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Editorial
Sexual Health, 2011, **8**, 5–8

HIV infection among men who have sex with men in East and South-East Asia – time for action

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Although the early HIV epidemic in Asia was characterised by HIV spread predominantly through injecting drug use, sexual transmission of HIV has increased throughout many parts of Asia.[1] For the past 5 years, alarming rates in HIV infection have been observed among men who have sex with men (MSM) across urban areas in many Asian countries,[2,3] with the HIV prevalence rates ranging from 30.8% in Bangkok,[3] 3.2% in Singapore,[4] 4% in Malaysia,[5] 5.7% in Tokyo,[6] 8.5% in Taiwan,[7] 4.3% in Hong Kong,[8] 12.5% in Chongqing (China)[9] and to 4.8% in Beijing.[10] Although HIV surveillance among MSM in these countries remains patchy and incomplete, recent epidemiological studies have consistently shown that HIV infections among MSM are increasing, a trend that has also been observed in MSM in other parts of the world.[11]

International agencies such as the Joint United Nations Program on HIV/AIDS,[12] the Global Fund to Fight AIDS Tuberculosis and Malaria,[13] US Agency for International Development,[14] and the American Foundation for AIDS Research,[15] have increased funding for research and HIV prevention programming for MSM in this region. Additionally, at the local level, various community-based organisations have emerged to provide preventive services for MSM communities.[16] Up until now, little attention has been given to the HIV epidemic among MSM in more developed parts of Asia. The 9th International Congress on AIDS in Asia and the Pacific in Bali 2009 was a symposium focussing on HIV and MSM in developed East and South-East Asian countries. The symposium highlighted epidemiologic data and prevention responses in seven countries and territories namely, Singapore, Malaysia, Thailand, Japan, Taiwan, Hong Kong and mainland China. We outline common challenges encountered in addressing HIV among MSM in these countries and lessons that should be learned.

China

Although 2% to 4% of the adult Chinese populations are estimated to be MSM, they constitute 12.2% of all new HIV cases in 2007 in China.[17] A recent 12-month cohort study of MSM in northern China reported an alarmingly high incidence of HIV and syphilis.[18] The emerging epidemic is not limited to big cities; it has been documented in Gansu, Harbin and Urumuqi.[16] Since 2000, the Chi Heng Foundation, a MSM community-based organisation with offices in Hong Kong, Henan, Beijing, Shanghai, Guangzhou, Anhui and Sichuan areas, has involved community stakeholders such as peer staff, police and owners of the MSM venues to develop and deliver HIV prevention programs. The community-based HIV programs have been integrated into popular MSM activities and their model has been named by UNAIDS the Best Practice Model for China.

Hong Kong

In Hong Kong, the number of new HIV infections in MSM tripled from 50 in 2003 to 151 in 2008.[19] Outreach activities by non-government organisations in gay saunas have detected increasing levels of HIV infection (1% in 2003 to 2.5% in 2005). Despite on-going HIV prevention campaigns for MSM, condom use among MSM in Hong Kong has remained low. In 2006, the Council for the AIDS Trust Fund, coordinated by the Hong Kong government, launched a Special Project Fund for MSM. A total of HK 13 million was allocated to fund 41 projects to strengthen MSM communities and forge partnerships among government and various stakeholders.[19] With funding, the community-based organisations were able to conduct community-based projects in various MSM subpopulations and provide comprehensive prevention activities at various settings.

Japan

Japan is perceived to have a low prevalence of HIV; however, MSM were found to have a 65-fold higher rate than the overall adult male populations and the HIV prevalence among MSM is increasing.[20] A record number of 690 HIV cases and 152 AIDS patients due to homosexual and bisexual contact were reported in 2007. Among males, 88% of HIV cases and 80% of AIDS patients were attributed to male-to-male sex. Ichikawa and colleagues, in a letter published in this issue of *Sexual Health*,[20] have stated that the MSM reports in National AIDS Surveillance data are most likely to be under-reported because of the low rates of HIV testing among Japanese MSM, and hesitancy in reporting homosexual transmission to medical staff in Japan.

10.1071/SH10124 1448-5028/11/010005

Besides Tokyo, HIV cases among MSM has also increased sharply in Osaka, Nagoya, Fukuoka and Okinawa, indicating that transmission via male-to-male sex is increasing in smaller cities. Epidemiological data collection on HIV and MSM has improved since the late 1990s; however, the response to HIV infections among MSM has lagged for many reasons. Early HIV prevention materials focussed only on heterosexual transmission and failed to include MSM-specific messages.[6] Medical staff who provided HIV testing received little training in issues surrounding sexual orientation and were often found to be judgmental of their clients. Furthermore, gay community organisers have been reluctant to work together and with researchers to improve health services for MSM.[6] Although funding is available for HIV and MSM research, few resources are allocated for building the non-government organisations capacity to provide services. Often, service project goals have to be disguised as research goals and project coordinators are funded through research grants.

Malaysia

The best estimate of HIV prevalence among MSM who attend social venues in Kuala Lumpur is 4%.[5] Data from the Pink Triangle (PT) Foundation, the only MSM community-based organisation in Malaysia, reveal that HIV infection among MSM has been rising since 2002.[21] As is the case in other countries, many MSM are not aware of their serostatus and many are diagnosed only when they develop AIDS. Working under restrictive legal and moral rules and with inadequate funding, the PT Foundation implements their HIV programs only in Kuala Lumpur. MSM have not been included as the National Action Plan against HIV. Current programs at PT Foundation have yet to reach non-English speaking, non-Chinese ethnic MSM. Compared with other ethnic MSM, Malay MSM may be at higher risk for HIV infections. In a recent behavioural survey, Malay MSM reported poorer knowledge in HIV transmission and were more likely to have engaged in unprotected sex with a casual partner in the past 6 months compared with Chinese MSM.[5]

Singapore

The dominant route of HIV transmission in Singapore is heterosexual, comprising more than 60% of total HIV infections from 1991 to 2007.[4] However, HIV cases contracted via male-to-male sex increased from less than 10% in 2000 to more than 30% in 2007.[4] In a large venue-based outreach testing project by Action for AIDS in 2008 ($n = 1225$), 2.6% of bar or club patrons and 4.1% of sauna patrons were HIV-positive. Sexually transmissible infections, such as syphilis, chlamydia, and HIV have increased from 2001 to 2009 among MSM in Singapore.[4] In 2007, the Ministry of Health convened a working committee on MSM and HIV/AIDS to reduce risk-taking behaviours among MSM, and to increase HIV testing by 2012. Specific strategic plans were delineated and responsibilities of each participating party were defined. Government funding for MSM-specific HIV/AIDS programs has increased, however concerns and challenges remain. Criminalisation of homosexual sex remains a major barrier to HIV education and awareness, making it difficult to reach non-gay identified MSM, young MSM, and male sex workers who serve MSM clients. These sex workers usually move and work across national borders in the region.

Taiwan

In Taiwan, the number of reported HIV cases due to homosexual contact has increased steadily from 2000 to 2007. MSM accounted for an estimated 57% of new HIV infections in 2008. A study of eight gay saunas in major cities shows that positive HIV tests among MSM patrons significantly increased from 7.8% in 2004 to 15% in 2007.[22] About 38% of MSM tested were recently infected during the previous 4 years.[23] Data from the Taiwan Centre for Disease Control reveal increasing numbers of HIV cases among young MSM in particular.[23]

Thailand

The HIV prevalence among MSM in Bangkok increased from 17.3% in 2003 to 28.3% in 2005 and to 30.7% in 2007.[3] Among male sex workers, the HIV prevalence also increased from 18.9% in 2003 to 27% in 2005.[3] To respond to the escalating epidemic, the Thai government, community-based organisations, and international agencies have initiated the National MSM programs, which include: (1) research and surveillance systems, (2) MSM community-based and peer-led HIV prevention programs, (3) MSM-friendly HIV and sexually transmissible infection clinics, and (4) promotion of equality and social acceptance towards MSM.[24] In addition to expanding existing HIV programs to MSM, the National MSM programs aim to develop organisational capacity for new non-government organisations. A total of USD$880 000 was budgeted for the 2008 National MSM Programs, which should reach an estimate of 25 900 MSM in nine provinces. However, it is estimated that 1123 peer educators and 562 outreach workers will be needed. Notably, the Thai Sexual Diversity Network, chaired by Rainbow Sky Association, currently provides preventive services for MSM and transgendered persons across all provinces of Thailand.[24]

Summary

The epidemiological data reported from these countries paint a worrying picture of HIV infection and transmission among MSM. Common areas of concern include use of recreational drugs in combination with sex, use of the internet for sexual liaisons, growth of sex-on-premises venues, regional sex travel, and group sex parties. The symposium identified subpopulations of MSM who are at greater risk of HIV infections, in particular, young MSM. A recent review by van Griensven and van Wijngaarden on epidemiology and HIV prevention responses among MSM in Asia[16] has called for rapid scale up of intervention programs in order to avert a public health catastrophe.

The responses to the HIV epidemic among MSM in these countries vary and are determined by the capacity of community-based organisations, commitment and support from the government, as well as the legal and socio-cultural environments. A common feature is that HIV prevention

programs for MSM have been difficult and under-resourced and therefore reach only a small proportion of MSM. Sex between men is criminalised in 19 out of 48 countries in the Asia Pacific region[25] and is stigmatised by traditional Asian values and cultures. Many MSM are afraid to acknowledge their sexual orientation, to disclose it to their family and friends, and to access available health services such as HIV testing.

In many of these countries, budgets for MSM-specific services are disproportionately low. Some countries such as China and Malaysia have been resistant to include MSM as important component of HIV/AIDS planning. In order to increase the response from government, public health, and medical sectors, it is necessary to reduce stigma and discrimination at multiple levels.[26] Decriminalisation of homosexuality and a human rights approach to prevention are recommended by experts[27] and the international agencies[28,29] as crucial to achieve these goals.

It is implicit that programs provided for MSM have to involve community-based organisations and infected persons in planning and delivery. As exemplified by the work in Hong Kong and Japan, HIV prevention programs must be tailored to the local cultures. The programs must appeal to and address the needs of MSM clients. HIV and STI testing and counselling, increased access to lubricants and condoms, and outreach at various social venues are the basic services that non-government organisations must provide. To some degree this is the case in some developed countries in Asia. With relatively more funding, non-government organisations in Hong Kong and Singapore have been able to scale up programs, and to provide more comprehensive services that address sexual health needs and psychosocial issues among MSM.

The clear commitment of government in HIV responses is also crucial. As is the case in Thailand, Hong Kong and Singapore, governments provide financial and technical assistance and coordinate MSM research and programming activities. Government financial support is crucial to ensure the survival of the non-government organisations and community-based organisations such that they would not have to rely on funding from donors or international agencies. In Singapore and Hong Kong, coalitions of clinicians, researchers, public health officials, and community-based organisations collaborate and have increased coverage of prevention services, leading to the most significant impact in reducing risk behaviours and HIV infection among MSM in the region. This partnership approach has also been recommended.[12–14,16,27–29] A central body, supported by government, that coordinates MSM research and programming activities is critical to ensure a concerted and sustainable effort to reduce HIV among MSM populations in the region. Other countries must put into place similar coordination structures, increase resources and energise their community networks and organisations if they are to contain the alarming explosion of HIV transmission in their MSM communities.

Conflicts of interest

None declared.

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Manuscript received 28 September 2010, accepted 25 November 2010