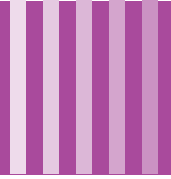




Treatment Access for
Positive MSM
in the Asia Pacific



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Introduction

Background

In collaboration with various community-based organisations, APN+ conducted a peer-led mixed method research project in six Asian countries to document the range of services available for MSM and transgender people living with HIV and to identify barriers to access and use of these services.

Methodology

A quantitative survey of 897 MSM and transgender people living with HIV to assess healthcare service provision, access and availability in the Asia Pacific region was conducted in 6 countries: India (n=424), Indonesia (n=128), Myanmar (44), Nepal (168), Singapore (50), and Malaysia (83). The study methodology was based on an action-based peer-led study design by APN+¹ which aimed at developing an understanding of the nature and pattern of treatment access. The project was designed and implemented by people living with HIV.

Survey sites include: **1. India:** Mumbai & Pune, Maharashtra; Goa; New Delhi; Hyderabad, Andhra Pradesh; and Chennai, Tamil Nadu. **2. Indonesia:** Padang, Southeast Nusa, Batam, Bali, East Java, West Java, Central Java, and Yogyakarta. **3. Myanmar:** Lashio, Mandalay, Monywar, and Pyin Oo Lwin. **4. Nepal:** Birgunj, Nepalgunj, Bahirahawa, Naryangaht, Kathmandu, Bhaktapur, Lalitpur, Kirtipur, and Pokhara. **5. Singapore. 6. Malaysia:** Selangor, Federal Territory, Kedah, Sarawak, Johor, and Perak. Data were analysed using SPSS Version 12.

After the initial survey, Focus Group Discussions (FGD) on treatment access for positive MSM were conducted in the six countries – one at each of the following sites: 1. Indonesia: Bali, Banten, Malang, and Batam Sumatra. 2. Myanmar: Mandalay (n=15 participants), Monywa (n=15), and Lashio (n=10). 3. Nepal: Kirtipur (n=17) and Lalitpur (n=15). 4. India: Delhi, Hyderabad (n=12), and Mumbai (n=11). 5. Malaysia. 6. Singapore. Participant selection for the FGDs was through referrals from MSM community leaders and NGOs working with

positive MSM. All focus groups were peer-led, organised and facilitated. Detailed notes were taken during the FGDs including writing quotes ad verbatim. This data was then analysed in the context of sociological theory.

The Report

The following report consists of six separate country reports: India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. Each report has a standard format and can be read independently. A summary of key findings has been included at the end of this section. Summary findings are also provided for each country report for easy reference.

Quantitative survey data forms the background of each country report, both to provide an overview of population demographics and to establish the structural barriers that shape treatment access among communities of MSM in these populations. The statistics give a sense of the size of the problem faced by local communities.

From this general picture, findings from peer-led FGDs are analysed² and remain the main thrust of this report. The primary objective of this report is to explore the dynamic interplay between structural barriers and local socio-cultural environments, and how together these factors influence treatment access for MSM.

Structural barriers can be both material (availability and price of medications, for example) as well as activity-based (the time it takes to travel for treatment and disclosure to obtain time off work to do so). Within this dynamic, MSM would also need to negotiate environments particular to their social, cultural and local contexts.

Taken together, this report focuses on how individual treatment access for HIV and OI (opportunistic infections) is defined by structural barriers within the contextual environments MSM find themselves. The following highlights particular areas of analytical focus and should by no means be taken as exhaustive:

A. Structural barriers

1. Availability of treatment

- medication (HAART, OI)
- healthcare services (including counselling, general medicine, HIV/STI screening, health status—CD4 and VL—tests)
- medicine stock

2. Accessibility

- geographical locality and distance to healthcare facility
- transportation infrastructure
- social and cultural barriers

3. Economic costs

- costs of medicine
- costs of medical tests (CD4, VL, resistance)
- travel costs
- opportunity costs (time off work, etc.)

It is important to note that contextual variations can also exist within a country depending on urban-rural settings, socio-economic class of recruited participants, level of education, gender, and other social factors. Where possible—as is the case of multiple data collection points within a country and inclusion of both men and transgender persons in the focus group discussions—the diversity of local perceptions will be made clear.

A separate section focusing on treatment access for transgender individuals is also included to highlight how treatment access in each country can be gender biased. However, findings should not be generalised to the transgender population in each country or the region since the survey methods have been ineffective in sampling the

population: In two of the six countries (Indonesia and Singapore) sample sizes for transgender individuals were too small or non-existent. These countries have been removed from the analysis in this section.

With the call for universal access, it is hoped that these country reports will contribute to the discussion about the importance of considering multiple contexts when addressing treatment access and treatment prospects for MSM in the Asia Pacific region. In scrutinising the interplay between local structural and environmental constraints that inhibit treatment access among MSM, these reports seek to put social causes of health in the context of individual and community health outcomes.

B. Socio-cultural environment (healthcare/family/MSM community/ employer)

1. Social support

- relationships
- disclosure
- information sharing and seeking

2. Social costs

- stigma and discrimination
- unauthorised disclosure
- impact on employment

3. Daily life

- fitting-in with treatment regime
- sex (with partner or casual encounters)
- seeking support

Summary of Findings

- 1 Obtaining ARV treatment when needed remains uncertain for the majority of sampled respondents.
- 2 The constant interplay between infrastructural barriers and socio-cultural environment in each country impacts on individual healthcare options and treatment access for positive MSM.
- 3 Even where treatment is available for free, the costs of medical tests and transportation to seek treatment can be prohibitive.
- 4 Treatment centres, often located in cities or capitals, make access difficult for those not living in urban areas.
- 5 Stigma and discrimination, particularly amongst healthcare providers, is a major disincentive to seek treatment.
- 6 Unethical disclosure of sexuality and/or HIV status by healthcare staff perpetuates distrust in local healthcare infrastructure.
- 7 Strong cultural norms pertaining to sexuality impede availability of accurate treatment information, create the fear of disclosure and an increased chance of social isolation and loss of social support.
- 8 Gender-based discrimination makes treatment access an additional challenge for transgender individuals.

India



Background

424 HIV positive men who have sex with men (MSM; 48 of whom are transgender) were interviewed in India³. Three of four participants (75.4%; n=422) were in a relationship with a partner at the time of the survey and just under half (42.5%) have disclosed their status to their partners. Over one third (38.4%) of participants' families know of their HIV status while only a quarter (24.9%) of their families reportedly know of participants' sexuality. More than half of participants (63.9%; n=421) resided in a city.

Average age at the time of diagnosis was 28 years, with the majority of participants (76.2%, n=420) having been diagnosed in public healthcare settings. Most participants (86.2%, n=421) reported receiving some form of counselling at the point of diagnosis. However, almost 2 in 10 (18.9%; n=280) stated that counsellors became unfriendly with them once their sexuality was known. Crucially, in the survey, more than one in 10 reported unethical disclosure of sexuality (14.3%; n=272) and HIV (14.3%; n=419) status by healthcare staff.

Of the 188 participants (44.5%; n=422) who reported needing ART, 75.5% were receiving medication. More than half (58.8%; n=415) had access to treatment for opportunistic infections. Nonetheless, in general more than three out of four participants (77.9%; n=421) admitted it is a challenge to access HIV services. Among the main reasons surveyed as barriers to access (n=328) had to do with travel difficulties (49.4%)⁴, travel costs (41.2%) and fear of stigma from family/partner (38.4%)⁵. Surprisingly felt stigma was low among participants accessing treatment, with only 5.8% (n=328) reporting it being a barrier to accessing services. Almost one third of survey participants (31.6%; n=418) have experienced healthcare service refusals; and critically, 4.8% of participants (n=418) have reported assaults by healthcare staff.

Discussing Treatment Access

Data were collected from three focus groups held in India at the end of 2008 in New Delhi, Hyderabad and Mumbai. 33 participants took part in peer-led

discussions which highlighted how HIV positive MSM in India are concerned with treatment access on multiple fronts; concerns that are made complicated by strong cultural norms in Indian society, poverty, and stigma in healthcare settings.

As a result of strong heterosexual norms in Indian culture, many MSM marry women as a pretext and end up leading highly complex lives. Such dual lives are made more complicated by HIV:

"My wife does not know that I am MSM... that I am HIV+... She doesn't even know that I am eating these pills." (New Delhi)

In the survey data, this duality is shown by the higher proportion of MSM who are in simultaneous relationships with both men and women—which sees an almost three-fold increase from 27.5% to 72.5% (n=299)—for participants living in the cities. This trend is repeated for MSM whose partner is another man (20.9% for those living in towns and villages as opposed to 79.1% in cities; n=299). City living and the concurrent loosening of more traditional norms could be argued to make choosing such lifestyles alternative to cultural expectations easier.

However, breaking away from traditional norms can have an effect on the social support networks of positive MSM. The fear of stigma from within their own families makes it difficult for some to disclose their status to those closest to them. As a result, the social support structures on which they depend is felt to be threatened:

"If my wife comes to know that I am MSM and HIV+, what will be my life then. If she comes to know I don't know what I will answer her." (New Delhi)

Measuring the association between HIV status disclosure with alternative lifestyles in the survey sample finds that MSM in relationships with other men or with both men and women are significantly less likely to disclose their HIV status to their partners ($\chi^2=31.156$; $p=0.000$) or their families ($\chi^2=18.576$; $p=0.000$).

It is possible that this dejection could lead to reliance on healthcare staff for social support.

Some healthcare staff may, unfortunately, be complicit in the policing of strong cultural norms. As such, doctors' responses to fears their patients may have can appear unsympathetic.

Treatment Access in Brief

Structural Barriers

- Lower social status from poverty or occupation limits treatment options
- Medical tests not included in free treatment
- Service refusal experienced by 1/3 of those surveyed

Social Environment

- Strong heterosexual norms
- Many live dual lives: being married while engaging in MSM activity
- Fear of stigma hampers disclosure of HIV status and sexual activity to families
- Healthcare staff involved in stigmatising behaviours

"I also fear a lot standing in the hospital line to take medicine as it's very near to my home and someone may see me some time. I requested the ART centre doctor to shift me to another ART centre but he refused." (New Delhi)

For those who have the option of choosing private medical care, the solution appears deceptively simple:

"I was so fed up with going to the hospital... doctors were not friendly and would speak very rudely, that is when I decided that enough was enough, I will rather spent money in some private hospital" (Maharashtra)

Not everyone, however, has this choice.

Poverty is a main concern raised during the discussions. This is confirmed by findings in the survey, where travel difficulties and costs rank higher than stigma as primary barriers to accessing treatment.

"I have to travel a long distance to access treatment. I do not have any income and sometimes do not get two meals a day." (Andhra Pradesh)

The costs of important medical tests to determine health status (CD4 and viral load) have yet even to be factored into the equation, as is the treatment for some sexually transmitted diseases and opportunistic infections that are not available for free. For those who need second line ART, treatment costs can be more than a person's average monthly salary.

In short, the situation with regard to Indian healthcare and service provision can and do greatly impact not only on treatment access per se, but also the well-being of positive MSM in general; as can be seen when HIV status is unethically disclosed by healthcare staff. As with any situation, those who bear the brunt tend to be the most marginalised:

"I was making good money by selling sex, now that people are aware of my status they do not want my services." (Andhra Pradesh)

When left unchecked, unprofessional behaviour by healthcare staff has extended to sub-optimal treatment received by MSM.

"I had some painful rashes in my private parts, with much difficulty I went to the hospital as the rashes were very painful... I had been waiting for a long time... when the doctor came... [the doctor was] first hesitant to even look at me... just scribbled out some prescription without as much as looking at the infection." (New Delhi)

Furthermore, violence is just one step beyond sub-optimal treatment. Structural violence⁶ as a result of service refusal and physical violence / physical abuse have already been demonstrated by survey findings to exist in the Indian healthcare system.

Treatment Access in India

There are significant barriers to treatment access for Indian MSM, most of which are culturally constructed. While in numbers, MSM who reportedly need and are able to access ART is high (three in four), the quality and level of care they receive are decidedly poor in some areas. This may be the result of institutionalised stigma and discrimination within the Indian healthcare system, a situation made worse for those who are already marginalised because of their occupation, and/or socio-economic status. More targeted work will need to be done to find out how marginalised communities of MSM face their, as yet, uncertain future with HIV.

Indonesia



Background

128 HIV positive men who have sex with men (MSM; 5 of whom are transgender) were interviewed in Indonesia⁷. Almost all the participants (95.3%)⁸ were in a relationship with a partner at the time of the survey and just 12.5% (n=122) had disclosed their status to their partners. Less than one in ten (9.4%) of participants' families know of their HIV status while only 6.3% of their families reportedly know of participants' sexuality. Almost seven in ten participants (69.5%) resided in a city.

Average age at the time of diagnosis was 26 years, with the majority of participants (75.8%) having been diagnosed in public healthcare settings. Almost all participants (98.4%, n=126) reported receiving some form of counselling at the point of diagnosis. None stated that counsellors became unfriendly with them once their sexuality was known. Crucially, however, 6.3% reported healthcare staff unethically disclosing their sexuality. Almost one in 10 experienced disclosure of their HIV status (8.5%; n=117) without their consent by healthcare staff.

Of the 23 participants (18%) who reported needing ART, 39.1% were receiving medication. More than half (58.7%; n=63) had access to treatment for opportunistic infections. Just over half of participants (56.5%; n=115) admitted it is a challenge to access HIV services. Among the main reasons surveyed (n=65) as barriers to access were treatment costs (66.2%), travel difficulties (56.9%) and travel costs (40.0%)⁹. Average travel time to seek treatment is 1.10 hours while waiting time at healthcare settings averaged at 1.07 hours¹⁰. Surprisingly all participants reported no felt stigma as a barrier to accessing services. Fortunately, too, there were no reports of service refusals or assaults in healthcare settings.

Discussing Treatment Access

Data were collected from three focus groups held in Indonesia at the end of 2008 in DKI Jakarta, West Java, Middle Java, Yogyakarta, East Java, Bali, Padang, and Banten. Between 6 and 12 participants took part in peer-led discussions in each of the 8 regions. Results highlight that treatment access for positive MSM in Indonesia is beset by misinformation, fear and self-stigma.

The general tone of discussion suggests that reliable treatment information in Indonesia is lacking. One participant obtained treatment information from mainstream entertainment television to ill effect:

"I am almost stress[ed] and afraid because TV talkshow noted that HIV drug is rare, and then I make sms to my manager to [seek] certain[ty], [my manager told] ...me [to] ignore it. But such news still make me nervous until now." (West Java)

Given that survey findings indicate that almost all of the participants (98.4%; n=126) received some form of counselling upon diagnosis, and all participants stated that they knew where to seek treatment information, this discrepancy is worth noting¹¹.

Looking more closely at the survey data, a picture of secrecy (and/or perhaps taboo) emerges. While the majority of participants were in a relationship (95.3%)—more than half (52.5%) of whom were with a male partner—disclosure of HIV status to partners is relatively low at just over 1 in 10 participants (12.5%; n=122). On the back of low disclosure rates, an overwhelming majority of participants (96.7%; n=128) reported that their families are unaware of both their sexuality and HIV status.

In addition, despite findings in the survey that self-stigma is non-existent, data from these discussions reveal otherwise:

"MSM status and Positive Status make me avoid health service, I am ashamed [about my] secret." (Lombok)

A further discrepancy between survey data and focus group discussions stems from the reporting of experience with stigma in healthcare services. While more than half of the sample (50.8%) reported no stigma, what is telling is that the rest of the sample declined to answer the question. Yet, at the close of focus group discussions, when participants were asked what their hopes were for the future of MSM health service, there was a telling remark:

“Doctor or nurse can more understand us, friendly and do not say: ‘Must [have] take[n] risk[s] for you are positive... blame yourself.’”(East Java)

While it is not conclusive given the difference in sampling and methods between the two data sets, it is nonetheless clear that there is significant under-reporting of stigma and discrimination in healthcare services. This deserves closer attention, especially since it potentially presents a significant barrier to treatment access.

Participants also discussed several individual level barriers that pose problems to accessing services: Not being able to go to government centres on week days as they cannot leave their work and not wanting to access services when asymptomatic were sentiments shared by many participants. Again, this is indicative of the level of secrecy to which they hold their status. Association with NGOs and community organisations seems to facilitate access to government services.

Some participants stated their preference in alternative medications and hence not very keen to start ART or use allopathic medicines. The fear of treatment side-effects is also an issue raised in discussions:

“[An opportunistic infection] attacked me and [the] doctor recommended... [that I] consume ARV, but now I am queasy and tired, irritat[ed] so that disturb[s] my daily activity.” (Bali)

Paying closer attention to and treating these side effects will undoubtedly help to improve treatment access.

Treatment Access in Indonesia

Dealing with stigma and discrimination in the healthcare sector is important. It is the primary avenue for treatment in Indonesia and where the majority of MSM get tested for HIV. Allaying the fears of individuals and providing accurate

INDONESIA

Treatment Access in Brief

Structural Barriers

- Lack of reliable information on treatment options
- Unethical disclosure of status and sexuality high
- Institutionalised stigma exists in service provision

Social Environment

- Secrecy and taboo surrounds HIV status and sexuality
- Disclosure of HIV status to partners low
- Disclosure of sexuality to family low
- Possible social isolation and lack of psychosocial support

information about HIV will certainly build trust in the healthcare system and encourage treatment access. In short, a welcoming healthcare system that is sensitive to the practical and psycho-social needs of MSM will go a long way in improving treatment access and addressing treatment myths surrounding HIV.

It is likely that the survey may not be capturing social information networks through which MSM in Indonesia are sharing information about HIV in general, and treatment access and options in particular. Regardless, however, it is clear that the level of secrecy to which MSM hold their status is high. The effects of social isolation and mental distress among MSM in Indonesia from having to deal with HIV on their own, and with limited information, will need to be carefully explored.

This report asks more questions than it answers. Good quality survey data and discussions are paramount if we are to satisfactorily resolve the discrepancies unearthed by the two data sets used in this report.

Malaysia



Background

83 HIV positive men who have sex with men (MSM; 22 of whom are transgender) were interviewed in Malaysia¹². Almost seven in ten participants (67.5%)¹³ were in a relationship with a partner at the time of the survey and eight of ten participants (80.4%; n=56) have disclosed their status to their partners. Almost one third (32.5%) of participants' families know of their HIV status while almost half (44.6%) of their families reportedly know of participants' sexuality. More than half of participants (57.9%) resided in a city.

Average age at the time of diagnosis was 30.5 years, with the majority of participants almost equally split between diagnosis in private (41.0%) and public (38.6%) healthcare settings. More than half of participants (65.1%) reported receiving some form of counselling at the point of diagnosis. There were no reports of counsellors becoming unfriendly with participants once their sexuality was known. Crucially, almost one in ten reported disclosure of their sexuality (9.6%) and almost one in five disclosure of their HIV status (18.5%; n=65) without their consent by healthcare staff.

Of the 62 participants (76.5%; n=81) who reported needing ART, 82.3% were receiving medication. Almost all participants (97.6%; n=82) had access to treatment for opportunistic infections. Less than one third (29.3%; n=82) admitted it is a challenge to access HIV services. Among the main reasons surveyed as barriers to access (n=24) had to do with treatment costs (41.7%), travel difficulties (37.5%), distance to healthcare provider and stigma from family/partner (both 33.3% respectively)¹⁴. One in three participants (33.3%; n=24) reported felt stigma as a barrier to accessing services. Although a small percentage, critically participants have reported service refusals (3.7%; n=82) and assaults by healthcare staff (2.4%; n=83).

Discussing Treatment Access

At the end of 2008, a peer-led focus group discussion with 8 participants was held in Kuala Lumpur. Walking through the process of seeking and obtaining treatment, the discussion highlights concerns with the practical aspects of treatment access: availability and costs of treatment and related medical tests, treatment information and organised social support.

In general there was agreement among participants that accessing treatment per se is not difficult. Social networking, however, plays a major role in facilitating access.

"I just got to know the right person from a friend who has a direct contact with PT [a local NGO]. The friend directly introduced me to Dr. K and... was directly referred to Dr. T and within one week I know where to refer for my status."

Even if the point of diagnosis is at a private healthcare setting, access to treatment in government hospitals was not seen to be a problem with this group of participants:

"Same go with me, the minute I was diagnosed at the private hospital. They say will refer me..."

Good referral is important given that, among MSM, diagnosis in private healthcare constitutes a higher proportion than in public healthcare (41% to 38.6% respectively) as has been demonstrated by survey findings.

Once successfully enrolled in treatment at a government healthcare facility, there appears a sentiment of compliance with treatment procedures:

"The doctor ask me to start medicine, I'll start medicine. The side effects, any complains I go see the doctor."

The level of trust reflected above signifies a good working doctor-patient relationship in the local MSM community. It also provides testimony to the level and ease of access the community has with their doctors. Nonetheless, this should not be taken as being merely compliant:

"For my case, I was already prepared [from fact-finding via internet]. That means I have all the information before starting, so no issues"

Being proactive with information seeking can and does play a role in fostering active involvement in treatment

"[E]very one of us should be equipped with basic treatment literacy... the reason why medicines have to be taken at this and that hour, we have to know."

However, it must be noted that all participants in the discussion have had some form of tertiary level education. To what extent this situation is reflected in the general MSM population needs to be ascertained.

The current treatment setup in Malaysia is such that all access to treatment is funneled through government healthcare settings, inevitably causing high caseloads. While there are no known incidences of stock outs, the rationing of medication can be problematic:

“They even only gave me two weeks, because stocks were very low.”

For some, this poses a logistical difficulty, typically for those who need to take time off work, and entails lengthy waits at the hospital. Travel time to seek treatment among respondents surveyed is 1.17 hours while waiting time at healthcare settings can go up to 2.23 hours on average¹⁵.

This process is further complicated by the requirements of some doctors to see their patients just to replenish their prescriptions:

“Most of the time the doctor is not doing anything, just taking your weight”

“[Just] because of taking medication we have to see the doctor”

Contextualising these complaints, we find that their causes lay beyond logistics alone. As documented in the survey, the majority has not disclosed their status beyond their partners. Of note, only 25.3% of MSM surveyed have reported disclosing their status to their family. To take time off work for a doctor’s appointment would entail a certain amount of cover-up:

“..normally when I have to go I’ll [lie to] my boss, that I want to send my mother to the clinic... so we have to lie and tell stories”

Although doctors do provide medical certificates as testimony of a genuine visit, this is not a viable long-term solution as

“..the MCs [medical certificates] are marked ID [Infectious Diseases] clinic.”

The resulting stress from the fear of stigma should the truth be known can be palpable and not be taken lightly.

MALAYSIA

Treatment Access in Brief

Structural Barriers

- Rationing of medication
- Expensive medical tests a burden for those not on free treatment
- High unethical disclosure of HIV status by healthcare providers

Social Environment

- Fear of social reprisal, should status become known, leads to subterfuge
- Fear of government reversing decision to provide free treatment

While it is true that the Malaysian government does provide free first line ART, this subsidy does not extend to associated treatment costs such as medical tests.

“Because every time its 400 ringgit plus... And if you’re doing your liver function tests, red/white blood cells and all that will add up... Last time I had to do it every two weeks or 1 month when I first started out because they had to monitor me.”

As such, due to the chronic nature of HIV, the necessity of continuous health monitoring can take its toll financially. Overhanging this is the ever-present fear that free treatment will one-day end:

“One day the FTA [Free Trade Agreement] will be imposed and we’ll have to pay... the pharmaceutical companies will have to impose their patent fees and we may no longer enjoy free medication one day.”

Given that treatment costs are seen as the main barrier to treatment access among the MSM surveyed, the impact from economic stressors needs to be evaluated.

Treatment Access in Malaysia

Treatment access—at least in the capital, Kuala Lumpur—is generally good. Further work will need to be done to assess if this is the case throughout Malaysia; a necessity given that 42.1% of MSM surveyed did not live in cities. More emphasis should also be given to psychosocial aspects associated with medical treatment.

Myanmar



Background

44 HIV positive men who have sex with men (MSM; 33 of whom are transgender) were interviewed in Myanmar¹⁶. Almost seven in ten participants (68.2%)¹⁷ were in a relationship with a partner at the time of the survey and almost one in three participants (34.1%; n=30) had disclosed their status to their partners. Almost half (45.5%) of participants' families know of their HIV status while more than half (56.8%) of their families reportedly know of participants' sexuality. Almost three in four (72.7%) resided in a city.

Average age at the time of diagnosis was 26.9 years, with the majority of participants (70.5%) diagnosed at healthcare centres operated by non-governmental organisations. More than nine in ten participants (90.9%) reported receiving some form of counselling at the point of diagnosis. However, a small proportion of participants (6.5%; n=31) stated that counsellors became unfriendly with them once their sexuality was known. Crucially, a small proportion also reported disclosure of their sexuality (4.5%) and almost one in ten reported disclosure of their HIV status (8.1%; n=37) without their consent by healthcare staff.

Of the 19 participants (43.2%; n=44) who reported needing ART, 63.2% were receiving medication. Almost all participants (92.7%; n=41) had access to treatment for opportunistic infections (OI). More than half of the participants (61.4%) admitted it is a challenge to access HIV services. Among the main reasons surveyed as barriers to access (n=27) had to do with travel difficulties (70.4%), treatment costs (66.7%), travel costs and stigma from family/partner (both 63.0% respectively)¹⁸. More than one in ten participants (14.8%; n=27) reported felt stigma as a barrier to accessing services. Critically, almost one in ten participants have reported assaults by healthcare staff (9.1%). There were no reports of healthcare service refusals

Discussing Treatment Access

Three focus group discussions were held in Myanmar at the end of 2008. 40 participants—15 in Mandalay, 15 in Monywa, and 10 in Lashio—took part in peer-led discussions. Results highlight that the uncertainties of MSM who are HIV positive in

Myanmar are about treatment access; in particular, in negotiating access within the government system, treatment costs should they have to obtain treatment privately, as well as stigma.

While it has been reported in the survey that more than half who require ART—and nearly all who require OI medication—have access to treatment, MSM from Myanmar continue to fear that this may not be the case should the need arise.

"I went to NAP asking for OI pills, paracetamol and metronidazol. God! I had to wait 1 hour to see a doctor... and I got paracetamol only. The doctor wrote a prescription for... OI drugs and said 'go buy it yourself'. I was very nervous [that] I [will] not get ARV when it is needed... [if] they cannot provide such cheap pills."

Their uncertainty may be justified: According to one participant,

"We cannot get ARV when we needed it unless we have TB, for there are two programme[s]... Intensive Health Care (IHC) [with] more quota for ARV [and] NAP, the only programme [that] provides for those who are non-TB. [It is] usually full quota with no more clients [being] accepted for a long time already."

Out of desperation, those who need ART have been known to go to great lengths:

"So people are seeking to be infected with TB... for example, breathing in [coughing] of TB patient[s]. It really should not be."

Stories like this do not give positive MSM much hope and can be a source of anxiety.

Furthermore, for positive MSM who have not disclosed their status to their families, their anxiety in accessing treatment is even more acute:

"Only those whose CD4 is below 200 can get ARV... [but by then they] surely look [...] pale and weak, maybe having other co-infection. My family and surrounding community will surely notice my status and it is impossible for me to wait [for] that time."

This catch-22 situation is apparently leading many to obtain ART privately.

“So people visited... private clinics for ARV. From that time on, his CD4 [will be rising] and [there will be] no more chance for ARV at public health at all. The problem is that he cannot [afford] to buy ARV for his whole life.”

However, treatment costs can become prohibitive, leaving them worse off than where they were initially.

These economic and socially driven challenges faced by MSM are further compounded by the need to assess their health in order to have access to treatment.

“When I need to test for CD4, my NAP doctor said: ‘We don’t have that facility, all we can do is refer you to [the city]... and at your own cost, [they] charge 35,000 kyats [approximately 30 US dollars] normally.’ Oh dear, I can’t afford it.”

In the survey, travel difficulties and treatment costs rank as the highest barriers to accessing treatment. Even if they could afford traveling to, and paying for private healthcare, the community still has to put up with cases of stigma as the following account makes clear:

“I was hospitalised at a private clinic and the nurses were gossiping about me: ‘Hey there is a gay man in Room number xxx, HIV positive patient, dressed like [a] woman, go see and tell me whether... he look[s] like [a] female or not.”

In the survey, more than half (58.3%; n=12) of transgender participants admitted discomfort when accessing healthcare services. Thus while:

“quality of health care at private clinics are good, they are bad at... confidential[ity] and [with] counseling.”

Critically, almost one in ten surveyed reported disclosure of their HIV status (8.1%; n=37) without their consent by healthcare staff.

Stigma perpetrated by healthcare staff can both be demeaning—

“one doctor from public health [even] told me that ‘as long as you are a homo-sex you are at risk of HIV... maybe God don’t want to see you MSM on earth any more”

MYANMAR

Treatment Access in Brief

Structural Barriers

- Government clinics offer limited places for treatment
- Private treatment is available but with prohibitive long term costs
- Reliance on NGOs for treatment access and service provision
- Institutionalised stigma in public/private healthcare

Social Environment

- Fear of inability to access treatment when needed
- Fear of stigma hampers disclosure of HIV status and sexual activity to families

— and demoralising; leading some to take out their angst on their own communities:

“I purposely do not use condom and let my sex partners get my HIV for they are cheating me [and will] finally leave me forever... they deserve [to] die”

Without a doubt, the consequences of such retaliation will be detrimental to an already fragile community.

With discrimination on both sides of the public-private divide, positive MSM are left with the option of accessing treatment through international non-governmental organisation (NGO). However, this option is not without its problems:

“I was suggested not to come again to NAP when the staff at NAP found out that I was getting the support from other INGOs for nutrition and medicine assistance, he said: ‘Then why you need to come to us while you have other supports, what a waste!’ very rudely.”

The net result could be a sense of alienation for positive MSM.

Treatment Access in Myanmar

The situation on the ground for positive MSM in Myanmar is one of desperation and of fear. From the results of available data presented here, their concerns are founded and real. In view of the political situation in Myanmar, this report expresses concerns for the welfare of the MSM

community in general, and those of positive MSM in particular. While there are many treatment access priorities that remain to be fulfilled in the community, one aspect of healthcare that should not be neglected is the mental health of positive MSM. In living under such stressful

conditions, the toll on mental health from coping with being seemingly surrounded on all sides cannot be emphasised enough. Where possible, proper mental health assessment, counselling, and psychosocial support, should be built into programmes directed at this community.

Nepal



Background

168 HIV positive men who have sex with men (MSM; 71 of whom are transgender) were interviewed in Nepal¹⁹. Almost all participants (98.2%; n=167) were in a relationship with a partner at the time of the survey and more than half (63.0%; n=162) had disclosed their status to their partners. More than half (58.4%; n=166) of participants' families know of their HIV status while almost half (42.7%; n=164) of their families reportedly know of participants' sexuality. Less than one in five participants (19.6%; n=163) resided in a city.

Average age at the time of diagnosis was 26.3 years (n=56). Almost half of the participants (44.8%; n=165) were diagnosed at healthcare centres operated by non-governmental organisations, followed by public (28.5%) and private (22.4%) healthcare settings respectively. More than half of participants (61.1%; n=167) reported receiving some form of counselling at the point of diagnosis. However, a small proportion of participants (3.3%; n=61) stated that counsellors became unfriendly with them once their sexuality was known. Crucially, almost three in ten reported disclosure of their sexuality (28.9%; n=166) and more than one in three reported disclosure of their HIV status (35.5%; n=121) without their consent by healthcare staff.

Of the 92 participants (56.1%; n=164) who reported needing ART, 62.0% were receiving medication. Less than one in three (31.7%; n=161) had access to treatment for opportunistic infections. Almost eight in ten participants (78.0%; n=168) admitted it is a challenge to access HIV services. Among the main reasons surveyed as barriers to access (n=131) had to do with travel difficulties (67.9%), travel costs (63.4%) and treatment costs (56.5%)²⁰. A significantly small proportion of participants (0.8%; n=131) reported felt stigma as a barrier to accessing services. Nonetheless, a critically

high proportion of participants have reported service refusals (30.8%; n=159) and assaults by healthcare staff (37.7%; n=154).

Discussing Treatment Access

Data was collected from five focus groups held in Nepal at the end of 2008. 77 participants took part in peer-led discussions: 25 at NarayanGhat, 13 at Nepalgunj, 14 at Birgunj, 13 at Bhairahawa, and 12 in the capital, Kathmandu. Results from discussions highlight that stigma and discrimination towards MSM is especially rife in government healthcare facilities. This and other economic concerns contribute to making treatment access for Nepalese MSM who are HIV positive problematic.

Nepalese culture is conservative and:

“society has a negative perception of male to male sex.”

Unsurprisingly, this conservatism pervades governmental healthcare and makes honest discussion with doctors regarding medical problems difficult:

“...MSM cannot get the services from a doctor in an open manner... they are hiding their problems.”

While the lack of disclosure does itself pose significant challenges in accessing proper treatment and advice, institutionalised discrimination within the healthcare sector is a critical concern among the MSM community.

“They don't even like to touch the patients. They put on the wall indicating beware... 'here is the HIV positive'.”

The hostility displayed towards MSM is not just passive aggression. Crucially, among the MSM surveyed, almost one in five (19.6%; n=148)

had suffered the injustice of both physical abuse and service refusals. Statistical tests found a significant association between both these transgressions ($\chi^2=16.676$; $p=0.000$). Furthermore, after controlling for gender, findings indicated that both physical abuse and service refusals were significantly associated with being transgender ($\chi^2=5.678$; $p=0.017$) - demonstrating that structural violence²¹ perpetrated against MSM is systemic and gender-based.

Besides the fear and self-stigma that such discrimination and abuse can afflict, taken together they reflect a justifiably low level of trust in governmental healthcare facilities in catering to the needs of MSM:

“They don’t have MSM specific service... and MSM think of those services in a negative way as they are not MSM PLWHA specific. VCTC centre is available. STI clinic is available. Awareness program is available. But MSM feel uncomfortable accessing those services.”

Even where facilities are available, positive MSM remain wary in accessing them. In this environment of suspicion, stories of sub-optimal treatment inevitably circulate.

“A positive TG... and a negative person... were admitted for... surgery of stone... our [positive TG] friend was discharged with the same problems... [but for the negative patient surgery was successful.”

Thus while felt stigma was not seen to be a barrier to accessing treatment in the survey (0.8%; $n=138$), it does in fact exist. The net result is deeper entrenchment of community distrust of government healthcare systems.

For most, however difficult the situation may be, it is not possible to do without government healthcare entirely.

“Drugs are available only in government hospital at [the capital] but [it is difficult to reach there. Transportation costs are very high... “

Amongst the positive MSM surveyed, travel difficulties and costs were cited as main barriers to access treatment. Centralised healthcare is based at the national capital of Kathmandu, where most health status tests are carried out. This further complicates the process of accessing care.

“We get ARV after [our] CD4 count level is

NEPAL

Treatment Access in Brief

Structural Barriers

- Treatment only available in the capital Kathmandu
- Frequency of medical tests and travel costs make treatment prohibitive
- High institutionalised stigma, physical abuse and unethical status disclosure by service providers

Social Environment

- Social aggression towards alternative sexualities systemic and gender-based

below 200. It is difficult to have CD4 count as it takes more than a month to wait and we have to go to the capital.”

In view that less than one in ten of positive MSM surveyed resided in the national capital (9.2%; $n=163$), this is a generalised predicament faced by MSM. Average travel and waiting times to seek treatment is 8.76 hours and 1.92 hours respectively²².

Once they do successfully begin ART, positive MSM have to deal with a different set of complications, for which they receive little assistance:

“Information about side effects is given [but] no clear information on ARV... no ARV counseling, no check ups for adherence. There is not any advanced technology to deal with the side effects of ARVs.”

Furthermore, there are also hidden costs to treatment. The facilitator of the peer-led discussion explains:

“They do not have to pay for ARV but they have to pay for vitamins and other drugs [for] opportunistic infections... hospitals do not provide [for free] the medicine for OI and STI which comes free to them.”

In view that Nepal has a high tuberculosis (TB) burden²³—and where less than one in three MSM surveyed (31.7%; $n=161$) reported having access to opportunistic infection treatment—this is a reprehensible situation and a significant worry.

Treatment Access in Nepal

Positive MSM in Nepal face an uphill struggle for

equitable treatment access from severe structural barriers, systemic failure and institutionalised discrimination. While, to be fair, much work has been accomplished in the preceding few years to highlight the plight of positive MSM, it is clear

that more work needs to be done if the community is to have a fighting chance of survival. In an environment that is so much against them, it is necessary to lobby for socio-cultural change that goes beyond economic contributions.

Singapore



Background

50 HIV positive men who have sex with men (MSM; none of whom are transgender) were interviewed in Singapore²⁴. Almost half of the participants (44.0%)²⁵ were in a relationship with a partner at the time of the survey and 86.4% (n=22) had disclosed their status to their partners. Almost one third (32.0%) of participants' families know of their HIV status while more than one in three (38.0%) of their families reportedly know of participants' sexuality. Singapore is a city-state.

Average age at the time of diagnosis was 31.2 years (n=48), with almost half of participants diagnosed in public (49.0%; n=49) healthcare settings followed by private healthcare (20.4%) and at non-governmental organisations (12.2%) respectively. Almost nine in every ten participants (89.8%; n=49) reported receiving some form of counselling at the point of diagnosis. There were no reports of counsellors becoming unfriendly with participants once their sexuality was known. Crucially, a small proportion of participants did report disclosure of their sexuality (6.0%) and HIV status (7.9%; n=38) without their consent by healthcare staff.

Of the 28 participants (58.3%; n=48) who reported needing ART, 82.1% were receiving medication. Almost nine in ten (89.6%; n=82) had access to treatment for opportunistic infections. More than half (58.3%; n=48) admitted it is a challenge to access HIV services. Among the main reasons surveyed as barriers to access (n=28) had to do with treatment costs (75.0%), legal redress (39.3%) and difficulties with travel (28.6%)²⁶. Average travel time to seek treatment is 1.26 hours while waiting time at healthcare settings averaged at 1.66 hours²⁷. Felt stigma was not seen as a barrier to accessing services. Although a small percentage, some participants reported service refusals (4.0%). There were no reports of assault by healthcare staff.

Discussing Treatment Access

At the end of 2008, a peer-led focus group discussion was held in Singapore to discuss treatment access for positive MSM. Data obtained indicated that the MSM community in the city-state are most concerned with the economic aspects of seeking treatment and the lack of governmental help in treatment costs.

It is widely accepted that with ART, HIV infection has become a chronic manageable illness²⁸. The key, however, is not only having access to ARV therapy, but in being able to do so sustainably:

"The government does not provide any financial subsidy for anti-retroviral medication... Most have problems forking out cash to purchase their ARV... on a monthly basis."

For positive MSM who cannot afford to purchase ARV on their salaries, they have had: *"to tap into their personal retirement fund... to draw up to the maximum of S\$550 per month to buy one Protease Inhibitor [with] triple combination therapy costing much more than that."*

As with other chronic illnesses that necessitate continuous monitoring and care, participants are worried about:

"... the adverse effect [accessing care is having] on their long term savings plan to meet their retirement needs."

Treatment access in effect becomes, consensually, an economic problem.

Nestled among developing countries in Southeast Asia, first world Singaporeans:

"[need] to pay for medication that are pegged at first world prices [when most] are earning third world salaries... S\$2000 or less per month."

Alternatively, they can become medical tourists:

“...to either Malaysia or Thailand [to buy cheaper] generics.”

However, it is not an option for everyone:

“It is very inconvenient to travel overseas every month, to buy medication. Many may not be in the best of health and cannot travel long distances.”

Even if they are healthy enough to travel for treatment, there are

“many [who] do not earn much, so traveling overseas is not a viable option.”

Among the MSM surveyed, three in four (n=28) cited treatment costs as a barrier to accessing treatment. Almost three in ten (28.6%) attributed it to travel difficulties.

Effectively, the healthcare system marginalises those who are economically unable to afford treatment. This situation is further reflected in costs associated with treatment such as professional fees and routine health status monitoring crucial for people with HIV; leading some discussion participants to suggest that:

“doctors’ consultation fees and various blood tests such as CD4, Viral Load, Resistance Testing, can be made cheaper.”

Such an inequitable health system could have adverse effects on the health of more than half of the new cases of HIV detected in 2007 have been found to be in the late-stage of disease progression (53%)²⁹, which opens up the risks for opportunistic infection³⁰. Crucially, a 2004 observational cohort study of AIDS patients in Singapore concludes that despite the availability of ARVs, “the most frequent causes of AIDS-defining illnesses in Singapore are similar to those reported in the West, prior to the introduction of anti-retroviral therapy.”³¹ Commenting on the government’s recent drive to expand voluntary testing and counselling for early detection of HIV, focus group participants conceded that:

“[while] there is a need to encourage more anonymous HIV testing [but] many do not bother to seek early treatment because they know it is expensive and not subsidized...”

This is indeed a worrisome knock-on effect of healthcare inequality.

SINGAPORE

Treatment Access in Brief

Structural Barriers

- Lack of government subsidies makes
- Many resort to medical tourism for treatment - not an option for the infirm

Social Environment

- Fear of discrimination from employers should HIV status be disclosed
- Low disclosure of HIV status and sexuality to family erodes traditional forms of social support

Furthermore, systemic inequality extends beyond the healthcare sector:

“There are no anti-discrimination laws, especially in the workplace, to protect anyone with a medical condition such as HIV from being unfairly terminated... there can be no legal redress...”

Such system-wide failures to protect the rights of people with HIV can be an extra disincentive to test for HIV. Indeed, more than one in three surveyed indicated legal redress as a barrier to accessing treatment. In general, focus group participants agree that:

“more can be done to reduce the stigma surrounding HIV.”

As the barriers to access are structural in nature, the onus is on the government to:

“lead the way by showing their support to removing all these obstacles that hinder the work of reducing HIV infection rates [in Singapore].”

Treatment Access in Singapore

As a rich developed nation, Singapore’s healthcare system is structurally failing some of its citizens most in need of governmental support. Economically marginalised positive MSM face a tough choice between buying treatment that transmutes their illness into lifelong manageable conditions or saving for retirement. More work needs to be done to assess how this particular group of MSM is coping in such an environment; as well as to understand why their government is not yet held accountable for neglecting their welfare.

Transgender

Background

179 HIV positive transgender³² individuals—48 (12.3% of total MSM sampled) in India; 22 (26.5%) in Malaysia; 33 (75%) in Myanmar; and 71 (42.3%) in Nepal—were interviewed in the sample³³. Surveys in Indonesia managed to sample five individuals while none were sampled in Singapore; and as such these two countries have been removed from the analysis reported in this section. With the proviso that findings not be generalised to the transgender population in each country and/or the region due to sampling constraints, results obtained from the survey are noteworthy and give an interesting perspective on gender bias in the context of accessing treatment.

This section relies mainly on survey data. Focus group discussion reports were generally not gender-segregated and as such gender analysis cannot be performed. The main focus of the analysis remains the interplay between structural barriers and the socio-cultural environment that impact on treatment access in each of the Asia Pacific countries featured here. Variations between the experience of treatment access for transgender and MSM in general will be noted. Results are given and summarised by country.

India

Of the 48 transgender individuals interviewed (n=424), almost one in two (47.7%) said that they were uncomfortable when accessing healthcare services; where unethical disclosure of sexuality is significantly associated with being transgender ($\chi^2=24.357$; $p=0.000$). Service refusal and assault by healthcare providers, while they exist as barriers, were however not found to be significant to gender. Accessing core treatment services in obtaining ART when needed do not appear to be gender-biased.

Malaysia

Of the 22 transgender individuals interviewed (n=83), nearly four in five (78.9%; n=19) respondents said that they were comfortable when accessing

healthcare services. There were reports of isolated cases of service refusal and assault by healthcare providers but these were not found to be gender-biased. Nonetheless from the relatively small sample the measure of association, using Fisher's Exact Test, observes that successfully obtaining ART when needed tends to be gender biased ($p=0.006$).

Myanmar

Of the 33 transgender individuals interviewed (n=44), six in ten (60.6%) said that they were comfortable when accessing healthcare services. According to survey findings, unethical disclosure of sexuality and HIV status, and abuse by healthcare providers—while they exist as barriers—have not been found to be associated with gender bias. From the relatively small sample the measure of association, using Fisher's Exact Test, observes that successfully obtaining ART when needed tends to be significantly gender-biased ($p=0.000$) in favour of transgender.

Nepal

Of the 71 transgender individuals interviewed (n=168), almost one in two (47%) said that they were uncomfortable accessing healthcare services; where being transgender is significantly associated with the unethical disclosure of sexuality by healthcare providers ($\chi^2=15.080$; $p=0.000$), assaults by healthcare staff ($\chi^2=12.854$; $p=0.000$), and being refused healthcare services ($\chi^2=26.279$; $p=0.000$). However, accessing core treatment services to obtain ART when needed, while remaining problematic for those surveyed, do not appear to be gender-biased.

Treatment Access for the Transgender

Survey results point to the possibility of gender-based discrimination in treatment access. Countries with strong cultural norms such as India and Nepal observed a higher tendency for reporting discomfort with healthcare services. More targeted sampling methods and rigorous statistical tests would be necessary to explore the concept of gender bias further.

Nonetheless, it is highly probable that transgender individuals suffer from greater challenges when accessing treatment in comparison with MSM in

general. These challenges depend on localised socio-cultural contexts and treatment infrastructures on the ground.

TRANSGENDER: Treatment Access in Brief

India
and
Nepal

Almost 1 in 2 reported discomfort when accessing healthcare services and where unethical disclosure of sexuality is gender biased

Nepal

Assaults by healthcare staff and service refusals associated with gender-based discrimination

Individuals trying to obtain ART when needed are highly likely to face gender discrimination

Malaysia

Myanmar

Positive gender bias in ART treatment access for transgender

Conclusion and Way Forward

This research project shows how structural barriers and socio-cultural environments in localised contexts impact on treatment access for positive MSM.

While research methodology precludes generalisation of findings to the positive MSM population, it is clear that more research needs to take place to better understand how social forces—such as gender bias, ethics in healthcare, social roles, and healthcare infrastructure—play a big part in impeding treatment access, and translate into practical barriers to seeking treatment. As such, this research project points toward a strong need to re-evaluate the social factors impacting on treatment access in order to better prepare for its affects.

Besides the interplay between social structures and the social environment in determining treatment access, the research has also demonstrated the importance of taking into account local cultures when assessing treatment access. Thus while broadly speaking, the Asia-Pacific can be taken as

a whole and with similar treatment concerns, each locality will exert different influences on individual life chances in context.

In light of the World Health Organisation's (WHO) pursuit towards universal access to anti-retroviral therapy (ART)³⁴, these findings emphasise the necessity to account for localised social structures and cultural norms; which, while they may be beyond singular individual control, are nevertheless intimately tied to their rights to health.

Lastly, the GIPA³⁵ principle underlying the peer-led research design is based on a broader ethical philosophy of research through peer empowerment³⁶. Being peer-led, the project is also able to tap into local knowledge and gain insight into local dynamics. The project hopes this data will lead to pragmatic solutions at the community level. To close, it is hoped that this report highlights the importance of a holistic approach to healthcare provision in general, and treatment access for positive MSM in particular.

Notes (Endnotes)

Introduction

- 1 APN+ (2004) AIDS Discrimination in Asia. Available at <http://www.gnpplus.net/regions/asiapac.html> [Accessed 3 March 2009] for detailed description of the methodology.
- 2 While both survey and focus groups sample from the MSM population of each country, they are not necessarily recruited from the same cohort of respondents. To maintain methodological integrity, a clear demarcation of data application is necessary.

Country Analysis: India

- 3 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 4 Average travel time to seek treatment is 1.61 hours (after linear interpolation to fill in missing values).
- 5 India produces its own generic ARV medications, allowing the Indian government to offer cheaper or free ART.
- 6 Structural violence, a term coined by Johan Galtung and by liberation theologians during the 1960s, describes social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential (Farmer, Nizeye, Stulac and Keshavjee 2006 DOI: 10.1371/journal.pmed.0030449)

Country Analysis: Indonesia

- 7 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 8 Unless stated, percentages are derived from total sample size of 128 participants.
- 9 Theoretically, ARV therapies are free for all Indonesian citizens who need them. International organisations such as the Global Fund finance most of the programs in the country. However, ARV treatments are not freely available in pharmacies. Instead, they have to be collected in special hospitals.

- 10 After linear interpolation to fill in missing values.
- 11 The purpose of this comparison is not to conflate the quantitative and qualitative data since they are from two distinct samples, but to present the juxtaposition between the two.

Country Analysis: Malaysia

- 12 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 13 Unless stated, percentages are derived from total sample size of 83 participants.
- 14 Malaysia has implemented compulsory licensing to purchase generic ARV and is able to offer free first line ART to its citizens.
- 15 After linear interpolation to fill in missing values.

Country Analysis: Myanmar

- 16 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 17 Unless stated, percentages are derived from total sample size of 44 participants.
- 18 The government of Myanmar does offer limited ART but the bulk of the country's treatment is provided by the international NGO, Doctors Without Borders (Medecins Sans Frontieres).

Country Analysis: Nepal

- 19 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 20 Nepal's political instability has resulted in nominal government support for national HIV and AIDS programs. Therefore, most HIV/AIDS activities are funded by external development partners. ART drugs are provided through a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- 21 Structural violence, a term coined by Johan Galtung and by liberation theologians during the 1960s, describes social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential (Farmer, Nizeye, Stulac and Keshavjee 2006 DOI: 10.1371/journal.pmed.0030449).
- 22 After linear interpolation to fill in missing values.
- 23 Nepal estimates an incidence of 173 cases of all forms of tuberculosis per 100 000 population, while the incidence of new smear-positive is estimated at 77/100 000 (WHO-SEARO, 2009); Available at: http://www.searo.who.int/EN/Section10/Section2097/Section2100_14801.htm [Accessed 7/12/09]
- Country Analysis: Singapore**
- 24 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.
- 25 Unless stated, percentages are derived from total sample size of 50 participants.
- 26 Singapore does not offer government subsidies for ART.
- 27 After linear interpolation to fill in missing values.
- 28 Scandlyn J (2000) “When AIDS became a chronic disease” in *West J Med.* 2000 February; 172(2): 130–133. Available on PubMed: PMID: PMC1070775 [Accessed 8/12/09]
- 29 MOH (2008) “Expansion of Anonymous HIV Testing Programme in Singapore”. Available at <http://www.moh.gov.sg/mohcorp/pressreleases.aspx?id=20158> [Accessed 8/12/09]
- 30 SFAP (2008) “The Stages of HIV Disease”. Available at http://www.sfaf.org/aids101/hiv_disease.html [Accessed 8/12/09]
- 31 Bellamy R, Sangeetha S and Paton NI (2004) “IDS-defining illnesses among patients with HIV in Singapore, 1985 to 2001: results from the Singapore HIV Observational Cohort Study (SHOCS)” in *BMC Infect Dis.* 2004; 4: 47. Available on PubMed: PMID: PMC 535553 [Accessed 8/12/09]

Transgender

- 32 Transgender' here is a loose term encompassing both transsexuals and transvestites. The lack of clear definition leaves participants to interpret the term and may lead to systematic bias due to unaccounted variance in cultural labeling. However, taken more generally, the term refers to gender roles at the fringes of normative roles; and as such allows us to explore gender based responses to treatment access in the four countries.
- 33 From a 2008 regional survey on treatment access in the Asia Pacific, conducted in India, Indonesia, Malaysia, Myanmar, Nepal, and Singapore. A total of 897 participants were surveyed.

Conclusion and Way Forward

- 34 Available at <http://www.who.int/hiv/topics/universalaccess/en/index.html> [Accessed 8 January 2010]
- 35 Acronym for Greater Involvement of People living with or affected by HIV/AIDS. For more information, please refer to UNAIDS document. Available at <http://www.unaids.org/en/PolicyAndPractice/GIPA/default.asp> [Accessed 8 January 2010].
- 36 APN+ (January 2004) Position Paper 2: GIPA. Available at http://www.ahrn.net/library_upload/uploadfile/file1777.pdf [Accessed 8 January 2010]

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