot of contacts were made that will lay the foundations for future fruitful cooperation. The quality of lectures, presentations and posters was very high, adding to the bulk of shared knowledge and the experience of all partners.

All in all, we are very happy that we got the opportunity to arrange this event and we want to thank all the participants for their valuable input!



Staffan Hallin

SENIOR PROGRAMME OFFICER, CONFERENCE MANAGER
SWEDISH INSTITUTE FOR COMMUNICABLE DISEASE CONTROL



PHOTO: FREDERIK ABBEVO

Introducing the report and its content

This report¹ is a compilation of the lectures and seminars held at the first pan-European conference to look at HIV prevention among MSM. Although a lot of scientific material can be found in the report it is not intended as a scientific report but an overview of knowledge, practices and challenges in the prevention of HIV among men who have sex with men in Europe.

The two-day event touched upon many issues that exist within MSM-specific HIV prevention efforts, sought to find explanations as to why some HIV prevention efforts work and some don't; and to find out what can be done in the future to curb the spread of the HIV virus among MSM. The main purpose of the conference was to bring together the four primary actors in the MSM prevention field: governmental agencies (including the health care sector), NGOs, academia and the commercial sector, and to connect the participants with existing European initiatives. The conference had a special focus on the situation in Eastern Europe and Central Asia², sharing best practices and research. This report does not include the full list of participants, due to the discrimination and threats that many men in Eastern Europe and Central Asia are experiencing.

380 men and women from 37 different countries were present at the conference. They were mostly from Europe but also from countries as far as the United States of America and Australia. More than 50 presenters held lectures and seminars during six plenary sessions and 19 parallel sessions³. A number of posters were also presented.

This report is divided into six main sections:

- It begins with an overview of the epidemic, and reflects on the current situation regarding HIV status and prevention among MSM in Europe.
- The second section comprehensively elaborates on better ways to understand the contexts and the determinants of the epidemic with regard to social and political contexts, as well as the norms and values of the environment in which gay men live.
- The third section gives an extensive account of the situation in Eastern Europe and Central Asia, with particular focus on the present situation for homosexual men in the region in respect of their human rights and their right to health care. The third section also proposes steps which could be taken to improve the situation in Eastern Europe and Central Asia.
- The fourth section takes a look at the lives of HIV positive men, their inclusion status in their respective societies, and presents ways in which negative attitudes and behaviours towards HIV positive gay men could be improved.
- The fifth chapter presents different examples of interventions, and gives recommendations on what needs to be done in order to make future interventions more effective.
- The report concludes with a summary of the two-day event and gives suggestions for future action in HIV prevention efforts among MSM.

¹The report is also published in an online version at www.femp2011.eu with links to all Power Point presentations and abstracts.

²The organisers of the conference chose not only to include the "EU definition" of Europe, but also the WHO definition, which includes countries from Central Asia.

³The original programme with links to abstracts from the presentations can be found at the end of the report!

Introduktion av rapporten och dess innehåll

Denna rapport¹ är en sammanställning av de föreläsningar och seminarier som presenterades under den europeiska konferensen om hiv/STI-prevention som riktar sig till homo- och bisexuella män och andra män som har sex med män (MSM) i Stockholm den 10-11 november 2011, FEM2011 – The Future of European Prevention among MSM. Konferensen arrangerades av SMI med finansiellt stöd av Europakommisionens Executive Agency for Health and Consumers (EAHC), Sidas Östersjöenhet, det Norska Folkhälsoinstitutet och WHO Europe.

En anledning till att SMI tog initiativet till konferensen var den ökning av nya fall av hiv som konstaterats bland MSM under början av 2000-talet, inte enbart i Sverige utan i också i hela Europa. Ytterligare en avsikt med konferensen var att föra samman de fyra främsta aktörerna inom hiv/STI-preventionen som riktar sig till MSM: olika myndigheter inbegripet hälso- och sjukvården, frivilligorganisationer (non-governmental organisations, NGOs), forskning samt den kommersiella/privata sektorn. En europeisk konferens skulle också öppna möjligheter för kontakt och utbyte mellan de olika interventioner, projekt och forskning som pågår över hela kontinenten. Konferensen hade också ett uttalat focus på situationen i Östeuropa och Centralasien.²

380 kvinnor och män från 37 olika länder deltog i konferensen. Övervägande delen av deltagarna kom från Europa men det var även föreläsare och andra deltagare från USA och Australien. Över 50 föreläsare höll föreläsningar och seminarier vid sex plenarsessioner och under 19 parallell sessions. Ett trettiotal posters fanns också utställda.

Denna rapport är indelad i sex kapitel:

- Den börjar med en översikt av epidemin samt av pågående preventiva insatser som riktar sig till MSM i Europa likaså presenteras ramarna för den stora befolkningsstudie EMIS som genomförts med 180 000 svarande i 37 länder i Europa mer än 20 presentationer på konferensen utgår från denna studie.
- Kapitel två ger en övergripande bild av de sociala och politiska kontexter och de normer och värderingar som präglar homo- och bisexuella mäns liv och därmed påverkar epidemin.
- Det tredje kapitlet ger en bred bild av den sårbara situationen för MSM i östra Europa och Centralasien, med särskilt focus på deras mänskliga rättigheter och möjligheter att få tillgång till både hälso- och sjukvård och hälsofrämjande och förbyggande insatser.
- Kapitel fyra tar upp situationen för män som lever med hiv och deras plats i det hälsofrämjande och förebyggande arbetet (Positive Prevention) och visar på männens behov och de insatser som behövs för att förändra omgivningens negativa och diskriminerande attityder.
- Kapitel fem ger en bred överblick över de interventioner och projekt som bedrivs över hela Europa och visar på behovet av kvalitetsarbete, uppföljning och utvärdering för att utveckla mer effektiva insatser.
- Det sista kapitlet summerar konferensen och ger förslag på åtgärder för framtida – förbättrade – hiv/STI-förebyggande insatser som riktar sig till homo- och bisexuella män och andra män som har sex med män.

¹ Denna rapport finns också online på www.femp2011.eu med länkar till alla Power Point presentationer och abstracts.

² Konferensarrangören har valt att inte enbart använda sig av "EU-definitionen" av Europa utan också att omfatta "WHO-definitionen", som även inkluderar länder i Centralasien.

INTRODUCTION

HIV PREVENTION – Time for a new approach



PHOTO: MAGNUS PERHSSON

Thirty years have passed since the first cases of HIV were discovered among young homosexual men in the USA. Fifteen years have passed since an HIV diagnosis ceased to be the equivalent of a death sentence.

Since then, a new generation of men who have sex with men (MSM) has entered the scene. This generation did not experience the horrors of the epidemic in the 1980s and early 1990s at first hand, and evidence suggests they may be less scared of HIV and less aware of the risks of unsafe sex.

Since the turn of the millennium, worrying reports from many parts of Europe show that the incidence of HIV among MSM is increasing. But reports also show that despite this group being the one most exposed to the virus in Europe, they are also often neglected when HIV prevention is being planned and carried out.

To increase HIV awareness among this new generation will require innovation, with positive messages and actions that are targeted at the at risk groups. Clearly the strategies and experiences we have accumulated will need to be shared and developed if we are to succeed.

This is why almost 400 delegates from some 37 different countries gathered in Stockholm from 10th–11th of November 2011 to participate in FEMP 2011, the first pan-European conference to deal solely with the future of HIV prevention among MSM. The conference not only brought together people of different nationalities but also from many different disciplines: NGOs, government agencies, health professionals, researchers and commercial interests.

I'm convinced that the conference provided a stimulating and visionary meeting place that made it possible for participants to share experiences and find new opportunities for cooperation. Government agencies obtained access to the vast experience of NGOs, and NGOs had the opportunity to learn from the structured approach and systems for follow-up of government agencies. Researchers helped to ensure that prevention methods would be evidence based, while commercial organisations provided an insight into the arenas where many MSM meet.

Since the first cases of HIV were diagnosed in the 1980s, societies have undergone profound changes, not least when it comes to mobility. It is therefore of crucial importance that we continue to cooperate across borders and that we do more to adapt our prevention methods to this new reality.

FEMP 2011 proved to be a unique opportunity to do just that.

Johan Carlson

DIRECTOR GENERAL

SWEDISH INSTITUTE FOR COMMUNICABLE DISEASE CONTROL



CHAPTER 1

Knowing the epidemic

KNOWING THE EPIDEMIC*

Throughout the epidemic, gay, bisexual and other men who have sex with men have been and remain the group at most risk to HIV infections in most European countries. The reasons why this is the case will be further elaborated in this report, but it is rather fair to say that one of the key reasons is the continued failure to recognise in full that MSM need specific interventions tailored to their specific needs.

In some countries it was only after the turn of the millennium that MSM began to receive targeted attention and funding for projects that were adapted to suit the MSM-specific HIV prevention efforts. However in spite of the increased focus on MSM, the number of HIV infections continues to rise.

The horrors of the 1980s are hopefully in the past. Names such as “GRID” (Gay-Related Infectious Disease) or “gay cancer”, as lurid head-

lines described HIV back then, have largely disappeared from the vocabulary. AIDS as a subject has disappeared from the public agenda, and HIV has become less visible despite the fact that new infections are on the rise. What can be done to improve visibility and reduce infections? In order to give an answer to these questions, it is essential to understand the present status of the epidemic and how it has changed and developed over its history.

This first chapter elaborates on the methodology of EMIS, the first pan-European survey on knowledge, attitudes, needs and behaviour with regard to HIV and STI transmission among gay, bisexual and other MSM. More than 180,000 men took part in the survey, making it the largest study ever made among MSM as a group. Considering that the surveys made so far have only been made on

national levels, there has never been an overall picture of the European MSM attitudes and behaviours.

The fact that FEMP2011 was a stage for more than 20 presentations, posters and parallel sessions showing results and statistics based on the results drawn from the study indicates how important EMIS actually is. It is obvious that EMIS has unravelled stunning new ways of looking into data which among other things, suggests a connection between the lack of human rights and the failure of HIV prevention. A similar conclusion was drawn by ECDC through its own research. This chapter describes some of the results from the ECDC research, gives a thorough account of how EMIS was set up, and explains what its true value is for the future of HIV prevention.

* Power Point presentations and abstracts related to this chapter can be downloaded from www.femp2011.eu

Marita van de Laar, European Centre for Disease Prevention and Control

1.1. Overview of the European epidemic – Need for tailored prevention

The text below is a summary of the session presented during the FEMP2011 conference.

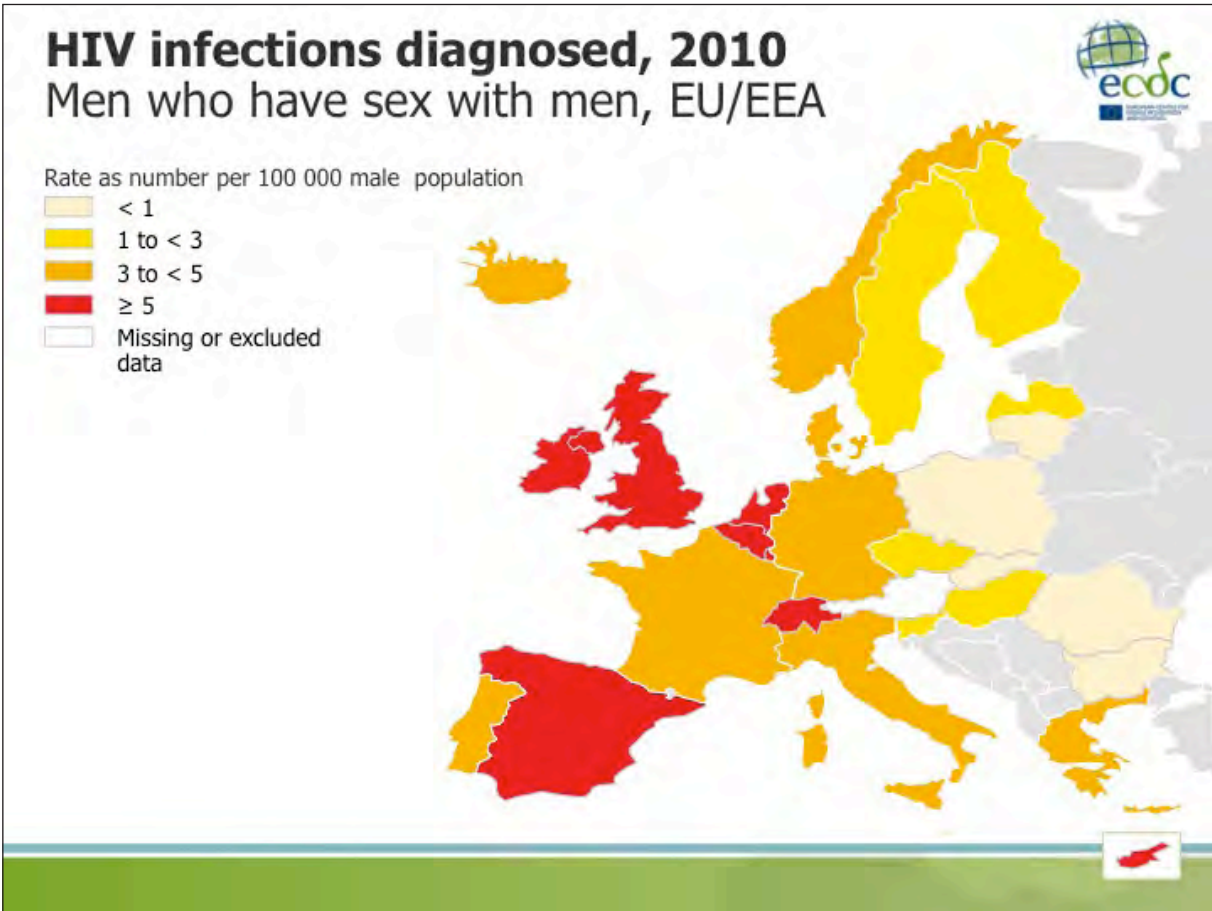
ECDC started to work with HIV as a priority disease from the very beginning. One of ECDC’s focus areas was to increase awareness about the epidemic among MSM. For example, a number of articles and papers were pulled from a number of countries and from different studies about HIV surveillance from 2009. The topic was then brought to the European Parliament at a lunch seminar with several members of the parliament, the director of ECDC, the civil society and the MSM community.

An evidence-based review of the effectiveness of key preventions in MSM in Europe was done by Rigmor Berg in Norway, and overall showed a dis-

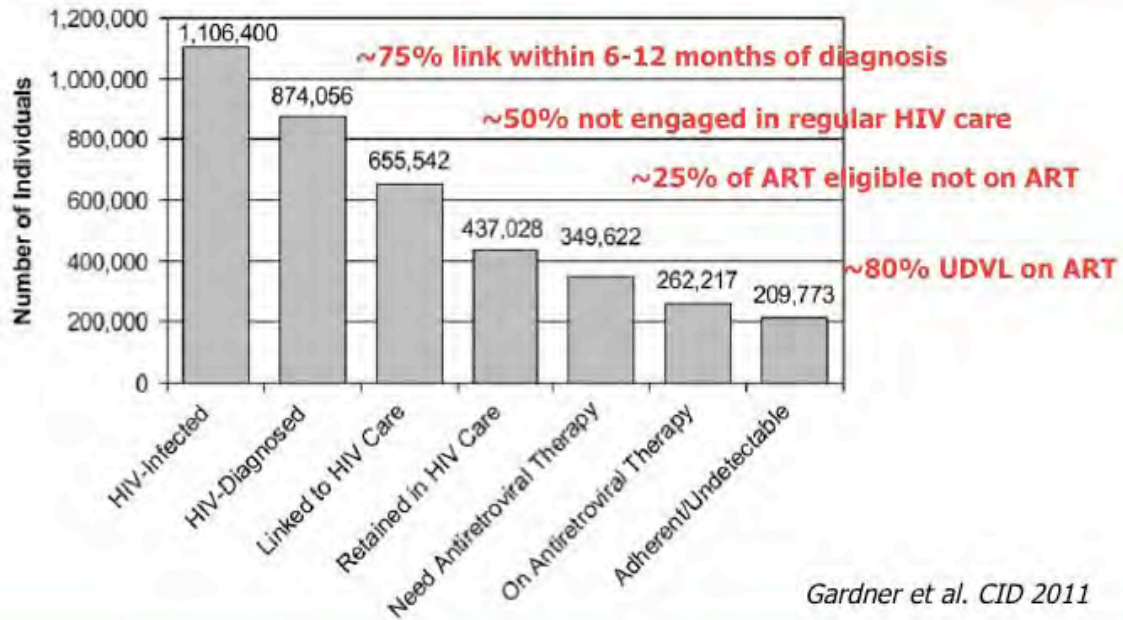
appointing result: there were too few prevention interventions studied, and even fewer that actually worked and continued to work six or twelve months later.

In order to take the work forward, ECDC then decided to have an MSM prevention project, which could be closely linked with the activities that were also being done in preparation for the FEMP2011 conference: a review of STI and HIV prevention interventions among MSM.

An overview of STI and HIV trends and outbreaks with focus on HIV and syphilis
The new data from 2010 shows that there is a



Engagement in HIV care and treatment-- US



slight increase of newly diagnosed cases of HIV in the male population. If one looks at the map of Europe for the number of MSM diagnosed with HIV, one can see quite a diversity across Europe with the highest rate in the West and the North. However caution is required when interpreting the trends and maps in the East. The low rates in the East do not necessarily suggest low incidence of HIV among MSM; who may be included in heterosexual statistics. The true position may be under-diagnosed among MSM as a result of men being reluctant to disclose their sexual orientation.

If one looks at the increase among MSM between 2004 and 2010, quite an increase in many countries is noticeable. So for instance, a country like Hungary, which is the third on this list, has a rate of 2.6 per 100,000 men, but they have experienced an increase of 170 per cent in the past five years. For countries like France or Denmark, or Luxemburg or Portugal, United Kingdom and the Netherlands, the rates are quite high, and they have experienced slight increases, but because of the high number of actual cases, there are many newly diagnosed cases among MSM.

Syphilis was a rare disease in the 1990s and early 2000s. But after anti-retroviral drugs became available in 1996 there was a huge increase in syphilis cases. In 2010, 55 per cent of syphilis cases were diagnosed in MSM. Denmark (like other countries) has experienced a huge increase of syphilis in the last three years in addition to the big increases noted in the early 2000s and late 1990s.

Increases in STIs and HIV among MSM in Europe as well as increases in co-infections between HIV and STIs, is really bad news. And if one looks at the trends in different STI as well as HIV and risk factors, the conclusion is that STI and HIV epidemics have been interacting, and have been influencing each other: STIs contributed to vulnerability. The high levels of co-infection with HIV coexists with increased high-risk sexual behaviour such as unprotected anal intercourse as well as limited awareness in certain groups and/or countries.

High levels of unprotected anal intercourse were reported in several studies, and it has been studied that outbreaks of STIs are correlated. However, there is evidence from several studies

that interventions actually influence risky behaviour:

- Interventions affect the status of knowledge.
- Some studies suggest risky behaviour reduced by half.
- Some studies show not only the effect in MSM, but also in the overall male and female population and even in drug users.
- 50 per cent of infections are estimated to derive from people who are unaware of their infection.

The increasing role of the internet and the social media is apparent, both in finding sexual partners and in doing prevention work, and the diversity in MSM affected by HIV supports the need to focus on tailored intervention for MSM as a community, but also for vulnerable groups within MSM.

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Early treatment

Is early treatment the answer to HIV prevention? In the summer of 2011 there was a lot of excitement about the topic of early treatment as prevention, and a study in the *New England Journal of Medicine* reported that transmission was reduced by 96 per cent in serodiscordant couples. However, to be effective for those who are HIV positive, they first must be tested, they must be diagnosed, they must be linked to care and then they need to adhere to treatment to achieve sufficient viral suppression. And one can see in the cascade described by Gartner that many people fall between diagnosis, treatment, adherence to treatment and viral suppression.

To have even 2/3 of HIV+ people virally suppressed would be a huge goal to achieve. If all efforts were maximised, it would still only result in 66 per cent being virally suppressed. We therefore have to be very careful in adopting “treatment as prevention” as our only strategy. Can we afford this? Can we put healthy people on treatment?

What happens to adherence rates over time? What are the risks of resistance development? What about acute infections and transmissions in the acute phase of infection?

Some evidence based preventive interventions have not been researched or proven with evidence for gay men; for instance: circumcision or early treatment under optimal conditions. The results may be different than when implemented in a community.

So while testing and linking to care in order to achieve viral suppression is very important, a comprehensive HIV prevention toolkit is needed that starts before that. We need to think more “out of the box.”

Preventive interventions for MSM a review

ECDC has started an additional project on MSM prevention that aims to review the evidence regarding what kind of STI and HIV prevention interventions (targeted at MSM) existed between 1995 and 2010, in order to assess the approaches to prevention and to evaluate the prevention interventions and to classify the level of evidence that was used in the studies or prevention programmes. The results show a wide focus on HIV and STIs, with classification by HIV status, age and region of origin. 170 interventions among MSM were identified; a review of the evidence and assessment of grading was done. The majority of these published interventions were actually about HIV, and mostly from North America, very few from Europe. The interventions were classified by whether they are based on theoretical behavioural change approach, or whether they are done by more simple campaigns, testing in venues, or counselling, whether they are focussed on education only; they are also classified for mode of delivery: whether it was a peer educating, mass media, trained counsellor and healthcare provider, or whether the intervention was done in a community-based setting or in a popular gay venue, through the internet or in a healthcare facility.

Based on the review that ECDC has done, the goal now is to develop a comprehensive and strategic approach in the wider context of HIV and STI prevention in which different key populations will be addressed, first and foremost MSM, but also other risk populations in Europe where such focus is needed.

Heterogeneity is vast. In addition, we have to be courageous to address the controversial aspects, and where possible, cultural values and potential misconceptions, as we have learned that the evidence is there and we need to tailor the prevention. We have

to apply what is working, what is known to work from public health and we have to ascertain the quality all across: scale of testing, partner services, and motivational counselling are among those.

We need better data – if you don't know which groups are affected by HIV or STIs, you cannot tailor your prevention.

We need more published evaluation data on behavioural interventions for HIV and STI prevention among MSM in Europe. One can say that if things work in the USA, they may work in Europe; this may or may not be true depending on the intervention. We have seen many interventions, but unfortunately they were not indicative as to what was good, and what works, or if it is cost-effective.

Sexual health agenda

The evidence strongly points out that the HIV and STI prevention among MSM for the future will benefit from positioning in a wider context with a comprehensive approach, talking about sexual health, but also alcohol and drug abuse prevention. The classical disease prevention, just focusing on gonorrhoea, or focusing on syphilis doesn't work any longer.

It doesn't work to prevent HIV and to forget all about hepatitis C and syphilis, there needs to be a wider approach in the future. We have to focus on targeting the populations that are at risk, tailor prevention, and focus the resources that we have for these interventions.

Axel J Schmidt, EMIS Project, Germany

1.2. The European MSM Internet survey. Building a network for harmonised European research on prevention of HIV and STI among MSM

The text below is a summary of the session presented during the FEMP2011 conference.

The European MSM Internet Survey (EMIS) was originally planned as a multi-country Internet survey with 22 participating countries at the stage of submission. As soon as the project was funded other countries announced their interest in participating. Finally, the survey was able to mobilize more than 180,000 men across Europe. In 33 countries, organisations and institutions actively collaborated, and in 38 countries, samples of more than 100 men each participated. An unprecedented number of participants answered a relatively long survey and submitted their data for further analysis. This makes EMIS the first pan-European scientific survey among men who have sex with men (MSM), and the largest transnational survey among MSM ever conducted – in terms of the number of participants, the number of countries covered by the survey, as well as the number of different language versions of the survey.

The huge response from MSM all over Europe

to a survey that had a focus on knowledge about HIV and STIs, sexual behaviour, and the use of services for HIV and sexual health is a strong indication that MSM in Europe care about HIV and sexual health issues. It defies the notion that 'carelessness' among MSM is at the base of high numbers of newly diagnosed HIV infections or increasing numbers of other sexually transmitted infections. Although the overall response was huge, there were large differences in relative participation rates across different countries. This can be explained by various reasons; among them are different levels of household Internet access and variations in the role of gay websites for connecting men who have sex with men.

The EMIS Associated Partners believe that the strategic goal of HIV/STI prevention is not to reduce the incidence and prevalence of HIV and other STIs among MSM at any price, but to enable men to make choices for the best sex with the least harm.

We identified 5 research areas:

1. The levels and distributions of HIV, other STIs, and sexual (un)happiness
2. The levels and distributions of sexual HIV/STI exposure and transmission facilitators (“behaviours”).
3. The levels and distributions of unmet (prevention) needs of MSM (“needs”).
4. The population coverage and acceptability of prevention interventions (“intervention performance”).
5. The information needed to compare samples and target interventions (“demographics”).

The data show considerable differences among the 38 national samples of MSM who participated in the survey: median age, level of education, proportions living in large cities, self-reported sexual orientation and identity, proportion of migrants, proportion having tested for HIV, proportion having received a positive test result for HIV, experienced gay-related and HIV-related stigma and discrimination all show a broad variability across countries.

For one, this reflects the existing diversities within Europe especially the diversity of cultural and legal conditions for MSM. It is also influenced by the differences in response, which poses unprecedented challenges for the analysis of the data and for comparisons among countries. For example, differences in demographic characteristics of national samples can be important confounders when analysing and comparing behaviour variables.

Since describing and comparing all findings and results for 38 countries is an almost impossible task, we aggregated countries into 9 different European sub-regions, defined by geographic, cultural, political, and historic characteristics. From these nine sub-regions other sub-regions like old and new EU member states, and WHO sub-regions of Europe, can be constructed. Many of the analyses presented at FEMP will refer to those regions:

Western sub-regions:

- West – Belgium (be), France (fr), Republic of Ireland (ie), the Netherlands (nl), United Kingdom (uk)
- North West – Denmark (dk), Finland (fi), Norway (no), Sweden (se)
- Central-West – Austria (at), Switzerland (ch), Germany (de), Luxembourg (lu)
- South West – Spain (es), Italy (it), and Portugal (pt), plus Greece (gr)

Eastern sub-regions:

- North East – Estonia (ee), Lithuania (lt), Latvia (lv)
- Central-East – The Czech Republic (cz), Hungary (hu), Poland (pl), Slovenia (si), Slovakia (sk)
- South East (EU) – Bulgaria (bg), Cyprus (cy), Romania (ro), plus Malta (mt)
- South East (non-EU) – Bosnia and Herzegovina (ba), Croatia (hr), Macedonia (mk), Serbia (rs), Turkey (tr)
- East – Belarus (by), Moldova (md), Russia (ru), Ukraine (ua)

The formation of the Schengen area, the enlargement of the European Union (1995-2007), and the rising market for cheap flights connecting European cities have substantially increased the mobility of men who have sex with men (MSM). Internet dating sites – PlanetRomeo’s contribution to the success of EMIS cannot be stressed enough! – and mobile phone applications allow for long-term planning of sexual encounters. Consequently, sexual encounters abroad have become very common: Between 15% of respondents in Ukraine and 57% in Luxemburg reported sex abroad in the previous 12 months. Among those, the dominant European destinations were Spain and Germany. The high degree of mobility of MSM in Europe is a strong reason for analysing data on MSM on a European level, rather than on national levels.

Using large networks of different players in HIV prevention and research proved to be effective for implementing a multi-language, cross-border questionnaire and for successfully recruiting gay and other MSM across Europe. EMIS data is more comparable than data based on national questionnaires using different recruitment strategies, particularly for research on European MSM prevention needs and behavioural surveillance. EMIS data further allows analyses on city, country and regional levels.

EMIS results continue to be jointly analysed and interpreted with a view to a common understanding of HIV prevention challenges and to foster cooperation between sectors and agencies. These benefits are particularly valuable for countries where gay communities and HIV prevention responses are not well established.

EMIS community reports, national EMIS reports, a brief overview of 5 UNGASS indicators, as well as academic outputs can be accessed at www.emis-project.eu

The Associated Partners of the EMIS project are very pleased to see that the conference on

The Future of European Prevention among MSM includes 23 different EMIS oral presentations or posters, covering all five research areas. As Scientific co-ordinator of the EMIS project and in the

name of the six Associated partners, I would like thank all collaborators for being part of something huge.

EMIS

#184,472

<p>Благодарим ви за проявени интерес към проучването EMIS, което вече приключи. За да научите повече за проекта, моля посетете www.emis-project.eu</p>	<p>Díky za Váš zájem, avšak anketa EMIS již byla ukončena. Více informací o projektu naleznete na www.emis-project.eu</p>	<p>Tak for din interesse, men EMIS undersøgelsen er nu afsluttet. Læs mere om projektet her www.emis-project.eu</p>	<p>Vielen Dank für Ihr Interesse an EMIS. Die Befragung ist nun beendet. Mehr Informationen finden Sie unter www.emis-project.eu</p>	<p>Tänname huvi tundmast meeste uurimuse vastul Andmete kogumine on tänaseks lõppenud. Projekti kohta saab infot aadressil: www.emis-project.eu</p>
<p>Σας ευχαριστούμε για το ενδιαφέρον σας αλλά η έρευνα έχει ολοκληρωθεί. Για περισσότερες πληροφορίες επισκεφθείτε την www.emis-project.eu</p>	<p>Thanks for your interest, but the EMIS survey has now closed. To learn more about the project please see www.emis-project.eu</p>	<p>Gracias por tu interés, pero la encuesta EMIS está cerrada. Si deseas más información sobre este proyecto puedes consultar el sitio web: www.emis-project.eu</p>	<p>Merci pour votre intérêt, mais le questionnaire EMIS est maintenant terminé. Pour en savoir plus sur ce projet, vous pouvez suivre ce lien: www.emis-project.eu</p>	<p>Grazie per l'interesse, ma la ricerca EMIS e' ora conclusa. Per maggiori informazioni sul progetto, vai a www.emis-project.eu</p>
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<p>Dziękujemy za zainteresowanie, ankieta EMIS jest już zamknięta. Więcej o projekcie na stronie: www.emis-project.eu</p>	<p>Obrigado pelo teu interesse, mas o questionário EMIS terminou. Para saber mais acerca do projecto por favor consulta www.emis-project.eu</p>	<p>Va multumim pentru implicarea in acest proiect, insa chestionarul EMIS este acum inchis. Pentru a afla mai multe despre EMIS, accesati www.emis-project.eu</p>	<p>Спасибо за проявленный интерес, однако опрос EMIS уже завершен. Чтобы узнать больше о проекте, пожалуйста, посетите www.emis-project.eu</p>	<p>Zahvaljujemo se ti za tvoj interes, vendar je raziskava EMIS zaključena. Če želiš izvedeti več o projektu, prosimo poglej na www.emis-project.eu</p>
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Peter Weatherburn, Sigma Research, London School of Hygiene and Tropical Medicine, United Kingdom

1.3. Lessons learnt from implementing a 25-language questionnaire. The role of gay social media and NGOs for recruitment

The text below is a summary of the session presented during the FEMP2011 conference.

There were five main stages to the development and implementation of EMIS: fundraising and partnership building, questionnaire design, piloting and agreeing to the final content, translation and online preparation, survey preparation and completion, and data cleaning, analysis, report writing and knowledge-transfer activities.

Questionnaire development, piloting and translation

The EMIS questionnaire contains questions that are relevant for the entire European MSM population, regardless of their biological or social gender, their sexual identity, or the social and political environment in which they lived. Maastricht University initially asked all signed-up partners to submit any previous questionnaires for MSM they had ever used. Examination of those previous questionnaires, the ECDC indicators, scientific literature and consultations with experts and across the partnership gave rise to the first draft of the questionnaire eight full months after the project actually started. From this point, it took five drafts with 3 major consultations and another six months to get out the questionnaire into the public domain, pilot it, sign it off, translate it and begin promoting it as an actual survey.

Piloting was in English on paper in 14 different countries. It was piloted together with cognitive interviews in English with participants on how they understood the questionnaire and what they got from it. 278 items of data were required from each man. 70 per cent of all men who answered the first question, also answered the 282nd question, which is a phenomenally high rate of retention in a survey as long as this one. Overall completion time was 20 minutes across all languages. It must be said though that the questionnaire was long, but it was also very coherent and very clear in its instructions.

The questionnaire is an agreed compromise and it is fair to say that absolutely none of the partners got the questionnaire they desired, but everybody moved forward once the questionnaire was signed off. Translation was another massive feat: it was ultimately available in 25 languages simultaneously, including 20 of the 23 official languages of the EU, excluding Maltese, Slovak and Gaelic Irish. In addition to these 20 languages, Norwegian, Ukrainian, Russian, Turkish and Serbian were included. Translation was an interactive process involving native-speaking stakeholders from the field and two native-speaking translators in most places. Several multi-language translators and proofreaders were also involved to compare each questionnaire to each other.

Online preparation, promotion and survey preparation

Finally, 15 months after the process was started, the questionnaires could all simultaneously go live online. Custom-designed privacy options were enabled, so that no IP address was ever recorded, no cookies were ever installed and all data was encrypted at source. All surveys had their own individual URL and could be accessed from the language-landing page emis-survey.eu

All online promotion appointed people to that language-landing page, so that men who saw the advert in, for example, German could subsequently decide to complete the questionnaire in any of the 24 languages. All partners could view the data in real time as the survey progressed. Also, a consolidated version of the 25 languages was created on Demographix Stockholm, so that all partners could sign into Demographix while the survey was running and view the data in real time. It sounds like an unnecessary innovation, but it was crucial to the success of the survey: the partners and Sigma literally watched the data ac-

cumulate on a day-to-day basis, and especially in the last four weeks of the survey, and changed the strategy every Monday morning in order to target the countries that weren't doing so well in the survey. All the surveys look the same and all looked like the promotional material that the partners agreed upon. For example, every language-landing page explained the purpose of the study and the qualifying criteria for the study, trying to establish consent to participate and that the likely participant is over the age of sexual consent in the country where he lived. The steering group agreed upon broad parameters of EMIS visual identity: the survey went through two online polls across the partnership to agree upon the look and feel of the survey. The core slogan of the survey had also been consulted on: "Be part of something huge". National partners were at liberty to change the promotion in their language, and many of them did so. Ultimately, 191 different banners and buttons were produced to promote the survey in 24 of the 25 languages. In addition, offline material was also produced to promote the survey, like cards and posters. Ultimately 27 different versions of business cards were produced, and 140,000 were printed and delivered to 37 EMIS partners. In addition, 23 versions of the poster were produced and 7,000 were sent out to EMIS partners. All these were passed on to their partners for promotion.

The bulk of the responses came from the mass promotion of the survey through five major advertisers: GayRomeo were absolutely instrumental in the success of the EMIS. They worked with Sigma Research to design the instant message that was sent out to 1,060,000 members in the language that that member had registered at GayRomeo, which included all 25 languages. They then followed up with new stories on their website, further mailings, and they continued to work with Sigma Research to promote the outputs of the EMIS and promoting the benefits for the community of the participation in EMIS. On top of the 103,000 people recruited by GayRomeo, which is something like 10 per cent of their active membership across the 25 countries where EMIS had actively been recruiting for the survey, Manhunt sent out messages to 200,000 members across the EU and recruited 12,000 to the survey, GAYDAR that sent out a variety of messages to their members in about a half of the countries recruited about 12,000 of their members. In the

former Soviet Union QGuys were also engaged, and in Scandinavia it was Qruiser – both contributed with about 3,000 people to the final sample size. A wide range of people was also recruited via Facebook, which was incredibly labour intensive, setting up events-pages in every country where recruitment was desired. 227 national websites promoted EMIS, and less than 10 per cent wanted money to do so.

Sample, participation and costs

This mass promotion of EMIS was achieved with substantial hard work from national lead partners in most of the countries. These partners actively sold the benefits of EMIS to NGO and commercial websites, and the meaningful relationships they managed to establish on Sigma's behalf resulted in a great-will towards the survey and a large number of recruits coming into the survey.

184,469 men were in the database after 12 weeks of promoting efforts. If the data excludes men who don't qualify and who show other inconsistencies, there are still 174,209 men in the sample. The many different countries also recruited different amounts of men to the survey, ranging from about a hundred in one, to for example 50,000 in Germany. At one point, EMIS recruited 21,400 men in 24 hours right at the beginning of the GayRomeo promotion. If one looks at the recruitment by the number of people that live in each country, recruitment of men by 10,000 inhabitants in a country, it balances up a little.

Having 83 partner organisations is an astounding achievement, almost as astounding as having more than 180,000 recruits. The questionnaire was hosted on a purpose-built internet survey platform that was infinitely modifiable and stable even at times when 21,000 men in 24 hours were recruited. Cooperation with multi-language super-national dating websites was strong and collegiate and this was absolutely crucial for the success of the project. GayRomeo literally contributed a vast amount to this project and continued to do so long after the survey had gone offline. A vast variety of recruiting websites offered a much more diverse sample.

50,000€ in total were spent on recruiting, and 180,000 men were recruited, which equals to about 30 cents per man recruited. That's about a tenth of the amount that is usually spent on a similar survey.

Ulrich Marcus, Robert Koch-Institute, Germany

1.4. Comparing self-reported HIV prevalence / incidence from EMIS with surveillance system-derived data

The text below is a summary of the session presented during the FEMP2011 conference.

As In 2010, the first pan-European internet survey for men who have sex with men (EMIS) collected self-reported data on HIV prevalence and HIV diagnosis within the last 12 months among more than 180,000 MSM in 38 countries. Since participation rates (in relation to the total adult male population) from different countries varied considerably, we analyzed the comparability of self-reported data with surveillance system data to determine possible sampling-dependent selection biases.

The scientific literature was searched for publications on the proportions of MSM in representative surveys of national general (male) populations. National surveillance data on newly diagnosed HIV infections among MSM in 2009 was updated and verified by contacting the respective authorities. To make surveillance and survey data comparable, surveillance data were related to the estimated size of the MSM populations. We then compared these data to survey-derived indicators for HIV prevalence and incidence (in 2009). A self-selection bias (SSB) for survey participants was calculated; and by using the upper and lower bounds of the SSB, a range for the expected number of new HIV diagnoses among MSM was estimated for countries which do not provide such data.

Different participation rates in EMIS as well as

the literature suggest different relative sizes (in relation to the total adult male population) of MSM populations across Europe. Taking these differences into account, survey-derived self-reported indicators for HIV prevalence and incidence were strongly correlated with data and estimates from national surveillance systems ($R^2=0.88$ for prevalence, $R^2=0.69$ for incidence). HIV positive MSM had a 1.5 to 3-fold higher likelihood to participate in EMIS when compared to HIV negative/untested men. SSB adjustment changes the country rankings regarding HIV incidence and prevalence compared with the crude survey and surveillance data.

Comparison with surveillance data suggests only minor sampling biases in the survey that would not seriously distort inter-country comparability, despite large variations in participation rates across countries. However, adjusting for sampling biases may further improve comparability. Despite self-selection Internet surveys are highly complementary to existing national surveillance systems. They may point out deficiencies in the national surveillance systems and even allow estimations on the range of newly diagnosed infections, and of HIV prevalence among MSM in countries where surveillance systems fail to accurately provide such data.

Dr. Kevin Fenton, CDC Atlanta, United States of America

1.5. An American comparison – MSM sexual health: Rethinking engagement, approaches, and outcomes

The text below is a summary of the session presented during the FEMP2011 conference.

Context – Where is CDC with the HIV epidemic in the USA?

About 1.2 million Americans are currently living with HIV. There has been a gradual and steady increase in prevalence of HIV since the early 1990s, partly because people live longer and healthier lives with HIV, and HIV incidence in the USA is relatively stable – each year there are about 48,000 or 50,000 new HIV infections. Across the categories, there have been gradual declines in HIV incidence in all risk groups apart from men who have sex with men.

In the United States, about 60 per cent of new HIV infections, which occur each year, occur among men who have sex with men, about one in four among heterosexuals, and about 10 per cent among injecting drug users. When one looks at the actual number of HIV infections that are occurring, MSM account for the top three of all race and transmission category groups in the US; so both white, black and Hispanic MSM account for the largest share of HIV infections that are occurring each year.

There is a tremendous heterogeneity in the age of MSM in which HIV incidence peaks in the United States. The African American MSM population in the US show the highest levels of HIV infections occurring among young MSM, those aged 13 to 29 years old. As African American MSM age, HIV incidence declines. There is also a very similar pattern for Hispanic/Latino MSM, although the burden of new HIV infections is not as high. Among white men, there is a relative stability in new HIV infections that occur across all age groups. Among the MSM subcategory, we are really dealing with different epidemics occurring concurrently, and there needs to be a far more nuanced and targeted approach to all prevention strategies.

Data from CDC's 2008 US national HIV behavioural surveillance system, in which more than 8,000 men were interviewed in 21 of the largest cities in the United States suggested that HIV

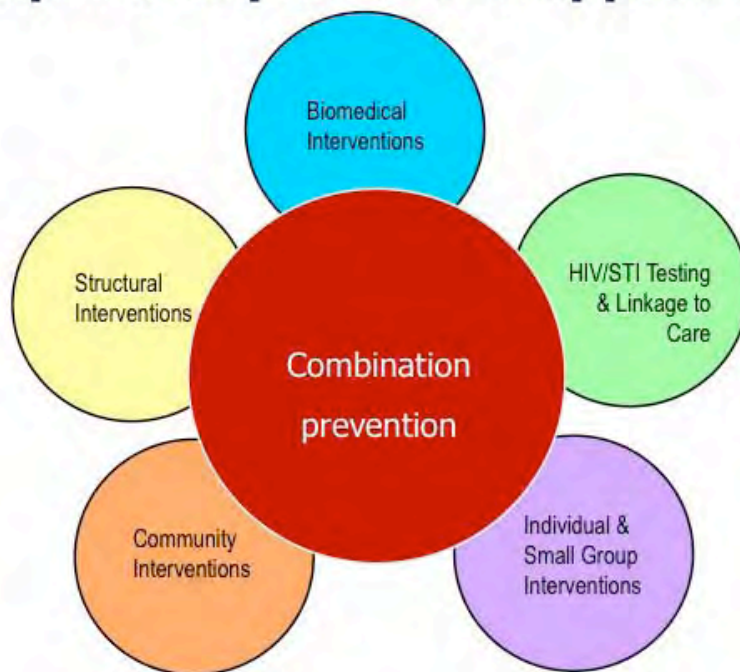
prevalence among MSM in these jurisdictions was about 19 per cent, with highest prevalence occurring among African American, followed by Hispanics and then whites. About 44 per cent of men in this study and these jurisdictions were unaware of their HIV infection.

CDC is not only concerned with HIV/AIDS among MSM in the US – there is also a high burden of sexually transmitted infections – about 62 per cent of syphilis cases that are infectious occur among MSM, and this is up by about 4 per cent since the year 2,000. So, consistently with most of the Western European industrialised countries, there has been a tremendous outbreak and increase in HIV and syphilis incidence among MSM. Consequently, higher rates of co-infection between HIV and syphilis, and HIV and gonorrhoea occur in the USA. There are fresh signals of increasing incidence of HCV, LGV, and HPV associated infections among MSM.

There is an increase in reporting on unprotected anal intercourse, as well as serodiscordant unprotected anal intercourse/non-concordant UAI; there is also an evolution in the epidemics of drug use among MSM with a special increase in non-injecting drug use, in part reflecting the changes with crystal meth use, which has been moving across the US, and the differential patterns of drug use by race, ethnicity and social class among MSM in the US.

Clearly, CDC has been looking at the literature about the nature of prevention tools that are currently available. In fact, the data up to June 2010 would suggest that there are only three randomised control trials proved interventions in the nearly 29 years of the epidemic that have been demonstrated to have an impact on reducing HIV incidence, and these include the Thai vaccine trial, SCD treatment and male circumcision for the prevention of HIV. To date, PReP for MSM remains the only randomised control trial proven intervention that reduces the HIV incidence among MSM, and of course many of the studies have

Combination Prevention Multiple disciplines and approaches



Adapted from Coates *Lancet*, 2008

demonstrated the impact of behavioural interventions or other interventions in either changing risk-behaviours or reducing STI acquisition, but PrEP remains the only intervention that has been proven to reduce HIV incidence.

In thinking about sexual prevention, there are a number of interventions that can be effective in either influencing risk behaviours, reducing STI acquisition or reducing HIV incidence. But when asked which of the interventions have been implemented effectively in the United States and that have been brought to scale within the jurisdictions in order to have a population impact, the list gets small. They have not been implemented with high quality and high coverage for population level impact among MSM; The new era technologies provide a new hope for men who have sex with men, and most importantly remembering that there is no magic bullet and that even these new era ARV-based technologies need to be combined as part of an effective prevention strategy.

What has also become clear in 2011 is that ARV-based HIV prevention has become increas-

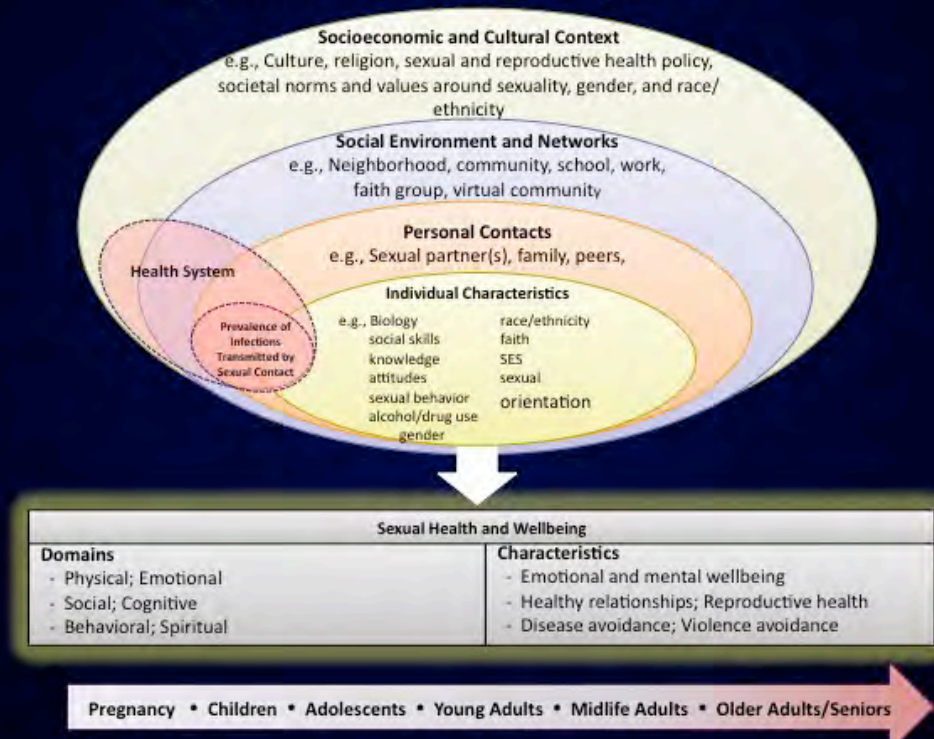
ingly fundamentally dependent on knowing one's HIV status.

New strategic approaches to enhancing HIV preventions

The existence of a range of prevention tools is very hopeful and it has been guiding CDC in the US to combine interventions for greatest impact. However, it is not simply picking and choosing interventions and then putting them together that would make a difference: one needs to pay attention to implementation, to scaling up monitoring and evaluation, and of course monitoring impact. Therefore, applying the science of implementation and programme management to maximise impact and improve quality will be incredibly important in the next phase of our response for gay and bisexual men.

CDC is developing some new areas for the future of prevention: first, how do we combine the range of tools that we have available to us, whether biomedical structural interventions, linking in HIV testing and linkage to care, building in the community-level interventions and the small-

Determinants of Sexual Health: A public health perspective



group interventions. As an agency, CDC is being far more critical in understanding the pathway of translation from basic science to proven concept to efficacy studies and addressing the barriers that currently exist as far as real-life implementation of interventions are concerned and the problems that exist with scaling of interventions at a local level. In the past few years, CDC has developed a new strategic approach that is far more deliberate about bringing epidemiologists and the prevention specialists and the policymakers together to think about effective implementation and scale up of prevention approaches – the “programme science” – the science of delivering prevention programmes. Finally, in the last year CDC has launched another strategic initiative, which is focused on integrating implementation science, programme science and combination prevention ensuring that our interventions are capable of dealing with some of the social and structural drivers of the epidemic.

CDC has also launched a very strong programme on social determinants of health that

includes working with mathematical modellers. This will help understand the US epidemic by providing readily usable mathematical tools, so that states and local jurisdictions can model their own epidemics and begin to choose the interventions that would meet their own local needs. These approaches will help do a better job with evaluation and resource utilisation.

Case studies

CDC will embark on a public health approach to address the social and structural determinants of health, and look at strategic approaches that focus on health, fitness and resiliency. There are four key goals to the sexual health initiative: improving knowledge, communication and attitudes about sexual health, increasing the use of coordinated, high-quality educational, clinical and preventive services, beginning a conversation about healthy, responsible and respectful sexual behaviours and relationships, and decreasing adverse health outcomes which include HIV and STDs, unintended pregnancies, etc.

In January 2011, CDC used this sexual health approach (for the first time) to develop a strategy for sexual health among MSM. The strategy itself is focused on three main pillars: strengthening the way in which the community is engaged – by bringing to the table new partners to work on HIV prevention and sexual health. The second pillar is expanding evidence-based interventions – looking at the prevention toolkit, doing research to explain the toolkit, but also by beginning to scale effective interventions. The third pillar is related to CDC’s work to strengthen monitoring and evaluation in the US for HIV and sexual health – The second key case example is the focus on prioritising, implementing and bringing to scale the most effective interventions for MSM, and realigning resources and technical assistance to meet today’s epidemic. CDC is providing a far better guidance to its local partners on how to select interventions and how to bring these interventions to scale. The five key interventions are: implementing HIV testing and scaling HIV testing, scaling of interventions for people living with HIV/AIDS i.e. prevention for positives, scaling of condom distribution – getting back to providing free condoms in the bars, in saunas, in other important places, and having new condom strategies and approaches in the US, scaling up post-exposure prophylaxis – and tackling some of the structures, policies and regulations which continue to adversely affect gay men’s health. Once the grantees demonstrate good progress with these interventions, CDC asks

the grantees to focus on the range of other tools within the toolkit.

There are four key lessons learned about the scale-up in the US: All prevention work is done in partnership with communities, as well as the professionals and other federal agencies. Legal barriers must be mitigated to convene the intervention and scale-up efforts. Stable funding streams are important once the process of scale-up has started.

Proactive monitoring and evaluation is a key strategy. CDC has also developed new funding announcements for CBOs that work specifically with young men who have sex men of colour as well as young transgender persons of colour and in 2011 CDC has acquired more funding to support 34 CBOs to do this work. At the same time, CDC is being more prescriptive in demands from the CBOs and what they need to deliver CDC is also limiting the range of effective behavioural interventions that these CBOs are asked to do, both in providing behavioural interventions for HIV negative individuals, as well as scaling up interventions for HIV positive individuals.

The prevention toolkit is growing, but all in all so far everybody has failed to fully leverage the existing tools, and not a very good job is being done on implementing or scaling up or monitoring the impact of existing tools. As more is added to the prevention toolkit, unless the focus is put on implementation, the danger is that the mistakes of the past decades could be repeated.



CHAPTER 2

Understanding vulnerability, the context and the determinants of the epidemics

INTRODUCTION*

The second chapter gives an account of the current situation in HIV prevention and relates its success/failure to different social determinants. A clear relationship between societal homonegativity, discrimination, internalised homophobia and mental health, excessive use of drugs and increased HIV vulnerability and risk is shown. Stigma and internalised homophobia are the main reasons for negative behaviour, and main obstacles to healthy behaviour.

Rigmor Berg from the Norwegian Knowledge Centre for Health Services explains: "... a homonegative policy climate appears to have pervasive effects on MSM's internalisation of such structural-level senti-

ments. Internalised homonegativity was also associated with not being connected with gay peers and lower levels of HIV preventive behaviours, which may have serious implications given that HIV testing is integral to HIV prevention, treatment and care efforts."

The connections between social vulnerability and living as a gay man, and between being gay and HIV positive show a direct correlation between human rights and HIV. This is supported by results from the SILAS study. Simon Rosser explains: "Overall impression is that men who have sex with men in anti cities report higher health risks and alcohol problems, than men living in pro cities."

Ford Hickson and other presenters in the following sessions pointed to the disconnection of prevention from the existing and common drug habits in the gay community and addressed the total lack of discussion of the gay leisure time arena as a determining factor. His conclusion is that there is a need for a broader health and especially sexual health agenda that would replace the previous focus on exclusively HIV prevention. This broader health agenda must be built on sexual health issues, and include human rights aspects, prioritising "best sex with least harm."

* Power Point presentations and abstracts related to this chapter can be downloaded from www.femp2011.eu

2.1. Structural inequalities are associated with internalised homonegativity in European men who have sex with men

The text below is a summary of the session presented during the FEMP2011 conference.

Prejudice is a regrettable feature of many countries and communities, usually being based on obvious stigmatising characteristics, such as race or appearances. But also less visible stigmatising statuses: homosexuality and homosexual behaviour have been the target of discrimination, inequity, prejudice, negativism, homophobia – many different terms for this can be used.

Concrete examples of negative sentiments and behaviour towards homosexuality include spray-paint on people's houses, newspaper stories, public signs and posters, civic demonstrations, rallies, and so on and so on. Most of you are probably familiar with the violent attacks on gay pride participants in Eastern and Southeastern Europe in recent years.

It seems that homonegative attitudes are ubiquitous aspects of contemporary social mores in many areas of Europe. The extent of dominant cultural values and institutional norms regarding homonegativity was recently presented in a study by Stulhofer and Rimac, who undertook a secondary analysis of the European Values Survey to examine homonegativity across 32 European countries. They found that the most tolerant or least homonegative countries were the Scandinavian countries and the Netherlands, while the most homonegative countries were Lithuania, Romania, Ukraine, Russia and Belarus.

On an institutional and political level, manifestations of negative attitudes towards homosexuality include political and social opposition to gay rights, such as no recognition of same-sex relationships – this is the case in Estonia and Latvia for example – no possibility for same-sex adoption – Austria and Hungary are examples – and absence of LGB antidiscrimination laws, such as in Lichtenstein and Russia.

The prevailing cultural ethos in which a person lives affects socialisation, which is described as

the internalisation of the values, symbols, regulations and attitudes that are inherent to people's developmental milieu. Weinberg, who in the early 1970s was one of the first to theorise internalised homonegativity, explained the construct of internalised homonegativity in gay and bisexual men as an internalisation of stigma and negative attitudes and assumptions about homosexual people.

Motivated by questions about the relationships of internalised homonegativity and inequity, and varying patterns of cultural and policy disadvantage among sexual minorities, we analysed internalised homonegativity levels by country structural variables including legal discrimination and income inequality, and, in turn, its associations with person-level variables.

The analyses are based on EMIS. Given the large sample size, this was a perfect dataset to examine both internalised homonegativity structural predictors and its associations with person-level variables. EMIS included a culturally stable form of the internalised homonegativity scale, which was created so that a higher score meant higher internalised homonegativity. Two variables were not part of EMIS: we therefore created the country structural variables 'legal climate' and 'income inequality' from the legislative measures of LGB status list and UN human development report respectively. We also examined internalised homonegativity relationship with size of location of residence, HIV testing and degree of "outing" as gay or bisexual.

Among the analytic sample of men with a valid internalised homonegativity score the mean score varied across countries from 1.22 in the Netherlands and Sweden – lowest – to 2.58 in Bulgaria, the country with the highest mean internalised homonegativity score among respondents.

For the cluster analysis we employed a two-step procedure using Euclidian distances and used

Results: IH across Europe



measures of legal climate supporting LGB rights, proportion of verbal discrimination, and proportion of physical discrimination reported. The analysis identified three clusters:

1. A group of liberal Scandinavian and western European countries
2. The second cluster included central European countries and some Mediterranean countries
3. The third cluster included a group of predominantly former Soviet countries, Russia, Ukraine and the Balkans characterised by the highest levels of internalised homonegativity among EMIS respondents.

The liberal cluster had much lower internalised homonegativity mean than the moderate cluster and especially the conservative country cluster.

Results showed that internalised homonegativity was, on a structural level, predicted by legal discrimination, which was measured by scoring the presence of six legislative protection measures of LGB status. There was a clear and strong relationship: When there were few measures in

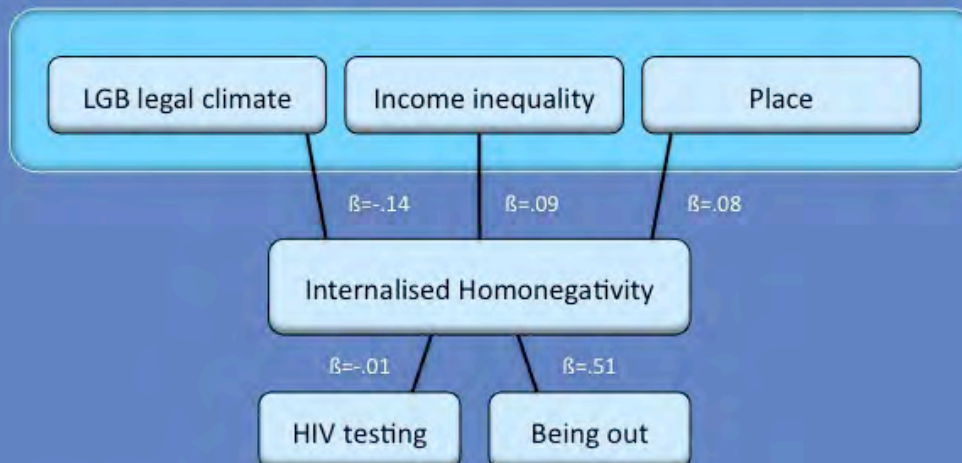
place to protect LGB communities legally against discrimination, there was higher internalised homonegativity among MSM.

There is another strong relationship with secondary data: the higher the income inequality in a country, measured with the Gini coefficient; the higher gay and bisexual men's internalised homonegativity.

In addition to showing that legal climate and inequality were strongly associated with internalised homonegativity, men with higher internalised homonegativity resided in smaller towns rather than big cities. Internalised homonegativity, in turn, was associated with being out as gay or bisexual: men with higher internalised homonegativity score were out to fewer people. Lastly, in an HIV prevention perspective, it is important to note that men with a high internalised homonegativity score were less likely to have tested for HIV.

From the first analysis, the cluster analysis, it was easy to see that the clusters mirrored the results of the European Values Survey, which suggests that internalised homonegativity is likely

Results: Structural and person-level links



to be a reaction to societal homonegativity. Next, the results showed that a homonegative legal and social climate appears to have persistent effects on MSM's evaluation of the self, with higher internalised homonegativity found in environments characterised by a lack of state-level protective policies for sexual minorities. Internalised homonegativity was also associated with not being connected with gay peers and not testing for HIV.

However, while there is strong political and socio-cultural opposition to gay rights in some countries, affirmative tendencies should not be overlooked: A few years ago, Slovenia and Czech Republic passed a law on registered same-sex partnership, and the European Parliament passed a resolution condemning homophobia in the European Union.

Policies are powerful means for organising the values and general strategies of governments to reduce inequity: aside from the human rights aspect, the EMIS results suggest that improved affirmative policy environments can have positive health impacts on MSM populations.

As one of the first studies, EMIS shows that a homonegative policy climate appears to have pervasive effects on MSM's internalisation of such structural-level sentiments. Internalised homonegativity was also associated with not being connected with gay peers and lower levels of HIV preventive behaviours, which may have serious implications given that HIV testing is integral to HIV prevention, treatment and care efforts.

– Discriminatory policies is not only bad law, it is bad psychology and bad medicine.

**Simon Rosser, University of Minnesota
(American/Non European Experience)**

2.2. The relationship between discrimination, homophobia, mental health and HIV risk – Findings from the SILAS study

The text below is a summary of the session presented during the FEMP2011 conference.

Homophobia is probably the number one issue for gay men throughout the world, and certainly the number one issue in terms of human rights, but it's increasingly being recognised as a barrier to public health.

SILAS is a structural study, and the interest was to look into the effects of laws on gay bars. The study has a broad focus looking at alcohol, drug use, mental health and HIV risk. As a com-

munity, MSM suffer from great health disparities including higher alcohol and drug use, abuse and addiction, depression and suicide, HIV and STIs, childhood physical, sexual and mental abuse and violence. The key question is why? In the 20th century there has been a leading explanation: that our poor gay health is an outcome of discrimination and societal homonegativity. There are a number of papers, including a few by the SILAS team,

Health Disparities of MSM

SILAS
STRUCTURAL INTERVENTIONS TO LOWER
ALCOHOL-RELATED STI/HIV-RISK

Research shows MSM at higher risk of:

- **Alcohol and drug use, abuse, and addiction**
- **Depression and suicide**
- **HIV and STIs**
- **Childhood physical, sexual, mental abuse**
- **Victims of violence**

Why?

UNIVERSITY OF MINNESOTA

that have shown that internalised homonegativity, and not homosexuality is the better correlate with negative mental and sexual health outcomes. But the SILAS team asked the question: What is the actual evidence that the theory of internalised homonegativity has any evidence? Somehow we believe that the negative attitudes expressed in our laws, our policies, our nations have lifted out more community violence, which in turn are internalised by those of us who are gay, and it affects gay mental health, which is then lived out in behavioural outcomes and ultimately in worse societal health impacts and disparities. So, we decided to test that model.

Most laws in the United States are decided at the state level. There are at least four areas where states differ: same-sex marriage, gay adoption, hate-crimes in terms of anti-discrimination, employment and housing. This is a perfect scientific incubator at the moment to study the differences across the United States.

SILAS is a naturalistic comparative study of 16 moderately sized US cities, and eight cities with the most pro-legislations were identified (i.e. cities were chosen over states because the goal was to explore the number of gay bars in each of the selected cities). Then the remaining eight cities were identified that were matched on approximate size of the city, the racial and ethnic composition of the city, the region of the country, and as many other factors that could be matched in order to set the study up as a fair and balanced experiment. The duration of the SILAS study is four years so that the change over the time could be measured. The first half of the study was entirely an online study with men recruited from gay.com and Manhunt. In terms of analysis, there was a focus on three levels: First, what you see when you first go and look, similar to the EMIS study; second, what happens when you start controlling some of the other variables that happen scientifically; And finally, to take a look and see how all these relationships fit together to test the actual model.

Obviously, the interest was looking into laws, either pro or anti; then at the next level, a new scale was developed to measure tolerance and hostility at two different levels, one level was named individual hostility by focusing how gay-friendly or gay-hostile are one's friends, family and working colleagues – a more micro-level of hostility, and then the more macro-level: how gay-accepting or gay-hostile is one's immediate neighbourhood, city and state. In terms of mental health, the interest was in the homonegativity scale, and it is the scale used to measure depression. In terms of

behaviour, sometimes in HIV prevention work we forget that the gay community has a number of other challenges around the area of alcohol use, and illicit drug use. And finally, HIV risk behaviour – a rather conservative measure of unprotected anal intercourse was taken, distinguished by two or more partners, which would meet anybody's definition of unsafe sex versus zero or one that would account for a long-term relationship.

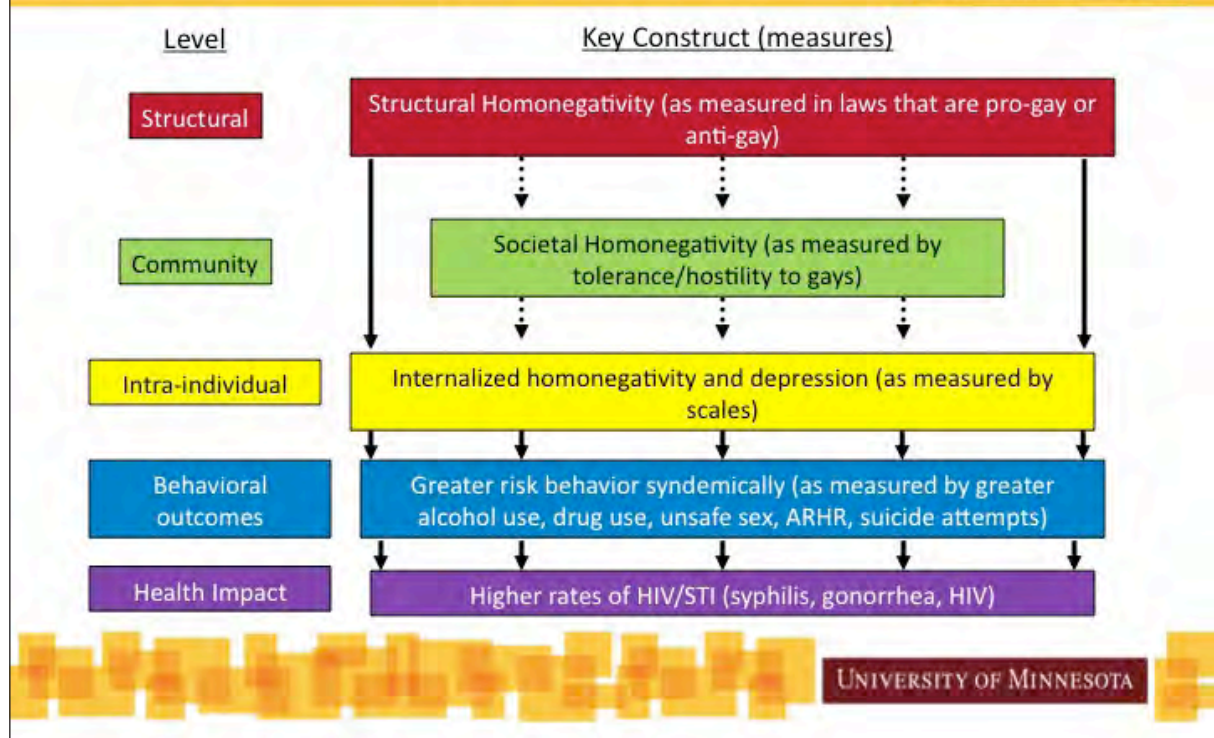
What could be noticed overall is that the samples are white, young, educated, liberal, and mostly unmarried, they are gay identified and HIV negative. In the anti states, the guys were slightly older, they were a little less white, more likely to be in a relationship, but less likely to be married and they were much less educated in the anti states as well as less gay-identified. People from anti states were more likely to vote Republican and more likely to have kids.

As compared to the men in the pro states, the men in the anti states rated their family, friends and working colleagues less tolerant and more hostile; they rated their neighbourhood, city and state as less tolerant and more hostile, they reported significantly higher internalised homonegativity. SILAS also proved that internalised homonegativity can be measured. Overall impression is that men who have sex with men in anti cities report higher health risks and alcohol problems, than men living in pro cities.

For this study it was important to control for city clusters effects and for demographics – when one does this, what is noticeable is that although, most differences remain, the levels of internalised homonegativity disappear, or are no longer significant.

There is a finding in the SILAS study that in the crude analysis pro or anti states relates to internalised homonegativity, but when adjusted for city and sexual identification, this finding disappears. It turns out that gay identification is a critical modifier, and what that means is that if one considers whether somebody identifies themselves as gay or bisexual, and considers this an outcome of internalised homonegativity, then there is some small support for the theory that we internalise the negative environments around us. If one considers it, however, a demographic, then there is very limited support once you control for the other things between cities. What is also interesting is that MSM in the anti states reported less individual tolerance, and less community gay tolerance, and that will be important to study in the future studies. This, in turn, predicts both internalised homonegativity and depression. If

Theoretical Logic Model



one imagines for a moment that gay people are not gay people, if one imagines that gay people are for example an immigrant group, they integrate within about 45 to 60 years. What happens is that when immigrant groups first arrive to the country, they are often seen as the outsider, they are often seen as dangerous, politicians often make politics out of them, and what happens here is that the groups stay together, they stay in neighbourhoods, and if they are allowed to assimilate, they gradually assimilate into the broader society.

What is also interesting is that there used to be a general opinion that internalised homonegativity is something that somebody has, something deep inside a person that needs to be worked on, but the research through SILAS is suggesting that maybe it is something relations-related or environmentally driven, that it's something between a person and their community.

Internalised homonegativity was not significantly related to alcohol use, and that was a surprise. Internalised homonegativity also seems protective of drug use, and this is one of those really interest-

ing findings that needs to be considered: that if a person hates their sexuality, and loathes being attracted to men, that person is going to spend a lot of energy avoiding it, and maybe that there is more sense of conservative alcohol and drug habits that go with more conservative sexuality. So, there are tradeoffs here to be considered. By contrast, depression is correlated with both alcohol and drug use, and so both EMIS and SILAS must take a closer look into depression and depression levels in the gay community. Only marijuana use and poppers ultimately influenced unsafe sex – marijuana decreased risk, while poppers increased it. It's curious that alcohol use was not associated with increased risk since it's been shown so in many studies. What's also interesting is that pro-gay or anti-gay laws, hostility and depression were not directly associated with unsafe sex. This slightly reflects that the decisions to engage in unsafe sex are determined by more proximal factors, or to put it simply, if I arrive to Sweden and decide to have sex, I'm probably not deciding that since Sweden has excellent laws, so I'm going to have

safer sex tonight, and then when I fly to Russia, I say: “Oh dear, Russia is not so accepting, so I better have unsafe sex.” – it doesn’t work that way. We have to think more deeply about what structural factors mean.

There is another controversial interpretation: marihuana use as associated with less unsafe sex. If causal and according to this theory, then HIV prevention should encourage more marihuana use among gay men to decrease HIV risk: it’s cheaper and a lot less controversial than giving PReP to HIV negative men.

Men living in the anti states reported significantly more individual hostility, community hostility, depression and less marihuana use than men living in the pro states. It is then fair to conclude that in the anti states gay men experience more violence, less support and poorer mental health, but abuse less drugs.

SILAS has already gone in and repeated the study with a fresh sample, and the model replicates closely, which means that the results are reasonably reliable. Internet-using MSM are a more homogenous subgroup and the sample was large, hence we think that if we find something and we replicate it, we think that it’s likely to be real. Pro- and anti- laws appear to be associated with measurable differences in gay men’s health. But for most variables of interest, the effects are indirect and small, and hence there is only modest evidence supporting the theory of internalised homonegativity.

In terms of understanding gay health disparities, there is a series of things such as laws appearing to be strongly related to hostility, which in turn influences the mental health, which in turn influences a gay man’s behaviour, which in turn influences the man’s HIV risk. For HIV prevention, it’s not enough to identify risk and risk factors, but there needs to be a deeper understanding of how all these pieces fit together in the way that we can make sense of them.

In terms of advancing interventions, if the relationships are causal, at each stage intervention may be able to counteract any negative effects on health. So, for example, changing laws on same-sex marriages or equal employment is likely to improve tolerance amongst family members, work place and neighbourhood. Together with EMIS, there are now two studies that say: changing the law is a legitimate intervention for gay men’s health in combination with other interventions.

In the past when studies were published on gay men’s and individual health it was commonly stated that more research is required to understand general visibility. In the future we need to start recommending that the researchers assess the laws and the document policies in those areas where they’ve done their studies, since we now know that different environments associate with different mental and sexual health outcomes. EMIS and SILAS also suggest that there are at least two divergent experiences of being gay: in more pro-gay legislation areas men are more out, they report greater support, gay tolerance, they have less internalised homonegativity and depression, they report more liberal voting, and they probably smoke some dope. In the more anti areas, the men are more closeted, they report greater hostility, have more internalised homonegativity and more depressed, which can lead to more alcohol and drug use. Each system appears self-sustaining at multiple different levels. It’s not enough to just encourage somebody in an anti state to come out, there needs to be a systemic change as well.

So, implications for the EU: we can’t assume everyone or every community is having the same experience of being gay. How can gay communities in countries with full rights aid those in countries with no or less optimal rights, or areas where there is greater hostility? And while it may be healthy personally to migrate to places with better conditions for gays, for optimal social change the migration actually has to happen the other way around.

2.3. Working towards better sex with less harm for gay and bisexual men in Europe

The text below is a summary of the session presented during the FEMP2011 conference.

The title of the conference asks us to consider the future: The future is inevitable, but what it looks like is not. The evidence base for conferences making a difference is fairly slim. However, this meeting can result in getting a stronger will to improve sexual health among MSM in Europe, and it can also result in obtaining a greater power to do so.

One of the key differences between success and failure is that success knows where it's heading. If we don't have goals, how will we know if we have achieved them?

What's the goal?

In order to make a reduction in HIV incidence, one collective goal is not enough on which to build a common future. On the one side is an uncomfortable alliance between homophobes and a public health imperative that insists on less harm at any cost to gay and bisexual lives. On the other side is the gay liberation past and a gay leisure-sex industry present, that portrays the best gay sex life as being a Pornotopia that is both a birthright and an obligation. This dynamic has resulted in a false choice between sexually happy populations with a lot of HIV or sexually miserable populations with little HIV. It is a dynamic which suggests that we

can only move up and down this axis.

We can in fact, collectively move towards better sex with less harm.

MSM under threat

There should be no doubt that gay and bisexual men continue to fight for their lives across Europe. Gay men continue to be targets for demonisation, discrimination, and murder. It is in this context that HIV health promotion occurs, a context that both creates and exacerbates HIV prevention needs, and limits and hampers efforts to educate and empower men in their sex lives.

The countries of Europe share a history of varying degrees of nationalistic pride, built on military strength, cultural dominance, or fantasies of ethnic purity. These are no longer European values. Instead, we should be proud that our countries are mature and tolerant of diversity, that they are able and willing to support all their citizens, and that diplomacy and cooperation are our key strengths.

The ten choices

There are ten choices facing MSM that have been identified by CHAPS, the HIV health promotion collaboration in England.

The ten choices are:

The 1st choice is, whether to test for STIs, including HIV if we have not already been diagnosed, or to put off testing.

The 2nd choice is; if we are diagnosed with an infection, whether to treat it or not.

The 3rd choice is whether we have sex with another partner, or whether we decline, defer or date him.

Choice 4 is whether or not sexual partners share what they know of their HIV statuses, or not. In other words, whether they attempt to establish HIV sero-concordancy.

Choice 5 pertains to men in steady relationships; whether or not they are sexually exclusive to that partner, or whether they have an open relationship.

Choice 6 is whether or not to engage in anal intercourse, the sexual act most associated with HIV transmission.

Choice 7 arises if anal intercourse occurs and is whether or not use a condom, the central plank of HIV prevention education for MSM for the past two decades.

Choice 8 is whether ejaculation occurs outside or inside the body.

The 9th choice is whether to avoid poppers, or whether to use them.

The 10th choice faces HIV negative MSM and concerns whether or not to take chemo-prophylaxis against HIV, either Pre- or Post-exposure.

Not all of these choices will be open to all MSM in the future, although most will be. The contribution of each of the choices to HIV incidence will vary across countries. However, in all countries the future of HIV depends on the availability of these choices and the ways in which they are made.

	Precaution	Risk
1	HIV/STI screening	Putting off screening
2	HIV/STI treatment taking	Putting off treatment
3	Declining new sex partner	Having another sex partner
4	Establish sero-concordancy	Silence
5	Monogamy	Open relationship
6	Non-penetrative sex	Anal intercourse
7	Condom	No condom
8	Withdrawal before ejaculation	Ejaculation into body
9	Avoid poppers	Use poppers
10	Post-exposure prophylaxis	Inaction



Sigma
RESEARCH

The ten choices are derived, described and analysed in Making it Count, the collaborative planning framework of the CHAPS partnership. These are the primary choices that, taken together, determine the shapes of the HIV epidemic. Each choice involves choosing precaution, or choosing risk.

Diverse populations need diverse tactics

Marcel Proust wrote that the one thing more difficult than following a regimen is not imposing it on others. Authorities try to impose singular solutions on diverse populations and most of these tactics have advocates for their exclusive or near exclusive use. Homophobes such as the Pope tend to go for choosing never to have sex. Promiscophobes such as Cliff Richard would like to see all MSM in long-term monogamous relationships. Those who are appalled by anal intercourse would like all MSM to have manual sex only.

Perhaps the most common insistence on a singular tactic is that all MSM use a condom every time. This is advocated by safer sex authorities who value promiscuity and public health officials who have a limited conception of the diversity of gay sex lives. More recently, fierce advocates of test and treat have joined the fray. Advocates of

a singular tactic tend to dismiss other tactics as either unnecessary (because people only need to follow their rule), ineffective (because they would not work every-time for everybody) or out of the realm of possibility (claiming men will not choose to decline sex, to not fuck, to be monogamous, etc.). However, the condom alone has not delivered us to the promised land of the best sex lives with the least harm. Nor will any of these tactics deliver this for all men, with all partners, on all occasions.

Combination prevention

Combination prevention encourages us to consider programmes of work that enable individuals and couples to reject those things which carry no utility for them, and to adopt those precautions that enable them to approach the things they value, with as much risk as they are willing to bear.

Evasive and defensive tactics

HIV prevention has for some time focussed on those tactics that involve a product – take a test, use a condom, and more recently, take the pills. (in the future, the use of microbicides will hopefully be added). These might be called the defensive tactics.

The evasive tactics tend to be counted in terms of “don’ts”: don’t have another sex partner, don’t have open relationships, don’t fuck, don’t use poppers. These choices we tend not to promote to any extent. There are three main reasons why not:

The first is that in health it is usually easier to tell people to do something than it is to tell them not to do something. We need to get around this by representing precautions as active choices and by promoting the benefits that are of value to MSM, such as more time to invest in sociable and enriching pursuits; emotional security; clean, convenient, brotherly sex; no headache.

Another reason we shy away from promoting evasive tactics is that some HIV risks make money. Poppers is an obvious example. Less obvious is that the partner turnover is the raw material of a gay leisure-sex industry that intertwines prostitution, drugs, pornography, clubs, cruising websites, promotional advertising, lifestyle magazines, sex paraphernalia, saunas and fitness facilities.

Casual sex, open-relationships and poppers are normative among gay communities and a considerable economy runs on them. The gay leisure-sex industry dominates our visual landscape of what it is to be gay, which is to have numerous sexual encounters whose only consequence is sexual satisfaction and social standing.

Unlike the tobacco-control lobby, HIV interveners do not lobby against promotion of some HIV-related risks, such as the provision of the means of acquiring new partners, the graphic representation of anal intercourse, or the sale of poppers. Instead, these are things that have been promoted by those who would deny the right to them altogether.

So, the third reason why we do not acknowledge these evasive tactics is that they are invented by the homophobes who have traditionally tried to impose them on gay men. We need to get over this by not telling people what to do (or what not to do). We need to stress our belief in men’s right to take risks within the law and that our defence of that right is not the same as our endorsement of taking the risk. Otherwise we are simply competing with other authorities in claiming dominion over men’s bodies.

Another sex partner?

A nation’s homophobic response to HIV in MSM results in a defensive backlash by gay communities. When you threaten my way of having sex, you threaten my being.

When under threat, we retreat to black-and-white positions. When some say all gay sex is bad,

we respond by saying that all gay sex is good, and more gay sex partners is better. One of the tenets of the gay liberation movement of the 1970s that so informed the gay response to HIV in the 1980s was that having gay sex is liberating, and the more sex partners you had the more liberated you would be. When the closet is the dominant source of harm to our sexual lives, this strategy makes sense. But when sexually transmitted infections are a major source of harm it is counter-productive.

Even in the 1990s the gay safer sex movement was encouraging men to increase sexual partner acquisition, as long as they always used a condom. This approach was and is supported by the gay leisure-sex industry which portrays the greatest sexual happiness as being the same as the greatest number of sexual partners. However, this industry has not delivered widespread sexual happiness to gay and bisexual men. It has improved it (by providing sexual contact) but in the process has also generated a mass sexual performance anxiety and widespread sexual misery over our inability to live in Pornutopia.

Gay and bisexual men greatly overestimate how many partners other men have. Our constant exposure to images of successful and happy cruising and contracting gives us the impression that everyone is at it all the time. Subsequently, the majority of men think they are less promiscuous than others and that they contribute less to population risk than they in fact do.

We have to acknowledge that the best sex life for MSM is not the Pornotopia portrayed by the gay leisure-sex industry. Frequent sex does bring greater sexual happiness but more sex partners also bring greater harm. The direction of travel should, therefore, be better sex with fewer partners.

Current HIV prevention practice seems not to distinguish the value of different sexual partners. All sexual partners are equally risky and equally valuable. However, different partners do have different values. The fewer sexual partners we have, the more valuable each becomes. We could both reduce harm and increase the quality of our sexual lives by eliminating sex that carries risk but has little utility. This includes sex we regret, or that takes time that could be more happily invested in some other activity. Another sex partner is not always the best decision and we need to move away from our fear of expressing this.

There are many men with large number of partners who are unhappy. And many unhappy men who want not more partners but a stable, steady, regular partner. Many of them would like to be monogamous.

Lack of regulation

We know that education, information and services can help men to make capable, informed choices. But someone capable and informed will not always make a precautionary choice because capability and information are not the only things that influence choices. We need to recognize the complex structures that exist in the provision of goods and services in the licit and illicit gay leisure-sex and drugs industry that allows and encourages men to take risks.

Despite the efforts of local projects and international projects such as Everywhere, many sex-on-premises venues continue to show bareback porn, or fail to provide sufficient soap and water to wash away faecal bacteria before returning to the bar, or do not supply condoms or precaution-positive imagery. Condoms in gay pornography are less normative than a hard-hat on a building site, sex on premises venues are less regulated than a local restaurant. Workforce health and safety protection in the gay leisure-sex industry is weak.

Service quality regulation is variable. We need to challenge these situations by acknowledging and defending the legitimacy of these industries and our expectation that they comply with the existing legislation on health and safety of the workforce.

HIV-ogenic environments

The ‘othering’ of HIV risk drives us to seek explanations in the character and failings of individuals, when in fact our choices are strongly, some would say predominantly, determined by our circumstances and our surroundings. Making the problems “those risky men,” prevents us from identifying and altering the risky environments we live in. The notion of the obesogenic environment is now common in accounting for the increasing trend towards obesity, especially

among poorer people in richer countries. Why are we so resistant to acknowledging the HIV-ogenic aspects of current day socio-sexual structures and institutions? Why is homophobia the only structural facilitator we seem willing to identify?

We identify fast-food outlets as being an issue for obesity, but we turn a blind eye to the role of fast-sex outlets in STIs and HIV. Are we frightened of the vested business interests, are we afraid of appearing to get into bed with homophobes, or are we not wanting to acknowledge these are the risks we ourselves choose to take? I suspect all three are in operation, along with other explanations. I know that we need to understand and overcome these obstacles if we are not to inadvertently promote risks to men whose sex lives would be better without them.

A homofuture is inevitable

We cannot coordinate our activities unless we share sufficient goals and aspirations. Stressing the singular goal of reducing HIV at any cost aligns us with the enemies of gay and bisexual men and fosters suspicion, distrust and reaction. Attempting to impose a singular risk reduction tactic on a diverse population also causes reaction and it fails to exploit the range of precautionary tactics available. Making everyone else’s decision for them is not going to work, since we can’t all decide which decision everyone should take.

We desperately need a common goal on which those concerned about HIV and MSM can collaborate. Not simply collaboration between agencies, authorities and activists, but between those speaking and those on whose behalf we speak. A desire to see less HIV is not enough.

I believe we must be moving towards both better sex and less harm, if we are to pull in the same direction.

Gay men, bisexual men and other men who have sex with men are not simply an HIV risk group. Love and sex between men...

... is natural and healthy,
... is part of every tradition,
... in every country,
... is robust,
... has and always will be with us,
... is warm and intense,
... is fun and pleasurable,
... is sociable,

... helps bind the social fabric,
... fosters valuable skills,
... is a precious experience,
... brings honour and reward,
... comprises sacred acts,
... is a highly correct moral choice.

The future cannot but contain something so valuable. HIV, on the other hand, is just a virus; Still, a very serious virus, but nothing more.

2.4. Life as an ongoing party? – Drug use and MSM

The text below is a summary of the session presented during the FEMP2011 conference.

2.4.1. Substance use among Portuguese MSM – Results from the EMIS study

Ricardo Fuertes, Grupo Português de Activistas sobre Tratamentos VIH/ SIDA (GAT), Portugal
Abstract number: 1771588

Substance use and sexual practices have been subject to continued interest, particularly in relation to their interaction and the resulting effect on communicable diseases. Also, substance use and homosexuality are often associated with discrimination and stigmatisation posing additional challenges both to the individuals and to effective health promotion strategies.

Through EMIS, an anonymous online questionnaire was provided in 35 European countries and in 25 languages. Data from the Portuguese sample was extracted and analyzed (SPSS 19). For analysis only, cases with non-discrepant data were included resulting in 4,584 participants (mean age: 32±10.6 yrs.). Information on sexual behaviour, HIV infection and substance use was collected. Categorical variables are presented as counts and proportions. Continuous variables are presented as mean ± standard deviation (SD).

Injection of steroids or other drugs was uncommon: 96% of the participants had never injected anabolic steroids or any other substances. However, 26% reported cocaine use within the previous 12 months. Excess of alcohol intake was perceived by 33%. In the previous month, 10% assumed consumption of nitrite inhalants (poppers) and 4% of substances that enhance erection. The consumption of drugs typically associated

with sex and parties - ecstasy, amphetamine, crystal methamphetamine, methadone, GHB/ GBL, ketamine and cocaine – was reported by 31% of study participants within the previous 12 months, and by 5% in the previous four weeks. There was a significant association between drug use in the previous four weeks and the perception of HIV transmission risk: 7.2% of those who'd had unprotected anal intercourse had such drugs, compared with 4.1% of those without such behaviour ($p < 0.0005$). Such consumption was also significantly associated with having sex abroad in the previous 12 months; 10.2%, being out to nearly everybody (9.3% vs. 3.7%) or being HIV-positive (9.0% vs. 4.3%). 10% of participants were worried about their own recreational drug use. Age was not significantly associated with consumption of those drugs usually associated with sex and parties. Also, sexual identity, sexual happiness, being single or engaged in a steady relationship, or comfort with one's homosexuality were not significantly associated with drug use.

This study showed that recreational use of drugs is common among Portuguese MSM and its use is associated with other risk taking behaviours. The association with HIV needs to be specially addressed.

2.4.2. Alcohol use, illicit drugs, type of sex partner and sexual risk-taking

Lena Nilsson Schönnesson, Infektion Venhälsan, Sweden
Abstract number: 1766405

While international HIV-prevention research within the MSM population shows strong correlation between sexual risk-taking, alcohol/illicit drug use prior to sex, and type of sexual partner, the information coming from Sweden in this regard is limited.

The goal of this study was to cross-sectionally examine the degree of sexual risk-taking and its associations with the type of sexual partner, alcohol and/or illicit drug use prior to sex, and HIV status among MSM visiting the STIs screening service and the outpatient HIV clinic at Venhälsan, South General Hospital, Stockholm.

Participants included 352 MSM (ages 16–74 years, mean age 41) of whom 50% have HIV infection, 25% reported being HIV-negative and another 25% had unknown HIV status. An anonymous, self-administrated questionnaire was used to obtain data about demographics, type of sex partner (one partner, casual partners, and recreational sex) past 6-month sexual behaviours, and condom use and alcohol/illicit drug use prior to sex for each type of sex partner. Data was analysed using Spearman's correlations coefficients, chi-square tests, and t-tests.

One fourth of the sample reported that they and their partner(s), in the previous 6 months had practiced unprotected anal sex. The highest frequency of unprotected anal sex was with the main

partner and the lowest with casual partner(s). The majority of the sample practiced unprotected oral sex regardless of the type of partner. The majority of the sample used alcohol prior to sex. While alcohol with a casual partner was associated with unprotected oral sex, alcohol with the main partner correlated with unprotected anal and oral sex. More than one third of the men used illicit drugs when having sex with casual partners and while practicing recreational sex respectively. There was a significant correlation between illicit drugs, casual sex partners, recreational sex and unprotected anal sex. HIV status also played a role in sexual risk-taking. Non-HIV positive men and their casual partners and fuck buddies used condoms more often when having anal sex compared with their HIV positive counterparts. Men with HIV infection and their partners practiced protected oral sex more often than non-HIV positive men regardless of type of sex partner.

Among the Swedish MSM, patterns of alcohol and illicit drug use associated with sexual risk-taking were similar to those found in US studies. However, the level of alcohol and illicit drug use was significantly lower than in similar US studies. This data suggest that in Sweden, alcohol and illicit drug use reduction interventions may most usefully be targeted by partner type and context.

2.4.3. Care on the dance floor: Gay party circuits and the fabric of risk

Laurent Gaissad, Université Paris Ouest Nanterre – Université Libre de Bruxelles, Belgium
Abstract number: 1771569

This presentation is grounded on an ongoing ethnography of gay men sexual networks, agency, drug use and traffic in West European Gay party circuits. The research initially entitled “The construction of gay men's sexual compulsivity, addictions and multiple risks” (Post-Doctoral Young Researcher Grant,

Sidaction, France) seeks to question statistic evidence of extensive surveys validating a wide range of addictive conducts without defining the nature of neither their mutual interactions, nor the degree of their correlation with the continuously high HIV prevalence amongst gay men.

The results highlight concrete sexual and licit / illicit drug use and harm reduction practices, pointing out the discrepancies with current behavioral trends in scientific literature or in coincident socio-medical debates. In contradiction with the contemporary fabric of risk in what is designated a “problematic” population, it describes interurban mobility (Bruxelles, Paris, London, Frankfurt, Madrid, Amsterdam, Barcelona, Berlin), and above all the territorial networking of sex and drug trade, as key-elements for the understanding of gay festive, sexual and psychotropic identity.

Moreover, such social interactionist approach of gay circuit parties shows how profane pharmaceutical and deal expertise are commonly used to maximize sexual experiences, and more particu-

larly, it reveals collective forms of attention, self-support and care amongst party goers from which traditional NGO and public health interventions seem disconnected. Party managers’ often informal involvement in the concrete handling of risks should also be accounted for to open alternative perspectives of community action in the party subculture, likely to challenge the widely held medicalization of sex, pleasure and gay identity somehow inherent to contemporary epidemiological knowledge and emergency.

Gay circuit party goers local expressions of care, grounded on social pragmatics of pleasure (Race, 2009), therefore need to be further and fully described in order to challenge the ongoing efforts to cure them, implicitly yet mostly at stake in biomedical approaches.

2.4.4. Rich with meaning: Poppers use among homosexually active men

David Reid, London School of Hygiene and Tropical Medicine, United Kingdom
Abstract number: 1771252

The research entitled “The construction of gay men’s sexual compulsivity, addictions and multiple risks” (Sidaction, France) initially seeks to question statistic evidence of extensive surveys validating a wide range of addictive conducts without defining the nature of either their mutual interactions, or the degree of their correlation with the continuously high HIV prevalence amongst gay men. The results highlight concrete sexual and licit/illicit drug use and harm reduction practices, pointing out the discrepancies with current behavioural trends in scientific literature or in coincident socio-medical debates. In contradiction with the contemporary fabric of risk in what is designated a problematic population, it describes interurban mobility (Brussels, Paris, London, Frankfurt, Madrid, Amsterdam, Barcelona, Berlin), and above all the territorial networking of the sex and drug trades, as key-elements for the understanding of gay festive, sexual and psychotropic identity. Moreover, the social interactionist approach of gay circuit parties shows how profane pharmaceutical and deal expertise are commonly used to maximise sexual experiences, and more particularly, it reveals collective forms of attention, self-support and care amongst

party goers from which traditional NGO and public health interventions seem disconnected. Party managers’ (often informal) involvement in the handling of risks are also accounted for as a way of opening alternative perspectives of community action in the party subculture likely to challenge the widely held medicalisation of sex, pleasure and gay identity somehow inherent to contemporary epidemiological knowledge and emergency.

This study included six qualitative interviews with MSM who uses poppers.

Poppers is a substance that dilates the blood vessels in the rectum, which increases the risk of becoming infected with HIV by 2-5 times when practicing unprotected anal intercourse.

Poppers are seen as permissive (makes things happen), controllable (no high risk of addiction and short effect) and semi-illegal. But there is a right and a wrong time/place for poppers – they should only be used in some contexts (such as the bedroom – not so common in clubs anymore).

Poppers are often seen to be so common that they cannot be drugs and they make you focus on your partner and the shared sexual act. Other drugs are also taken in place of poppers but they are considered to reduce anxiety during sex.

Addressing negative self-perceptions³

2.4.5. Designing interventions to enhance HIV/STI preventions by targeting internalised homonegativity

Michael Ross, University of Texas, United States
Abstract number: 1771615

“Internalised homonegativity” is a term commonly used for situations when gay men feel uncomfortable about their sexuality and apply homophobic opinions of others on themselves. Groups that stand out with very strong homophobic views leads to a build-up of a very stressful environment for men who suffer from internalised homonegativity. Additionally, this stressful environment can be reinforced by homophobic opinions and measures from all parts of the society and governmental institutions: for example, a government can pass laws that restrict or even take away some of the basic rights from homosexual persons, but it can also be reinforced on much simpler levels: by old-fashioned medical staff who react strongly when they need to offer medical assistance to gay men. Other sources of stress can be attitudes expressed through the media, or offensive gay jokes in schools and other educational institutions – attitudes strongly contaminated with prejudice. However, some of the worst reactions can come from gay men who have not yet acknowledged their sexual orientation, and this is because, due to their own homonegativity, they expect negative reactions when they themselves come out.

People with internal homonegativity tend to shy away from events organised by and for gay people, generally avoiding any public setting. This leads to casual sexual partnerships, often with unprotected sex, which increases their risk of HIV transmission. When a person with internalised homonegativity gets infected with HIV, they tend to blame themselves and their behaviour for the infection making it very difficult to have good intimate relationships in the future.

A survey from 2008 shows a strong connection between internalised homonegativity and unprotected anal intercourse. In addition, gay men who do not acknowledge their sexual orientation often find it unpleasant to tell their partner about their previous sexual partners or safe-sex habits. The feeling of sexual discomfort is often a reason for sex without a condom.

Internalised homonegativity manifests itself differently depending on how liberal the country is in which one lives. Gender roles, religion, culture can all reflect on homosexual stereotypes in different ways. Making changes in legislation that are more favourable to gay rights is a great help to decrease internalised homonegativity.

³This title is an overall title of a parallel session held during the conference. The subtitles below it are names to summaries of different lectures that were a part of that parallel session.

2.4.6. Negative experiences of LGBT identity increase sexual vulnerability and risk of HIV transmission

Mina Gäredal, RFSL Ungdom, Sweden
Abstract number: 1748084

Mina Gäredal addressed the low self-esteem in young transgender people, making them a high-risk group for HIV transmission.

Heteronorms create barriers for LGBT persons, especially for transgender people who differ very clearly from the heterosexual norm. At the same time, heteronorms can connect those who don't follow them, and since the LGBT community is subjugated to heterosexual norms, this can often be a reason to unite. To explore this further Qruiser.com was created, the largest network of LGBT people. On their news page, QX published a questionnaire to which all interested could respond. The fact that the poll was about different interests could naturally affect the final results of the survey, but it still gives an indication about how much young transgender people suffer.

The surveys clearly show that LGBT people have less confidence than heterosexuals, this is especially true of young transgender people who on average have lower self-esteem than cisgender people.

Self-confidence was checked through Rosen-

berg's self-confidence survey. People with lowest levels of self-esteem were people who had negative reactions from family and friends. Those who lived in rural areas had lower self-esteem than those who lived in major cities. Older people have higher self-esteem than younger ones.

17 per cent of those surveyed in Sweden had been sexually assaulted, and 7 per cent of those assaulted were penetrated. Of all respondents in the survey, 57 per cent were sexually assaulted, 28 per cent of whom were penetrated. It clearly showed that those who had not been assaulted had higher self-esteem. The definition of assault in this case corresponded to being forced to having sex without wanting to.

17 per cent of respondents would have agreed to have unprotected sex in spite of the fact that they had not wanted to have sex in the past 12 months. Again, it is in particular young transgender persons that are most vulnerable. It can clearly be concluded that young transgender people have low self-esteem and are sexually vulnerable; hence, they are a group at high-risk for HIV transmission.

2.5. MSM Migrants

The text below is a summary of the session presented during the FEMP2011 conference.

2.5.1. Migrant men who have sex with men: An exploration of sexual risk in Europe

Percy Fernández-Dávila, Stop Sida, Spain
Abstract number: 1771729

2.5.2. Sexual behaviour and risk among Latino MSM in Spain

**Raul Soriano, Secretariat of the National AIDS Strategy Ministry of Health,
Social Policy and Equality, Spain**
Abstract number: 1762332

The conclusions of both Spanish studies show positive correlations between MSM-migrants and a higher rate of HIV, meaning that MSM-migrants are more exposed to the risk of becoming HIV-positive than the native population.

A comparison between sexual behaviour and variables that are associated with risk was made. Investigating HIV incidence in migrant gay men further must be prioritised, since it is a large group that is often exposed in the society.

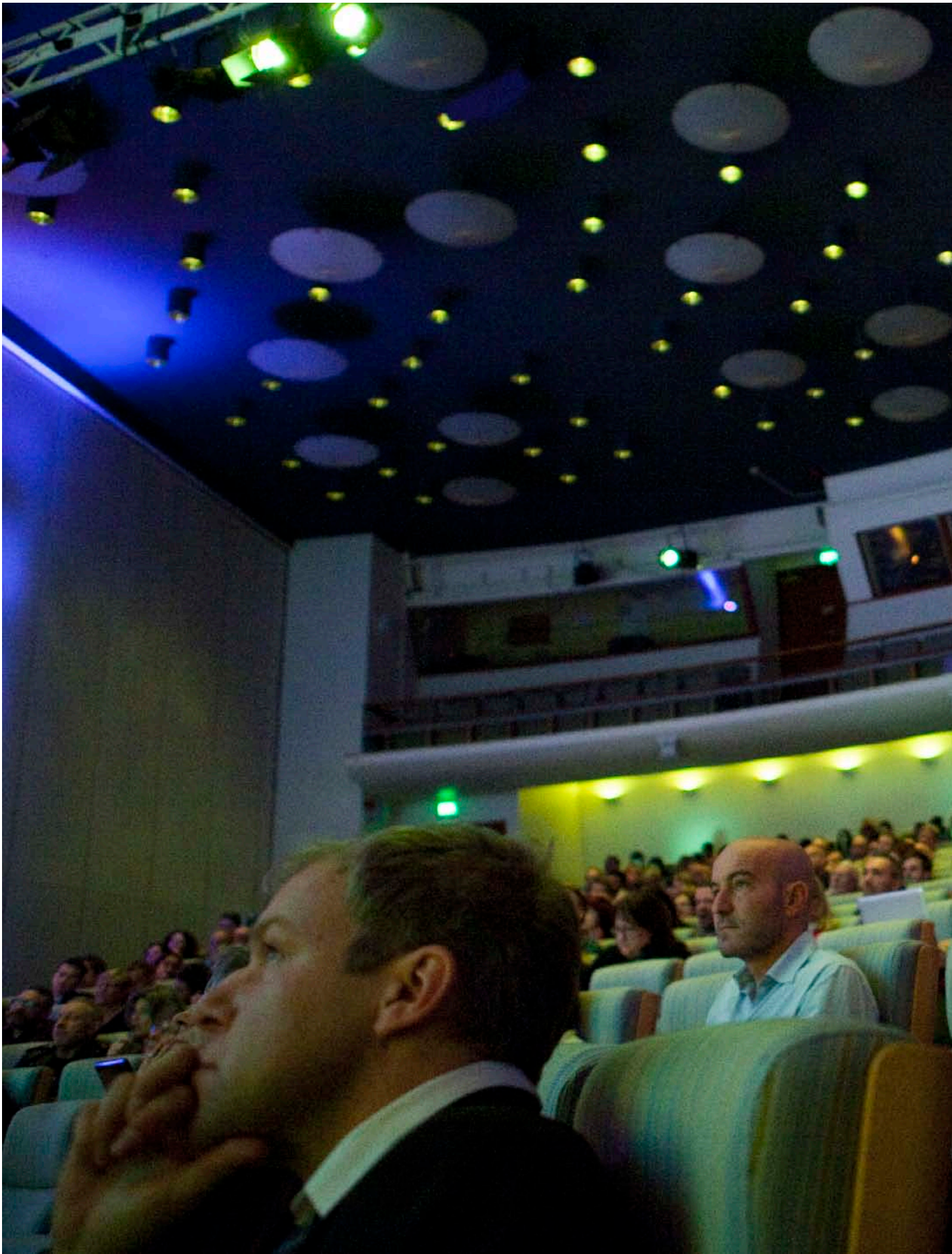
MSM-migrants are more exposed to the risk of becoming HIV-positive, and therefore resources have to be allocated to improve HIV prevention interventions targeting this particular group in order to prevent spread of HIV in an effective way. There are projects throughout Europe (Ireland, France and Spain) specifically targeting MSM migrants. Such projects include studies, networking campaigns for organisations focusing on HIV prevention among MSM and opening clinics especially for MSM. Worth noticing is that all these projects include MSM in the planning, in order to form prevention strategies that are appropriate and relevant for MSM.

In 2006, Projecte dels NOMS-Hispanosida implemented BCN Checkpoint, a community-based centre (CBC) for MSM in Barcelona's gay area in order to: offer HIV rapid testing, promote early HIV detection and linkage to care, increase HIV risk perception and reduction through peer counselling. BCN Checkpoint became a very successful project that could serve as a model for

other countries as well. The success lies in a few concepts:

1. The clinic is run by peers
2. The clinic is accessible and offers anonymity
3. Telephone or email reminders help the target group remember when to come back and get tested again
4. 95 per cent of the HIV-positive get linked to care within one week, which can be an encouraging motivation to get tested, because clients know that they can get help immediately after they were tested positive for HIV.

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2.6. Risk

The text below is a summary of the session presented during the FEMP2011 conference.

2.6.1. Coverage of HIV prevention programmes and knowledge about STIs and HIV among MSM across Europe

Todd Sekuler, Berlin Social Science Research Centre, Germany
Abstract number: 1768940

A Declaration of Commitment on HIV/AIDS was adopted during the 2001 UN General Assembly Special Session (UNGASS). To monitor its implementation, UNAIDS developed indicators to assess, among other things, coverage by HIV prevention programs (UNGASS 9), and knowledge about HIV prevention (UNGASS 14) among groups most at risk for HIV. The definitions for these indicators, however, are not relevant for men who have sex with men (MSM) in Europe, although MSM constitute a major group at elevated risk for HIV. Consequently, the present study offers new definitions for these variables and applies them to a pan-European study on the sexual health of MSM.

From June through August 2010, the European MSM Internet Survey (EMIS) was promoted on 235 internet sites for MSM in 25 languages. Over 180,000 men from 38 countries took part in the study. 16 questions were designed to assess knowledge about: HIV testing and transmission, STIs, and HIV post-exposure prophylaxis (PEP). Whereas UNGASS 14 suggests asking about monogamy as an HIV risk reduction strategy and potential transmission via mosquitoes and food, EMIS asked about transmission via saliva and anal, vaginal and oral sex; whereas UNGASS 9 suggests asking about having received condoms from an outreach worker, EMIS asked about condom accessibility in general, and about having received MSM-specific information about HIV and STIs. These variables were analyzed on an individual level within countries, and on a country level across Europe.

61% (country median) of respondents had met all criteria assessing coverage by HIV prevention programs (77% in CH to 36% in TR). The median of national mean knowledge scores was 72% (81% in NL to 62% in TR). The highest percentages of respondents reached by prevention programs were in northern and western parts of Europe (77% in CH, 76% in NL, and about 73% in DK, UK, FR, BE and FI), and were lowest (<45%) in TR, LV, MK, BA and CY. Knowledge about HIV testing was the highest of all knowledge areas across Europe. Knowledge about HIV transmission was higher than about STIs, and knowledge about PEP was lowest in every country. The percentages of MSM reached with HIV prevention programs correlated very strongly with national knowledge scores ($R^2=0.70$).

Given the correlation between program coverage and knowledge about HIV and STIs, future research should examine potential pathways in this relationship, and should attempt to describe disparities in knowledge and program coverage within national MSM populations. Although improvements in program coverage and knowledge across Europe are needed, countries scoring especially low on these measures are most in need of attention. Discussion with community members, researchers and health experts about the potential impact and means of improving knowledge about PEP among MSM is needed. The definitions of UNGASS indicators and their relevance for diverse groups should also be reviewed.

2.6.2. Risk behaviour, risk reduction & their determinants – Overview from the Amsterdam cohort studies

Udi Davidovich, Amsterdam Public Health Service, The Netherlands
Abstract number: 1790566

The Amsterdam cohort studies (ACS) are ongoing open, prospective cohorts that started in 1984 to investigate the epidemiology, pathogenesis, and prevention of HIV among HIV-negative and positive MSM and drug users. Here presented is an overview of recent studies among MSM.

Over 2450 MSM are included in the cohort since its initiation (over 50,000 cohort visits in total). Each biannual visit to the cohort is comprised of HIV (and in recent years also STI) testing as well as behavioural questionnaires.

Serosorting in the context of casual sex was measured within three types of causal partnerships (one-time, multiple-time & sex buddies). Men with a sex buddy had more unprotected anal intercourse (UAI) (OR=2.39, 95%CI 1.39-4.09) but also reported more serosorting (OR=5.20, 95%CI 1.20-22.52) than men with a one-night stand. As a result, the proportion of risky UAI (without serosorting) is lower for men with a sex buddy. However when protective value of serosorting in casual sex was examined, three seroconversions were recorded within the only-serosorting group, producing an OR trend for seroconversion of 2.66, (95%CI 0.94-7.53, $p=0.07$) in comparison to condom use. In the context of the group sex, men were less likely to engage in UAI (OR_{adj}=0.41, 95%CI 0.24- 0.70) but more likely to be diagnosed with an STI (13.4% versus 5.1%; $p=0.013$) compared to men engaging in one-on-one sex only. Among HIV positive men, risk behaviour before and after HIV diagnosis was studied as well as

the introduction of Antiretroviral therapy (ART): the acquired data indicated that the risk of having UAI one year after HIV diagnosis decreased significantly when compared with one year before HIV diagnosis in both the pre-ART era (difference=30% [95% CI:22%-36%]) and ART era (difference=19% decrease [95% CI:9%- 30%]). In contrast to a continuing decrease of UAI in the pre-ART era, the probability of UAI in the ART era increased to 61% (95% CI: 48%-74%) four years after diagnosis, and reached similar levels to that prior to diagnosis. To try and understand this rise, we examined the use of undetectable viral load knowledge during UAI (viral sorting) among HIV positive MSM with HIV negative or status unknown partners and found indeed it was practiced by 57% of those with casual sex partners, 40% of those with sex buddies, and 64% of those with steady partners.

Strategies such as serosorting and viral sorting are common among HIV negative and HIV positive MSM. Serosorting as presently practiced offers limited protection against HIV and requires further conditioning. However, on the epidemiological level, measuring UAI without correction for serosorting might produce an overestimation of risk. The practice of viral sorting is increasingly common among HIV positive men and might explain the rise of discordant UAI practices in that group. Group sex does not seem to be the context of increased HIV infection risk but rather that of STI's among MSM.

2.6.3. Understanding variation in sexual practices preceding HIV-infection among gay men in Berlin

**Michael Bochow, Wissenschaftszentrum für Sozialforschung
Berlin, Germany
Abstract number: 1755474**

Since 2003 increasing HIV infections among MSM have been widely discussed in Germany. A number of hypotheses aiming to explain new infections (such as condom fatigue, social and emotional turmoil) were examined in this qualitative project focusing on the diversity of contexts of new HIV infections.

On behalf of the German Ministry of Health and in cooperation with a Berlin-based HIV medical practice, 30 gay men infected between 2002 and 2006 were interviewed from June 2006 to May 2007. The median duration of the semi-structured interviews was 95 minutes. Interviewees were 24 to 46 years old, median age was 34, interviewees came from a wide range of socio-economic and ethnic backgrounds.

Reported lifestyles included being single or having “monogamous” or “open” relationships. Typical contexts for risk exposure were erectile dysfunction when using a condom, momentary lapses in otherwise consistently protective behavioural patterns, insufficient knowledge of the steady partner’s serostatus, misguided assumptions regarding the serostatus of other sex part-

ners, and a weakening of preventive intentions during group sex. Not a single interview disclosed intentional “barebacking”. Strong emotional desire for sex with physically attractive partners or with partners fantasized as future boyfriends were additional factors for engaging in unprotected anal intercourse. Social (often including sexual) proximity to positive men resulted in an increased familiarity with the high quality of life for many men living with HIV and, as a consequence, a reduced fear of HIV infection. Five interviewees reported having used condoms consistently in anal sex and having always avoided oral contact with seminal fluid, leading to emotional turmoil and profound distrust in safer sex messages after HIV diagnosis.

Prevention needs to take into account the various specific meanings which HIV/AIDS has taken on in the lives of gay men. This includes recognizing the limits of conventional prevention practice which emphasizes the primacy of condom use. A critically reflective prevention is needed which acknowledges its own limits in the face of subjectively determined life contexts.

2.6.4. Demographic distribution of non-concordant unprotected anal intercourse in three European regions

Marita van de Laar, ECDC
Abstract number: 1771697

In 2008, a mapping of the current state of art on HIV/STI behavioural surveillance in EU/EFTA countries was performed by the European Centre for Disease prevention and Control (ECDC). The study revealed gaps in implementing behavioural surveillance among MSM in Europe, even though MSM remain the group most affected by HIV. The European MSM Internet survey (EMIS) sought to meet this unmet need of HIV- and STI related behavioural surveillance while conducting the first pan-European MSM survey, including the ECDC suggested core indicators for all populations, as well as the MSM-specific indicators. This analysis describes the demographic distribution of non-concordant unprotected anal intercourse (ncUAI) with steady and non-steady partner across three European regions.

The EMIS data is based on non-probability sample. Between June and August 2010, 180,000 respondents from 38 European countries completed an online questionnaire. Questions included HIV testing history, anal intercourse, condom use and perceived HIV serostatus of sexual partners. The outcome variable was dichotomised as; at least one episode of unprotected anal intercourse in the previous 12 months with a partner whose serostatus was unknown, or perceived discordant to the respondents. The demographic factors were categorised as; age (<25, 25-39, 40+ years), education (low/mid, high), sexual attraction (men only, women and men) and migration status (linguis-

tic resident, linguistic migrant/minority). Based on geopolitical considerations, countries were grouped into three regions, old EU (1995)/EFTA, new EU (2004/07) and non-EU/EFTA.

Within new EU/EFTA (20%) and non-EU/EFTA (20%) ncUAI with a steady partner was reported almost twice as often as within old EU/EFTA (12%); whereas ncUAI with a non-steady partner was only slightly more common in non-EU/EFTA (old EU/EFTA: 18%, new EU: 18%, non-EU/EFTA 23%). Clear and consistent differences in ncUAI by demographic factors were found with steady partners across the regions. NcUAI with a steady partner was reported more frequently by younger respondents, those with lower educational attainment and sexually attracted to men only, as well as non-migrants. Demographic differences for ncUAI with a non-steady partner were minor within all three regions. Contrary to ncUAI with a steady partner, ncUAI with a non-steady partner was reported to occur more often among migrants, within old and new EU/EFTA regions.

Analysing ncUAI by demographic factors stratified for steady and non-steady partners can provide valuable information about the context in which risk behaviour and HIV transmission is more likely to occur among MSM. This allows more precise planning of prevention interventions, which should include the message that testing for HIV should precede engaging in UAI in a steady relationship.

2.6.5. Non-concordant unprotected anal intercourse (ncUAI) among MSM across Europe

Axel J. Schmidt, Robert Koch Institute, Germany
Abstract number: 1769623

In Europe to date, there has been no consensus on how to best measure the level and distribution of HIV-related sexual risk behaviours among MSM. Comparability of risk indicators has therefore been a challenge for European prevention planning, which is further hampered by different strategies for recruiting MSM to studies. The European MSM Internet Survey (EMIS) sought to harmonise current national approaches to measuring behavioural and other indicators regarding HIV prevention and surveillance across Europe, by applying the same sampling protocol, targeting a broad population of MSM, and including indicators suggested by the European Centre for Disease Prevention and Control (ECDC). This analysis aims at describing levels of non-concordant unprotected anal intercourse (ncUAI) among MSM across Europe.

From June through August 2010, EMIS recruited more than 180,000 respondents from 38 countries to complete an online questionnaire in one of 25 languages. Questions included HIV testing history, anal intercourse, condom use with steady and non-steady partners, and perceived HIV serostatus of sexual partners. Sexual risk was defined dichotomously as at least one episode of unprotected anal intercourse in the last 12 months with a partner whose serostatus was unknown or thought discordant to the respondents. Multivariable logistic regression was used to group countries while adjusting for age and recruitment site.

Across Europe, 32% of respondents (range: 21-

49%) reported ncUAI. The level of ncUAI showed a broad East-West gradient across Europe – being lowest in LU, AT, SI, and CH (reference), followed by FR, DE, GR, BE (adjusted Odds Ratio <1.3); FI, IT, PT, DK, ES (<1.5); SE, MK, NL, HU, PL, NO, MT, UK, CZ, RS, BA (<1.7); IE, CY, EE, UA, RU; BG; HR; MD; SK (<2.0); LV, LT, BY, RO (<2.5); TR (3.2). In addition, at least one episode of unprotected anal intercourse with a non-steady partner known or assumed to be seroconcordant for HIV was reported by another 6% (range: 2-9%).

Harmonising measures of sexual risk among MSM is feasible. In all countries the majority of respondents have adopted the central principles of Safer Sex. However, with wide variation across Europe, a substantial proportion of MSM reported episodes of ncUAI. It is of note that new (2004-2007) EU member states were found at both ends of the range: While Slovenian respondents had levels of ncUAI equal to nearby old EU member states, Latvia, Lithuania, and Romania were among the countries with the highest levels of ncUAI. HIV prevention interventions need to be culturally sensitive and not apply one model for all MSM across Europe. However, the range of ncUAI even within WHO European sub-regions calls for joint efforts to identify best practice of structural and individual level approaches towards HIV prevention for MSM. Given the increasing mobility of MSM across Europe, more pan European collaboration in HIV prevention is needed.



CHAPTER 3

The challenges in Eastern Europe and Central Asia

INTRODUCTION*

Considering the fact that homosexuality, homosexual behaviour and homosexual acts are still illegal in some of the countries in Eastern Europe and Central Asia, MSM are suffering immensely from discrimination, abuse of their rights and lack of freedoms in addition to restrictions that the rest of the population might be going through. Homosexual men in the region are regularly

subjected to insults and beatings, denied access to health services and are insufficiently or not at all integrated into the society. Because of all this, most homo- and bisexual men in the east are made “invisible” and still remain “in the closet”. This, of course, affects the reporting of HIV incidence and as a consequence, the actual number of MSM living with HIV and becoming infected

is severely underreported. Consequently, this undermines the development of adequate prevention interventions.

This chapter contains further elaborations on challenges that MSM in Eastern Europe and Central Asia are faced with and gives suggestions for ways to advance the HIV prevention.

* Power Point presentations and abstracts related to this chapter can be downloaded from www.femp2011.eu

Smiljka de Lussigny, WHO Europe

3.1. The face of the hidden HIV epidemic in MSM in Eastern Europe and Central Asia: Environment, response and unaddressed need

The text below is a summary of the session presented during the FEMP2011 conference.

The WHO has been working for many years (together with UN agencies and civil society organisations from Eastern Europe and Central Asia) to describe and try to impact and mobilise the response to the issue of HIV epidemic among MSM in Eastern Europe and Central Asia. Today, we are far from converting all anti states into pro states, but some progress has been made. There are many unanswered questions regarding the HIV epidemic in Eastern Europe and Central Asia.

“There is a very low openness about gay orien-

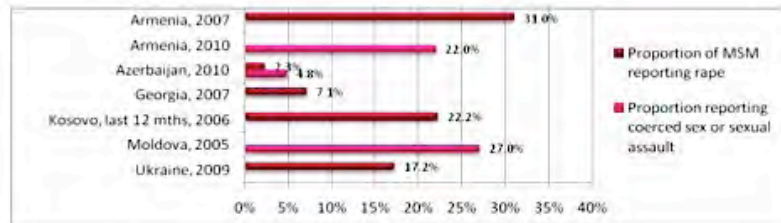
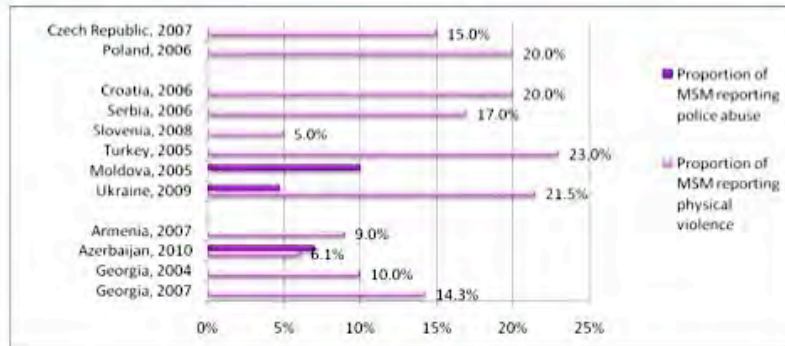
tation, and when people test, it is easier to say that they use drugs or come up with some other reason for testing, than to say that maybe it’s because I had sex with men and this is why I came to test.” (Zorjan – a gay activist)

We lack correct data

For many years, the WHO and ECDC have been collecting data that the countries and national surveillance systems have been capturing in their countries. There has been a quite clear picture

Country	Reported cases, cumulative through 2009	MSM population size, estimate	HIV prevalence among MSM, estimate	Number of MSM+, estimate	Accounting for undiagnosed 60% estimate
Armenia	16	30,500	2%	610	244
Belarus	47	51,000-71,000	3.1%	1,581	632
Kazakhstan	63	100,000	0.3%	300	120
Kyrgyzstan	2	18,000-36,000	1.2%	216	86
Montenegro	29	11,000	1.7%	187	75
Republic of Moldova	30	19,800	4.8%	950	380
Ukraine	316	175,000-430,000	8.6%	15,050	6,020

Violence and abuse



about how many people in the East are infected with HIV. And if one looks deeper into the centre, and central Europe includes some new states and southeast Europe including the Balkans, as well as former Soviet Union countries, the HIV epidemic among MSM in the East is almost non-existent according to the national official data. Looking into actual numbers, there is a glaring discrepancy: for example in Kyrgyzstan two out of almost 3,000 cumulative HIV cases are registered to be among MSM, in Uzbekistan it's 29 out of 20,000, in Tajikistan there are no cases registered. So, do these numbers give a picture that corresponds to reality, or is there something else going on?

Gross underestimation of the MSM epidemic

In the past two years, the WHO have been summarising results of all the possible studies, behavioural studies, and other studies that have happened in 30 countries of Central and Eastern Europe and Central Asia. Some studies were good, but some studies were not so good in terms of their design. The picture is clear: there are many

MSM who test in these countries, but the numbers are showing that there is not so much HIV present among them. The question arises whether this could really be true. The national reports from seven countries that cover the span from the beginning of the epidemic till 2009 (roughly 25 years) show that (for example) in Kyrgyzstan there are only two MSM reported as HIV infected in the past 25 years. Some studies, (for example) in Ukraine they estimate the population size and the likely HIV prevalence among MSM. There are about 5,700 people in Ukraine who have been diagnosed with HIV but have been misplaced into categories other than MSM: those men have either said that they are testing because they use drugs, or they said that they went to the dentist and got infected, or that they had sexual intercourse with a woman.

Homonegative environment

Another example of the environment that these men live in, as shown in a recent study in Ukraine, shows that many people/general population in Ukraine when asked whether gay men should have equal rights as the rest of the Ukrainian popula-

tion increasingly and over the years give a negative answer and say that this should not be the case. In this environment fewer and fewer gay men will come to testing facilities and state their sexual orientation, which will in turn mean that there will not be enough reliable data showing the level of HIV infections among gay and other MSM.

The environment that is shaping the response to and the life with HIV in these countries also shapes the vulnerability, both indirectly and directly. WHO studies show very high levels of stigma and discrimination in these countries, including in the health care settings. Ford Hickson explained how religion and homosexuality or homonegativity interact; we have seen what has been going on in Serbia in 2011 with the banning of the Gay Pride. Homosexuality is usually regarded as disease, seen as perversion and even criminalised in two countries, while in some countries it has only recently been decriminalised. And even if homosexuality is decriminalised, there are still many cases of verbal and physical violence, abuse, rape, coerced sex and sexual assault that are committed by the police and other state actors in those countries.

Problems with disclosure in the health care

When one looks into the data coming from countries in Eastern Europe, there are higher rates of partner change, rushed contact and public sex, environments with limited opportunities to negotiate condom use, more sex work, more transsexual sex; use of health care services is widespread, but only when the sexual orientation didn't need to be disclosed, or the use of health care services was completely avoided. This not only gives a wrong picture about the HIV epidemic among MSM, but really prevents the care and attention that needs to be given to MSM, attention and care that they need and deserve.

Also, almost no country in Eastern Europe and Central Asia invests governmental money into the response, and it's easy for e.g. Kyrgyz politicians to say: "Why should I invest money when I only have two people infected?" In some countries even the studies that are anonymous and confidential fail, because people are afraid to come out and speak about their sexual orientation and their sexual behaviour.

A gap of 15 years in the response

The HIV epidemic in Eastern Europe has actually started among gay men: gay men were the first in Eastern Europe in mid-1980s to get their HIV status diagnosed, but the response and the first

prevention programmes have started only in the early 2000. There is a 15-year gap during which gay men were not provided with any response to HIV epidemic; it was often NGOs who provided some help with external funding.

The activities are usually the most basic ones such as giving out condoms, lubricants, and information brochures, and all these are in a very small-scale manner, usually happening in capitals or bigger cities. There is no response in smaller towns or where there is, there is a lot of homonegativity or the entire environment is much more hostile. Condoms are often provided within the programmes, but otherwise, condoms are very expensive – one of the sex workers from Georgia said in a study, that he has to invest one fifth of his daily earning just to buy one condom.

Advocacy and guidelines

The advocacy efforts are going towards improving the social and legal environments, to describe better who gay men are and their numbers, what their risks are and how they can get responses to what they need, and then to allocate the funding and ensure that they have appropriate care and services that they need and that is tailored to MSM.

For the first time ever public health guidelines have been published that set the framework on how to respond to the epidemic. They start with the most essential, which is to create the enabling environment to actually introduce anti-discrimination laws, other protective laws and to ensure their implementation, because what is noticeable across many East European countries is that the laws are only put on paper and are passed for the sake of passing, but actually lack implementation. There also needs to be reassurance that all the health and protective services that exist should be inclusive of MSM with principles of the right to health and medical facilities.

In terms of the political commitment, there is a sense that the political promises are most often only words on paper, but one should never stop believing that national changes will happen, and that political decisions like the Dublin declaration which approved (in September 2011 by all 53 member states) the European Action Plan for HIV/AIDS which gave strong references to HIV epidemic in MSM, could also work in Eastern parts of Europe.

For the first time there is a regional advocacy mechanism that is actually trying to change the situation in Eastern Europe and Central Asia that has only started to exist in June 2011, and it needs a lot of support.

3.2. MSM in Eastern Europe and beyond

The text below is a summary of the session presented during the FEMP2011 conference.

Eastern Europe contains the vast majority of the European population and a large number of MSM. Homosexual attitudes and same-sex attitudes are often influenced by legal issues (i.e. homosexuality being illegal). MSM is a closed group with no official data illustrating the hidden epidemic of HIV among MSM and transgender people in EECA.

- Support mechanisms for the HIV positive is not available for MSM
- Needs for care and support for MSM clients

ECOM is a platform for communication between diverse organisations and networks. The mission unites all parties Eastern Europe and CA working with human right.

3.2.1. Behavioural research among MSM and transgender people in Dushanbe, Tajikistan

Kiromiddin Gulov, Tajikistan
Abstract number: 1761739

The aim of the research was to create representation and support for MSM – a group under strong stigma and social exclusion in Tajikistan. Attitudes and stigma are major barriers for the work.

A survey study for MSM was undertaken to study the HIV awareness level, the level of safe-sex behaviour and access to health care. The result showed that knowledge and awareness about STIa and HIV/AIDS was fairly low, as was the knowledge about details of HIV transmission. Condom use is more or less non-existent due to cultural factors within all groups. Diverse answers for the low use of condom show that there is a low rate

of knowledge about protection. Economic factors such as inability to afford condoms due to their high price and difficulty to obtain them are some of the barriers.

Results show that there is:

- A high risk for HIV infection due to low/no condom use
- Low level of HIV awareness on a community level
- Stigma/ Taboo
- Lack of trust towards the medical personnel
- Need of institutional and policy work

⁴“MSM in Eastern Europe and beyond” is a summary of lectures presented during two parallel sessions.



3.2.2. Regional differences in behaviour of MSM in Russia: Results of European MSM Internet survey (EMIS study)

Ekaterina Shmykova, Russian Federation
Abstract number: 1761615

This particular part of the EMIS study had 5,263 respondents. Conclusions from the EMIS study showed that MSM living in smaller cities feel worse than MSM living in big cities due to less access to LGBT-related social venues. The lack of gay venues is often due to high levels of social stigma characteristic for a small community. As a result, it is very difficult for young gay people to come out. This creates a vicious circle, and following behaviours occur:

- Less frequent use of condoms in small cities
- Low levels of HIV testing
- Small differences between knowledge depending on size of the cities
- There is an overall need for information about STI/HIV and condoms
- No official data describing the real numbers of HIV positive persons.

3.2.3. HIV behavioural survey among MSM in the Republic of Armenia

Dr. Karen Badalyan, Armenia
Abstract number: 1749510

The official data in Armenia shows that there are only 19 registered cases of HIV in 2011, although estimates show that there are more than 6,600 MSM. Few men felt that they were at risk of becoming infected with HIV. Zero per cent identified themselves as high-risk. However, surveys show that people have knowledge about STIs and know how to protect themselves. In spite of this, casual sex partners are usual and condom use within this group was only 4.3–39.1 per cent. Responding to a question why they are not using condoms, men said, for example: “if we suggest condoms they think we are sick!” A general opinion among Armenians is that “Armenians are safe, it is only Europeans who transmit infections.”

Certain activities must be undertaken in Armenia in order to improve prevention interventions. Such activities include:

- Awareness-raising
- MSM-friendly medical services
- Addressing the stigma concerning MSM HIV and condom-use
- Increase trust in health care
- Ensure quality care
- Involvement
- HIV education
- Boost HIV knowledge through peer activities
- Mass media
- Accessibility to tests

3.2.4. Innovative measures to enhance knowledge on HIV prevention among MSM in the Republic of Armenia

Rafael Ohanyan, Armenia
Abstract number: 1767874

A project was conducted in Armenia that aimed at raising awareness about risk behaviours and HIV/STI infection among MSM, a group that is highly marginalised in the Armenian society. Gay people in Armenia don't have the equally easy access to community information as their hetero-

sexual counterparts. Mini seminars in groups of five to eight people turned out to be an effective way to communicate information about HIV prevention, because participants experienced the information sharing as more relaxed and personal, and as being done in an intimate environment.

3.2.5. Effective strategies for MSM-focused HIV prevention programmes in Russia

Olga Samoylova, Russian Federation
Abstract number: 1762249

In order to curb the rising prevalence of HIV among MSM, LaSky – Trusting Each Other project was launched in ten Russian regions. The focus of the project was on condom distribution, sharing information through the internet, holding small group seminars and training of medical personnel. The target group of the project were MSM between 20 and 30 years of age, middle-income earners with tertiary education. The results show that participants in the project generally practiced safe sex (i.e. used condoms) and tested for STIs more frequently than people who were not reached by the project.

Prerequisites for successful prevention results are for example training of medical personnel on MSM-related issues, especially because MSM as a group are highly stigmatized in Russia. Through the training of medical personnel, the programme could be more integrated into the normal health care system, which would give MSM a chance to, in a more “normal” way, seek medical care without having to feel stigmatized. Establishing a good patient-doctor relationship was of the utmost importance, which was made possible to a greater extent through the project.

3.2.6. Gender approaches in HIV prevention among MSM: Follow the Voice of Life project, Orenburg, Russia

Dzmitry Filippau, Russian Federation
Abstract number: 1771780

This session correlates to Ms. Samoylova's lecture in that it explains the high levels stigmatisation of LGBT people in Russia, even in health care. This complicates LGBT people's opportunities to get good care. Through interviews/discussions with managers in the health care, the project tried to raise awareness about the fact that LGBT people are at a high risk of getting infected with STI-

related diseases including HIV. This has major implications for the society, in addition to great personal suffering.

The ultimate goal of the project was to achieve change in health care policies, as well as to create favourable conditions for good health care for LGBT people.

3.2.7. The mechanism of protection of the LGBT community rights in Ukraine

Denys Chyshov, Ukraine
Abstract number: 1771501

Increased LGBT competence is needed among the police, lawmakers and people in general! That LGBT people are treated differently from heterosexuals is a direct violation of human rights. The Ukrainian society is becoming more and more homophobic. If in 2002 and 2007 33.8% and 46.7% of Ukrainians had said that homosexuals shouldn't be granted equal right with other citizens, in 2010 the situation became much worse. The sociological study, held by Gorshenin Institute in December 2010, showed that 72% of Ukrainians have negative attitudes toward sexual minorities. Due to the discriminatory policy of the state and the society, LGBT persons can't live an open life: they're forced to hide their sexual orientation.

It is commonly known that human rights violations on the basis of homophobia may lead to open hostilities, violence and crime. In Kiev there were a series of murders of gays because of homophobic attitudes. In addition, there are also other violations in various branches of law, especially labour law. There are tendencies for rights violations in other regions of Ukraine (physical abuse, robberies, offensive attitudes, bias, discrimination, etc.) as evidenced by messages and appeals. So, a criminal offence in Lviv was committed against LGBT community member and despite his appeal to the law enforcement authorities, there was no reaction. Another incident took place in Odessa – a physical assault based on homophobia on an organisation's social worker. In 2010 the majority of documented cases of rights violations and discrimination against homosexuals still occurred in relation with law enforcement. There were viola-

tions of rights such as limitations to freedom and personal immunity, prohibition of torture and inhuman treatment, the right to an effective legal protection, the right to privacy and to own property. At the same time, an objective assessment of the situation concerning discrimination of sexual minorities' rights is almost impossible due to high levels of closeness of LGBT community. The fear from disclosing sexual orientation usually makes abused homosexuals avoid contacting public organisations or tolerant representatives from authorities. This is why for the Ukrainian CSO Miy Vybir it was utmost important to actively inform LGBT community about opportunities and ways to solve the problems that occur due to violation of their rights. The task was to mobilise and prepare the active community members to lobby for community interests, as well as to provide support when violations of human rights occurred. In addition, Miy Vybir instantly coordinated LGBT community representatives, informing them about the changes in existing laws, and made sure that they have representation in public authorities. The goals of Miy Vybir's project were also to draw attention of LGBT community to the problems concerning human rights violations, raising awareness of the LGBT community in the field of law, giving an overview of actual problems of the LGBT community and developing key areas of action to protect their rights, activating the LGBT community to effectively fight against homophobia and discrimination (including by public authorities) and the promoting active civil position for the protection of LGBT rights.



CHAPTER 4

Positive prevention, sex and health

INTRODUCTION*

In the initial phases of the epidemic, men living with HIV tended to be (consciously or unintentionally) omitted from participation in the prevention efforts. The major bulk of the HIV prevention interventions were targeting HIV negative men in order to avoid them getting infected. Fearing stigma and fearing being perceived primarily as a carrier of infection, many men refrained from getting tested. This also led to many men not disclosing their status, once they found out that they were positive.

However, primarily since the introduction of successful treatment and thus growing numbers of men living with HIV, prevention has come to mean that positive men must play an active role in formulat-

ing and carrying out of interventions. Equally they must also be included as targets of any prevention strategy. This chapter elaborates not only about positive prevention that targets gay men living with HIV, but that also extends to encompass sexual health and wellbeing of both HIV negative and HIV positive men. Interventions targeting HIV positive men must be based on a number of premises: that HIV men are entitled to know their serostatus or viral load, that they have the right to a good quality of life in spite of their positive status (and this includes a healthy sexual life), and that they have access to health care interventions that are tailored to their specific needs. In addition, posi-

tive prevention must include psychosocial support that will help acquire and maintain a risk-free sexual behaviour.

Needless to say, HIV negative men remain targets for prevention. The responsibility to maintain safer sex practices lies on both partners and HIV negative men have also needs to psychosocial support, albeit of a different nature. In other words, the man living with HIV and the HIV negative man in their sexual encounter, are both targets for “primary prevention” and they should be equally prepared/supported, on the bases of their different needs, when they meet – “it takes two to tango” successfully.

* Power Point presentations and abstracts related to this chapter can be downloaded from www.femp2011.eu

**Mathew Weait, Professor of Law and Policy,
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4.1. Punitive economies: The criminalisation of HIV trans- mission and exposure in Europe

The text below is a summary of the session presented during the FEMP2011 conference.

The European region is suffering from the epidemic of criminalisation. Across the European continent people living with HIV are being investigated, prosecuted, convicted and imprisoned for non-deliberate HIV exposure and transmission. It's an epidemic that's causing significant harm, not only directly to people who are being exposed to harsh and punitive responses, but indirectly to efforts aimed at normalising HIV and reducing stigma, to HIV prevention work and to attempts to affirm shared responsibility for sexual health. It's an epidemic whose impact is felt especially by people who already experience particular social and economic exclusion and vulnerability. It is an epidemic that is created/based on UNAIDS prevalence estimates for 2009, some 2.2 million potential criminals in Western and Central Europe. It's an epidemic to which we have to respond collectively and for which we have to find a cure.

Our knowledge of criminalisation in this region as compared to the rest of the world is far from perfect. What is known about the existence of punitive laws and the extent to which they are being used is based on surveys that were undertaken by GNP+ and UNAIDS, and the data independently gathered, collated and analysed by individual activists. This data gave a relatively clear picture about the historic and current situation, but resource limitations, differences in legal systems and terminology and the absence of any internationally agreed methodology for data collection and analysis mean that we have to proceed with a certain degree of caution. Almost without exception countries in the European region have laws which criminalise HIV transmission and/or exposure. There is no evidence to suggest that the majority of those who have been the target of criminal proceedings have been gay or bisexual men. Indeed, the evidence, if anything suggests that it's heterosexual men and women, and especially migrant African men who have carried most of the burden, certainly in terms of the numbers of convictions that are known about. But

this doesn't take away from the fact that all sexually active gay and bisexual men living with HIV in these countries are by the virtue of the very existence of these laws rendered into potential criminals.

How many countries have punitive laws?

From the global scan in 2010 and bearing in mind the limitations on that data, we know that of 53 countries in Europe and Central Asia, 40 definitely allow for the criminalisation of the transmission and/or exposure, two don't, and for eleven the information is lacking or it's unclear. Of the 40 that do criminalise, the majority, 23, impose liability merely for exposing another person to the risk of transmission rather than transmission itself. As to the seriousness to which these offences are viewed, of the 35 countries in the region from which there is data, three allow for maximum life imprisonment and 22 provide for sentences of five years or more. It is only by looking in a little bit more detail at these that we could begin to get more sense of the challenges which campaign reformers face.

Variations in punitive law

Below are the differences in laws and their enforcements in particular countries. These differences express themselves in a number of ways and have a number of practical consequences as far as decisions to prosecute and handling of cases is concerned. Looking first at HIV specific and non-specific laws: how one should categorise these is often debatable. My own view is that we can distinguish usefully between:

1. Countries that use general criminal law relating to the offences against a person,
2. Those that use general communicable disease legislation
3. Those that have laws dealing with STI transmission
4. Those that specify HIV transmission either uniquely or in a list with other specified infections.

In the European and Central Asian region all these modes of criminalisation exist, with larger economies typically using general criminal law and/or communicable disease legislation that has existed since before the epidemic, and the smaller ones, especially those in Eastern Europe and Central Asia using recent HIV-specific provisions with more recent origin and introduce it as a dedicated response to the epidemic. There are however exceptions in both of these categories. While it is of concern that there are so many countries that do have HIV-specific legislation and this forms the largest category in the region, this is no indication at all of its use in practice. Indeed in those countries, which do have HIV-specific laws, only three are in the top ten criminalising countries as measured by conviction rates per 1000 people living with HIV, and one of those countries, Denmark, has suspended its law pending possible repeal. Any objection to these laws, and they are objected to especially in a number of policy literature, especially from UNAIDS, can't therefore be based on its deployment and its use in practice, but on its impact on marginalising people living with HIV as a peculiarly dangerous category and reinforcing HIV-related stigma.

The second significant variation in the region is between countries that criminalise exposure, which are in the majority, and those that don't. This is a critical issue for people living with HIV for the obvious reason that the potential for being prosecuted successfully is greater where the potential arises simply from having sex, which carries the risk of transmission. And it's also brought science to the forefront of national and international law reform efforts. For example, where transmission is criminalised, it's for the prosecution to prove that the defendant infected the complainant. In many cases this is being done by using phylogenetic analysis evidence, and this evidence can conclusively prove that the source of the infection was not the defendant, but as virology experts have consistently emphasised, it can't conclusively prove that it was. Despite this, many people have been prosecuted, and their convictions achieved in part through the misuse of phylogenetic analysis. Some of us are also concerned that the tests developed to determine recent infections, the so-called RITA testing, may begin to be used inappropriately to identify suspects within a timeframe despite the fact that its reliability for these purposes is far from certain. As for the signs relevant to exposure liability, the key issue here is the significance of viral load. This is a developing area, but there are a number of countries, notably

Switzerland, the Netherlands and Austria, recognising that prosecutions for non-intentional exposure may be inappropriate where effective ART has resulted in a non-detectable viral load and other conditions are met. As Yves Bertossa, the prosecutor from Geneva who accepted the validity of the now famous Swiss statement said that one shouldn't convict people for hypothetical risks.

The third area of variation is on fault requirements. Again, because of the number of different jurisdictions and problems that exist because of legal translation, it's difficult to provide an entirely accurate comparative picture, but put generally, countries typically use some version of following degrees of fault, intention, recklessness and negligence. What is clear is that a significant number of countries, contrary to UNAIDS guidance and best practice, allow for the prosecution of recklessness and negligence, and when one combines that with liability for mere exposure, it should be obvious that this extends the potential scope of criminalisation considerably. So, a good example is in fact Austria, which prior to the AIDS 2010 conference in Vienna the Ministry of Justice had to produce a statement, its law states that anybody who negligently commits an act, which is likely to spread a transmissible disease maybe sentenced to up to one year in prison. That's a very wide standard of liability.

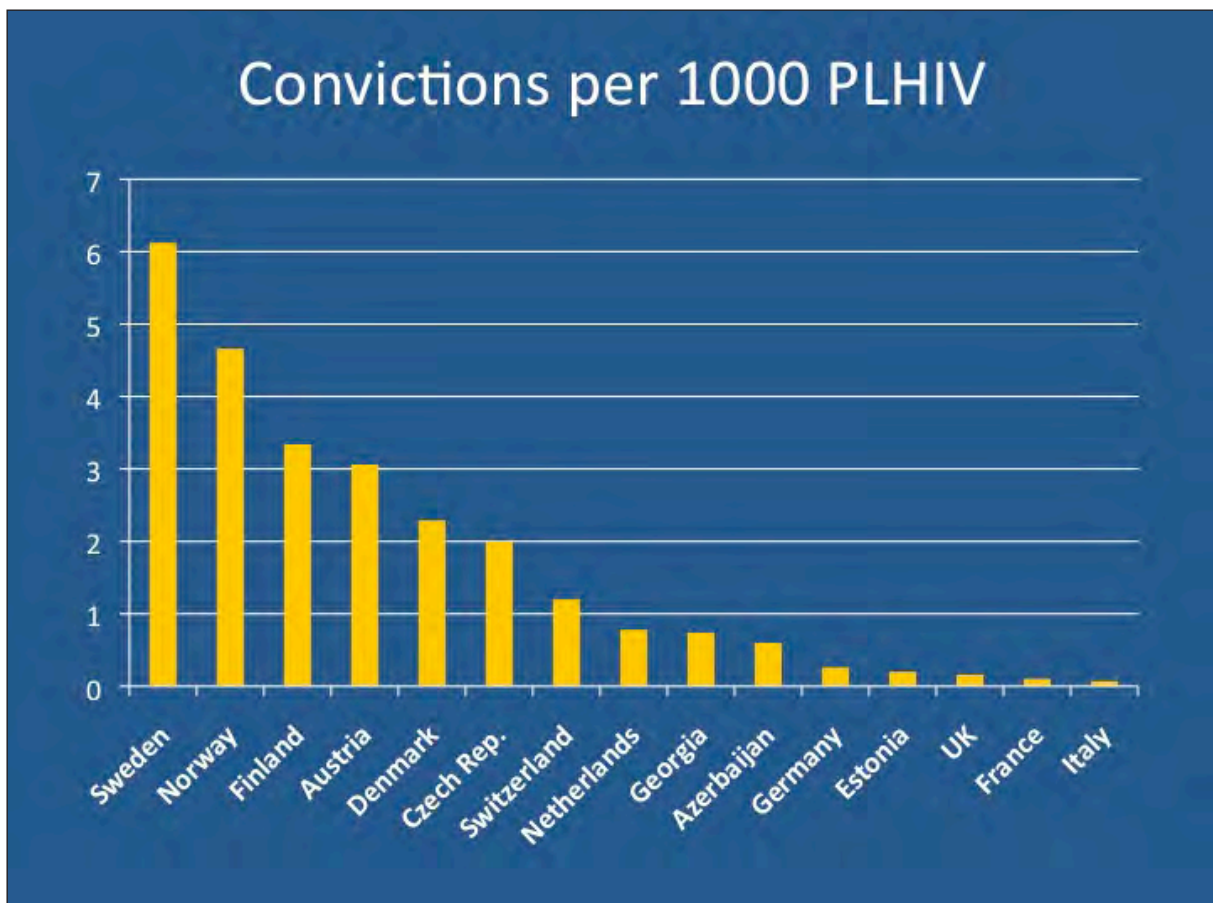
The final point about variation is about the difference between the criminal law logic and public health law logic. The existence of reckless or negligent exposure liability demonstrates the existence of distinction in the region between those countries that use criminal law in a traditional way as a mean for punishing people for immoral acts that cause harm, and those that see it at least in part as a means of enforcing public health norms, and of preventing harm. That distinction is critically important for a number of reasons, the most important of which is that the public health approach used in criminal law in this area means that little or no emphasis is placed on the consent of a sexual partner to the risk of transmission. In England and Wales where only transmission is criminalised and where the general criminal law is used, consent of a partner via disclosure of HIV status operates as a defence because the law there recognizes the autonomous right of people to make their own choices about risk. In contrast both Switzerland and Norway have a public health orientation in which the defence of consent is denied or restricted, and it's of particular concern that the Norwegian law is being reformed, so that it will allow the consent of a partner, which it hasn't allowed till now, to operate as a defence where a partner is married to or in a committed relationship with the

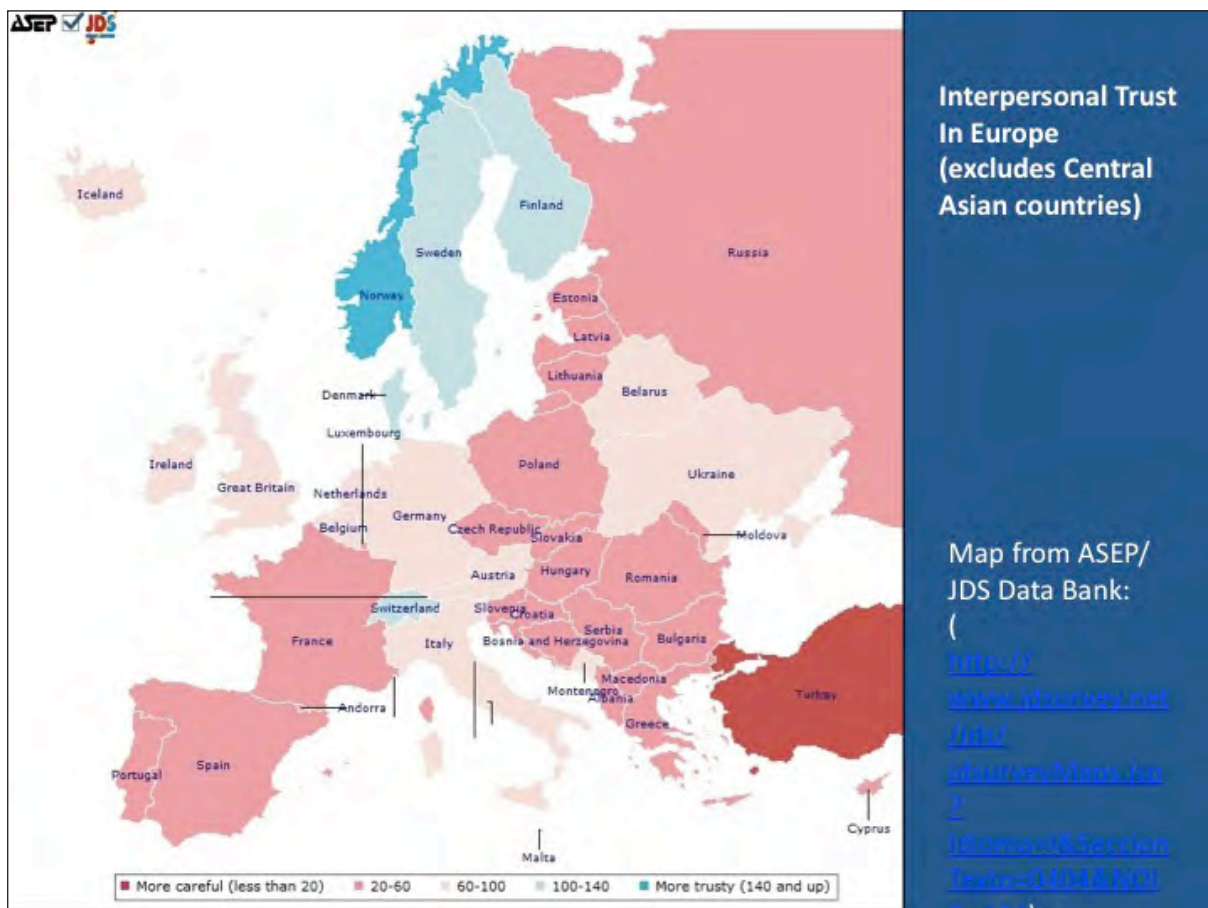
person living with HIV, but not in the context of less-established relationships, which seems to be at least in some way a form of discrimination against people who are not necessarily in a position to be able to marry or form those kinds of relationships, or don't want to. A second important consequence of this distinction between public health and criminal law logic is that it makes the meaning of safer sex a vital matter. If it's recognised by prosecuting authorities and courts that the consistent and appropriate use of condoms minimises the risk of transmission, then there is simply no justification for imposing exposure liability when condoms are used, and it was the Austrian Ministry of Justice acknowledging that in its guidance to the participants of AIDS 2010 conference in Vienna as a result of the international pressure despite the fact that the law in Austria allows for prosecution of negligent exposure.

These specific matters aside, the strongest objection to the use of criminal law as the HIV prevention tool is that there is simply no empirical evidence that suggests that it is effective in that way.

Distribution and intensity of criminalisation in the region

The data used is from the 2010 global criminalisation scan, which contains a calculation of the number of conviction per 1,000 people living with HIV, when we look at the data for the European region, what is noticeable is a higher rate of convictions in northern European countries, especially those in Scandinavia compared with the rest of Europe. Sweden is on top of the list with 6 per 1,000, while Italy is in the bottom. Now, this variation in intensity of criminalisation as measured by convictions seems strange at first glance especially when it's contrasted with HIV prevalence estimates: it appears that there is almost an inverse correlation between criminalisation and prevalence with the highest prevalence countries having the lowest conviction rates and vice versa. And it's especially notable that the bottom three countries with respect to criminalisation (Italy, France and UK) have conversely the highest number of people living with HIV and in general higher than average prevalence.





So, what might be the explanations for this? As indicated, one has to proceed with caution with this data. However, one can begin to understand the pattern by considering some of the social, cultural and historical differences between the countries in the region, as well as the impact of some of the different legal variations. So, for example, one can see that the top five criminalising countries in the region all have laws, which impose liability for reckless or negligent exposure and thus have a wider potential scope for criminalisation, and one can also see that all these countries have higher confidence in their judicial systems. And of course, if people have high confidence in their judicial systems, than that may go some way to accounting for a person's willingness to prosecute after a diagnosis, believing perhaps that their complaint will be dealt with efficiently and fairly. Even more interesting are the correlations when one looks at the variations in interpersonal trust in the region. Using data from the World Value Survey, one can see that the top five countries in the region with respect to interpersonal trust, those are Norway, Denmark, Sweden, Finland and Switzerland, where the majority of respond-

ents trusted that the other people had a positive trust-response, are all countries in the top half of criminalising countries with the rates of convictions in excess of one per 1,000. For Europe, these correlations between conviction and interpersonal trust rates in the region become even more interesting when we learn that according to reliable and empirical research, the Scandinavian countries have a lower fear of crime, are less punitive in their attitudes to those who have committed crime, and in general have lower rates of imprisonment for convicted offenders compared with other countries. And if this is the case, why would HIV transmission and exposure cases be so high in these countries? It is plausible to suggest that the sexual HIV cases that get as far as a court and a conviction are ones that are paradigm examples of breach of trust. And it's not inconsistent for a society to have a lower than average generalised fear of crime or lower than average set of punitive attitudes, and at the same time to respond punitively and particularly punitively to specific experiences of harm, especially when that arises from belief that the person behaving harmfully could have behaved otherwise

and chose not to. Indeed it seems entirely plausible that where there are higher levels of trust, breaches of trust, for example, non-disclosure of status are treated as more significant than where value and trust are low. And if one combines the countries such as those in Scandinavia that are committed historically to using law to ensure public health and that are consequently prepared to use it to respond to the risk of harm – HIV exposure, as well as harm itself from HIV transmission – then one could perhaps see why the pattern of criminalisation appears to be as it is.

Current developments and responses

The first thing one needs to remember is that knowledge is power. In the absence of comprehensive, reliable and accurate data about criminalisation in this region, we will find it harder to present evidence to support anti-criminalisation arguments that we want to make, especially in regard to its impact on people living with HIV in general and gay and bisexual men in particular. Everybody should continue their work to gather this data and to ensure that the Global Scan is as accurate and up to date as possible.

Secondly, we have to work together to develop research projects that explore the impact of criminalising HIV exposure and transmission. In particular, we need to undertake more research into the impact of criminalisation on testing uptake, treatment access, and the relationships between people diagnosed with HIV and their clinicians; many of whom have expressed their concern about having to warn newly diagnosed patients about their legal responsibilities.

Thirdly, we have to campaign vigorously for the reform of laws that criminalise non-intentional exposure and transmission and provide every support for our friends doing this work in their countries.

We've seen in the case of Denmark, which has suspended its HIV specific law, that campaigns can make a real difference. The HIV manifesto group in Norway too has provided the inputs for the establishing of a review, which is currently looking at its country's law, and colleagues in Finland have been in discussions with their ministers too. And of course in Sweden as well – this is something that has been on the agenda of the Scandinavian HIV organisations for some years now.

Fourthly, even where it is politically problematic to achieve legislative reform, we can minimise the impact of criminalisation by limiting the enforcement of those laws. In England and Wales there has been some substantial success in

developing guidance for prosecutors. This guidance sets out the limitations of scientific evidence, explains how little risk there is from people with undetectable viral loads and/or who use condoms, and which will at the very least reduce the number of prosecutions even if reforming the law is very difficult. In a similar way we have to continue to educate the police about these matters so as to minimise fruitless, inappropriate and distressing investigations which in fact go nowhere, because the proof simply doesn't exist but where people still experience the horror of having their computers taken away, undergone raids by the police, etc.

Finally and critically, we need to reflect on why it is that people who discover their HIV infection or that they have been exposed to HIV by a partner might think that going to law is an appropriate course of action. It is only where someone really constructs himself or herself as a victim of a crime that criminalisation occurs in practice. If the vast majority of convictions are the results of cases where a person with HIV has not disclosed his or her HIV status to the complainant prior to exposure or transmission, we have to develop better ways of facilitating disclosure, and we have to emphasise our shared responsibility for sexual health and HIV prevention. We also have to challenge wherever and whenever we can the frequently misleading and stigmatising media coverage in which HIV transmission and exposure are allegations are reduced to oversimplified and sensationalist crime stories with evil defendants and innocent victims. Over the past few years there have been a number of significant initiatives. The Global Commission on HIV and Law, which took evidence about criminalisation from high-income countries and elsewhere including Eastern European countries, will be reporting quite soon. UNAIDS has been consulting on the use of science in criminal cases. Expert virologists have been working across the world to develop a protocol for the use of phylogenetic analysis as evidence in criminal trials to ensure that it is not misinterpreted. Researches on the European partner study are evaluating the risk on onward transmission when on effective treatment, which would prove relevant in allegations of reckless and negligent exposure. And activists and civil society organisations, nationally and regionally continue to campaign for reform, and it is their work that has sustained the momentum in the European region more than anything else.

We know how effective safer sex is. The time has come for recognising the importance and the value of safer law.

**Gennady Roshchupkin, The Eurasian Coalition on Male Health (ECOM):
“to create an enabling environment”**

4.2. HIV positive MSM in Eastern Europe and Central Asia: Public health and dreams of love

The text below is a summary of the session presented during the FEMP2011 conference.

It is good to remember how the HIV epidemic in Eastern Europe started. The first registered HIV positive person in the region was a gay man and this happened in 1987. Until 1996, MSM were the most affected population in the region. Gay and bisexual men were the first groups approached by targeted prevention and care projects and the first HIV activists were also gay men. They laid the ground for the community HIV movement in East-European countries that made and continue to make a significant input into prevention, care and support in the region, and not only targeting MSM.

What is the current incidence and prevalence of HIV among MSM in Eastern Europe?

How many HIV positive MSM live in the region? According to the official data, just up to 4 per cent of MSM are HIV positive, i.e. about 4,000 HIV cases registered among MSM in the region. It is just a very small drop in the general picture of the region where UNAIDS counted 1.5 million HIV cases.

Some figures from different reports show that there are 16 cases in Armenia, 30 cases in Moldova, a bit more than 2,000 cases in the Russian Federation and 2 cases in Kirgызstan. However, these figures are not trustworthy.

A very respectful member of the Russian ministry of health took part in the meeting of MSM service organisations and he said that he fully understands and respects the work that MSM service organisations do in Russia in the area of HIV prevention, but he finished his speech with these words: “Please do your work quietly, so that you cannot be seen or heard.” Many positive gay men say that they do not want to disclose their sexual orientation for the fear of losing services.

It can be concluded from the numbers above and the testimonies from gay men that unfortunately, officials as well as activists and people living with HIV, don’t know how many MSM

living with HIV there are in the region. There are absolutely no data on HIV positive transgender persons, that’s a hidden issue in Eastern Europe and Central Asia.

What services are available for MSM living with HIV in Eastern Europe and Central Asia?

According to UNAIDS, a bit more than 20 per cent of those in need have access to every treatment in Eastern Europe and Central Asia. Moreover, there is a lot of treatment interruption because of the lack of funds, but lack of funds is not the only cause for these interruptions. A big percentage of these interruptions happen because of bad supply management and low adherence to treatment. Almost 30 projects declare provision of counselling and psychosocial support to HIV positive MSM in the region, but most of them work in capitals only. And there is no system to measure the quality of their work.

Treatment of co-infection exists; it looks like access to TB treatment is more or less good but it is not known exactly. Treatment of hepatitis C in the Russian Federation is for free but just for couples. There is no data on coverage of these services.

It is important to understand that considering the reluctance of MSM to discuss their sexual behaviour with a majority of epidemiologists and practitioners, it is impossible to count how many MSM are receiving every treatment. It is a very transparent procedure where a doctor gives a pill to a patient, but even here no data exists.

Sustainability is another important issue to discuss. There are only four countries in the region that cover every treatment from the governmental budget: the Baltic States and the Russian Federation. Only Estonia and Lithuania cover some psychosocial support to HIV positive MSM from the government budget. And up to 70 per cent of all funds needed for treatment, prevention, care and support is provided by the Global Fund.

Strategies

As can be seen, the quality of statistics is quite low and there is almost no reason to expect that the situation will improve dramatically in the coming two or three years. Issues such as homophobia, weak management and corruption cannot be easily eliminated.

The most appropriate strategy is to rely on the experience and activities of those persons affected by HIV who are personally interested in decreasing the HIV epidemic threats. If affected people keep silent, then no government will do anything. If affected people will loudly call on their government to do something, the government will just try to muffle the call. Only if affected people start helping themselves and others who are at risk will the government start to do something real.

More than 25 years ago international donors started the provision of funds for work with MSM and HIV people in Eastern Europe and Central Asia. Until now the majority of these funds were spent on service provision. The services die fast

after the donor support ends, and an additional threat is corruption.

Donor support should not be rejected, but there needs to be a dramatic revision of this support. There is no doubt that the Global Fund is a great initiative; it helps EECA countries get significant funds for long-term programmes. However, the Global Fund is not flexible enough to support local initiatives and pilot new methods. Governmental funds usually have the same weakness. When the Global Fund came into the region, a lot of other big and small donors decreased or just closed their programmes. So this is a huge barrier to develop adjusted projects and programmes for MSM – there is simply no funding even from the GF.

There has to be a diversity of coordinated funding channels, both national and international, to permit the rise of local initiatives, to pilot prospective methods in order for us to finally have big and long term national programmes also for MSM in Eastern Europe. We have to bridge the 15-year gap.

Below are a few citations from MSM living with HIV. These citations are collected from a group that unites up to 180 HIV positive gays and bisexuals from six countries in Eastern Europe and Central Asia.

“For seven years of living with HIV I many times tried to build relations. Guys disappear as soon as I tell them about HIV. But anyway, I think I have to tell them.”

“As a peer consultant I many times told others that there is nothing in the IV treatment to be scared about. Now I have to start IV treatment myself and I am in panic.”

“I started the IV treatment in 1998 and in 2008 I got diabetes.”

“My friend studies Chinese. Last month he got a positive test and he is almost crushed because as HIV positive he can't go to China to continue his education. How can I help him?”

“They call gay sex untraditional, so does that mean that sex between men and women is just a tradition? Just as some church ritual?”

“I am 22 years old and got HIV two years ago. Everything is good in general but sometimes I lose the ground under my feet. Thank you guys for being with me.”

Kevin Moody, GNP + the Global Network for and by People Living with HIV, United Kingdom

4.3. Positive health, dignity, and prevention: A policy framework

The text below is a summary of the session presented during the FEMP2011 conference.

What is positive health, dignity and prevention?

Positive prevention was in the past looked at as something that was done to people living with HIV. People living with HIV decided at a consultation in Mexico City in 2008 that a new definition was needed to determine what that meant. It meant that people living with HIV should lead the positive prevention, one that would be based on human rights and that should be about much more than just prevention.

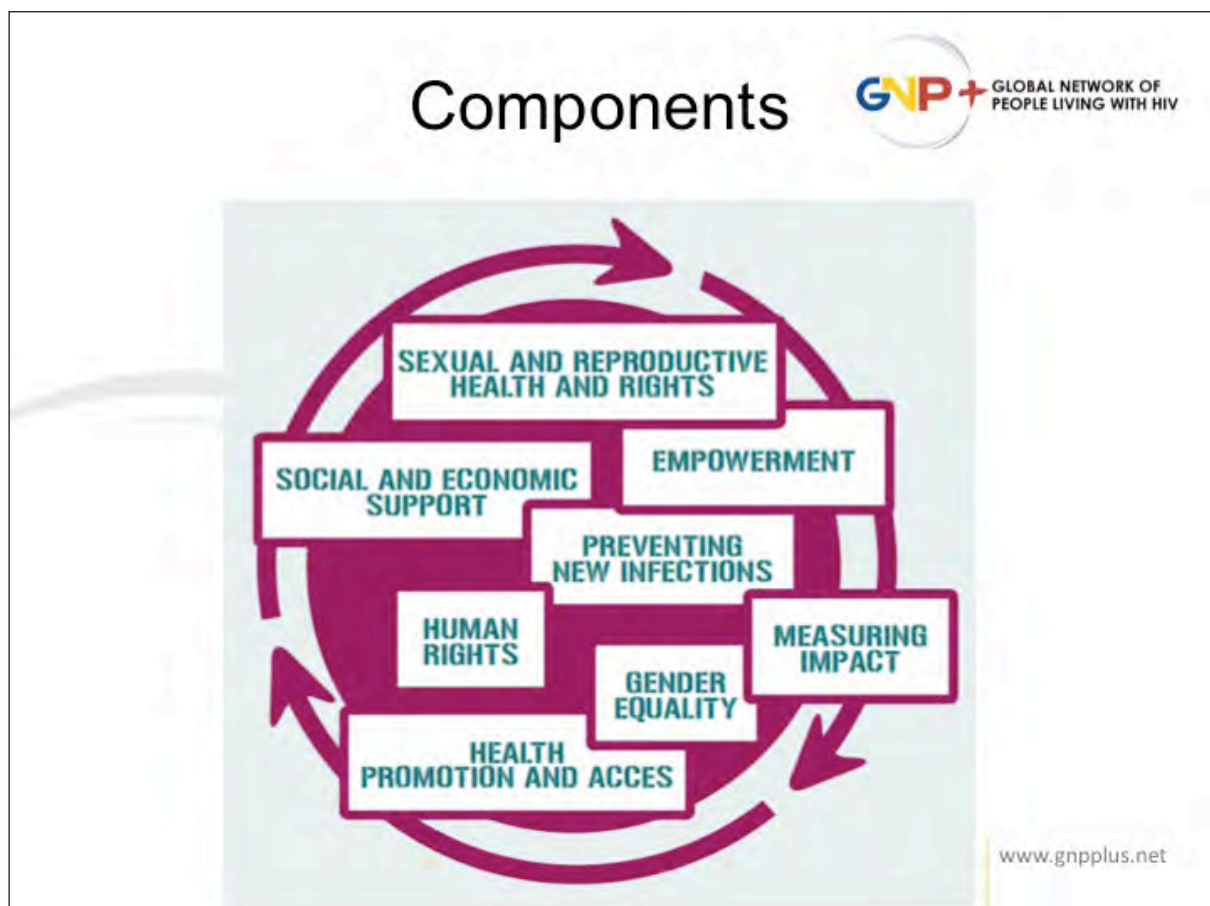
The primary goal of positive prevention is to support people living with HIV to achieve health

and wellbeing with the secondary goal of benefiting public health.

There are a number of values and principles on positive health, dignity and prevention.

Positive men are people, not patients. People living with HIV must be leaders in the design, programming, implementation, research and monitoring and evaluation of all programmes and policies affecting them. Any prevention effort should be shared by both partners regardless of their HIV status.

Positive men are people with needs and desires. People living with HIV should be entitled to



sexual and reproductive health and rights in order to choose to have families and to enjoy fulfilling sexual lives.

Positive health, dignity and prevention

Positive prevention is about improving and maintaining health and wellbeing of people living with HIV. Notice that that is the first thing, it is not about preventing onward transmission alone. It is about promoting a holistic approach to health and wellbeing. This means not just focusing on the virus in people but focusing on their overall health. It is about addressing psychosocial, economic, educational and social/cultural vulnerabilities and gender in sexuality.

Positive prevention efforts need to be tailored to the diversity of people living with HIV, including MSM. And it all has to be done within a supportive and protective legal and policy environment free of stigma and discrimination.

These are the components of positive health and prevention. There is no hierarchy of the components, they are all interlinked and they support each other.

Stigma and discrimination are important barriers to the wellbeing of people living with HIV.

The PLHIV stigma index programme was conducted in 2009 in the UK. 867 people living with HIV were interviewed out of which 381 people identified as gay or MSM. 22 per cent of these men experienced physical harassment in the 12 months prior to being interviewed. 11 per cent took the initiative to test under pressure, 5 per cent were coerced and 7 per cent were tested without their knowledge. This is not in a country that doesn't support people living with HIV, it is not in a country that doesn't support gay men, it is in the UK, so these are very troubling results.

The stigma index was also rolled out in other countries, for example in the Ukraine with a much larger sample size in 2010. 6 per cent of the sample identified as MSM, gay or lesbian and 51 per cent of the total experienced stigma and discrimination due to their HIV status. There are some data problems but this gives you a snapshot about what is going on in the Ukraine around stigma and discrimination from the perspective of people living with HIV.

12 per cent of people living with HIV stated that testing was conducted without their knowledge and 10 per cent by force. This is also in line with what happened in the UK. And what is frightening is that 37 per cent were faced with a lack of confidentiality and the unauthorised disclosure of their HIV status. It is sad to see that

10 per cent of people living with HIV report that there are insufficient ART regimens for them. What is also concerning is that 25 per cent stated that their HIV status was in whole or in part a reason for denial of access to social or medical services.

In the Netherlands in 2008 there was a study done by researchers in collaboration with the HIV association. There were two components: study one looked at people living with HIV in general, almost all of whom were MSM; study two looked at people living with HIV and HIV negative people from Africa, the Antillean Islands and Suriname.

Study 1 showed that 54 per cent of people living with HIV were advised to conceal their HIV status. Almost 30 per cent were encouraged to do the opposite, to go out and disclose, so this contradictory advice is really difficult for people living with HIV to manoeuvre around and it has led to confusion and insecurity.

Study 2 showed that HIV-related stigma is linked to promiscuity and homosexuality and impacts on the extent to which there is a perceived personal responsibility. A quote from an HIV positive Surinamese man: "they say that it is more of a gay thing and that is not allowed and that is not good. You have some families that accept it but not many. From the time you are a kid you know it, it is not good. Many Surinamese people think that homosexuality is not from God and that is why you get the disease." So even non-gay people in the Netherlands are being discriminated against because HIV is associated with gay men. The Dutch study also showed the manifestation of self-stigma.

So, stigma and discrimination lead to self-stigma, And in this case they found that people living with HIV had increased physical distance from people, they avoided social situations, they had excessive hygiene measures and there was indifference. It is really important to look at the impact of stigma and discrimination on the self-view of people living with HIV. Stigma plays a huge role in access to services and access to treatment, it plays a huge role in whether people will get tested, and it also plays a role on people's self-esteem.

European enabling framework

Thankfully in Europe there are enabling laws supported by the European convention on human rights and positive judgments from the European court of human rights. Examples include securing employment rights for MSM in the armed forces, most notably in the UK, and also protection from

inhumane and degrading treatment by guaranteeing ARTs to people living with HIV and preventing deportation to countries without treatment. However laws are not systematically enforced and practices are still influenced by discriminatory social attitudes. This quotation is an example from Moldova, but this could be from many countries: “We must violently beat those mentally ill in the same way they have been beaten before when they tried to hold their sick parades on the streets of Belgrade, Moscow, Sarajevo, Zagreb and other cities. Only in this way you can get rid of them and then they will never dare to come to Chisinau.”

In spite of clear guidance from UNAIDS that criminalisation of transmission of HIV is bad for public health, Europe is highly represented on the list of countries with the most convictions for HIV transmission and exposure. This is unsettling because, for example if one doesn't know their status and they knew that knowing their status would make them at risk for being prosecuted against, then it is questionable whether the person would come forward to get tested.

Late treatment and treatment as prevention

Finally, late treatment is a problem. It is difficult to understand how intelligent people in societies that are accepting of gay men and people living with HIV for some reason are not seeking services. It is something everybody needs to work on.

Treatment for prevention is a huge topic. The question is though, how do we treat treatment as prevention? GNP+ looks at treatment for prevention as primarily for the individual who needs treatment, it is really important to look at the need of the individual, where the preventive effect as beneficial side effect is considered. But more evidence is needed and certainly a new policy is needed. At what point is someone's viral load sufficiently controlled that they can make decisions around safe sex options or starting families? These issues must not be confused, because treatment as prevention doesn't mean that we are not responsible anymore for prevention, we still need to look at shared responsibility for people living with HIV and their partners.

A policy framework

Right now, there is development of an international policy framework on positive health, dignity and prevention; consultations were done in two regions - in the Caribbean and also in central Africa - to develop guidelines to support PLHIV leadership in countries. Operational guidelines

are on their way; hopefully they will be finished by the end of 2011 or in the beginning of 2012. The aim is that they should be used for countries to assess where they are. Countries that have HIV programmes can look at the components in the guidelines and see if they are meeting all the different needs of people living with HIV and their families through the positive health, dignity and prevention framework. For the people living with HIV and their organisations, these guidelines can be used as a watchdog tool, to be able to see if the countries are meeting their obligations to ensure that their health and wellbeing are being optimised.

They key to positive health, dignity and prevention will be to articulate leadership for people living with HIV and to make sure that people living with HIV are at the centre of the response, not just as patients. GNP+ has a number of monitoring tools that are already in use. They are used in a watchdog function to make sure that programmes and countries are fulfilling their obligations. For positive health, dignity and prevention, there is a research tool that has enabled people living with HIV in three countries to drive policy changes with the government in and around prevention. There is also the PLHIV stigma index. Human rights count is a tool that reports human rights violations against people living with HIV. The GIPA report card measures how well the greater involvement of people living with HIV is being implemented in countries. The global criminalisation scan is a scan of over 150 countries that show the status of laws against people living with HIV for onward transmission of HIV. Then there is a comprehensive package on sexual and reproductive health and rights of people living with HIV.

Finally, a number of recommendations:

First of all, services need to be improved to support the holistic health and wellbeing of MSM living with HIV.

And the secondly: Knowledge. People living with HIV and those at risk need greater literacy in health, treatment, prevention and law in order to promote shared responsibility of prevention but also to confront discrimination and to challenge laws that are barriers to optimal health and wellbeing. The evidence base on MSM living with HIV in Europe needs to be strengthened. There needs to be more research and the data needs to be desegregated. And finally, there needs to be evidence-formed policy across Europe in order to allow individuals to make choices that benefit their own health and to benefit public health, and again, in order for this to happen it has to be a people-centred approach.

Thirdly, it is extremely important to involve people living with HIV in prevention efforts. When one looks around at various campaigns around HIV prevention, they are mostly targeted at negative people or people who don't know their status.

Therefore, people living with HIV are part of the solution, not part of the problem, and we need to find a way of integrating people living with HIV into prevention programmes.

4.4. Needs of MSM living with HIV

The text below is a summary of the session presented during the FEMP2011 conference.

4.4.1. A new training path for HIV positive MSM, focused on peer-group here-and-now dimension

Emauele Pullega, Arcigay, Italy
Abstract number: 1750772

Moving from the hypothesis that in HIV+ MSM exists a connection between internalised homophobia and the difficulty to get a satisfactory level of one's own identity's acceptance, a training path was designed to promote access to personal skills and growing tools, helping to implement each own wellness status. Through a non-virtual interaction in the peer-group, participants experimented with the acquisition of a new self-consciousness of doing, thinking and feeling, with a particular focus on self-assertion as HIV+ MSM.

The intensive workshop, named HIVoices, is produced by Arcigay Bologna's Cassero Salute. In a protected environment, during three days, participants alternated informal times of cohabitation to formal training sessions. A non-formal group education methodological approach was used, based on non-steering, experimental and "learning-by-doing" concepts. The group was stimulated to help gain a new consciousness, without any revision or interpretation of participant's personal past life. Two trainers (F. Porcari and E. Pullega) propose a (individual, pair, little-group and large-group) series of structured and un-structured activities, with a combination of bodily, verbal and emotional languages, helping participants to take part actively and both cognitively and emotionally activate themselves. The training path was structured on the following themes: socialisation and sense of belonging; self-esteem and acceptance of themselves as living with HIV; connec-

tion between HIV status and sexual orientation. HIVoices was done twice, with a total of 46 HIV+ homo-bisexual men, aged between 24 and 63, the majority of them coming from North and Central Italy.

At the end of each HIVoices training group, all participants filled out a final evaluation form, with 1 to 10 rating scales. Here are reported some of their average answers: - increasing their own self-esteem (7.96); recognising fears related to their own HIV status (8.91); finding analogies between the process of acceptance of their own sexual orientation and their positive HIV status (7.80). As a further result, participants continued to stay in contact, and develop their relationships both online and face-to-face, thanks to the creation of two active Google groups.

The feeling of belonging to the peer-group and the creation of community tools confirms the isolation and the invisibility of HIV+ MSM, even inside the LGBTQ community. To counteract this, according to participants' motivations and suggestions, a new training group has been designed as the second step on an ideal path started with HIVoices.

Sono sieropositivo, that was scheduled for September 2011 with 24 participants from both HIVoices groups, deepened themes already touched upon in HIVoices, with a special attention to: connections between sexual identity and HIV status; body, sexuality and affectivity in HIV+ MSM.

4.4.2. Peer support – Responding to need, delivering the project and achieving outcomes

Niel Bird, Waverley Care - Positive Scotland, United Kingdom **Abstract number: 1761929**

This presentation focuses on how the peer support project was set up by HIV + gay and bisexual men and how it is delivered in Scotland. Case studies and personal stories were included in the presentation. Examples of individual assessments were shown evidencing the impact of the project and how it addresses: mental health; physical and sexual health; social isolation; empowerment and encouraging men to make healthy lifestyle choices. Many challenges have occurred, particularly around personal boundaries and how relationships of trust are developed and supported. Indicating how we address these issues through one to one supervision and regular peer support meetings.

Referrals are made into the project. Individual assessments are carried out and personal support plans are put into place. Peer support is then planned, delivered and reviewed, including feedback after each interaction. Key objectives of the peer support project service:

- To offer regular, confidential and flexible peer support meetings.
- To offer a safe and supportive space for men, to listen and accept feelings just as they are, e.g. isolation, fear, loneliness, rejection and avoid telling people how to live their lives.
- To encourage Peer Supporters as role models in showing that life goes on after diagnosis.
- To help support individuals to have good and effective relationships with HIV clinic staff and other involved in their care.

- To help individuals to be more informed, through group discussion, information sharing and training, etc, about living with HIV and other STI's.

A year into the project, there were 12 enthusiastic and motivated trained peer support volunteers who support themselves and help support others to live well. The men came from different cultures, backgrounds and life experiences. Lessons learned: The men have been consulted and involved with development of an assessment tool. This comprised a series of ten scoring questions and measures the difference the interactions had made. An initial baseline assessment was made followed by regular impact assessments. Examples were shown to include where men have made changes and what steps they took to do this or where no changes were recorded.

A natural outcome of the project has been that men built their own support networks. The men have now formed peer support groups, a fitness group and have taken part in workshops on healthy eating, stress management and healthy sex lives etc. Next steps include developing a peer support model aimed at affected men, with a clear focus on information and prevention, rolling out the existing peer support model to men in rural areas, reviewing and changing the assessment process which address sexual health, to enable a more open and honest sexual health discussions, thus changing the focus from 'are you just having safer sex'.

4.4.3. The first MSM-PLWH self-help group in Belarus as a result of cooperation between services providers

Kiryl Prasniakou, Republican Youth Public Association “Vstrecha”, Belarus
Abstract number: 1767449

On July 1, 2011, 73 cases of male same-sex transmission of HIV were officially registered in Belarus. However, as the sentinel surveillances shows, HIV prevalence among MSM in Belarus is 2-3%. This allows us to conclude that the real number of MSM-PLWH is within the limits of 1,400-2,100. High level of homophobia in the society, AIDS phobia in MSM communities, and fear of disclosure of one’s same-sex relations to medical staff force MSM-PLWH not to report their risky behaviour. For the same reasons, MSM/PLWH refuse HIV related care and treatment, and don’t participate in self-help groups for PLWH in which IDUs make up the major part of participants.

In 2008, NGO Vstrecha made an attempt to organise a self-help group for MSM-PLWH. However, MSM-PLWH who were offered to meet at the self-help group either refused to participate or failed to disclose their status during the first meeting of the group.

In Belarus there are several NGOs working with PLWH. NGO Pozitivnoje Dvizhenie (“Positive movement”) is one of those organisations. Extended individual work with MSM-PLWH allowed the establishment of trust relations with each of them. Thanks to such relations, it was possible to involve a number of MSM-PLWH in Vitebsk for creating the first self-help group. The group started working in the beginning of 2011 and meets 2-4 times per month. A number of the group participants ranges from 10 to 16 people, some of the participants are from other cities.

The following topical issues are discussed during the group meetings:

- internal stigma and double discrimination (be longing to MSM and availability of HIV status);
- psychological problems;
- how to get acquainted with other MSM-PLWH via Internet;
- safe sex both in case of discordant or positive partners;
- ART side effects;
- adherence to ART;
- acceptance of diagnosis;
- ways to tell relatives and family members about the diagnosis.

The group participants posted their wishes on a specialised Belarusian Internet resource and Internet mailing for MSM-PLWH where one could be consulted on important issues, and get acquainted with each other. The pressing problem for MSM-PLWH is their limited access to services of friendly medical specialists: proctologists, urologists, psychotherapists and others. Prices of the services provided by these specialists are not affordable for many MSM-PLWH. However, the self-help group as well as other social and medical services for MSM-PLWH require financial resources, as there is no adequate support from the current national project funded by the Global Fund.

The experience of the Vitebsk MSM-PLWH self-help group shows that cooperation of PLWH-organisations and MSM-organisations can become an important aspect in the development of such groups.

4.4.4. Access to effective HIV care among MSM across Europe

Ulrich Marcus, Robert Koch-Institute, Germany

Universal access to effective HIV treatment and care is one of the key aims of the Joint United Nations Programme on HIV/AIDS (UNAIDS). A pan-European survey allows for country level comparisons in access to care. Europe includes diverse countries with regard to development: of the 169 countries listed in the UN's Human Development Index (HDI), countries covered by the European MSM Internet Survey (EMIS) range from Norway (rank 1) to Moldova (rank 99). This paper examines (1) patterns related to HIV care among men who have sex with men (MSM) in Europe, and (2) country-level associations with the HDI and other possible relevant variables.

From June through August 2010, the EMIS mobilized more than 180,000 respondents from 38 European countries to complete an online questionnaire in one of 25 languages. Respondents with diagnosed HIV were asked the year of their diagnosis, when their HIV infection had last been monitored by a health care professional, whether they were receiving antiretroviral treatment (ART), the result of their last viral load (VL) test, and experienced HIV-related discrimination. Multivariable regression models were used to identify factors associated with not receiving effective HIV care.

Out of 174,209 respondents eligible for analysis, 13,533 were diagnosed with HIV (country median: 4%, range: 0-16%); of those, 12,447 (93%, 67-97%) had their HIV infection monitored within the last 6 months, 9,484 (66%, 45-77%) were

receiving ART at the time of the study, and 7,619 (50%, 27-64%) reported an undetectable VL. There was a clear east-west-gradient with half as many men on effective treatment in the WHO Eastern Europe sub-region compared to the Western sub-region, even when adjusted for time living with an HIV diagnosis. 15% of respondents from Eastern Europe said their VL had not been measured, as compared to 3% in Western Europe. On a country level, for the 30 countries with at more than 10 HIV positives in the national sample, we found a strong correlation between HDI and access to effective HIV care (adjusted $R^2=0.42$). The median number of years living with an HIV diagnosis, and the amount of reported HIV-related discrimination completed the model (adj $R^2=0.52$).

Substantial proportions of MSM diagnosed with HIV, particularly in new EU member states and non-EU/EFTA countries of Europe, reported deficits regarding HIV-specific care – monitoring of infection, VL testing, and ART. This may partly reflect differences in CD4 thresholds for starting treatment. However, the strong correlation with the external HDI data suggests a socioeconomic development explanation for variation in access to HIV care. Not all European countries are able to provide adequate health care for people with HIV – to decrease HIV-related morbidity, mortality, or population VL. In many countries, interventions are also needed to reduce HIV-related discrimination that blights lives and hampers access to health care for MSM.

4.5. Medical aspects of living with HIV

The text below is a summary of the session presented during the FEMP2011 conference.

4.5.1. Increased mortality among HIV-positive MSM – in the era of efficient antiretroviral treatment (ART)

Göran Bratt, Gay Men's Clinic, Venhälsan Stockholm, Sweden
Abstract number: 1769789

Since 1996 there has been a decrease in AIDS-related mortality. After 1-2 years of antiretroviral treatment testing, a report was issued talking about severe metabolic side effects.

Although AIDS-related mortality has decreased tremendously in Sweden, there has been an increase in non-AIDS related mortality caused by:

- Increased risk of cancer such as anal, lung, melanoma, liver
- Heart disease
- Diabetes, Kidney, Liver Hepatitis (co-infectious), Vitamin D deficiency (fracture risk)

Systematic metabolic testing was done between the years 1998 and 2000 with a follow-up and evaluation in September 2011. 346 HIV-positive MSM from the beginning, 15 drop out follow-up on 331 in total.

- 50 per cent exposed to toxic drugs (D4T)
- Non-AIDS cancer 25 per cent of mortality reasons
- Hepatitis B/C 11 per cent
- Severe bacterial infections 14 per cent

- Smokers, ever D4T, insulin median had significance with an OR of 2.2 and 2.0

Although people who are HIV-positive live longer due to antiretroviral treatment, they still may die early due to non-AIDS mortality – there has been about three- to four fold increase within this group. Lifestyle factors are the only independent factors associated with long-term mortality in HIV-positive MSM. Changes in behaviour and lifestyle such as smoking cessation, exercise, decreasing abdominal fat, better sleep, sunlight (vitamin D) could prolong life.

- Be alert for the shift in disease pattern causing mortality
- Prevent and treat cardiovascular risk factors such as cholesterol levels, diabetes, high blood pressure
- Screen aggressively for anal cancer
- Immunisation
- Resources and funding.



CHAPTER 5

Response to the epidemic

INTRODUCTION*

The fifth chapter gives different examples of past and present interventions made to curb the spread of HIV, interventions that have worked and those that can be used as an inspiration.

This chapter elaborates on three factors that are crucial for the success of HIV prevention work:

1. Evaluating intervention efforts in order to get a better picture about developments that occurred during an intervention
2. In addition, for an intervention project to succeed, there needs to be a consistency in funding, which gives a certain security
3. Finally, being dependent on each individual partner involved in the intervention, any process must be undertaken with good cooperation between main stakeholders on all operational levels (academia, NGOs, government and gay businesses).

process and following-up on the issues that resulted through the evaluation. These are excellent tools that will help not only improve the ongoing interventions, but serve as lessons learned for the planning of future projects.

throughout the existing process and guarantees better outcomes.

* Power Point presentations and abstracts related to this chapter can be downloaded from www.femp2011.eu

Ronny Tikkanen, University of Göteborg

5.1. Response to the epidemic – The Swedish experience

The text below is a summary of the session presented during the FEMP2011 conference.

It is very important not to forget the history and to continue to pass it on to future generations. Many Swedish gay men remember the 1980s and the fear that struck many gay men when faced with the fatal disease. Many Swedish newspapers in the 1980s talked about “gay cancer”, many articles claimed that gay men should not donate blood, that gay men should be “tattooed” with the word AIDS, or that sex in gay saunas should be criminalised. Gay and bisexual men with a lethal cancer were threatening the heterosexual population and should therefore be controlled. In the middle of all this there were real people with real lives, and people who actually died, often in silence, were brought back to the closet by their relatives after they died, often denying the sexuality and the cause of death of the deceased. Sixten Herrgård was a Swedish fashion designer who gave AIDS a face in Sweden. Sixten and all the others who left too early are heroes that need to be remembered. This is why it is so important to continue celebrating the World AIDS Day with candle vigils in order to keep the memory of the history alive. But there are also bright sides of the 1980s too. A poster by the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights from the 1980s says “Security, community, openness”. This is a marker for the prevention of late 1980s and early 1990s – the broad engagement in the community, in the gay, lesbian, bisexual, transgender, queer community and the actual feeling of community and the feeling of solidarity existed. Lesbian, transgender persons and other queers were very much engaged in the prevention towards men who have sex with men, so therefore gay and bisexual men owe thanks to these groups for the solidarity they showed. That’s one reason why sexist transphobia among gay and bisexual men is so upsetting and should be fought by all means: there is a special place in hell for gay men who are sexist and show transphobia against transgender people.

The 1990s

The prevention in the 1990s that was produced by the gay, lesbian, bisexual, transgender and queer community influenced the prevention conducted

through national campaigns, and the national campaigns learned a lot from the struggle in the lesbian, gay, transsexual and queer community. Promoting sexuality in a positive way and sending out optimistic messages was significant for prevention in Sweden the 1990s. However in the Swedish prevention there was the tendency, as the social anthropologist Mary Douglas would have said, to create the “dangerous other”, and Sweden constructed for instance the “dangerous Danes”.

It’s a quite an impossible task to give a whole picture of the contemporary Swedish response, some examples can be highlighted that mirror some of the issues dealt with in the contemporary response. In Sweden there are national and regional campaigns such as “The Colour of Love” that are broader in focus and include men, women and transgender people regardless of their sexual orientation. This is a good example of peer-education driven prevention that is more general in its perspectives. As a contrast, there is also a project “Sexperts” that is more focused on adult gay, bisexual and transgender persons and this is a good example of more sexually explicit HIV prevention projects that meets the needs of urban, self-identified gay, bi, transgender persons. The third project that has started in 2011 is called “The Compass”. The Compass is a group intervention for gay, bi and transgender person, and is built on 15 short films that serve as a basis for discussions and exercises. The intervention aims at increasing self-esteem, which is a quite an important issue to deal with, especially among young people, and at the same time, it aims at reducing risk behaviour. Another important part of the contemporary intervention is interventions focusing on people living with HIV and here it is important to highlight “Positiva Gruppen”(The PositHIV Group). PositHIVa Gruppen is a support group for MSM living with HIV, and their work on the individual basis with “heart-to-heart” that is an one-to-one peer support, as well as the group intervention called “Positive talking” aiming at empowering MSM living with HIV, but still, many needs to be addressed in terms of positive prevention. They are also going on line. This is another develop-

ment to set up interactive outreach work over the internet. One example is “Sexperts”, working their way on gay sites to create dialogues on risk estimation and reduction.

Contemporary response

Something that is significant for contemporary response in Sweden is the professionalization of HIV prevention, which has in a way replaced the broad community engagement that was present in the 1980s and 1990s. Concepts such as evidence-based, knowledge-based, empirical proof, outcome and evaluation have been embraced by the large part of contemporary interventions focusing on MSM.

But what are the challenges of today? What will the future responses to the epidemic be like? The FEMP conference is aimed at the future prevention and maybe even change, or at least challenge the paradigm of MSM focused prevention. The responses should focus more on sexual rights, and more specifically on the needs among gay and bisexual men and other men who have sex with men. Unsafe sex can be viewed as a consequence of unmet needs in terms of sexual rights. Sexual rights are fundamental rights and universal rights; they are universal human rights. Sometimes we tend to talk about sexual rights and human rights when we talk about the global south, but sexual rights and human rights are very much a subject for the global world in general. MSM have the right to good-quality counselling and information when getting tested. The Swedish MSM surveys indicate that the quality differs quite a lot depending on where you go to get tested. Specialised clinics that only exist in metropolitan areas in Sweden are the best to provide counselling and meet the needs of men who get tested, while other clinics and general hospitals outside the large cities meet those needs poorly if at all. The late activist, researcher and educator Eric A. Roth said fifteen years ago: “If gay, bisexual men and other queers do not perceive prevention as trustworthy, or as recognising the needs and sexual rights, it will simply be empty words and gay and bisexual men will develop their own ways to deal with risks and handle the epidemics.” HIV prevention becomes the enemy, and not the virus. One fundamental thing in avoiding the gap between prevention and MSM is to be critical of the way risk and risk-takers are constructed within discourses surrounding HIV prevention.

Intersectionality

We have to remember that unprotected anal intercourse is not always irrational; on the contrary,

most gay and bisexual men and other men who have sex with men are making rational choices about sexual behaviour, but these choices might be seen as irrational by the positivistic public health discourse with its focus on knowledge, attitudes and behaviour – often linking these together.

There are also other important areas in that need to be highlighted for the coming responses to the epidemic. One could label all these areas with the concept of intersectionality – a concept that was developed thanks to the early work of black and feminist movements. Intersectionality recognises that there are intercepting or overlaying layers of oppression. These different layers of oppression might result in seclusion, neglect or stereotyping, which are all violating, not only to sexual rights but also to human rights. The intercepting or overlaying layers of oppression that could be identified within MSM prevention are many: We have to start asking questions about the impact of racism and islamophobia within the gay, bisexual, transgender and queer communities, and in health- and social care. And we have to ask what kind of an impact does racism have on prevention and health promotion. We also have to be more critical to the discourse that HIV is constructing, a discourse that reproduces norms about a young perfect body without disabilities. There is generally a lack of analyses about what consequences social class and social exclusion have on prevention towards MSM. Is prevention more geared towards white, urban, gay-identified man? We know from other studies that people who are socially more excluded from the society are more vulnerable when it comes to health, so we have to become much better in responding to this in HIV prevention. Finally, there are two more aspects to which we have to respond better to as well: transgender men and women, and people living with HIV. It is very sad to see that transphobia and stigma towards people living with HIV still exists within the gay, lesbian, bisexual, transgender and queer communities, and in health care and social care. This has to be dealt with immediately.

One can summarise the Swedish prevention experience like this: we started with engagement and community support and moved into a more professionalised times of prevention, and we are still facing several problems that have to do with human rights. Therefore, one could hope or wish and work for a paradigm shift where the community is included in demanding rights to prevention and health care that meet the needs. As Bruce le Bruce said: “Out of the bedrooms and into the streets!”

Colin Batrouney, Victorian AIDS Council, Australia

5.2. From intervention to engagement: How do we make health promotion relevant to gay men?

The text below is a summary of the session presented during the FEMP2011 conference.

27 years ago, two years before “The grim reaper” campaign, which was an Australian version of England’s “Tombstones” campaign, HIV and AIDS were a terrifying reality for gay men. AIDS was galvanising gay communities into all sorts of action from street demonstrations and civil disobedience to creation of formal organisational structures and high-level political and bureaucratic partnerships. In short, the attention of gay men around the world was focused, and it was focused on AIDS.

Engagement in HIV among MSM and in the gay community

Over the course of the last decade, one of the constant debates in health promotion that’s still relevant today is how do we keep gay men engaged in safe sex and condom use? Many would argue that gay men have been heavily engaged in safe sex and condom use for the good 27 years, and in fact, our level of commitment to prevention is largely unprecedented in sexual health. But within the terms of HIV and AIDS, the gay community and community in general, health promotion can never do enough. Gay communities are accused of being complacent about HIV infection; community organisations are constantly being accused of not doing enough and it seems that every new infection is an indication about inadequacies of our response as a sector and as a community. The problem seems perennially out of reach, something we aren’t seeing, something we aren’t hearing; we might be reaching some gay men, but what about that pocket of hard-to-reach non-gay identifiers who just aren’t engaged. What about straight men who go to gay saunas? What about young gay men who don’t know what they are doing? And what about the recreational drug users who just don’t care? In focus groups all over the world health promoters have asked gay men: What do you think do gay men need to reengage with prevention? And the answer is invariably the same: another “Grim Reaper” or “Tombstones” campaign. We just can’t seem to shake the public

health obsession with punishment and terror. It is interesting that while we may get frustrated with the answer to the question of what can we do to get the gay men reengaged with prevention, we don’t realise that the problem is actually embedded in the question itself; that a better question might be: What do we need to do as health promoters to engage with you? It is argued that, with successful antiretroviral treatment gay men have become more comfortable with the idea of unsafe sex and risk, and maybe with the idea of living with HIV as well. Now, as health promoters, we’ve been right to question this advice, because it’s built on a fallacy. In the largest study of its kind in Australia “The Pleasure and Sexual Health” (PASH study) that collected data from over 2,000 men, despite the sense that in general gay men feel that HIV poses less of a threat that it once did, and that an HIV infection can still mean a long and fulfilling life, this does not mean that they are dismissive of HIV. Indeed, among men who believe themselves to be HIV negative, 72.8 per cent indicated that they believe that HIV is still a big deal. A substantial proportion of men still remain extremely concerned at the possibility of HIV transmission. As for HIV treatments taking the worry out of sex, 84 per cent of the men surveyed disagreed or strongly disagreed with that contention.

How should health promotion engage?

The engagement exists but it is dynamic, fluid and creative. As health promoters, our engagement with gay men needs to be just as dynamic, fluid and creative, but that dynamism does not just mean internet, SMS messaging and Twitter. Nor does creativity mean inventive sloganeering and innovative condom distribution, and fluidity does not just mean employment of multiple media platforms. All these things are delivery mechanisms, but no one is going to care, if what we are delivering is more of the same. Since 1996 the epidemic of HIV has changed almost beyond recognition for gay men in first-world cultures. The emergence of highly active antiretroviral therapy

and the concept of undetectable viral load, the gradual deployment by gay men of risk reduction strategies as opposed to consistent 100 per cent condom use, the mainstreaming of gay as a cultural signifier, the revival of sexually adventurous subcultures within gay communities after decades of safe-sex and condom reinforcement; these are the major shifts since 1996 that include the effects of a decade of neoconservative individualism in the society in general and gay men in particular, competing social agendas regarding parenting, gay marriage, relationship recognition and equal human rights, and growing levels of conservatism in Western societies (and in turn in gay communities), and the emergence of chemo-prevention, undetectable viral load, post-exposure prophylaxis, pre-exposure prophylaxis and microbicides.

The challenges set out for us in communicating these shifts in the prevention landscape aren't just in the complexity of the science, or the fact that it's possible that some of these technologies and strategies may only be applicable to a small proportion of gay men. The challenges lie at a more fundamental level in the ways we engage with gay men. We run the risk as sexual health promoters of being considered irrelevant safe sex technocrats unless we find ways of facilitating a real and substantiated exchange with gay men about what our priorities are when we have sex, and how desire, passion, need and opportunity interplay when it comes to wanting sex. And finally, we need to reconceptualise HIV within this prism.

The potential and limitation of social marketing

This will not be the work of social marketing alone. There are two highly successful campaigns that can be used as an example to point out what this particular tool in health promotion can do well, but paradoxically, although highly successful these very examples also demonstrate clearly the limitations of social marketing campaigns and their potential to be overburdened with unsustainable expectations.

The "Drama Down-under" campaign was implemented in 2007 as a general sexual health campaign that addressed the issue of regular STI testing, awareness of syphilis testing and treatment, anal health, and the problems associated with asymptomatic STIs. We decided on a strategy that sought to delight and amuse rather than terrify gay men into considering their sexual health. The campaign differed from everything else that was done in this area in that we were funded to put this campaign into the mainstream. So, gay

men saw this campaign on trams, busses, tram and bus stops, and billboards.

Conversely, the protection campaign" was a highly targeted condom reinforcement campaign. This initiative sought to put sexual pleasure at the centre of the campaign in that it emphasised the need to use condoms in a variety of settings and situations that included anonymous sex, serodiscordant sex, sexual positioning and preference, and of course included information about post-exposure prophylaxis.

With over 90 per cent of recognition and comprehension rates for both initiatives, these campaigns are the most successful social marketing campaigns ever implemented by the Victorian Gay Council as demonstrated by two independent evaluations. Over 90 per cent of the gay men surveyed remember the campaigns, understood them and could recall specific campaign messages. So, VAC/GMHC got the attention of gay men, which was a fantastic achievement since the feedback received in the focus groups prior to implementing these initiatives was that the AIDS council had nothing interesting to say and that it was just more of the same. But getting the attention of gay men was only a part of VAC/GMHC's job, and probably not the most important part, in that all the communication in these campaigns was and is one-way: from us to them.

Active two-way communication campaigns

There are three specific projects that the VAC/GMHC health promotion team has embarked upon, that in their designed content and implementation creatively utilise the active engagement of gay men. "Staying negative" is a very long-running campaign in Victoria, over the last five years, and it is only nominally a campaign, but it does something that no other campaign implemented by GMHC has done before: it's entirely designed around the notion of listening and exchange. Volunteers give a first-person narrative of how they've lived their lives over the course of the epidemic and as such they offer an interesting barometer, on the range, scope and depth of contemporary gay experience. From teenagers to octogenarians, they include stories of loss, isolation, drug and alcohol use, religion, family, friendship, abuse, discrimination, risk, love, violence, and sex, and sometimes HIV. The men in the campaign control their own narratives, how they are presented and promoted.

Currently there are over 60 volunteers who are engaged in this process.

The "Sexually Adventurous Men" project is

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<https://www.facebook.com/QAFxxk#!/video/video.php?v=547425185562>

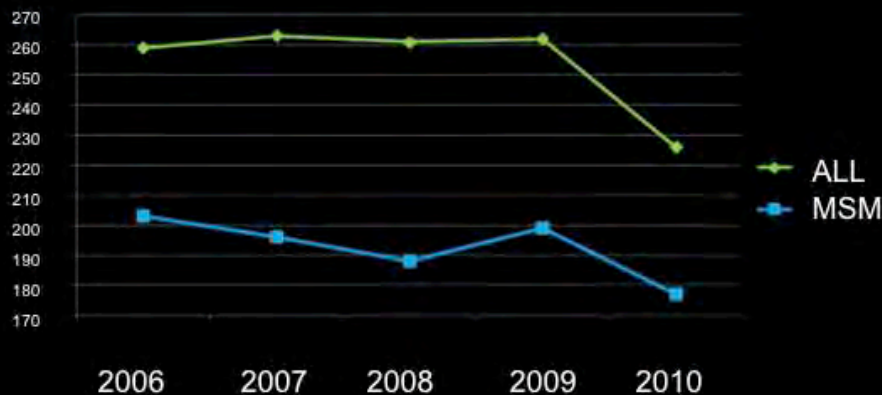
www.facebook.com/QAFxxk

an ongoing collaboration between VAC/GMHC, People living with HIV/AIDS Victoria, and the Australian Research Centre in Health, Sex and Society. It's an initiative that seeks the involvement of sexually adventurous men to determine the direction of the project. It was actually the health department in Victoria that invited VAC/GMHC to put together a proposal that was build around a framework of community development rather than intervention as the best way to precede this work. Of course, it's common practice for community development projects to be heavily directed by the perceived needs, knowledge gaps or skill deficits of targeted population. Researchers demonstrated that the sexually adventurous men are very well informed about sexual health, regular testing, and risk-reduction strategies. Still they are contracting HIV and STIs. Proximity to sexual engagement with HIV positive men and men of unknown zero status, multiple sexual partners, group sex activity in addition to the application of imperfect risk-reduction strategies and to a lesser extent concurrent recreational drug use are the elements that make up their risk environment. As pointed out before, the historical model for approaching

HIV prevention and sexual health is to identify a need, usually characterised by a deficit or a problem, and devise a strategy or an intervention in the hope of impacting on these difficult behaviours. This approach will not work, most specifically with the sexually adventurous gay men. In most cases, these men are ambivalent or antagonistic to interventions from AIDS councils by whom they feel ignored over the past few years. Indeed, many of live in opposition to the "good gay citizens" that they view as the inevitable subjects of AIDS council initiatives. So, a significant part of the project was to gain the trust of these men and these communities, and this was done in two ways: staff recruited for the project was drawn from the sexually adventurous men communities themselves, and we have actively listened to their concerns, suggestions and ideas for the project and worked to make them happen. For example, when sexually adventurous men wanted to hear stories from other sexually adventurous men about their lives, we helped them create a video-narrative project to form the basis of sexually adventurous men website which content is driven by the men themselves. The project sponsors major community cultural events such as Melbourne Leather Pride,

HIV in Victoria – The last 5 years

- In Victoria, the trend in HIV infections has remained stable over the past 4 years
- However, in 2010 there was a 10.4% drop in HIV notifications



Fetish Expo ensuring that our engagement is not just about safe sex resourcing. The project workers regularly consult with venue owners, party organisers and community leaders to determine the future direction of the project, and in turn this has encouraged an enormous sense of ownership of the project and its work, and this is largely due to the commitment and determination of peers and their communities.

The final initiative seeks an engagement with the online community. “Queer as Fxxk” is a gay soap opera with three regular characters who share a house in metropolitan Melbourne. VAC/GMHC would insert health-promoting messages into the drama and see if the online community, in this case nearly 4,000 fans on Facebook, would engage with the project. The narratives were derived by conducting a series of four extensive focus groups; each focus group had 35 to 40 men, and they got to talk about the kinds of things that they would like to see in this drama. So the narrative threads for the drama were actually derived from the men themselves. While people are unwilling in a semi-public space like Facebook to discuss their own sexual health issues, they are happy to support, criticise or objectify fictional characters. Subsequent series have put

health promotion content into the background as it concentrates on zero-discordant relationships, stigma and discrimination, homophobia and problems related to coming out for younger gay men. The hope is that in the absence of embedded health promotion messaging within the dramas and subsequent series that the narratives and stories would prompt more active engagement from viewers. Time will tell whether the project was successful, but it will continue throughout 2012.

The default position for our sex drive is not safety; it's pleasure, and sometimes that pleasure involves risk. As health promoters we can, and do make a difference, but we are only able to continue making a difference if our programmes are sustained over time and we continually question ourselves and subject our work to critical analysis.

Some possible effects

The epidemic in Victoria stopped rising; it stabilised over the last five years, and last year we saw a 10 per cent decline in HIV notifications. In a way, it is tempting to declare this an unambiguous success for health promotion. But, we have to resist that temptation. It would be misguided to declare that the decrease in HIV notifications in 2010 was due to the help of the health promotion

programme and VAC/GMHC. We've always considered our prevention efforts to be but one component part of the organisational response, and if our broader effort on the part of the Department of Health, other community based organisations, the medical and social research fraternities and more importantly the gay community itself.

In the creative ways in which gay men have adapted the safer sex information during the 27 years of this epidemic, we can see that our role as sexual health promoters is important but limited,

and sometimes self-limiting. We need to understand that the problem does not lie within gay men, but rather our expectations and assumptions of them. It is very important as we continue our efforts in health promotion that we not get bogged down or blinded by the potential of technology or the limited utility of the campaigns and sloganeering. We need to find ways on how to view the world through a complex lens of how gay men think, feel, live and love. One important way to achieve this is through active listening and real engagement.

5.3. Different intervention arenas

The text below is a summary of the session presented during the FEMP2011 conference.

5.3.1. Health online – prevention work online

5.3.1.1. Is social media the Holy Grail to re-engage gay men with safe sex messaging?

Yves Calmette, ACON, Australia
Abstract number: 1761867

Even 30 years after the beginning of the HIV epidemic, engaging MSM around a safe-sex message is proving to be a great challenge. Research shows that MSM pay less attention to the message, in particular when delivered through the traditional media. Therefore, health care systems should use new and modern ways to spread the message. In Australia, three innovative ways have been tried out to reach MSM with safe sex messages. A condom campaign was launched with the message “Wherever sex happens, slip it on.” Activities included:

1. Interactive web banners

On websites such as Manhunt, Gaydar, Aussie-men, Samesame, which are frequently visited by MSM, an interactive web banner was shown that engaged men to go to the website of the campaign and learn more.

2. Facebook

On Facebook, in connection with Mardi Grass, many posts were made about the campaign and people were encouraged to tell where they have sex (and slip it on). This gave the best qualitative response – people tended to stay longer on the website and write/discuss more about it on the site and on Facebook.

3. Grindr ad

In connection with this application, a banner/link was placed in order to attract people to the website of the campaign. This gave a massive quantitative spike in number of people that visited the website, though they tended to leave the site rather quickly.

In order to attract people and get them to visit a certain website, the banners or simpler teasers should be very interactive. If one tries the apps, they should get to a site where they can very quickly get the message (they tend to leave rather quickly). Research is needed to find out more about the habits of MSM on the internet and how they can be reached out to.

In cases when the internet is used for health promotion, campaigns must be planned very carefully and must include certain elements, such as who do you want to reach with the campaign, how should the message be delivered etc. in order to keep up to date, latest technological development must be followed and the freshest sites/methods must always be used. As many as possible angles should be considered, as well as working together with sites such as Grindr and Gaydar. A special consideration should be paid to how to catch people in this fast changing world.

5.3.1.2. Eurosupport 6: CISS – Developing a positive prevention

Christiana Nöstlinger, Institute of Tropical Medicine, Belgium
Abstract number: 1755335

At the Institute of Tropical Medicine in Belgium, they have developed a computerised programme that helps health care providers to support HIV positive people. The same programme also helps find ways to make HIV positive men active persons with a positive and enjoyable sexual life.

The programme has three steps:

- Focus on emotions (understand your motivation to sexual health)
- Working through (find personal tools to your goal)

- Make your plan (what, when and where)

The aim of the programme is to use a medium that the men are comfortable with (computers). The aim is also to establish clear regulations as to how the health care providers should work with an HIV positive man, while putting a particular focus on making people care about their health in general and sexual health in particular.

This method is rather new and therefore has not been fully tested and evaluated.

5.3.1.3. Disseminating prevention message while chatting in gay websites

Maria Cosmaro, Fondazione LILA Milano ONLUS – Lega Italiana per la Lotta contro l’AIDS, Italy
Abstract number: 1770394

Many MSM meet on the internet and therefore the internet is an excellent place to reach MSM with a safe sex message. In Italy, a project was started through which peer educators were trained, to through workshops deliver a safe sex message by chatting under an anonymous identity with other MSM. They were trained in how STIs are transmitted and how to find tools for prevention. They were given a protocol to follow with rules and ethical principles. 18 peers were given a one-month period to chat with other MSM in different chat rooms and through MSN messenger, whereby their chat logs would be stored. They would then have debriefing workshops with the researchers.

This is a very cost-effective intervention. Reading the stored chat logs, it becomes quite clear that this is a very effective method to get MSM to consider using condoms. However, the MSM were not aware that they were chatting with a peer educator due to their undisclosed identity, so the ethics could well be discussed.

The internet is a good way to reach MSM, but one has to follow the development carefully and make sure to use interactive methods and act quickly (evaluate continually during the study and get started rather quickly, don’t plan for years before and be flexible in choosing the freshest place/method).

5.3.2. Business and pleasure – Role of commercial actors in prevention

Yves Calmette, ACON, Australia
Abstract number: 1761865

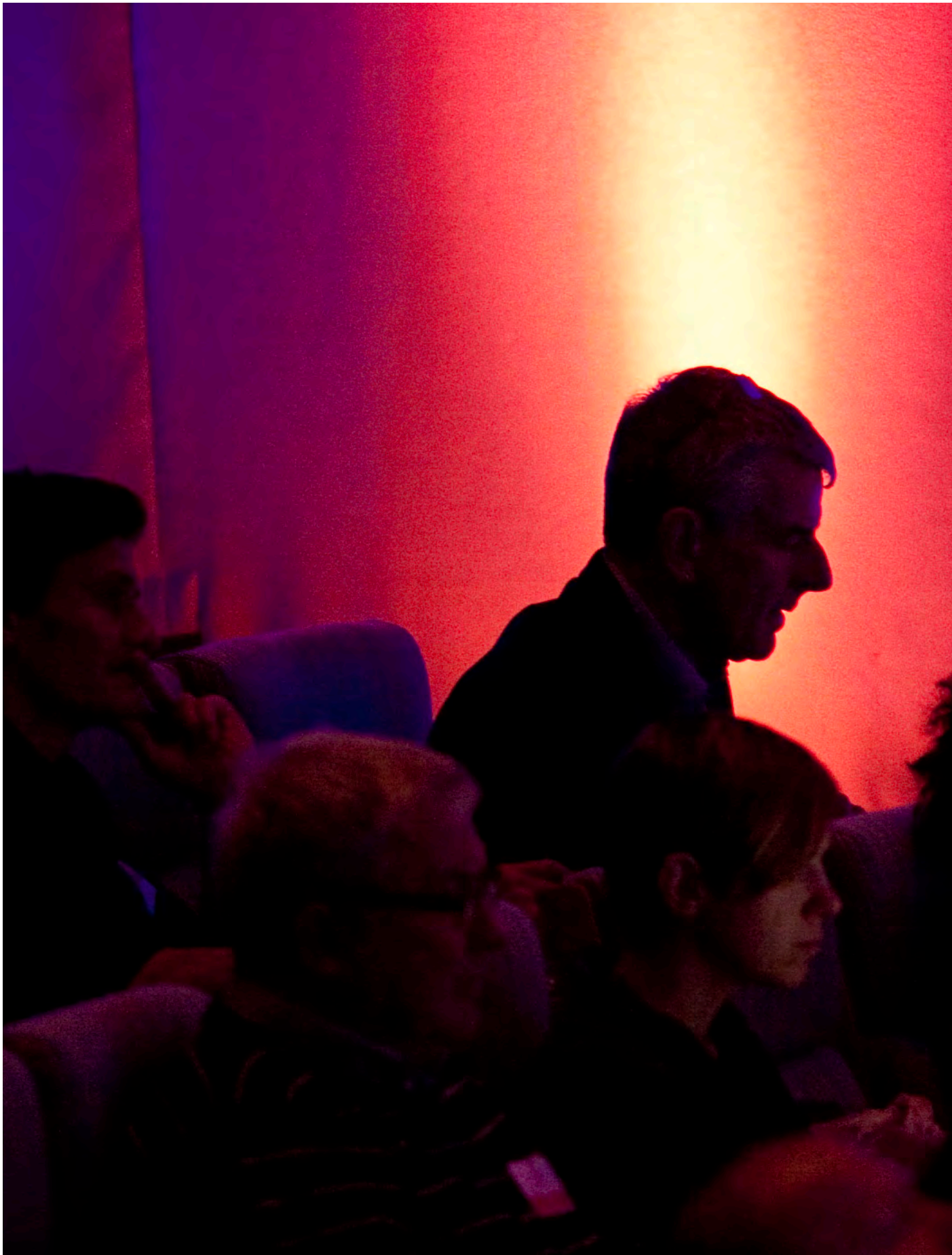
Nigel Sherriff, Centre for Health Research, University of Brighton, United Kingdom
Abstract number: 1761923

It is very important for health promoters to collaborate with gay bars, dating websites and sex venues to reach their different target groups. “Everywhere” is an EU project with many collaborating partners, which is a seal of approval awarded to businesses if they meet certain safe sex standards. This project was launched to gain commitment of gay businesses in HIV/STI prevention activities with both social and economic benefits as a result. There are two “levels”; “Everywhere minimum”, which means that the place supplies condoms, lubricants and information about HIV testing and “Everywhere premium” which in addition to this, adhere to antidiscrimination policies and train their staff regularly. Some of the benefits that came out of this collaboration according to some businesses was to be part of a big European network, it was good publicity, it attracted tourists, and it was good economically, since “healthy customers comes back more often”, as one business owner said.

Similar “signs of approval” have been around before, just not to this extent, for example the “charte de responsabilité” in France and “Playzone” in the UK. These two collaborated with “Everywhere” and might also have been a reason why some of the businesses were keen on the idea. However, more funding is needed to continue with these activities. For example, the condom distribution is something that businesses pay out of their own pockets as it becomes quite costly. In Spain, the Ministry of Public Health assists various companies with funds, so that the companies can meet the requirements. Everywhere is now expanding and is taking its aim to Hong Kong and Japan among other countries. In the future, they hope to create apps for smartphones in order to easily make people aware of “Everywhere-approved” sites.

The gay community webpage “GayRomeo” contributed immensely to EMIS (The European MSM Internet Survey) by asking their members to participate. This is also a way for a commercial actor in prevention. However, a representative from GayRomeo said there is a need for balance; their members will just get irritated if they get a lot of requests and spam-mail. Therefore, one needs to carefully choose when to send these messages and to whom. Another problem, which was also brought up by a representative from QX, and Qruiser from Sweden, was that authorities often overestimate the size of gay businesses, and expect them to pay for the movement (of HIV/STI prevention) themselves. It is hard to raise money for HIV prevention these days since it’s not a common problem for the general public. The gay community is a key actor in HIV prevention activities.

In Sydney, Australia the “Slip It On” campaign was launched by the LGBT organisation Acon. The organisation had limited funds so they went out looking for collaborators among leading brands in the gay community and found “Teamm8”, a Sydney-based underwear company. The goal was to improve condom-use among MSM. The campaign featured a series of Andy Warhol pop art inspired bananas covered with a condom. Teamm8 let Acon put their images on the regular Teamm8-ads free of charge and even on some of their t-shirts and underwear. In this way, Acon got to use all of this media-space at no cost. The campaign was a success. 94 per cent of MSM recalled the ads and “Slip It On” is now well established in the Sydney gay community. Teamm8 also got good publicity out of this “random act of kindness”.





5.3.3. Traditional outreach work

5.3.3.1. StopHIV group, collaboration between regional authorities and voluntary organisations in Stockholm

Gunilla Neves Ekman, Stockholm County AIDS Prevention Programme, Sweden

Abstract number: 1771514

Valuable collaborations for outreach, counseling and testing between different authorities such as state-, county- and municipalities with NGOs such as Venhälsan, PositHIVa Gruppen and Stockholm Pride could be achieved through continuity and sustainability. The efforts have been evaluated and found to be effective in reaching MSM. It is important to make fast but simple

evaluations, so that those surveyed have the opportunity to respond and express what they think is good and what needs improvement for next time. In order to achieve a good collaboration, it is important to assign specific persons who would be responsible for specific areas, have specific tasks and who would be responsible for all the documentation within their area.

5.3.3.2. Mentoring Support Programme among MSM in Ukraine

Myroslava Debeliuk, ICF international HIV/AIDS Alliance in Ukraine

Abstract number: 1770471

The Ukrainian MSM prevention habits are very bad in spite of the fact that there is a lot of knowledge about the risks from HIV infection. As one of the good prevention method outlined is motivational interviewing (MI) and is done as a part of the Mentor Support Programme among MSM. The gist of the project is to assign one mentor per one man under the period of four to five months to meet about 10 times. The meetings are called: Introduction, Safe Sex Behaviour, History Sharing, Self Esteem, Drugs and Alcohol, Being Gay, Partnerships, Facing the issue, Social Role, Goal Building. These meetings include discussions with psychologists, HIV testing, BASK 45-question questionnaire similar to the one done in Great Britain, evaluations, as well as final gathering where men meet with other MSM.

The problems that the project encountered along the road included: a lot of administrative

work, difficulties in recruiting mentors, as well as problems reaching out the LGBT community, as they are more of an underground group in Ukraine than in Europe. However, the good news is that the project is a major step in the right direction and that Ukraine is strongly supported by other LGBT organisations in Europe.

The fact that the MSM community in Ukraine insufficiently practices the use of condoms in spite of the great knowledge about HIV risk is due to several factors that include scaremongering about HIV which had the opposite effect, as well as the rejection of information on prevention efforts with the thought that “there are people who are worse off than me.” In addition, it may also be due to low self-esteem, low self-confidence and self-respect, which leads many MSM not to value their health or that of other MSM.

5.3.3.3. “ICH WEISS WAS ICH TU“ How to implement a community and scientific-based MSM-prevention-campaign

Matthias Kuske, Deutsche AIDS-Hilfe, Germany
Abstract number: 1763799

”Ich Weiss Was Ich Tu” is a nationwide MSM prevention campaign in Germany organised by the Deutsche AIDS Hilfe.

The campaign began with a variety of different actors with different jargon, all of whom had different aims and objectives, which made the initial cooperation difficult. A lesson learnt therefore is to clarify all these aims in order to achieve a good and clear cooperation. “Umbrella thinking” might be one of the solutions the problem. Umbrella

thinking helps at times when there are many good ideas that are difficult to collect. A special highlight is put on the importance of a thorough preparation and how different synergy workshops could be utilised to their full potential. The project also proved how important it is to give a good response to all actors involved and to work with them and not against them. An example of good cooperation was the joint effort to certify a gay sauna.

5.3.3.4. EMIS: Deficits in targeted and comprehensive STI-testing for gay and bisexual men in Europe

Axel J. Schmidt, EMIS project, Germany
Abstract number: 1766813

An account of the mapping about how STIs are spread in Europe among MSM was given, and findings from the EMIS study were presented. Among other things, the survey tried to discover how much did men know about their right to be tested, how did the STI testing differ from one country to another, how often were MSM tested, and which infection they were tested for and why. Many took only blood samples and very few tested for penis, rectum and mouth diseases. The conclusion of this study was that all over the Europe there are a large number of unreported cases of men who are infected with STIs because of too few and too poor testing.

The sexual health of men who have sex with men (MSM) is often compromised by the presence of sexually transmissible infections (STIs) such as anal or genital warts, syphilis, and pharyngeal, genital, or rectal gonorrhoea and chlamydial infections. Rectal bacterial STIs are known to increase the per-contact risk of HIV infection. Early detection of asymptomatic STIs requires both regular sexual health check-ups (based on each person’s number of new sexual partners), and also physical examinations and clinical specimens collection that allow for the detection of STIs at infection sites more common among MSM and specific to their sexual practices. Differences in approaches to diagnose STIs among MSM between countries may also have an impact on the comparability of national surveillance data within Europe. For these reasons we compared STI-test-seeking behaviour among MSM living in different European countries,

and performance of STI-testing sites across Europe.

From June through August 2010, the European MSM Internet Survey (EMIS) mobilized more than 180,000 respondents from 38 European countries to anonymously complete an online questionnaire in one of 25 languages. Questions included perceived access to and recency of STI-testing; recency of diagnoses of STIs common to MSM; and the presence or absence of symptoms at the last STI test; and type of diagnostic approaches employed at the last STI test. Multivariable regression models were used to compare STI-testing performance in 38 countries. Analyses were stratified for HIV serostatus, and controlled for age, education, and size of settlement.

Across the 38 countries, the proportion of respondents who reported having been tested for STIs in the last twelve months varied between 20% and 50%. Most STI-testing took place in the absence of symptoms. Testing blood for antibodies was highly common across Europe. However, in 30 out of 38 countries less than 20% of sexual health check-ups included basic physical examinations of the penis or anus; and less than 20% included diagnostic procedures allowing for the detection of rectal gonorrhoea or rectal chlamydial infection. Even after controlling for differences in the sample composition, STI-testing performance was notably better in countries with specialized sexual health clinics, like the United Kingdom, Ireland, Malta, Sweden, or the Netherlands. Among MSM in most European countries, anal and

genital warts as well as rectal infections with *Neisseria gonorrhoeae* or *Chlamydia trachomatis* are likely to be profoundly underdiagnosed. This has implications for the sexual health of MSM, for HIV prevention, and

for comparing European surveillance data. There is an urgent need to implement or improve sexual health care tailored to men at risk for STIs, and to meet the health needs of gay, bisexual and other men who have sex with men.

5.3.4. Community testing and counselling

This is a compilation of four different presentations about initiatives from Spain, Portugal, Sweden and Belgium. A common feature of all four initiatives is that they reach out to the MSM

community inside, and more importantly outside existing health care systems towards increasing HIV testing.

5.3.4.1. Check-ear cohort: A community and researchers collaboration for STIs screening in HIV negative MSM

Pep Coll, Institut de Recerca de la Sida IrsiCaixa, Spain
Abstract number: 1767508

HIVACAT is an example of a successful collaboration between community and scientific developments. It is a joint study that involves different partners: hospitals, governmental agencies/institutions and others (e.g. BCN Checkpoint, CEEIS Cat). The aim was to stimulate the community to participate in scientific developments.

The study involved 226 participants, whereby the recruitment was done by giving out information leaflets at different checkpoints. The men selected for the study had to have the following criteria: they had to be MSM, HIV negative and at high risk for HIV/STI infections. Confidentiality was preserved.

Interventions included: visits to participants every 3 months, making a quick HIV test and

giving counselling, taking a blood sample every six months, and annually take syphilis serology, hepatitis serology, PCR for CT and NG in rectum and urethra, PCR for HPV in anus and mouth.

The participants had multiple benefits from the study: Early detection of HIV and other STIs, which in turn means better prognosis, early detection of asymptomatic STIs, assessment of a person's hepatitis status, and a follow-up vaccination when needed, regular screening for anal cancer (high prevalence among MSM), as well as the inclusion in the process to develop a vaccination. The study also allowed studying of recent infections and identification of HEPS, which was a great benefit for the scientific research.

5.3.4.2. Previous HIV testing experience among MSM in Lisbon. CheckpointLX first three months results

Maria José Campos, Grupo Português de Activistas sobre Tratamentos VIH/SIDA (GAT), Portugal
Abstract number: 1770349

At the CheckpointLX MSM had a chance to get rapid testing and were offered peer support. The project was promoted by targeting the venues close to the active MSM scene, such as gay bars, saunas, outdoor cruising sites and social networks

online. In order to reach out to as many men as possible, the project staff put posters on trees and bushes close to a beach known to be a gay beach and also engaged community partners, particularly bars and saunas. An enquiry done before showed

that some men did not want to test for HIV if they had to answer a questionnaire. However, the majority of men did answer the questionnaire and did have counselling. Because of lack of resources men were not tested for other STIs.

From April to June 2011, 211 MSM were screened for HIV, the median age was 30. More than half (55%) of the MSM had higher education, 38,4% medium-level education and 3,3% lower education. The main reasons stated for requesting an HIV test were “perceived prior risk” (53,6%), “routine testing” (26%), and “starting a new relationship” (5,2%).

The majority of MSM (84,8%) had been tested before, 67% of them in the previous 12 months. The average age of MSM who had previously been tested was 30 (range 18-64) and for those being tested for the first time, the average age was 24 (range 18-64). Among those who had been tested

before, 58,7% had higher education. This percentage was lower (31%) among men who were being tested for the first time. MSM with no history of HIV screening reported more frequently that risk situations are the main reason for testing (62%) than those who had been tested before (52,5%). The percentage of MSM with a reactive result was 5.68%, of which 83% had been previously tested, and the majority (70%) of these in the previous 24 months.

This sample of MSM was highly educated and often screened for HIV. MSM who had never been tested before were younger, less educated and more likely to report risk behaviour as a reason to request an HIV test. The percentage of reactive results was high (5.68%). These are preliminary findings that cannot be generalised to the Portuguese MSM reality. Outreach strategies are being developed to reach untested MSM.

5.3.4.3. STOP HIV! Experiences from a campaign co-operation with onsite HIV-testing during Stockholm Pride

Ronny Heikki Tikkanen, Gothenburg University, Sweden
Abstract number: 1755113

STOP HIV! is an on-site testing project that aimed to reach MSM with less experience of testing and MSM at high risk of HIV and STI infections. The project was also intended at starting a thinking process that will lead to more and frequent testing in the future. The number of clinical testing rose after the intervention.

StopHIV - group consisted of a number of different organisations both governmental and non-governmental. In 2007 there was also a successful collaboration with the Gothenburg University.

On-site testing project included different phases:

1. Pre-exposure – banners on the internet and in gay magazines to start thinking process about getting tested.
2. Counselling
3. Involvement of several actors in place in on-site testing
4. Reaching out to other arenas or target groups

The HIV-testing in 2007 resulted in testing of 97 men; 2 out of 10 were tested for HIV for the first time. 25 per cent of these had had anal sex with someone who didn't know their HIV status in the last year. 27 per cent were planning to take the

test at the on-site testing facility. Many men who tested for HIV came from smaller cities, and this indicates that they do not have access to good testing facilities. People were generally satisfied with both testing and counselling. Some planned to come back next year.

Throughout the testing at the on-site facility, four problems occurred:

- Providing support and counselling in a noisy environment proved to be very difficult,
- Confidentiality for men who tested positive (although rapid tests were not used)
- HIV testing is a too serious a project to be implemented in a social environment such as the Pride festival,
- It is questionable how much impact HIV testing has on the social environment.

Slovenia had the same experience with bringing testing to the community – the ratio of testing increased. No rapid tests were used on site either, because of the noise, the high consumption of alcohol etc. In the past few years, Slovenians did the testing at a close-by hospital.

5.3.4.4. Voluntary outreach counselling and testing in cruising venues for MSM: Lessons learnt after 3 years

Tom Platteau, Institute of Tropical Medicine, Belgium
Abstract number: 1763794

The project provided for a help centre where men could get free and anonymous HIV test. In addition, men received "to check up" email reminders every 6 months, which helped with partner notifications.

Outreach activities included a guarantee of free and anonymous testing for HIV, syphilis and hepatitis, hepatitis A/B vaccination and counselling. Venues in which testing and counselling sessions were done were fetish clubs and saunas. Testing sessions always included a presence of three people: "outreacher", counsellor and a physician. The sessions lasted for three hours each and the men would get first results ten days after the individual session. The results were shared through telephone calls, and if positive, persons were advised to contact the help centre for more information. In total, 21 sessions were held and 293 men were tested. Out of those tested, 7 new HIV infections were found.

Some of the difficulties that can occur in this

kind of a project include the fact that the on-site cooperation is a permanent investment, it reaches fewer new participants, and that it has high up-keeping costs due to staff costs.

In order to increase awareness and a number of people who regularly test for HIV and other STIs, some new strategies could be introduced, for example:

- Distribution of test packages – self-sampling saliva – tests that are sent to the lab by men themselves
- Communication results through secure websites
- Possibility to discuss with physicist

The advantage of self-sampling saliva testing is that no medical staff need to be involved, the procedure is not invasive and no specific sessions need to be held. The disadvantage of such testing lies actually in the reliability in the test itself.

5.3.5. HIV prevention among gay sex workers

5.3.5.1. A study to explore the experiences of men selling sex in Surrey UK

Ian Cole, Surrey Community of Health Services, NHS, United Kingdom
Abstract number: 1747111

Most research that has been carried out on sex work has focussed on women working in the industry and men have been little researched. Surrey is a County in the UK that borders both London and Sussex (which includes Brighton) and is considered a very wealthy county and assumed to not have a sex industry. We set out to understand the participant's view on their work and to learn about the effects on their health and the impact health inequalities has with this marginalised group. To ascertain their knowledge and practice around sexual health and HIV and see beyond them being vectors of HIV Methods. All participants were recruited through telephone contact via advertisements placed in local newspapers or

various websites (like Gaydar) all interviews were carried out in the participant's own homes and recorded for analysis purposes. All participants were male who offered sexual services, it did not matter whether the service was being offered to men or women, but it was only possible to recruit those that offered sexual services to other men. The approach used was a phenomenologically informed approach. The purpose of this approach was to aid full participation in the study of the participants and enable them to feel that they could contribute freely, yet have the choice to stop or withdraw, without feeling compelled to give reasons. Data was collected using a semi-structured interview which was recorded for analysis purposes, but

allowed participants to talk freely outside of the questions being asked. A process of thematic analysis was used to interpret the data collected and to add rigour to the study and reduce potential researcher bias. Ethical approval was gained.

There was a wide age range from 21-65 All men identified as being gay All men worked from their own homes and used their own names. All men felt they had choices and control over their career. For most it was a part time career. Vulnerabilities differed from those of women, for example fear of being found out, age preventing them from working, but not so worried about physical violence; access to sexual health services as a gay man and not a sex worker, worried about stigma. Their sexual health knowledge was excellent and they passed this onto

punters, helping to re-enforce boundaries.

Stigma exists for many groups in the British society. Participants were happy to identify as gay when accessing sexual health services, but lacked the confidence to be honest about their profession due to the fear of being judged. There were very clear divisions between their working lives and their private lives, although very clued up on the issues around HIV and safer sex. They acted as peer educators with clients, but not necessarily with personal sexual partners. Therefore male sex workers are not vectors of HIV, but are indeed educators. More work is needed with their clients around sexual health to minimise HIV risk. Blanket law enforcement will only increase stigma and access to services.

5.3.5.2. Male sex work in St. Petersburg, Russia – pilot study

Ksenia Eritsyay, Stelit, Russian Federation

Abstract number: 1771584

At a time of great interest in injecting drug users and female sex workers in HIV epidemic spread in Russia, the epidemiological and behavioural characteristics of MSM are quite uncertain. Official statistics do not reflect an accurate picture of the epidemic among MSM. Little is known about the size of MSM population or the HIV rate among MSM. Special attention should be paid to the issue of commercial sexual relationships among MSM. Male sex workers (MSWs) may be more vulnerable to HIV/STI, yet there have not been any systematic studies among MSWs in Russia. We conducted a pilot study to explore issues related to the frequency of commercial sex among MSM in St. Petersburg and types of MSWs, and to identify effective recruitment strategies for future studies.

Data were collected in St. Petersburg from February to July 2011 using a semi-structured interview guide. Three groups of key informants (KIs) included members of administration of gay identified night clubs, gay community NGO staff representatives, and MSWs. Non-MSWs were recruited via professional networks, and MSWs were recruited with help from MSM community members and via the internet. The following topics were discussed: proportion of MSWs in MSM community in St. Petersburg, popular gay venues in St. Petersburg, possible classification of MSWs, and potentially effective recruitment strategies.

The recruitment process differed for differ-

ent groups of KIs. For recruiting non-MSWs, the chain referral strategy was used. Non-MSWs were either professional contacts of research staff or referred by other respondents. Of 13 contacted or referred non-MSWs, 8 agreed to be interviewed including 3 from clubs and 5 from NGOs. Strategies for recruiting MSWs mentioned by non-MSWs were intercepted on gay venues (“pleshkas”), nightclubs and gay-saunas; the internet; and peer referral. MSWs were enrolled in 3 ways: personal contacts of research staff (n=2); peer referrals (n=5); the internet (n=5). All five peer referrals were interviewed. Of 10 contacts made via the internet (bbs-service), five were successfully interviewed. Two different internet strategies were used: starting the conversation with a general proposal to participate in the survey (1 interview after five attempts), and starting with a more personalised message based on the text on BBS website (four interviews after five attempts). Interception of MSWs in work-related venues was not sufficiently investigated in this study.

Results of pilot study demonstrate that MSWs can be recruited for research studies, though certain challenges need to be addressed. Preliminary analysis of interview data suggests that definitions of commercial sex in MSM community are flexible. A variety of male sex work in St. Petersburg was identified. More detailed classification will be examined in formal qualitative analysis.

5.3.5.3. Sex for exchange among LGBT young people in Sweden

Mina Gäredal, The Swedish youth federation for LGBT Rights, Sweden **Abstract number: 1762063**

In 2010 RFSL Ungdom (The Swedish youth federation for LGBT Rights) conducted a study to investigate the phenomenon sex for exchange among LGBT young people. The study was a part of the governmental commission that RFSL (the Swedish federation for LGBT Rights) received, to investigate the extent of LGBT people selling and buying sexual services as well as under what conditions and circumstances the sexual services are sold and bought.

Sex in exchange for different gifts among LGBT young people aged 15 to 26 was studied by 13 in-depth semi-structured interviews. The informants were recruited through a banner on Qruiser (the largest LGBTQ-community in the Nordic countries) and with an additional snowball sample. 8 additional interviews were conducted with professionals working in school health care, youth clinics and at child and adolescent psychiatry clinics.

The results show a great variation regarding conditions and circumstances, as well as the experiences of sex for exchange among young LGBT people. Also the reasons for having sex for exchange differ immensely among the informants. The reasons for selling sex might include one or several of the following factors: sexual arousal, excitement, self-destructive behaviour, the need of money or drugs, anxiety management and an urge to please others. Further on, our results show a heteronormative understanding of prostitution among professionals, and in the general understanding of the phenomenon. This results in an

exclusion of men selling sex to men and women, transgendered people having sex for exchange and also makes non-heterosexual women that have sex for exchange invisible. There is a great need for widening the understanding of sex for exchange and to make interventions more sensitive for the great variation of situations and needs among LGBT young people that have sex for exchange. The results show a very strong co-variation between sexual vulnerability and low self esteem among the informants. Informants with high self-esteem show much greater ability to take care of themselves and to manage vulnerable situations. Low self esteem among LGBT young people that have sex for exchange also co-varies with unsafe sexual practices and risk of HIV/STI transmission.

The study shows a great need of education among caregivers on how to speak about sex and sex for exchange in a way that would help and support young people with these experiences. The present study shows a great will to help the target group among health care professionals and other people working with social services, but that there's a great lack of knowledge and competence to meet the needs in a way that really helps young LGBT people with experiences of sex for exchange. Additionally, effective HIV/STI-preventive work should include interventions focusing on self-esteem and how to better respect ones own sexual boundaries among those LGBT young people that might be at risk for a sexual destructive behaviour.

5.3.6. Evidence as a key ingredient in HIV-prevention

5.3.6.1. Knowledge-based HIV prevention intervention targeting men who have sex with men

Ronny Heikki Tikkanen, Gothenburg University, Sweden
Abstract number: 1755128

The purpose of this presentation is to summarise international research reviews of effective HIV prevention interventions for MSM. The report includes a summary and discussion of the results of six international research reviews. The reviews examined ways of designing effective, successful HIV prevention interventions for MSM. This presentation also contains an overview of published research about such efforts in Sweden.

The results of the international research reviews may be summarised as follows:

- Group-level interventions are particularly effective.
- Multi-component interventions are more effective than single-component interventions.
- Multi-session interventions, or single-session interventions that last for at least four hours (such as a half-day workshop), are most effective. Furthermore, extending the time between group sessions and the like leads to more successful interventions.
- The inclusion of peer educators and popular opinion leaders is a successful component of HIV prevention intervention.

- Interventions containing a cognitive element generate favourable results.
- Skills training, such as role-play, lead to more effective interventions.
- A theoretical framework, especially diffusion of innovation and model of relapse prevention, contributes to more effective interventions.
- The effectiveness of HIV counselling and testing is unclear. The results are contradictory. Additional research and methodological development are needed.
- Research on the needs of men who have sex with men (MSM) is very important and can form the basis of effective HIV prevention interventions adapted to specific subgroups of MSM.

The general impression conveyed by the review is that Swedish HIV prevention is innovative and captures the currents of the time. The Swedish effort consequently needs to be more visible in international research. Swedish intervention will thereby not only gain status and recognition but become more rooted in the scientific approach.

5.3.6.2. Evaluation of the HIV-prevention campaign for men having sex with men “ICH WEISS WAS ICH TU”

Jochen Drewes, Freie Universität Berlin, Public Health, Germany
Abstract number: 1762795

In order to react to the rise in numbers of newly diagnosed HIV-infections in MSM, a nationwide HIV prevention campaign directed to this group was launched in 2008 in Germany. The campaign ICH WEISS WAS ICH TU (I KNOW WHAT I AM DOING) is carried out by the German NGO “Deutsche AIDS-Hilfe” in cooperation with several regional HIV-prevention agencies for MSM. The campaign is characterized by multiple

goals, the combination of different strategies, a role-model approach and the integration of HIV-positive MSM. To assure quality an accompanying evaluation was conducted comprising process and outcome evaluation. This abstract focuses on the results of the outcome evaluation regarding coverage, acceptance and effectiveness of this campaign.

Two nationwide online-surveys addressing

MSM were carried out before the start of the campaign, and again two years later. Both surveys operationalized indicators for effectiveness, the second survey also for coverage and acceptance of the campaign. The pre-post-design to determine effectiveness employed trend analyses and an ex-post-facto control group (non-campaign-users). To eliminate biases in the two samples and in the intervention/control group due to the methodical design, matching and stratification procedures were calculated including propensity score matching [still in progress, will be finished by conference date]. Participants were recruited via gay dating and information sites on the internet. 6,339 MSM living in Germany participated in the first survey, 21,928 in the second.

More than half of the participants (51%) reported knowledge of the campaign, 20% of the participants reported visiting the campaign homepage and another 21% report knowledge without visiting. A usage-index was built to form the basis of the intervention vs. control group design. 31% of the sample was identified as active users of the

campaign by visiting the homepage, reading leaflets, etc. Coverage of the campaign was higher in MSM with higher education, gay-identified MSM, sexually more active MSM and HIV-positive MSM. Acceptance of the campaign was good, users rated the campaign on average as “good”, and the campaign homepage on average as “good” and “helpful”.

Before correcting sample- and design-related biases analyses show the effectiveness of the campaign in for example intensifying HIV testing frequency, creating awareness for STI-testing, raising communication between sex-partners about HIV and Safer Sex and reducing HIV-stigma in MSM.

After two years the German HIV-campaign shows a satisfying coverage in the target population. Coverage should be raised especially in MSM with lower educational background and non-gay-identified MSM. Ratings of the campaign are excellent, showing a high acceptance by the target population. Preliminary analyses of the effectiveness show promising results but these results still have to be verified by adequate statistical procedures.

5.3.6.3. HIV/STI prevention intervention for MSM in Europe: Characteristics and approach to evaluation

Aryanti Radyowijati, Results in Health, The Netherlands Abstract number: 1762268

In 2009, the European Centre for Disease Control (ECDC) assessed effectiveness of behavioural and psychosocial HIV/STI prevention interventions for MSM in Europe, concluding an overall deficit exists in outcome evaluations. ECDC launched a project to review HIV/STI prevention intervention for MSM, covering an update of different prevention interventions, and a review of approaches to evaluation.

A review of HIV/STI prevention intervention literature from 1995 – 2010 was conducted, using a systematic search strategy. Approaches to evaluation were assessed through identification of reported study designs and their outcomes, applying the Tier of Evidence framework from CDC. 117 studies were included for the review; 96 were reviewed on approach to evaluation. Studies originated from North America (69%), Europe (20%), South America (3%), Australia (3%) and Asia (5%). The majority of them target adult MSM (105) with un-specified serostatus (76).

On intervention characteristics, educational

activity using mass media is the most popular (25), followed by counselling (15) and testing (12). Trained counsellor is the most frequent mode of delivery (28), followed by mass media (25) and health care provider (15). The interventions mostly take place in clinic/health facility (19), using internet (18) or popular gay venues (18).

On their approach to evaluation, 41 studies utilise experimental study design; 55 studies are observational studies. 15 studies are classified as evidence-based intervention; 36 studies are classified as theory-based evidence; and 38 studies were un-classified.

Current HIV/STI prevention intervention studies for MSM published in English are dominated by studies from North America and Western European countries.

There is a need to increase awareness for HIV testing among young MSM; tailored interventions for senior HIV-positive MSM and for MSM who are using substances; and for culturally accepted interventions for MSM of ethnic minority origin.

HIV/STI prevention interventions for MSM have employed a variety of activities, channel of deliveries and intervention settings. A number of HIV/STI preventions for MSM lacked scientific foundation in the design and implementation. Challenges exist in designing and implementing intervention which allows rigorous evaluation and feasible implementation in practice.

Future HIV/STI prevention interventions for MSM in Europe should be tailored to meet specific needs and sub groups.

Behavioural interventions should be designed in a systematic way and be evaluated on their effectiveness. Efforts should be made in supporting the development, implementation and dissemination of effective HIV/STI prevention interventions for MSM within Europe.

Research is needed for alternative ways of evaluating interventions that can provide similar level of evidence for effectiveness as the existing quantitative-based framework.

5.3.6.4. Second-generation counselling – effective prevention possibilities for MSM

Viveca Urwitz, Swedish Institute for Control of Communicable Diseases, Sweden

Abstract number: 1752629

Ever since it became possible to test for the HIV virus, VCT voluntary counselling and testing has been seen as an important intervention and entry point for prevention, treatment and care. It could be used as a preparation for, and mitigation of, a possible positive outcome of the test or as an opportunity to advice on risk reduction for persons with high-risk behaviour. But in reality the counselling has mostly been addressing a possible positive result.

An international research review of preventive interventions for MSM done in 2007 revealed that VCT has no proven risk reduction effect for people who were not found to be positive. In 2008 a study on risk reduction counselling in 850 clinics in Sweden demonstrated results which were well in line with the findings in the review. Only 30% of STI clinics and youth clinics had any type of protocol for their counselling, let alone any evidence based protocol. It is evident that the preventive risk reduction counselling within the test situation has not been given enough attention or even been fully understood.

In 1998 Fishbein et al published the Respect study, which proved stunning 35-50% risk reduction in STI patients using a special self-reflective counselling methodology in the test situation. Today, almost 15 years later, this methodology is known as Motivational Interviewing and has evidence of risk reduction for many other behavioural risk factors connected to health. These results have not been picked up by the HIV community

at large. It is not advocated by UNAIDS or WHO as a component in the combination prevention. While the medical community were quick enough to pick up male circumcision for heterosexual men and perform continuing studies, one must question why a methodology with up to 50% risk reduction, possible to use for all people at risk, has been met with such silence. Pre-test counselling is now often taken out of the protocol. Post-test counselling is only for the people who test positive. Decision makers are not distinguishing between the different types of counselling. While no one should object to as many people as possible accessing treatment, persons wanting to minimize the risk factors for MSM should be aware of the potential risk of throwing out the baby with the bath water.

Studies from Britain's Sexual Health Survey reveal that person with more than 10 partners in a year were responsible for the 50% of all STIs including HIV. The EMIS study demonstrates that although many gay men use safer sex – there are enough risk takers to keep the epidemic going in the MSM group. If testing is increased in the MSM group, many such risk takers will test. If these persons cannot access effective prevention and health promotion activities the negative test might even reinforce the risk behaviour – ultimately resulting in an HIV infection.

By implementing a “second generation counselling” in the VCT protocol in health care services, using the evidence based self-reflective

methodology now known as Motivational Interviewing, we could offer effective sustainable prevention support for the people who need it most. The same type of methodology could also be used

in positive prevention efforts. However, research demonstrates that, in order for MI to be effective, there is a need for proper training of executers and Quality Assurance.

5.4. Mission possible

The text below is a summary of the session presented during the FEMP2011 conference.

5.4.1. New findings urge the rethinking of HIV prevention strategy among MSM in Switzerland

Roger Staub, Swiss Federal Office of Public Health, Switzerland
Abstract number: 1761882

The Swiss Federal Office of Public Health has applied a mathematical model on data on the HIV epidemic in Switzerland, in order to identify what has been driving the epidemic and evaluate the efficiency of the “test and treat” approach to HIV prevention.

An urgent three-part “Action Plan” was developed based on the findings from the interpreted data. The Action Plan was derived from the theory that, in 2010, 13 per cent of the HIV infected men were unaware of their disease-status, and that they were the origin of 80 per cent of new infections. These figures indicate that the spread of HIV is driven by PHI (Primary HIV Infection, when viral loads are 20-100 times higher than in later stages) often in trustful relationships where no condom is used.

The hypothesis is that 50 per cent of the HIV transmission among MSM occurs during this PHI phase. 30 per cent is thought to take place in the asymptomatic phase before the diagnosis (about 2-2 years after the infection).

The “test and treat” approach to HIV prevention does not seem to be the solution, at least not in Switzerland where a slow increase in number of infections is predicted in the next 10 years.

Therefore a new Action Plan has been developed. It targets three phases: firstly, and most importantly the PHI phase.

The first action field aims to reduce MSM community’s viral load by having a communal anal-sex-free month every year. The idea is that

the campaign will go beyond only safe sex, which should be practiced all the time. Those who want to resume their previous sex lives after the One Month hold-up are invited to seek counseling and testing beforehand. This is thought to pick up people in the PHI phase infected before the sex stop, and thus, break the chain of PHI phase transmissions.

The second action field is more widely focused on the latent phase of HIV before diagnosis, where viral loads are low. General testing for “the big 5” (syphilis, chlamydia, HIV, gonorrhoea, kondylom (HPV) once a year is suggested if a person is not in a monogamous relationship.

The third action field concentrates on the time after the diagnosis, in order to avoid getting STIs in general, and HIV in particular, from a steady partner. Testing centres and general physicians should offer support in information, counseling and testing for clients and client’s partners.

The hope is that the MSM community will collectively participate in a one-month participation event that started in the beginning of 2012, which will hopefully reduce HIV transmission with 50 per cent by breaking the chain of PHI phase transmission. A brochure was published and launched on World’s AIDS Day 2011. It’s called “Sex between men – towards a better sexual health in 2012”. The brochure provides the information basis upon which the rest of the campaign, recruitment and marketing will be built.

5.5. IQHIV – Quality improvement and evidence in HIV prevention

Workshop IQhiv: Improving Quality in HIV Prevention

The text below is a summary of the session presented during the FEMP2011 conference.

Matthias Wentzlaff-Eggebert, IQhiv, Germany
Abstract number: 1762079

IQhiv is an initiative of governments and international organisations working to improve the quality and develop evaluation procedures for projects within HIV prevention. IQhiv has developed and applies three different tools to evaluate, develop and improve the quality of projects in HIV prevention.

Background

It is important to highlight quality in HIV prevention work. Quite often, it is difficult to achieve good quality and integrate lessons learned from previous projects in HIV prevention projects. It can also be quite difficult to implement standardised procedures for these types of projects as they are often very different and depend on many factors. It is also important to create a climate that is without fear of humiliation, but which allow for criticism and self-reflection .

Tools

There are several different tools through which quality in HIV prevention projects can be achieved. All of the tools are evidence based. they

can be accessed on the IQHIV website www.IQHIV.org :

1. Succeed – a method that was developed in Sweden and serves to improve the quality of health-related prevention work. It consists of an interactive PDF file where you can answer yes or no to many different questions. This tool can be used by an individual or a group.
2. QIP - Quality in Prevention. Similarly to “Succeed”, this method is also designed as a questionnaire, but is much more detailed than “Succeed”. This method requires completion of the questionnaire that can then be sent for external review and evaluation.
3. PQD-Participatory Quality Development is an integrated set of different methods that all focus on the importance of involving all stakeholders in a project.

During a workshop 3 groups of participants had the opportunity to test the tools and see how they could improve the quality in one of their own projects.

5.6. Formulating campaigns

Imagery and language – is fear the future of HIV prevention?

The text below is a summary of the session presented during the FEMP2011 conference.

Nicklas Dennermalm, RFSL Stockholm, Sweden

Abstract title: 1980s revisited – The Workshop! Imagery and language in safer sex campaigning

Abstract number: 1784250

Adam Bourne, Sigma Research London School of Hygiene & Tropical Medicine, United Kingdom

Abstract number: 1761982

There is a strong belief that intimidation is a strong tool in HIV prevention. Anything from the media, donors and politicians to MSM themselves like the idea that the risk group needs to be afraid of unpleasant pictures and change their behavior because of that. Another reason why more frightening tactics should be applied is that advertising messages are more lightweight and would therefore be more easily understood. Short messages are also easier to put on a poster.

It is difficult to make any good research on this type of advertising, but the studies are made on the subject show that the frightening images actually do not have a greater positive effect.

The fact is that when we see frightening images, our first reaction is to avoid the image. If this isn't the case, then we deny that there is a message that can be followed up with counter arguments. The last tactic available to avoid being receptive to this type of advertising is that one seems to understand which group is targeted with the advertisement, but consider themselves not to belong to the group that is the target. This phenomenon is also seen when the MSM themselves are given a chance to influence the advertising campaigns. When another intimidation tactic is suggested: making the recipient believe that others will be affected by the message, without realising that they themselves will also be affected by it.

There are both positive and negative effects of using intimidation tactics in HIV prevention work.

The positive effects include:

- Increasing awareness because the problem is made clearly visible
- We often remember the campaign

- Attitudes change (whether this tactic involves a change in behaviour is more uncertain)
- It is possible to increase the number of those who test for HIV, but fear-based campaigns are not likely to influence those in greatest need and are generally only persuasive for people who are already engaging in the desired, health protective, behaviour.
- It is possible to maintain a steady condom use among those who already use it. Those who already use a condom also appreciate having their behaviour confirmed.

Negative effects include:

- There is little evidence that it leads to any long-term change
- Those who are not motivated from the beginning are the ones that this type of advertising affects the least.
- Increased HIV stigma: These tactics give the impression that one can recognise someone who is infected because of the horror pictures of obviously sick people. If one thinks that they know how an infected person looks like, then they might also think that they don't need to use a condom with someone who looks healthy.
- If the fear effect is exaggerated, then the advertisement information is exaggerated so much that it's sometimes no longer correct.
- It becomes difficult to identify oneself with the situation

The question is also whether MSM are less fearful from HIV now than they were in the 1980s and whether this is the reason why condom use has been declining. Many believe that the com-

mercials with pictures of gravestones of those deceased from AIDS is what made people use condoms at the time. However, condom use has been steadily increasing in pace with the availability of information on how to protect oneself from the

infection. It is however highly likely that the very availability of information, and not the graves themselves, was the reason why people changed their behaviour.

5.7. Prevention and human and sexual rights – nothing for us without us

The text below is a summary of the session presented during the FEMP2011 conference.

5.7.1. Establishing innovative approaches to promote HIV prevention for MSM living in rural Ireland

Mick Quinlan, Gay Health Network, Ireland
Abstract number: 1770303

Gay Health Network (GHN) is an inter-sectoral organisation and includes MSM living with HIV. Since 1994 it has been promoting HIV prevention and sexual health awareness among MSM and seeks to combat the stigma associated with HIV. The Irish Government's HIV and AIDS Education and Prevention Strategy 2008-2012 calls for national information campaigns to be developed based on accurate knowledge of the behaviour of MSM. The strategy also calls for improved availability and access to sexual health promotion materials outside of cities. In December 2010, GHN submitted a proposal to Health Service Executive (HSE) to develop a joint HIV prevention campaign aimed at MSM living in rural areas of Ireland, based on the key findings of the All-Ireland Gay Men's Internet Surveys (Real Lives) and the European MSM Internet Survey (EMIS).

A year-long social marketing of HIV prevention and sexual health awareness campaign targeting MSM is being conducted, with a particular focus on men residing outside of the urban centres, as well as younger men aged 18 to 25 years.

The Social Media and Marketing Campaign is to include innovative approaches such as local and social media, social contact websites, and digital and virtual approaches to promote key messages of the campaign. It is also hoped to increase access to free (or low cost) condoms and lubricants through a new online ordering service. A series of health promotion workshops will be developed and delivered to the target population.

Key messages of the campaign are to be closely linked to relevant research, including EMIS. The response to EMIS in Ireland was the largest ever, with 130% more respondents than previous Irish MSM studies. The early data from EMIS shows the psychological health impacts on MSM in the form of homophobic verbal and physical attacks, and HIV related stigma among those living with HIV. Immediate issues arising from EMIS are: lack of knowledge that HIV and STI testing is available free of charge; pre/assumption of HIV negativity; sexual risk within relationships; condom usage and failure; untested MSM having less knowledge than those who have tested for HIV or other STIs; that significant numbers of MSM living outside main urban areas have not tested for HIV or other STIs. Campaign messages and designs are being driven by a younger MSM peer group and will incorporate messages of building self-esteem, empowering and equipping men to make safer sex choices. Messages will also incorporate and address HIV-related stigma. To date, initial feedback from the focus group of younger MSM indicate that simple (back to basic) messages are "not out there and are very much needed". This multi media presentation will summarise the steps taken to develop the campaign; present the campaign materials which commenced in June 2011; describe the innovative approaches being taken to promote the campaign (due to launch in August 2011); and the phases and key messages of the campaign being developed by younger MSM.

5.7.2. From information to community to community mobilisation: about an ANRS PrEP trial for MSM in France

Francois Berdoug, Groupe interassociatif TRT-5, France
Abstract number: 1767374

In France, incidence of HIV infection among HIV-negative MSM is 1% p.a. In 2011, ANRS sponsored randomised controlled trial in France that was to evaluate the efficacy of combination prevention strategies including HIV testing, diagnosis and treatment of other STIs, risk reduction counseling and ARV-based pre-exposure prophylaxis (« on demand » tenofovir-emtricitabine) to reduce seroincidence. The French HIV Community Advisory Board, TRT-5, was involved in trial elaboration. The hypothesis was that TRT-5 could consult HIV-negative MSM throughout France, collect comments and opinions about the trial thus informing TRT-5's contribution to its development. This kind of process could also lead to the mobilisation of other HIV/AIDS and gay/LGBT community-based organisations around the trial implementation.

The trial was conducted via a network of HIV/AIDS and gay/LGBT organisations in the main cities in France. Gay individuals and local HIV and gay community-based organisations were invited to information meetings/debates. Consultation was also conducted using LGBT web-based media. Opinions of participants were collected, synthesized and thematically analysed by a TRT-5 committee.

14 meetings were arranged in 10 large cities. More than 400 individuals were consulted, mostly gay men. Among those with known affiliation (n=188), 41% came from HIV/AIDS organisations, 23% from gay/LGBT organisations and 20% had no affiliation. About 70 people contributed via the

internet. Topics often discussed were: prevention among MSM, ARV-based prevention, combination prevention, PrEP impact on preventive behaviour, trial participants' safety, and community participation in trial preparation and implementation. While some difficulty mobilising gay/LGBT organisations was observed, reaching individuals was more difficult. Conscious of a reconfiguration in the tools of prevention, participants' contributions gave meaningful overview to their perceptions about ARVs in prevention, linking PrEP to other tools and essential issues in trial implementation.

This was the 1st experience of its kind undertaken in France concerning a biomedical prevention trial. The process should be relevant and applicable to future trials. The consultation did not entirely succeed in attracting broad participation by individual HIV-negative MSM at high-risk. Data represents more the views of people in community organisations. The process provided organisations with a framework for learning and exchange about a subject for which they expressed a keen interest and a need for information. Their opinions framed the context, partially giving valuable information about trial feasibility/acceptability. Further, the consultation report convinced ANRS to set up a Community Advisory Board linked to the trial. This body, which now includes 20 organisations, has a critical role to play regarding information and communication, participants' safety (e.g. informed consent) and implementation of the trial.

5.7.3. BCN Checkpoint: High effectiveness in HIV detection and linkage to care in MSM in Barcelona

Eduardo Ditzel, Projecte dels NOMS-Hispanosida, Spain
Abstract number: 1753981

The HIV epidemic in Western Europe is mostly driven by Men who have Sex with Men (MSM). In 2006, Projecte dels NOMS-Hispanosida implemented BCN Checkpoint, a Community-Based Centre (CBC) for MSM in Barcelona's gay area in order to:

- 1) offer HIV rapid testing;
- 2) promote early HIV detection and linkage to care;
- 3) increase HIV risk perception and reduction through peer counseling.

The objective of the project was to assess the efficacy of a Community-Based Centre for MSM in HIV detection and linkage to care.

Methods:

The annual HIV prevalence and linkage to care of all cases (2007-2010) have been evaluated. All HIV cases were confirmed by Western Blot. The linkage to care rate was measured as the proportion of HIV cases referred to an HIV Specialized Unit within one week. We also analyzed the proportion of recent infections in the period 2009-2010, considered to be those with a negative test result within 1.5 years of the diagnosis.

In 2007 in Catalonia (Spain) a total of 702 new HIV cases were reported, of which 314 were MSM (over 56% of all men). In that same year, the cases

detected in BCN Checkpoint represented 11.78% of all HIV cases in MSM reported in the country, and this proportion raised progressively to 24.57% in 2008 and 41.85% in 2009. Of all HIV cases in CBC in 2009 and 2010 (n=239), 36 (15.06%) got tested for the first time, 202 (84.52%) already had a previous negative result and 1 (0.42%) did not answer. Of the 202 cases, 124 (61.39%) declared a negative result within the last 1.5 years, and consequently were considered to have an early HIV infection.

BCN Checkpoint showed a high effectiveness in HIV detection. In 2008 an HIV prevalence of 6.20% was obtained while in that same year in Catalonia the general HIV prevalence was 0.85% (out of 293,304 tests). Many MSM don't access health centres regularly due to lack of comprehensive care. Furthermore, the absolute number of HIV cases detected in BCN Checkpoint increased during the period 2007-2010 (as more persons were getting tested), and the proportion of cases detected in BCN Checkpoint regarding the reported HIV cases in Catalonia raised progressively. From a preventive point of view, BCN Checkpoint has shown efficacy in detecting recent HIV infections, and over 95% of detected cases have been referred to an HIV unit for care. Therefore, a community-based approach should be an essential part of an HIV prevention strategy.

5.7.4. HIV-related health factors and sexual pleasure among transgender men who have sex with men in Europe

Todd Sekuler, Berlin Social Science Research Center, Germany
Abstract number: 1767580

Policies, research and interventions addressing the sexual health of at-risk groups typically distinguish between MSM and transgender (trans) populations. Due in part to ignorance about trans bodies, identities and experiences, policy makers and researchers either assume that all MSM are not trans or intentionally remove trans populations from their analyses or discussions. Furthermore, existing research on trans sexual health focuses disproportionately on trans women (male-to-female) and their risk for contracting HIV. Trans (female-to-male) MSM may also be at elevated risk for HIV, especially given structural forms of discrimination that render access to care difficult. Moreover, improving the sexual health of trans MSM demands not only thinking about the presence of and risk for illness, but also about pleasure, safety, and reproductive care.

Using data from the European MSM Internet Survey (EMIS) about sexual health, responses from 284 trans-identified MSM in Europe were analyzed for HIV-related health factors, and sexual pleasure. Given the difficulty reaching this population via on-line research directed broadly at MSM, the value of statistical analysis is limited. Even so, comparisons were made with non-trans (cis) MSM from EMIS to attempt to situate this data in the broader context of sexual health among MSM in Europe.

Compared with cis men, trans men in the study were markedly younger with slightly lower educational attainment. Despite comparable rates

of HIV testing once we controlled for these variables, 1% of those tested for HIV reported a positive diagnosis (vs 11% of cis men). Still, 17% reported having engaged in unprotected anal intercourse with male partners of unknown or discordant HIV serostatus in the last 12 months (vs 29% of cis men). The percentages of trans MSM reporting difficulty accessing affordable STI screening (29 vs 16%) or HIV testing (24 vs 12%) were around twice that of cis men. A smaller percentage of trans MSM reported being happy with their sex lives (48 vs 62%). Unlike for cis men, a high percentage of trans men unhappy with their sex lives reported lack of sex as a main factor explaining their unhappiness (36 vs 18%).

The prevalence of diagnosed HIV among trans MSM in EMIS is much lower than among cis-MSM. Nonetheless, there is a risk for contracting HIV and other STIs in this population, and access to HIV and STI testing appears to be considerably lower than for cis-MSM in Europe. In addition, trans MSM are less happy with their sex lives. As lack of sex is an important reason for unhappiness among these men, structural discrimination may also be influencing access to sexual partners. Given the small sample size and the limited trans-specific questions in EMIS and other projects on sexual health among MSM, research that takes into consideration the specificities of being trans and MSM in Europe is needed to better assess the sexual health needs of this population.



CHAPTER 6

Recommendations for the future

CONCLUSION

Although many stakeholders and the entire gay movement have been contributing enormously to prevention successes and better health for all by active work and by sternly maintaining the need to address sexuality in the preventive response, men who have sex with men in many places in Europe and elsewhere are still largely

unnoticed and unnecessary victims of the HIV virus. The good interventions are not numerous enough and some interventions are not good enough to meet the needs.

There is also a lot of new knowledge that should be taken into consideration when planning projects and interventions and which could influence

changes that work. The complexity of the preventive response is obvious. Countries in Europe are in different stages of preventive response and have different needs. MSM is not one but many groups with different behaviours and determinants influencing their lives.

Viveca Urwitz, former head of the National Unit HIV and STI Prevention and senior advisor at SMI, Sweden

Recommendations for the future

The text below is a summary of the session presented during the FEMP2011 conference.

In the article published in 2006 that was written by Peter Piot and his team at UNAIDS and that was called “Coming to terms with complexity”, the team maintained that we actually have produced enough knowledge to have a full-scale prevention treatment and support response. But we have to abstain from the notion that there is one magic bullet. Instead we have to come to terms with complexity. They put up a set of questions that would assist us in doing so. You need to answer them and do whatever the answers tell you. This article then resulted in the term “combination prevention”. There are combination prevention charts for the HIV epidemic in Southern Africa. However, no such charts exist for men who have sex with men in Europe. And the fact is that many of the proposed actions of the current combination prevention for the global south like male circumcision for instance seem less appropriate for men who have sex with men. Nonetheless, it became clear throughout this conference that we need combination prevention for MSM – combining what we know and developing answers to what we do not yet know.

Can we conceptualise combination prevention for men who have sex with men in Europe? Summing up this conference, I would say that we are now in a slightly better position to give answers and identify gaps and move forward. Let us try:

Question 1. Epidemiology – do we know where the epidemic is now, can we anticipate in which groups and what places the next 1,000 cases are likely to come and can we say something about probable social, economic and medical technology changes to predict what it will be like in 10 years for men who have sex with men?

The impressive EMIS study and many other smaller studies presented at the conference have made a large contribution to our answers to this question, so has the ECDC technical report in which we can clearly see the connection to other STIs and sexual health in general. A rapid assessment of presented posters made it very obvious

that countries that take home the data and make analysis from this data will have a much better platform to map out their response. In Bulgaria, the difference of geographical regions is striking. In Portugal almost 60 per cent of MSM had not been reached by the HIV-prevention efforts and MSM who were living with the virus need more positive prevention. In Azerbaijan over 60 per cent of MSM have little knowledge of HIV – many are unemployed and around 20 per cent sell sex via contacts over the internet. Some posters and seminars have illustrated that through in-depth analysis of EMIS data we will understand the determinants of sexual health of MSM much better than before. This will give an indication of what might happen in the future. Will we find information, identically as in the EU report, that although white middle-aged men still dominate the positive groups, migrant men are seen as relatively more vulnerable and more young people are becoming infected. Accordingly, should we expect HIV to slowly creep into the more socially vulnerable subgroups within the next 10 years and possibly remain there?

Every country should take their data home and hold an analytical workshop to digest the MSM data and find their focus for interventions and fill their gaps where they need more knowledge.

Question 2: What is most needed for the different groups of MSM and especially those that are most at risk?

It is obvious that needs are different in different European regions. In some countries there is an overall need of any type of MSM adapted services. In others, basic services exist but they are not addressing the needs of specific groups. We heard some good examples of different approaches for different groups of MSM from Australia. But what is clear from the data and discussions in the conference is that we have to move towards a wider health approach for men who have sex with men. As a result of social and individual risk factors and lack of protective factors, men who have sex with men are more likely to experience multiple

health problems at higher rates compared to other men, such as (other) STIs, mental health disorders, eating and body image disorders, some cancers, problems with alcohol and illicit drug use. The need for a wider approach to HIV prevention is evident. Marita van den Laar demonstrated the connection to other STIs; Ford Hickson stated the case for a positive sexual health approach based on many choices rather than one single message and the more traditional disease control approach for targeting the virus. Kevin Fenton told us about how the United States is moving in this direction. A sexual health approach would allow for a much better needs-based response. Several presentations during this conference also illustrated the need to address drug use as a part of the preventive and health promoting response. Not only because use of poppers doubles the risk of infection but also because it proves the connection between drug use and risk-taking in general.

Question 3: Do we know what works, respecting different types of evidence?

We know that some more medically oriented interventions work. Treatment as prevention works to a certain degree as well as PREP but when it comes to interventions for behaviour change, evidence is based largely on interventions in America and Australia where the context is sometimes different. However we should use that knowledge and test it in our different settings. And there must be something that works in Europe as well because men who have sex with men in Western Europe are still the best condom users of the entire population in Europe. Since the mid-1980s they have made a gigantic change in behaviour. The problem is that there are not enough studies in Europe exploring what works in different settings. And it seems that unfortunately in this century the focus for evaluation has shifted to evaluating what Ford Hickson called the preventive products rather than the promotion interventions.

In one seminar Ronny Tikkanen presented his review of preventive intervention summarising the evidence for some approaches. The lessons learned from Australian interactive campaigns and community development approaches could be used. Risk reduction counselling is getting more evidence based through increasing studies on MI. If these different approaches are combined with the more medical preventive products like well-managed treatment, and we create better methods for positive prevention, we might actually have the start of a combination prevention package. In this conference we have learned about a number

of structured approaches and possibilities where more systematic evaluation would contribute greatly to developing an effective response.

The EMIS study has proven how much power the internet has in reaching men who have sex with men. In the conference there has been a number of presentations on projects done through the internet, some of the examples include the Facebook campaign in Australia, active outreach in Sweden, pervasive gaming in Romania. These projects should have researchers evaluating them, learning, improving and evaluating again to give us information on what works.

There are new developments in positive prevention and in reaching the vulnerable migrant men who have sex with men.

That group work can give excellent results was demonstrated by a project in Moscow.

And we are all looking forward to the evaluation of the new Swiss approach to have a safe sex month to break the circle of new infections of HIV. One conclusion however is that we lack evidence on ways to constructively include drug issues in the preventive response- examples are very few.

But what about respecting different types of evidence? There is still a lot lacking in this respect and we are missing out on a lot of knowledge. In general, it is more difficult to evaluate behavioral interventions and most of all small-scale behavioral interventions that are run by volunteers in the community. Much MSM health promotion and prevention is small scale and run by NGOs in the community. Another problem is that the quality of the interventions is rarely considered while looking for evidence. It is only worthwhile looking for evidence if the quality of the intervention is possible to assess. Unless NGOs are given the possibility to address the quality issues in their operations and how to develop them, the good ideas and initiatives will have difficulties in providing evidence. A systematic inclusion of quality improvement activities will in the long run not only deliver better work for men who have sex with men, it will also enable us to have better evidence because a more structured approach better provides the possibility to evaluate.

The possibilities to convene and coordinate European research and development projects on health promotion and prevention for men who have sex with men on a larger scale is a critical mechanism to reach success. Today evaluations are often written in a national language. The evaluators might be social scientists but they lack resources to spend the extra month to convert these reports into scientific articles published in English-

speaking peer reviewed journals. But I have a suggestion: How about adding an extra question to the collection of UNGASS/Dublin data? How about asking the rapporteurs to include information on any evaluation done in the country during the previous period? Just to add information about the topic, the vulnerable group and the name of report and its author. This would give (for instance) ECDC a list. A consultant could then collect and compile the results from all the different reports. It would add considerably to the European based knowledge of what works. And countries must take responsibility in financing evaluations in connection to larger preventive interventions.

Question 4: How to scale up and set targets for coverage to ensure universal MSM access to HIV prevention, starting by using what we have more effectively?

There is an ongoing discourse on normalisation of the HIV-infection: That there should not be special funding or special projects, that we know enough and that this could be scaled up and possibly integrated into existing systems. To be able to scale up, normalise and integrate, you have to have very clear approaches – and these approaches for MSM are still non-existent. However, the EMIS study has proven that it is possible to mobilise and carry out large-scale operations once we have a clear approach. Unlike many other so-called “vulnerable groups”, the gay community is well organised and capable of running a number of complicated operations. This is very hopeful for the future. Once we have operations to scale up, the potential is certainly there.

One problem however is the abdication of the health care sector from the preventive work. The health care sector has gradually abandoned the preventive aspects of the HIV work such as risk reduction counselling and resorted to the more traditional medical aspects such as ART treatment, CD4 counts and medical side effects. From a health promotion point of view this is unsatisfactory. Health care is one of the arenas where men who have sex with men will come to access services. One of the obstacles to scaling up is the lack of capacity in general health care to address issues around sexuality in general and homosexuality or

homosexual behavior in particular. The existing gay clinics will not be enough. We need to develop and evaluate responses like the Checkpoint in Denmark where the able NGOs work in close collaboration with health care services.

Another arena is the commercial gay leisure businesses. The Everywhere project has operated in many EU countries and the need to include these businesses in the response has been made obvious throughout the conference.

There needs to be a scale-up of cooperation between NGOs; the Man-to-Man project in the Netherlands is a good example of what you can obtain if you compile all resources.

Scaling up means leaving the project format and entering into the programmatic format with more long-term operations and systematic monitoring. In order to reach this, more long-term funding is needed. The current economic climate in Europe is of course one of the biggest obstacles for scaling up even though it would save money in the long run.

Question 5: How to generate systematic social change to prevent the spread of HIV and reduce vulnerability among MSM?

The human rights issues are unfortunately largely unsolved. If this conference has proven anything, it is that there is a direct connection between poor human rights and vulnerability to HIV infection. Rigmor Berg’s stunningly clear analysis of the EMIS data should be presented in front of EU decision makers and should serve to support them in their strive to fight stigma and lack of human rights in individual member states. There is a dire need to devise a concrete strategy to do this.

Major European players like DG Sanco, ECDC and the WHO, and even governments realise that we have to put focused efforts into the preventive response for men who have sex with men. The tailoring of that response will depend on the collaboration between scientists, NGOs and the public sector, the health care and gay businesses.

If we do this, and work systematically while continuously evaluating our work, we will be able to give better answers to the UNAIDS questions and develop a better prevention strategy – a combination prevention for MSM.

THANK YOU

Someone said at the conference that you do not enter prevention work in order to become rich and famous. We will not win the Nobel Prize, but at least we had dinner in the Town hall of Stockholm like the Nobel Prize laureates. See it as a symbolic award for your engagement and an encouragement to develop your work for the future in a systematic and critical way; combining all the

knowledge. All the people that were not infected because of prevention do not know about it and cannot thank you. The result of good prevention is zero – nothing happens!

I would like to conclude by thanking Staffan Hallin for taking the initiative to organize this important conference and the EU and SMI and the Swedish Government and Stockholm city

and county council for financing it. I would also like to thank all of the people who have helped Staffan, the rapporteurs who helped me, all speakers who have contributed their knowledge and every participant for participating so actively.

Viveca Urwitz,
former head of the National Unit and STI Prevention and senior advisor at SMI, Sweden

A word from the Minister

The Swedish minister for Health and Social Affairs Göran Hägglund gave the following speech to the conference participants at the reception in Stockholm's City Hall.

Dear friends (conference participants),
It is with great pleasure I am welcoming you to Stockholm for this important conference. Sweden has a long tradition in communicable disease control and disease prevention and we are, as you all know, the host country for the European Centre for Disease Prevention and Control (ECDC). I am therefore very pleased that SMI (the Swedish Institute for Communicable Disease Control) has taken this initiative to arrange this first European conference dedicated to HIV-prevention amongst men who have sex with men (MSM).

I am also very pleased to learn that the conference has attracted more than 350 delegates, not only from EU member states but from all over Europe. This conference is not only bringing together people of different nationalities but also from many different disciplines: NGOs, government agencies, researchers and commercial actors.

The HIV infection is one of the major health threats of modern times. Since AIDS was first described some 20–25 million people have died due to HIV infection. In Europe, as in many other parts of the world, MSM were heavily hit by the epidemic, and the MSM community became a very important factor in the HIV prevention right from the start. The homo- and bisexual men, and their organisations, have contributed in a very significant

way to the fight against the spread of the disease.

Today, 30 years later, the MSM community still plays an important part of the preventive efforts but we are facing new challenges. The new MSM generations have not experienced the epidemic of the 1980s and early 1990s. They are not as scared of HIV and they are taking bigger risks, and in many parts of Europe the HIV incidence is increasing among MSM. This is one of many good reasons for arranging this conference here in Stockholm today.

Another issue that I would like to bring up is the discrimination and prejudice that many MSM still are facing all over Europe. This is not only a violation of their human rights, but may also lead to further spread of disease when preventive measures cannot be discussed openly in the society. I am therefore very pleased to learn that these issues will be addressed during this conference.

Once again, very welcome to this important conference. I am convinced that all of you will find new inspiration after having met and discussed various aspects of HIV prevention during these two days in Stockholm. I also hope that this meeting will be the start of a new era of innovative HIV prevention in Europe.

Thank you.



PHOTO: JOHAN ODMANN

SCIENTIFIC COMMITTEE

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Danilo Ballotta, EMCDDA
Torsten Berglund, SMI, Sweden
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STEERING COMMITTEE

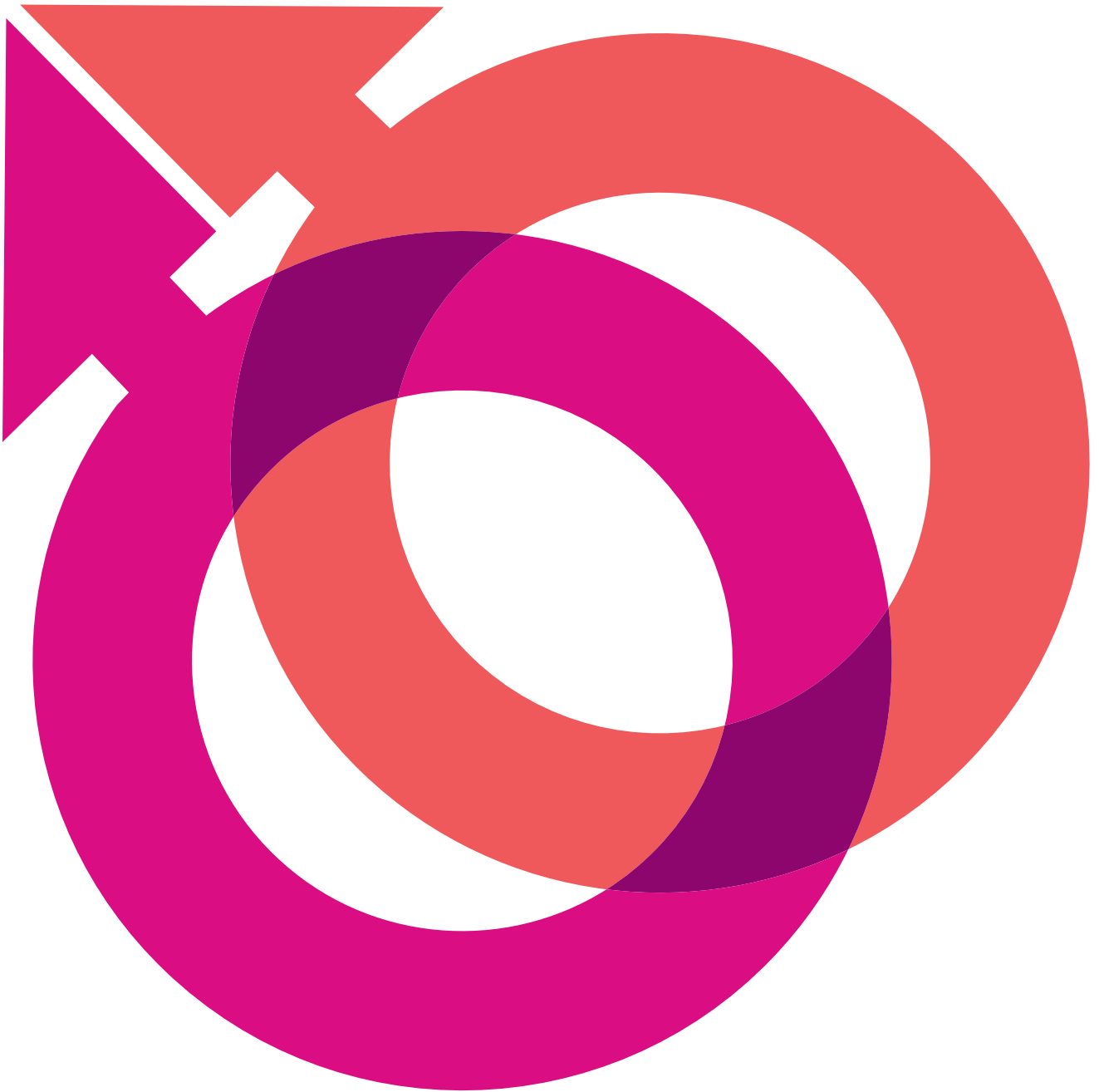
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Hans Nilsson, Positiviva Gruppen, Sweden
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Jon Voss, Stockholm Gay Life, Association of gay commercial establishments, Sweden

Conference/Project Manager

Staffan Hallin, SMI, Sweden

Conference Secretariat

Carlson Wagonlit Meetings and Events, Sweden



DAY ONE

PLENARY 1 OPENING PLENARY

Chair: Staffan Hallin SMI, Sweden
Johan Carlson Director General, SMI
Massimo Mirandola DGSANCO
Ulrika Westerlund President RFSL

- 1) **Overview of the European epidemic**
Speaker: Marita van de Laar, European Centre for Disease Prevention and Control (ECDC)
- 2) **Working towards better sex with less harm for gay and bisexual men in Europe**
Speaker: Ford Hickson, Sigma Research London School of Hygiene and Tropical Medicine, United Kingdom

PLENARY 2 THE EUROPEAN MSM INTERNET SURVEY (EMIS)

Chair: Marita van de Laar, ECDC
Moderator: Axel Schmidt, EMIS Project, Germany

- 1) **The European MSM internet survey. Building a network for harmonised European research on prevention of HIV and STI among MSM**
Speaker: Axel J Schmidt, EMIS Project, Germany
- 2) **Lessons learned from implementing a 25 language questionnaire. The role of gay social media and NGOs for recruitment**
Speaker: Peter Weatherburn, Sigma Research, London School of Hygiene and Tropical Medicine, United Kingdom
- 3) **Structural inequalities are associated with internalised homonegativity among European MSM**
Speaker: Rigmor Berg, Norwegian Knowledge Centre for the Health Services, Norway
- 4) **Comparing self-reported HIV prevalence/incidence from EMIS with surveillance system-derived data**
Speaker: Ulrich Marcus, Robert Koch-Institute, Germany

PLENARY 3 POSITIVE SEX AND PREVENTION

Folkets Hus
Chairs: Christiana Nöstlinger, Institute of Tropical Medicine, Belgium
Roman Dudnik, Regional Director for Central Asia, AIDS Foundation, East-West, Kazakstan

- 1) **Positive health, dignity, and prevention: A policy framework**
Speaker: Kevin Moody, GNP + the Global Network for and by People, Living with HIV, United Kingdom
- 2) **HIV positive MSM in Eastern Europe and Central Asia: Public health and dreams of love**
Speaker: Gennady Roschupkin, Eurasian Coalition on Male Health (ECOM), Interim Board

PARALLEL SESSIONS

PARALLEL SESSIONS 1

1. COMMUNITY TESTING AND COUNSELLING

Chair: Hans Blystad, Folkehelseinstituttet FHI, Oslo, Norway

- 1.1. **Check-ear Cohort: A community and researchers collaboration for STIs screening in HIV negative MSM**
Speaker: Pep Coll, Institut de Recerca de la Sida Irsi-Caixa, Spain
- 1.2. **Voluntary outreach counseling and testing in cruising venues for MSM: Lessons learned after three years**
Speaker: Tom Platteau, Institute of Tropical Medicine, Belgium
- 1.3. **Previous HIV testing experience among MSM in Lisbon. CheckpointLX first three months results**
Speaker: Maria José Campos, Grupo Português de Activistas sobre, Tratamentos VIH/SIDA (GAT), Portugal
- 1.4. **STOP HIV! Experiences from a campaign co-operation with onsite HIV-testing during Stockholm Pride**
Speaker: Ronny Heikki Tikkanen, Gothenburg University, Sweden

2. MONITORING TESTING BEHAVIOUR

- 2.1. **Socio-demographic factors predicting HIV test-seeking behaviour among MSM in six EU cities**
Speaker: Michele Breveglieri, Regional Centre for Health Promotion – Regione Veneto, Italy
- 2.2. **Factors associated with HIV testing among men who have sex with men**
Speaker: Ricardo Fuertes, Grupo Português de Activistas sobre Tratamentos VIT/SIDA (GAT), Portugal
- 2.3. **HIV testing rate and barriers for testing among MSM in Kiev, Ukraine**
Speaker: Yury Sarankov, Independent consultant, Ukraine
- 2.4. **EMIS: Determinants of late HIV diagnosis among MSM in Europe**
Speaker: Axel J. Schmidt, EMIS Projekt, Germany

3. MSM IN EASTERN EUROPE AND BEYOND – 1

Simultaneous translation to Russian

Chairs: Roman Dudnik, Regional Director for Central Asia, AIDS Foundation, East-West, Kazakhstan, Evgeny Pisemskiy, Eurasian Coalition on Male Health (ECOM), Eastern Europe and Central Asia

- 1.1. **Behavioural research among MSM and transgender people in Dushanbe, Tajikistan**
Speaker: Kiromiddin Gulov, Tajikistan
- 1.2. **Regional differences in behaviour of MSM in Russia: Results of European MSM internet survey (EMIS)**
Speaker: Ekaterina Shmykova, Russian Federation
- 1.3. **HIV behavioral survey among MSM in the Republic of Armenia**
Speaker: Dr. Karen Badalyan, Armenia

4. MISSION POSSIBLE WORKSHOP

New findings urge the rethinking of HIV prevention strategy among MSM in Switzerland

Chair & Presenter: Roger Staub
Swiss Federal Office of Public Health,
Switzerland

5. BUSINESS AND PLEASURE – ROLE OF COMMERCIAL ACTORS IN PREVENTION

Chair: Ben Tunstall, Terrence Higgins Trust, United Kingdom

5.1. Everywhere: A European seal of approval in HIV prevention for 'gay' and MSM businesses

Speaker: Nigel Sherriff, Centre for Health Research, University of Brighton, UK

5.2. Random acts of kindness: A win-win approach for commercial actors and the HIV sector

Speaker: Yves Calmette, ACON, Australia

5.3. Panel discussion with representatives of NGOs, authorities and gay businesses

6. IQHIV – PROMOTING QUALITY IMPROVEMENT IN HIV PREVENTION IN EUROPE WORKSHOP

NL 252 253

Chair: Matthias Wentzlaff-Eggebert, IQhiv, Germany

This informative and interactive workshop is aimed at those who plan and implement HIV prevention programs and projects of any size, including government, NGOs, communities and target groups.

7. IMAGERY AND LANGUAGE – IS FEAR THE FUTURE OF HIV PREVENTION? WORKSHOP

Speakers: Nicklas Dennermalm, RFSL Stockholm, Sweden

Adam Bourn, Sigma Research London School of Hygiene & Tropical Medicine, United Kingdom

PARALLEL SESSIONS 2

1. BETTER LIFE FOR POSITIVE MEN

Chair: Giulio Maria Corbelli, EATG, Italy

1.1. Increased mortality among HIV-positive MSM - in the era of efficient antiretroviral treatment

Speaker: Göran Bratt, Gay Men's Clinic, Venhälsan Stockholm, Sweden

1.2. A new training path for HIV positive MSM, focused on peer-group here-and-now dimension

Speaker: Emanuele Pullega, Arcigay, Italy

1.3. Peer support - Responding to need, delivering the project and achieving outcomes

Speaker: Neil Bird, Waverley Care - Positive Scotland, United Kingdom

1.4. The first MSM-PLWH self-help group in Belarus as a result of co-operation between service providers

Speaker: Kiryl Prasniakou
Republican Youth Public Association "Vstrecha", Belarus

1.5. Access to effective HIV care among MSM across Europe

Speaker: Ulrich Marcus
Robert Koch Institute, Berlin, Germany

2. MSM IN EASTERN EUROPE AND BEYOND – 2

Simultaneous translation to Russian

Chairs: Roman Dudnik

Regional Director for Central Asia, AIDS Foundation East-West, Kazakhstan

Evgeny Pisemskiy

Eurasian Coalition on Male Health

(ECOM), Eastern Europe and Central Asia

2.1. Innovative measure to enhance knowledge on HIV prevention among MSM in the Republic of Armenia
Speaker: Rafael Ohanyan, Armenia

2.2. Effective strategies for MSM-focused HIV prevention programmes in Russia

Speaker: Olga Samoylova, Russian Federation

2.3. Gender approaches in HIV prevention among MSM: Follow the Voice of Life project, Orenburg, Russia

Speaker: Dzmityry Filippau, Russian Federation

2.4. The mechanism of protection of the LGBT community rights in Ukraine

Speaker: Denys Chyzhov, Ukraine

The following sessions are continuing after the break:

3. MISSION POSSIBLE WORKSHOP

NL 459

4. BUSINESS AND PLEASURE – ROLE OF COMMERCIAL ACTORS IN PREVENTION

FH 357

5. IQHIV – PROMOTING QUALITY IMPROVEMENT IN HIV PREVENTION IN EUROPE WORKSHOP

NL 252 253

6. IMAGERY AND LANGUAGE – IS FEAR THE FUTURE OF HIV PREVENTION? WORKSHOP

NL 453

DAY TWO

PLENARY SESSIONS PLENARY 4

VULNERABILITY AND SOCIAL DETERMINANTS

Chair: Staffan Hallin SMI, Sweden

1. The relationship between discrimination, homophobia, mental health and HIV risk: Findings from the SILAS study
Speaker: Simon Rosser, University of Minnesota(American/Non European Experience)
2. The face of the hidden HIV epidemic in MSM in Eastern Europe and Central Asia: Environment, response and unaddressed needs
Speaker: Smiljka de Lussigny, WHO Europe

PLENARY 5

RESPONSE TO THE EPIDEMIC

Chair: Monica Idestrom, SMI, Sweden

- 1) From intervention to engagement; How do we make health promotion relevant to gay men?
Speaker: Colin Batrouney, Victorian AIDS Council
- 2) Response to the Epidemic – The Swedish Experience
Speaker: Ronny Tikkanen, University of Göteborg

CLOSING PLENARY

Chair: Staffan Hallin, SMI, Sweden

- 1) Punitive economies: The criminalisation of HIV transmission and exposure in Europe
Speaker: Matthew Weait, School of Law at Birkbeck College, University of London
- 2) MSM sexual health: Rethinking engagement, approaches, and outcomes
Speaker: Dr. Kevin Fenton, CDC Atlanta
Summary, conclusion and recommendations
Speaker: Viveca Urwitz, SMI, Sweden

PARALLEL SESSIONS

PARALLEL SESSIONS 3

1. RISK

Chair: Dirk Sander, Deutsche AIDS-Hilfe, Germany

- 1.1. Coverage of HIV prevention programmes and knowledge about STIs and HIV among MSM across Europe
Speaker: Todd Sekuler, Berlin Social Science Research Center, Germany
- 1.2. Risk behaviour, risk reduction & their determinants - Overview from the Amsterdam cohort studies
Speaker: Udi Davidovich
Amsterdam Public Health Service, The Netherlands

- 1.3. Understanding variation in sexual practices preceding HIV-infection among gay men in Berlin
Speaker: Michael Bochow, Wissenschaftszentrum für Sozial-forschung Berlin, Germany
- 1.4. Non-concordant unprotected anal intercourse (ncUAI) among MSM across Europe
Speaker: Axel J Schmidt, EMIS Project, Germany
- 1.5. Demographic distribution of non-concordant unprotected anal intercourse in three European regions
Speaker: Marita van de Laar, ECDC

2. SEX WORK

Simultaneous translation to Russian

Chair: Christian Antoni Möllreop, Vice President RFSL, Sweden

- 2.1. A study to explore the experiences of men selling sex in Surrey UK
Speaker: Ian Cole, Surrey Community Health Services NHS, UK
- 2.2. Male Sex Work in St. Petersburg, Russia – Pilot study
Speaker: Ksenia Eritsyana, Regional Public Organization of Social Projects in the Sphere of Population's Well-being "Stellit", Russian Federation
- 2.3. Sex for exchange among LGBT young people in Sweden
Speaker: Mina Gäredal, RFSL Ungdom, Sweden

3. MSM MIGRANTS

Chair: Bryan Teixeira, Naz Project, United Kingdom

- 3.1. Migrant men who have sex with men: An exploration of sexual risk in Europe
Speaker: Percy Fernández-Dávila, Stop Sida, Spain
- 3.2. Sexual behaviour and risk among Latino MSM in Spain
Speaker: Raul Soriano
Secretariat of the National AIDS Strategy
Ministry of Health, Social Policy and Equality, Spain

4. HEALTH ONLINE – MSM AND THE INTERNET

Chair: Gus Cairns, NAM HIV Treatment Update, UK

- 4.1. Is social media the holy grail to re-engage gay men with safe sex messaging?
Speaker: Yves Calmette, ACON, Australia
- 4.2. Eurosupport 6: CISS – Developing a positive prevention
Speaker: Christiana Nöstlinger
Institute of Tropical Medicine, Belgium
- 4.3. Disseminating prevention messages while chatting in gay websites
Speaker: Maria Cosmaro, Fondazione LILA Milano ONLUS – Lega Italiana per la Lotta contro l'AIDS, Italy
- 4.4. Social network for HIV positive men having sex with men (HIV+ MSM)
Speaker: Sergey Alekseevich Shagaleev, Positive wave, Russian Federation

5. ADDRESSING NEGATIVE SELF-PERCEPTIONS

Chair: Lena Nilsson
Gay Men's Clinic, Venhälsan Stockholm, Sweden

- 5.1. Designing interventions to enhance HIV/STI prevention by targeting internalised homonegativity
Speaker: Michael Ross, University of Texas, United States
- 5.2. Negative experiences of LGBT identity increases sexual vulnerability and risk of HIV transmission
Speaker: Mina Gäredal, RFSL Ungdom, Sweden

6. DESIGNING INTERVENTIONS – EVIDENCE AS A KEY INGREDIENT

Chair: Win Zuilhof, Schorer Stichting, The Netherlands

- 6.1. Knowledge-based HIV prevention intervention targeting men who have sSex with men
Speaker: Ronny Heikki Tikkanen
Gothenburg University, Sweden
- 6.2. Evaluation of the HIV-prevention campaign for men having sex with men “ICH WEISS WAS ICH TU”
Speaker: Jochen Drewes, Freie Universität Berlin, Public Health, Germany
- 6.3. HIV/STI prevention intervention for MSM in Europe: Characteristics and approach to evaluation
Speaker: Aryanti Radyowijati, ResultsinHealth, the Netherlands
- 6.4. Second generation counseling – effective prevention possibilities for MSM
Speaker: Viveca Urwitz, Swedish Institute for Control of Communicable Diseases, Sweden

PARALLEL SESSIONS 4

1. UNDERSTANDING EPIDEMIOLOGICAL DATA

Chair: Torsten Berglund, SMI, Sweden

- 1.1. High Incidence among MSM in Barcelona, Catalonia: The ITACA Cohort
Speaker: Laia Ferrer
Institut Català d'Oncologia, Spain
- 1.2. HIV Testing Uptake, HIV Knowledge and Personal Risk Assessment among MSM in Tbilisi, Georgia
Speaker: Nino Tsereteli
Center for Information and Counseling on Reproductive Health Tanadgoma, Georgia

2. PLANNING INTERVENTIONS

Chair: Jakob Haff, former CEO, STOP AIDS, Denmark

- 2.1. “ICH WEISS WAS ICH TU” How to implement a community and scientific-based MSM-prevention-campaign
Speaker: Matthias Kuske, Deutsche AIDS-Hilfe, Germany
- 2.2. StopHIV Group, collaboration between regional authorities and voluntary organisations in Stockholm
Speaker: Gunilla Neves Ekman, Stockholm County Aids Prevention, Programme, Sweden

- 2.3. Mentoring support programme among MSM in Ukraine
Speaker: Myroslava Debeliuk
ICF International HIV/AIDS Alliance in Ukraina
- 2.4. EMIS: Deficits in targeted and comprehensive STI-testing for gay and bisexual men in Europe
Speaker: Axel J. Schmidt, EMIS Project, Germany

3. NOTHING FOR US WITHOUT US – MSM, PREVENTION AND HUMAN RIGHTS

Simultaneous translation to Russian
Chair: Maria Sjödin, RFSL, Sweden

- 3.1. Establishing innovative approaches to promote HIV prevention for MSM living in rural Ireland
Speaker: Mick Quinlan, Gay Health Network, Ireland
- 3.2. From information to community to community mobilisation: About an ANRS PrEP trial for MSM in France
Speaker: François Berdougo Groupe interassociatif TRT-5, France
- 3.3. BCN Checkpoint: High effectiveness in HIV detection and linkage to care in MSM in Barcelona
Speaker: Eduardo Ditzel
Projecte dels NOMS-Hispanosida, Spain
- 3.4. HIV-related health factors and sexual pleasure among transgender men who have sex with men in Europe
Speaker: Todd Sekuler, Berlin Social Science Research Center, Germany

4. LIFE AS AN ONGOING PARTY? DRUG USE AND MSM

Chair: Bera Ulstein Moseng, Gay and Lesbian Health, Norway

- 4.1. Substance use among Portuguese men who have sex with men – Results from the EMIS study
Speaker: Ricardo Fuertes
Grupo Português de Activistas sobre Tratamentos VIH/SIDA (GAT), Portugal
- 4.2. Alcohol use, illicit drug use, type of sex partner and sexual risk-taking
Speaker: Lena Nilsson Schönnesson, Gay Men's Clinic, Venhälsan Stockholm, Sweden
- 4.3. Care on the dance floor: Gay party circuits and the fabric of risk
Speaker: Laurent Gaissad, Université Paris Ouest Nanterre – Université Libre de Bruxelles, Belgium
- 4.4. Rich with Meaning; Poppers use amongst homosexually active men
Speaker: David Reid, London School of Hygiene and Tropical Medicine, United Kingdom

POSTER PRESENTATIONS

(Click on the title to access the abstract)

RESPONDING TO THE NEEDS OF MIGRANT GAY MEN

Presenter: Adebisi Alimi

HOW TO IMPLEMENT CONTINUITY OF HIV-TESTING FOR MSM IN DIFFERENT HEALTH SYSTEMS IN EUROPE?

Presenter: Dirk Avonts

IMPROVING HIV-TESTING IN A PRIMARY HEALTH CARE CENTER IN ANTWERP, BELGIUM

Presenter: Dirk Avonts

REACH PARTNERSHIP: A CAPACITY BUILDING APPROACH TO BUILDING EVIDENCE WITH THE HIV COMMUNITY RESPONSE

Presenter: Colin Batrouney

CHECKPOINT @ HARDON VENUE BASED HIV COUNSELLING AND TESTING FOR MSM IN VIENNA

Presenter: Dominik Bozkurt

CHARACTERISTICS OF MEN HAVING SEX WITH MEN (MSM) HIV DIAGNOSED AT VENHÅLSAN, SÖS, STOCKHOLM

Presenter: Göran Bratt

CORRELATES OF CONDOM USE AMONG MEN WHO HAVE SEX WITH MEN IN PORTUGAL

Presenter: Sónia Dias

NEW HIV DIAGNOSES AMONG MSM IN ITALY

Presenter: Laura Camoni

LINKS BETWEEN SEXUAL BEHAVIOR AND SEXUALLY TRANSMITTED INFECTIONS IN MSM POPULATION IN LITHUANIA

Presenter: Saulius Caplinskas

PORTUGAL IN THE EMIS STUDY: A GENERAL DESCRIPTION OF STUDY PARTICIPANTS

Presenter: Cláudia Carvalho

EXPERIMENTAL ACTIONS FOR HIV PREVENTION TARGETED TO MSM: ITALIAN SUMMER INTERVENTIONS

Presenter: Maria Luisa Cosmaro

HIV/AIDS PREVENTION AMONG MSM IN UKRAINE

Presenter: Myroslava Debeliuk

KISS AND TELL? A CAMPAIGN ON SAFER SEX, CHEATING, OPEN RELATIONSHIPS AND COMMUNICATION

Presenter: Nicklas Dennermalm

IMPLEMENTATION OF A COHORT OF HIV NEGATIVE MSM AMONG CLIENTS OF A COMMUNITY CENTER IN BARCELONA

Presenter: Eduardo Ditzel

RISK FACTORS FOR SELF-REPORTED STI ANALYSED FROM A SWEDISH NATIONAL MSM INTERNET SURVEY

Presenter: Lars E. Eriksson

MEN WHO HAVE SEX WITH MEN IN A CLOSELY CONNECTED REGION OF TWO COUNTRIES – TWO CULTURES – ORESUND

Presenter: Niklas Eriksson

PROVIDING MEDICAL AND NON-MEDICAL SERVICES FOR MSM IN THE RUSSIAN PROVINCE

Presenter: Semen Ermolin

FACTORS PROMOTING RISKY BEHAVIOR OF MEN WHO HAVE SEX WITH MEN IN BELARUS

Presenter: Oleg Eryomin

RISK AND VULNERABILITY: MOTIVES AND MEANINGS ON THE SEXUAL RISK BEHAVIOURS OF YOUNG MSM IN BARCELONA

Presenter: Percy Fernandez-Davila

MALE COMMERCIAL SEX WORKERS IN PORTUGAL: SEXUAL BEHAVIORS AND PREVENTIVE PRACTICES

Presenter: Ricardo Fuertes

CHALLENGES FOR PREVENTIVE INTERVENTIONS AMONG FINNISH MSM

Presenter: Teppo Heikkinen

PLANNING INTERVENTIONS AIMED TO CHANGE RISKY BEHAVIOR AMONG MSM IN UKRAINE

Presenter: Taras Karasiichuk

HIV INFECTIONS ATTRIBUTED TO HOMO-SEXUAL TRANSMISSION ARE INCREASING IN GEORGIA. THIS STUDY AIMED TO EVALUATE PREVALENCE OF HIV, STIS AND SEXUAL RISK BEHAVIORS AMONG MEN WHO HAVE SEX WITH MEN IN TBILISI, GEORGIA AND LOOK INTO POSSIBLE CONTRIBUTING FACTORS FOR HIV INFECTION

Presenter: Kakhaber Kepuladze

AN APPLICATION OF PERVASIVE GAMING TO HIV PREVENTION WITH MSM IN ROMANIA

Presenter: Tudor Kovacs

BEST SEX LIFE IDEA AMONG SLOVENIAN MEN WHO HAVE SEX WITH MEN (MSM): RESULTS OF EMIS

Presenter: Ales Lamut

SOCIAL SITUATION OF MSM IN UKRAINE AND HIV PREVENTION STRATEGY

Presenter: Andriy Maymulakhin

FACTORS ASSOCIATED WITH HIGHER RISK SEXUAL BEHAVIOUR AMONG MEN WHO HAVE SEX WITH MEN (MSM) IN LATVIA

Presenter: Antons Mozalevskis

BULGARIAN MSM – HIV TESTING, KNOWLEDGE, COVERAGE WITH PREVENTION ACTIVITIES. EMIS DATA

Presenter: Emilia Naseva

BULGARIAN MSM – SEXUAL BEHAVIOUR. EMIS DATA

Presenter: Emilia Naseva

COLOUR OF LOVE: A LARGE SCALE HIV/STI PREVENTIVE OUTREACH PROJECT

Presenter: Carolina Orre

EMIS SURVEY AND SCHORER MONITOR 2010: SIMILAR SURVEYS WITH DIFFERENT RESULTS: HOW TO INTERPRET?

Presenter: Eva Roos

MEN WHO HAVE SEX WITH MEN AMONG PATIENTS WITH SEXUALLY TRANSMITTED INFECTIONS IN ITALY, 1991-2008

Presenter: Maria Cristina Salfa

MONITORING AWARENESS OF HIV STATUS AMONG MSM IN SLOVENIA: A TIME – LOCATION SAMPLE

Presenter: Miran Solinc

A NATIONAL STUDY BASED ON THE ECDC INDICATORS IN ITALY: RESULTS FROM AN ONLINE QUESTIONNAIRE

Presenter: D'Amato Stefania

THE COMPASS – PREVENTING HIV AND REDUCING RISK BEHAVIOUR AMONG YOUNG MSM

Presenter: Katarina Stenkivist

MULTIPLE HIV RISKS OF MSM IN AZERBAIJAN

Presenter: Javahir Suleymanova

MSM-SURVEY 2008 – RISK TAKING, HIV TESTING AND PREVENTION NEEDS AMONG MSM IN SWEDEN

Presenter: Ronny Heikki Tikkanen

A ROUGH GUIDE TO DIRTY SEX: HIV PREVENTION IN 2011

Presenter: Kathy Triffitt

FACTORS INFLUENCING THE HIV RISK BEHAVIORS AMONG MSM IN UKRAINE

Presenter: Olesia Trofymenko

HIV PREVENTION, IDENTITY AND TESTING: EFFECTING MEASURABLE CHANGES THROUGH PEER MENTORING

Presenter: Greg Ussher

MAJOR DEPRESSION AND UNPROTECTED ANAL INTERCOURSE AMONG AN ONLINE SAMPLE OF FLEMISH MSM

Presenter: Wim Vanden Berghe

MAN TOT MAN: A NEW APPROACH TO INTEGRATED HIV/STI PREVENTION FOR MSM IN THE NETHERLANDS

Presenter: Wim Zuilhof

THE FUTURE OF EUROPEAN PREVENTION AMONG MEN WHO HAVE SEX WITH MEN

Article number 2011-15-20 ISBN 978-91-86723-21-7

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