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Signs of a Hidden HIV Epidemic: Men Who Have Sex with Men in Eastern European Countries

Package of prevention, care and support services for men who have sex with men, and lesbian, gay, bisexual and transgender people

DRAFT FOR USAID COMMENTS

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I. Acronyms

AIDSTAR	AIDS Support and Technical Assistance Resources
ART	Antiretroviral therapy
BCC	Behavior change communications
CBO	Community-based organization
COCODES	Community Development Councils
CSO	Civil society organization
CSW	Commercial sex worker
E & E countries	Europe & Eurasia countries*
FBO	Faith-based organization
FP	Family planning
GBT	gay, bisexual and transgender people
GFATM	The Global Fund to fight AIDS, Malaria and Tuberculosis
IQC	Indefinite quantity contract
IR	Intermediate result
LGBT	Lesbian, gay, bisexual and transgender people
LDP	Leadership Development Program
MARP	Most-at-risk population
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MOU	Memorandum of understanding
MSM	Men who have sex with men
NGO	Nongovernmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWH	People living with HIV
PMP	Performance monitoring plan
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive health
SOW	Scope of work
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

In this report, E&E countries covered include countries within USAID's Bureau for Europe and Eurasia in Washington DC: Armenia, Albania, Azerbaijan, Belarus, Georgia, Moldova, Russian Federation and Ukraine

II. Executive Summary

The AIDSTAR Two project activity, *"Men having sex with men (MSM) in Eastern Europe: implications of a hidden epidemic,"* implemented by the International HIV/AIDS Alliance in Ukraine, aims to conduct an assessment of existing surveillance and other data on HIV prevalence and risks of HIV-infection in the MSM community, and the best practices among the response to the epidemic in eight select countries of Eastern Europe: Albania, Azerbaijan, Armenia, Georgia, Ukraine, Russia, Belarus, and Moldova. The goal: to support further country-level planning for the response, analyze existing effective practices and approaches in HIV prevention and care for MSM in the region, and identify best practices for regional scale-up and dissemination.

An appropriate combination of action and investment by all relevant stakeholders can make a dramatic difference in HIV prevention, treatment, care and support. The aim of the development of this package of services is to build regional consensus around the comprehensive package of prevention, care and support services for MSM based on regional best practices. Additionally, capacity assessments and subsequent capacity building plans need to be developed for MSM organizations in order that they can implement relevant components of the comprehensive package of services.

The Eastern Europe package of services for MSM is also modeled on experiences from other regions, recommendations from the Regional Assessment and additional collection of best practice examples from all countries of the region collected during October-December 2010. Key findings and recommendations from the UNDP led Eastern Europe and central Asia MSM consultation meeting held in Kiev in November 2010 are also part of the package of services.

The Package of Services for MSM in Eastern Europe consists of three main components:

1. HIV/STI Prevention Services for MSM
2. Treatment, care and support for MSM living with HIV
3. Enabling environment and community support for prevention and care

While this package of services has been developed primarily to assist USAID missions in determining MSM programming needs, the package also has wider implications for the region. The package supports the efforts of UNDP, WHO and UNFPA in raising the profile of MSM issues. WHO and UNDP regional offices have expressed interest in collaborating to further develop and implement the package and this interest should be pursued.

In order to effectively implement the package of services, consistent and quality programs need to be developed across the region. One way to achieve this is via the establishment of a regional center of best practice for MSM programming. This center would be able to provide appropriate technical support and develop standards of programming and implementation.

As Central Asia countries are historically and linguistically closely connected with post soviet Eastern Europe and have similar health and social care systems, a natural extension of the development of the package of services would be to include coverage of Central Asia in its application. This interest and need has already been expressed at the UNDP led regional MSM consultation. In order to include Central Asia in the package scope, complementary MSM assessments in select countries would be needed to validate the applicability of the package for that region. This may be something that USAID would like to consider.

III. General Project Description

Men who have sex with men (MSM) and transgender people are recognized as one of the key vulnerable groups in the concentrated epidemics in Eastern Europe and Asia.[1] According to UNAIDS, "various organizations, including UNAIDS, WHO and the International HIV/AIDS Alliance in Ukraine estimated that in 2006 there were between 177,000 and 430,000 MSM in Ukraine, of whom between 3 and 15 percent lived with HIV, which is several hundred times the figure reflected in the official studies."[2] Available data on MSM in low-income countries show lifetime occurrence of men having sex with other men as 6% to 15% in Eastern Europe, compared with 3% to 5% in East Asian countries, 6% to 12% in South and Southeast Asia, and 6% to 20% in Latin America. Approximately half of these men had sex with another man in the previous year, and among these, 40% to 60% engaged in unprotected anal sex or commercial sex in all these regions except South Asia (where figures were higher).[3] Consensus among an expanding group of stakeholders is that significant risk and infection among MSM is likely in E&E countries. The WHO's technical consultation concluded that in Eastern and Central Europe "among MSM, preventive behavior is minimal, knowledge is poor and HIV prevalence is high and rising."[4] This is reinforced by local examples of evidence that, while raising the issue of the need for further investigation, are worrying:

In Russia, Population Services International's 2006 survey of nearly 3700 MSM indicated that only 31% of those in a monogamous relationship always used condoms, with just 61% of MSM with non-monogamous sexual partners always using condoms. Less than half considered taking care of their sexual health to be a priority.[5] Armenia's main NGO for MSM has assessed behavior and attitudes; one survey found two-thirds of MSM had unprotected anal intercourse during their last sexual encounter. Another survey found only about half of younger Armenian MSM, those 18–30 years old, identified unprotected sex as a transmission route for HIV, although 82% identified injecting drug use as a transmission risk.[6]

The AIDSTAR Two project activity, *"Men having sex with men (MSM) in Eastern Europe: implications of a hidden epidemic,"* implemented by the International HIV/AIDS Alliance in Ukraine, aims to conduct an assessment of existing surveillance and other data, studies on HIV prevalence and risks of HIV-infection in the MSM community, political documents, and best practices of the epidemic response among this group in eight selected countries of Eastern Europe. The assessment was designed to have the practical applications provide detailed information on HIV epidemics and responses among MSM in selected countries (Albania, Azerbaijan, Armenia, Georgia, Ukraine, Russia, Belarus, and Moldova) to support

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[1] UNAIDS Action Framework "Universal Access for the Men who have Sex with Men and Transgender People"/ UNAIDS/09.22E/JC1720E

[2] 'Hidden HIV epidemic amongst MSM in Eastern Europe and Central Asia', UNAIDS (January 2009), (http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090126_MSMUkraine.asp accessed 17 July 2009).

[3] C Careres, et al. 'Estimating the number of men who have sex with men in low and middle income countries.' Sexually Transmitted Infections 2006; 82 (Supplement 3): iii3-iii9.

[4] World Health Organization (2008), op.cit.

[5] Russian Federation (2006): HIV/AIDS TRaC Study among Men who have Sex with Men. Population Services International (2006).

[6] 'MSM's attitude towards HIV infected people in Armenia'. We For Civil Equality (Armenia). (http://wfce.am/index.html, accessed July 17 2009).

further country-level planning for the response, analyze existing effective practices and approaches in HIV prevention and care for MSM in the region, and identify best practices for regional scale-up and dissemination.

According to the assessment findings, an appropriate combination of action and investment by all relevant stakeholders can make a dramatic difference in HIV prevention, treatment, care and support. Indeed, many of the earliest and most dramatic HIV prevention successes around the world involved men who have sex with men.[7] Most of the activities for MSM are conducted by local community based organizations (CBOs) and NGOs without the support of any state or local authorities. Last year, with support from the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM or Global Fund), programs on prevention among MSM appeared in the plans of most of the selected countries and were mentioned in their National AIDS programs.

The aim of the development of this package of services is to build regional consensus around the comprehensive package of prevention, care and support services for MSM based on regional best practices. Additionally, capacity assessments and subsequent capacity building plans need to be developed for MSM organizations in order that they can implement relevant components of the comprehensive package of services.

In October and November 2010, a team of nine regional experts worked on the structure of the package to present it for review and recommendation during the Review Committee meeting in November 2010.

The package of services consultation will cover these 12 Eastern Europe and Central Asia countries: Albania, Azerbaijan, Armenia, Georgia, Russia, Belarus, Moldova, Tajikistan, Uzbekistan, Kazakhstan, Kyrgyzstan and Turkmenistan.

Schedule of consultations on the package:

1 – Vienna HIV conference – MSM GF (July 18-23, 2010)
2 – ILGA Europe Annual conference (The Hague, October 28-31, 2010)
3 – Regional MSM consultation (Kiev, November 21-24, 2010)
4 – Review committee meeting (Kiev, November 25-27, 2010)

During the Review Committee meeting, key regional services by components were analyzed and discussed by the Review team. For every component of service package, a list of basic services was defined. For each of the services there was discussion on the possibilities to implement in different sub-regions of Eastern Europe (Russia, Caucasus countries) or in Central Asia.

A potentially significant outcome of the meeting is that representatives of the WHO, UNFPA and GFATM regional offices were actively engaged in the process. They recommended further advocacy and implementation of the final document and close coordination with UN regional and county offices. Additionally, the decision to place the UN logo on the cover of the document increases the likelihood that this document will be used for country level programming, planning and budgeting.

[7] Merson H M et al, "The history and challenge of HIV prevention," The Lancet, HIV Prevention, August 2008, pp. 7–20.

Participants were also given copies of a manual developed by the Alliance Ukraine office that contains additional resources for program managers, leaders and activists working with the LBG community. (http://www.aidsalliance.org.ua/cgi-bin/index.cgi?url=/en/library/our/lgbt/index.htm)

The following provides a summary of participants' evaluation of the consultative meetings:

- The meetings were critical for regional piloting and implementation of WHO and UN guidance and recommendations;
- Country level consultation on the package of services together with regional consultation on the package of services are both extremely important;
- For most of the countries it is important to have regional recommendations for service development. These recommendations become stronger with support from USAID and UN country missions;
- Using the methodology and mechanisms of civil society initiatives is important for advocacy and its sustainability;
- The process of service package development as a partial method for standardization of the services for MSM is important for our countries;
- As part of the next steps, participants need details of the services for budgeting and legal implications for each of the countries;
- The package gives participants the opportunity to see which services should be developed for each city and country;
- It is important now to build an advocacy plan for the implementation of the package of services.

IV. Service Package Components

In order for the package of services to be effectively implemented there are two overarching issues that need to be considered and addressed: (1) creating a supportive policy environment for services, and (2) research and monitoring.

Creating a supportive policy environment for services: The assessment found that although homosexuality has been decriminalized across the region, significant levels of stigma and discrimination still exist. MSM were still subject to arrest and harassment by authorities. This was either in direct contradiction to the laws, a misinterpretation of laws and statutes, or an inconsistent approach taken by different government departments in relation to MSM activities. Similarly health and HIV services provided across the region are not 'MSM friendly' and often MSM were refused services.

It is therefore important that the package of services is implemented with the knowledge that these issues need to be addressed up front to facilitate effective implementation.

Research and monitoring: According to the regional consultation resolution and the assessment findings, there is need to strengthen and promote the evidence base of proven, effective approaches, strategies and practices to reach men who have sex with men, transgender people and HIV. A comprehensive and consistent regional approach to MSM size estimation needs to be developed and implemented. Similarly, a comprehensive and consistent approach to MSM data collection through sentinel and other surveillance mechanisms needs to be developed and implemented. Priority areas for further research include size estimation; behavioral monitoring; epidemiological research; needs assessment research; and service evaluation.

There are three components to the service package, as follows:

Component 1: HIV/STI Prevention Services for MSM

HIV prevention is provided for both HIV positive and negative MSM on the premises of organizations and/or outreach on the streets and other areas where MSM are located.

Essential package will include:

- Access to voluntary counseling and testing (VCT) and rapid testing for HIV
- Access to STI testing and treatment
- Individual and group counseling on HIV and STI, safe behavior, sexual health (peer education)
- Information materials on specific risks, including dissemination through social networks, Internet and telephone counseling
- Distribution of condoms and lubricants
- Hepatitis B Testing and Vaccination (referral and promotion)
- Referral to harm reduction and sex worker services

Desirable services:

- Alcohol and drug dependency services (referral and friendly clinics)
- Services for male sex workers

Component 2: Treatment, care and support for MSM living with HIV

Access to medical services for MSM refers to:

- The availability of these services on the site/city or country,
- Possibility for MSM to get this services;
- Medical staff providing these services is trained on the MSM needs.

Essential package will include:

- Access to ARV treatment
- Access to prevention and treatment of opportunistic infections
- Access to TB prevention and treatment
- Access to prevention and treatment of STIs
- Psycho-social support for gay, bisexual, and transgender people living with HIV, including peer counseling, psychological support, HIV status disclosure to partner counseling, self-help groups, Internet and telephone counseling
- ARV treatment adherence programs
- Home based and palliative care (including peer support using a buddy system)
- Positive prevention and staying healthy for HIV positive MSM

Component 3: Enabling environment and community support for prevention and care

Essential package will include:

- Monitoring of human rights and legal support
- Psychosocial support of gay identity: self-help groups, peer-to-peer counseling, group support
- MSM/ LGBT community mobilization and involvement, organizational development of community groups such as CBOs, support of community events, and coordination among community centers

Application of Service Provision to Specific Target Groups

The package of services has been designed according to specific needs of target subgroups by age, identifications and social circumstances. These include:

- **Open MSM (including self identified gay men in the Western sense):** As a visible part of the population, open MSM feel more stigmatized and discriminated by society and are often discriminated against in social and medical services settings. At the same time, this group is the most easy to access for peer interventions. According to the needs assessments, the primary need for services for men in this group falls under Component 3 (Enabling environment and community support), especially psycho-social support and community mobilization. In addition, to create access to the medical and social services of Components 1 and 2 for this group, it is crucial to train health care and social service providers to reduce stigmatization.
- **Closed MSM:** This group consists of non gay identifying MSM and includes men who may be married to women. This most hard-to reach group needs access to HIV/STI prevention services not directly associated with having a gay identity. Access to this target group for services of Component 1 (HIV Prevention) could be made through STI clinics, cruising areas and male sex workers. There is no need for specific services of Component 2, as these services will be provided to them as a part of general PLHA population. This group is unlikely to use any of services of Component 3.

- **MSM-sex workers:** This group has a greater number of sexual partners/contacts, and therefore needs specific attention to services from Component 1 such as HIV/STI testing and treatment, and access to condoms and lubricants. Specific topics for counseling should include issues on prevention of and coping with violence, negotiation skills for condom use with clients, and self protection.
- **MSM in prisons:** This group is socially separated and the most denigrated group of the prison population; these men are often forced to have unprotected sex with multiple partners. Services under Component 1 and 3 should be provided by trained specialists who are familiar with prevention among the prison population as well as specific to MSM-targeted programs. Free access to condoms, lubricants and other hygiene items are the most needed services. Given the social isolation of this group, psychological support (Component 3) may be feasible and highly welcome in prison settings.
- **MSM youth:** No specific programs for this target grouped are developed in the region. In providing services to this group, an additional challenge that needs to be taken into consideration is the age of consent and legislative restrictions for counseling on homosexual self-identity.
- **Transgender:** This group is unique and different from other MSM subgroups. In the E&E region there are no services developed for this group and no specific research or data are available. There is a need for training and educating social service and medical specialists on the needs of the transgender population. Among other services of Component 1, this group may need access to specially trained endocrinologists for hormone therapy. This group will have strong need in services of Component 3, in particular, reducing stigma and providing psychological and social support.

V. Examples from the region of application of the package of services

Component 1: HIV/STI Prevention Services for MSM

Access to VCT and rapid testing on HIV

In the Ukraine, the procedures for NGOs providing voluntary HIV counseling and testing services with rapid/simple tests to MSM is based on WHO recommendations and guidance. Since 2007, thousands of MSM have received this service. Under the program implemented by International HIV/AIDS Alliance in Ukraine, supported by the Global Fund, testing by rapid tests is provided to most clients of MSM prevention programs at least twice a year.

HIV testing is provided in community centers, in mobile clinics, and in accordance with the set schedule of VCT services. Pre- and post-testing counseling may be delivered only by specially trained healthcare workers who are skilled in conducting examinations with simple/rapid tests, documentation, compliance with safety rules, counseling and other areas.

NGOs follow the procedures outlined below:

- Pre-testing counseling may be provided by a VCT consulting doctor, a nurse, a psychologist or a social worker who has completed the relevant training.
- Testing with the HIV rapid test may only be conducted by healthcare workers (nurses, medical/ laboratory assistants or doctors) experienced in rapid testing procedures who have completed the relevant training.
- The results should be interpreted and the primary post-testing counseling for clients shall be delivered by the consulting doctor involved.
- Post-testing counseling may be provided by a VCT consulting doctor.
- Information on the patient and on the results of HIV testing as well as information on pre- and post-testing counseling is entered into the relevant registers.
- Referrals are made to the proper healthcare facilities in order to confirm positive results.

STI diagnostics and treatment experiences of Ukrainian NGO

Counseling of clients and screening with rapid tests for specific antibodies to STIs will be provided by healthcare workers via both mobile and stationary points, and in community centers. Often, such diagnostics may take place at the same time as HIV testing, if blood is the testing material (tests for syphilis). If testing requires the use of urethral discharge (as in the tests for Chlamydia and gonorrhea), such diagnostics take place separately.

NGOs receive rapid tests for syphilis, Chlamydia and gonorrhea and ensure conditions to provide rapid testing (are responsible for availability of tests, premises, the target group and an STI doctor (gynecologist).

In cases of positive rapid test results or in cases where there are clinical implications from the disease, the client is referred to a clinic.

When an MSM individual is referred to a clinic, he is provided with counseling, laboratory examinations to establish his diagnosis, and prescribed treatment with the required medications.

Treatment is provided in state clinics, and in every clinic there should be a doctor appointed to work with most-at-risk groups including MSM. This doctor coordinates the treatment process and is responsible for documenting/reporting patients' treatments. Clinics are provided with medications (antibiotics, antimicrobial, antifungal, anti-herpetic medications and local antiseptics) and other materials (syringes, solutions, anesthetics) for treatment of the most widespread STIs.

Individual and group counseling on HIV and STI, safe behavior, sexual health

HIV/STI counseling for both groups and individuals is provided by majority of HIV-service organizations aimed at MSM in the E&E region. This section of the report, below, documents the experiences of a Belarusian NGO, Vstrecha:

Counseling by an outreach worker: Typically, this involves an individual conversation between an outreach worker and an MSM community member. It may be delivered in street cruising areas, an indoor site, a meeting of friends, or in a counseling or organizational office (in the case of a meeting between an outreach worker and a client). The aim of such structured conversation is to give counseling on the risks of HIV/AIDS and STIs transmission, and to promote safe sex behaviors. The conversation should be private and confidential, and the MSM client may preserve his anonymity. The counseling is carried out according to the following model:

1. The outreach worker introduces himself and the organization providing services.
2. He briefly explains the task of the project and provides free condoms, lubricants, and informational materials.
3. The outreach worker asks if the client has previously used the project's services.
4. The outreach worker speaks about the program and builds trust with the MSM client.
5. He asks the client about his unsafe sexual practices and other high risk behaviors (including number of casual partners).
6. He provides information on the asymptomatic progression of STIs and/or HIV, on the possibilities of the disease passing into its chronic stage, on the physical consequences of an uncured STI, and on the risks of infecting a regular sexual partner.
7. The outreach worker provides information on HIV and STI transmission prevention methods;
8. He informs the client of the possibility of anonymous, free services (if available), as well as paid examinations for STIs and other services.
9. Finally, he answers the client's questions.

Group counseling by an outreach worker in peer group: The outreach worker may use various opportunities to provide this type of counseling during informal gatherings of MSM (parties, home meetings). In Vstrecha's experience, the need for group counseling may be prompted by the showing of a prevention video. Group counseling provides information on project services, general information on HIV/AIDS and STI transmission, and information on safe sex and drug use behaviors. It is important to stress confidentiality (privacy issues might be discussed with participants or the counselor may avoid asking some identifying questions). In this model, the outreach worker:

1. Introduces himself and the organization he represents;
2. Distributes informational materials, condoms, and lubricants;
3. Provides information about the organization and the project's services;

4. Provides information on safe sexual practices, HIV and STIs;
5. Answers questions;
6. Offers individual counseling.

Mini trainings with specialists: Offered by Vstrecha since 2009, this method invites groups of 15 MSM to two trainings, held annually in every city where the project operates. The topics are "Basic Knowledge of HIV/AIDS transmission" and "STIs as a Factor Increasing the Risk of HIV Transmission." In 2011, a module for a third mini training will be developed, "HIV Transmission Risks for Users of Psychoactive Substances," and piloted through two experimental trainings. Mini-trainings are interactive and participatory, are offered in the form of a game, and are popular among the target groups. The Mini training module includes:

1. Presenting the HIV/STI epidemic situation among MSM;
2. Sharing the knowledge of the training participants on HIV/AIDS and STIs;
3. Group work on the routes of transmission and ways of protection for certain routes of transmission;
4. Discussions on the topic of condom use;
5. Feedback.

The mini trainings are led by a trainer from the MSM community and doctor specializing in STIs. Participants are not only motivated to attend to gain more knowledge about their own health, but also to learn knowledge that can be shared via peer counseling among their friends.

Group psychological trainings: Vstrecha has offered this service since 2006, inviting small groups of MSM – 5 to 15 members – to participate at one time. Trainings are held by psychologists on specific topics such as "Interpersonal Relations," "If Your Friend Has HIV," "Life after Breaking Up," and other subjects. These trainings are not directly aimed to facilitate testing, but rather create a favorable atmosphere for creating self-respect and an awareness of health among the group. They create a positive attitude among the target group towards the organization providing HIV-services.

Peer counseling: Peer counseling is provided by target group representatives having an influence on and enjoying the trust of a certain circle of friends. In 2010, Vstrecha started using the Popular Public Friend methodology based on the Popular Public Leader methodology. By filling questionnaires and making observations, MSM representatives enjoying trust in the circle of friends are identified in the widest circles of friends (circles of at least 50 persons). Those representatives attend trainings and deliver motivational counseling to their circles.

Doctor's counseling: This counseling is conducted by medical doctors who are involved in the projects (proctologists, STI specialists).

Mentoring Support Program in Ukraine

A structured system of individual consultations was implemented as an innovative pilot project called the "Mentoring Support Program" in Odessa, Ukraine in 2010. This HIV prevention program was based on the Metrosafe Programme that was developed The Metro Centre Ltd (UK). The program pairs trained volunteer mentors with men who have recently tested negative after placing themselves at risk of HIV infection. Each mentor/mentee pair meets bi-weekly to work through a series of 10 structured modules that explore the broad emotional and contextual issues that often fuel high-risk behavior.

Self-esteem, sexual identity, goal building and personal responsibility are among the topics covered. The 10 structured modules are as follows:

- Introduction
- Safe Sexual Behavior
- History Sharing
- Self-Esteem
- Drug and Alcohol Use
- Being Gay
- Partnerships
- Facing the Issue
- Social Role and Responsibility/Imagining the worst
- Goal Building

The success of the program is measured using the BASK Inventory, an outcome measurement tool developed specifically for the program (though now used in a variety of other contexts) to chart changes in a participant's behavior, attitude, skills, and knowledge with respect to the likelihood of his sero-converting. The first measurement is done for this program assessment and results will be available from the International HIV/AIDS Alliance in Ukraine in mid 2011.

Safe sex behavior promotion through Internet, Websites of Organizations and Social Networks

The number of Internet users has grown dramatically in Ukraine, to about 10 million users in 2010. Consequently, the level of use of web services by MSM has also grown, especially in terms of dating services. A survey conducted in 2008 by the "Gay Alliance" among MSM in the cities of Kyiv, Vinnytsia and Chernigiv, for example, found that 76% of the respondents use the Internet to find sexual partners, with 31% of them using it regularly for this purpose. In rural areas, 39% of those interviewed do not use Internet, while in Kiev, 30% of MSM do not use Internet.

In this context, it is clearly expedient to reach MSM through Internet. This mode of outreach in the E&E region remains underdeveloped and undocumented, even though many HIV prevention projects for MSM include Internet-based outreach in their sphere of activities.

A number of projects work through dating portals (Qguys.ru, bluesystem.ru, gayly.ru, mamba.ru), having posted profiles of their staff members and profiles of organizations. Other popular tools for working with MSM are the various social networking services, such as "V Kontakte," "Odnoklassniki" and Facebook, through which organizations that work with MSM create their own accounts, pages and groups. Many organizations maintain their own websites, where they post preventive information, offer online counseling, distribute information via mailing lists, etc. Some organizations also work directly with owners of dating sites, which enables them to distribute information in a targeted manner (e.g. among all registered MSM in a particular city or region), or to promote their own sites through the placement of banner advertisements, etc.

Development of services through social networks and the Internet could fulfill three main objectives:

- Anonymous data collection, through on-line surveys and needs assessment;
- Provision of Web-based distance counseling upon individual request;
- Dissemination of information about existing direct services, and invitations for counseling and testing provided by social and medical entities.

One good example of outreach counseling via the Internet comes from the Belarusian NGO Vstrecha, where outreach is carried out in Internet chats or dating sites. The purpose of such counseling is to inform target groups about the project's services and, if possible, make an individual appointment with the outreach worker. The model of the counseling includes:

1. Mailing general information on the services provided by the organization;
2. Answering questions asked by mailing recipients;
3. Rarely counseling may be carried out according to the algorithm described in model of individual counseling, which is more typical for chats.

Development and provision of Information, Education and Communication Materials (IEC)[8]
IEC materials are being developed and published at both national and local levels. In Ukraine, such materials may be published by donors or by local NGOs with relevant financial support.

The development of information materials for MSM occurs through the close cooperation of three parties: developers (organizational staff plus representatives from key groups), experts and the intended recipients of the materials. Key groups should be involved at all stages of the development including the identification of needs; writing of the text; selection of illustrations; and the working with focus groups. Experts should be involved in their particular area/topic of expertise; and other specialists, such as designers and writers, should be involved where needed.

The involvement of target group and community experts in the development of different stages of IEC materials can be seen through this chart:

Stages of developing IEC materials	**Target group's involvement**	**Experts' involvement**
Identification of the needs	Focus groups	
Writing of the text	May participate in writing process	Providing information
Selection of illustrations	Participate in focus groups	
Review	Participate in focus groups	By topic
lay-out and design		
Proofreading		
Finalization and approval		
Print		
delivery to NGOs; dissemination among MSM	Quantity request	

When creating IEC materials, the active involvement of the target audience in the development process is critical. For example, if an NGO is designing specific IEC materials, it is highly recommended that they organize focus groups in order to identify what information is currently of greatest demand for MSM, how to best present this information, how to illustrate IEC materials, and other particular concerns.

[8] This section provides description of best practices of HIV prevention projects for MSM in Ukraine implemented with the support of ICF "International HIV/AIDS Alliance in Ukraine" within the framework of programs "Overcoming HIV/AIDS Epidemic in Ukraine" and "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine (2007-2012), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and within the project "Scaling Up the National Response to HIV/AIDS through Information and Services" (SUNRISE), supported by the United States Agency for International Development (USAID).

Topics of information materials that may be of interest for MSM target groups include but are not limited to:

- Information about HIV/AIDS
- Information about sexually transmitted infections
- Viral hepatitis
- HIV testing with rapid tests
- Safe sex (including homosexual and heterosexual practices)
- Sexuality and sexual development
- Information about condoms and lubricants
- Coming-out and HIV prevention
- Partnership
- Me and children
- Me and police
- Gays rights in the context of human rights
- Prevention of negative phenomena (e.g. alcohol abuse, drugs, smoking)
- Hygiene
- Life with HIV

Other useful information about the development of information materials, including recommendations for publishers, and templates of various IEC materials can be found at http://www.aidsfiles.net.ua

Distribution of Condoms and Lubricants[9]

Condoms and lubricants are included in the basic package of prevention programs together with IEC materials and counseling. It is believed that only after receiving of all three components of the package of prevention, care and support services for MSM that it becomes possible to influence the behavior.

It is important to plan procurement of condom and lubricants in accordance to existing sexual practices and needs, in particular, condoms for anal sex. Planning for a number of different types of condoms should be done using data from existing behavioral surveys. The procurement process is impossible without the involvement of members from the MSM community, who should be invited to select the most appropriate products that will be offered by organizations during their project activities. To cover the needs of prevention projects that work with MSM, it is best to procure "Extra Strong" condoms (which have the highest density and can be used for anal sex) and water-based lubricants.

According to an assessment by the International HIV/AIDS Alliance in Ukraine, condom needs are calculated at the rate of 50 condoms per MSM per year (previously this rate was 150 condoms per MSM per year, but it was extremely difficult for local organizations to store such amounts of products and to disseminate them).

[9] This section provides description of best practices of HIV prevention projects for MSM in Ukraine implemented with the support of ICF "International HIV/AIDS Alliance in Ukraine" within the framework of programs "Overcoming HIV/AIDS Epidemic in Ukraine" and "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine (2007-2012), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, and within the project "Scaling Up the National Response to HIV/AIDS through Information and Services" (SUNRISE), supported by the United States Agency for International Development (USAID).

Condoms should not be provided without lubricants, which should be procured in small/single use packages to support the needs of the prevention projects. In the E&E region, it is important to ensure the market availability of lubricants in single use packages. There may be a need for specific advocacy efforts to promote the availability of and access to small packs of lubricants among retailers and pharmacies.

Condoms and lubricants are handed out to a client along with IEC materials and counseling on how to use them. Alliance Ukraine have developed quite a lot of various information materials on the use of condoms and lubricants, as well as relevant motivational materials.

Condoms and lubricants are disseminated through various outreach routes, in the community, in gay clubs (as are IEC materials). They are either given directly to clients, or are made available at bar counters, in "dark rooms," at free condom stands, and other appropriate areas. In addition, condom vending machines can be installed at places most frequented by MSM.

Storage conditions for condoms and lubricants, including shelf life and temperature requirements, are also very important. In order to ensure relevant conditions, organizations have to have appropriate storage facilities.

It is important to communicate correct information about usage of condoms and lubricants to consultants, outreach workers and social workers. Project staff should be trained in various forms of counseling to ensure more effective information sharing in the future.

During dissemination of condoms and lubricants among MSM, it is important to remember that the main goal of any project is not simply to distribute these materials, but actually to teach clients to use them correctly and regularly, and also to explain the importance of their use during each sexual contact. Moreover, it is important to teach a client to buy condoms and lubricants by himself.

Key obstacles for dissemination and use of condoms and lubricants among MSM may include the myths and unfounded perceptions listed below; these should be addressed both through IEC materials and through counseling at the moment of dissemination:

- Prevalence of various myths, such as:
    - Sex with condom is not pleasant.
    - Condom use may be painful.
    - Sex without condoms is better for partners' health
    - It is shameful and awkward to use condoms.
    - Lubricant is the same as crème or massage oil.
- Individual reactions of the human body (such as allergic reactions to latex or lubricant)
- Religious beliefs

Hepatitis B Virus Testing and Vaccination[10] (referral and promotion)

The WHO recommends that vaccination against the Hepatitis B Virus (HBV) be included in the immunization schedule. MSM is one of the groups for which this vaccination is recommended.

The process of HBV immunization in Ukraine can be conventionally divided into five stages – information, testing, vaccination, patient management and monitoring – as follows:

- **Information** about opportunity for immunization is disseminated by social workers (personally and through information materials) and doctors during counseling and testing;
- **Testing** with rapid tests is performed by specialists in community centers, STI clinics, AIDS centers, polyclinics with immunization wards;
- **Vaccination** is performed in immunization wards of polyclinics by health workers.
- Social and health workers are responsible for **patient management**;
- Project **monitoring** is ensured by NGO and Alliance; at the same time they conduct interviewing of clients, who received testing, refused from re-vaccination and completed the course of 3 doses of vaccine.

Project-related HBV activities begin well before actual project implementation: the first stage consists of the centralized procurement of HBV vaccines by the Alliance. After that, the vaccine is delivered to partner health facilities, which have concluded agreements with relevant NGOs.

The NGOs and health facilities designate a multidisciplinary project team, which consists of a project coordinator, a doctor, a nurse and/or social worker. The project coordinator ensures overall coordination of activities within the project. The doctor provides counseling; performs general examinations of the patients; and interprets results of screening throughout the entire project term. The doctor also identifies indications and contraindications to vaccines; prescribes immunization according to the schedule; and performs clinical monitoring of side effects in post-vaccination period. The nurse is responsible for administering the vaccine upon doctor's prescription/order. In addition, both the nurse and the social worker ensure patient follow-up, which includes counseling on the necessity of immunization and on possible side effects. They are also responsible for collecting contact information; registering the vaccination; monitoring the health of the MSM who receive the vaccination; and follow-up on the necessity and terms of re-vaccination, and so on.

These representatives from the multidisciplinary team participate in a two-day training, where they study issues such as Hepatitis B prevalence and how it is transmitted; screening diagnostics and vaccination against HBV; organization of project activities.

Mandatory precondition for vaccination within the project is negative results of HBsAg and/or anti-HBcor testing with rapid tests; this means that in addition to vaccine itself, relevant test-kits for HBsAg or anti-HBcor testing should be also available.

[10] This section provides description of best practices of HIV prevention projects for MSM in Ukraine implemented with the support of ICF "International HIV/AIDS Alliance in Ukraine" within the framework of programs "Overcoming HIV/AIDS Epidemic in Ukraine" and "Support for HIV and AIDS Prevention, Treatment and Care for Most Vulnerable Populations in Ukraine (2007-2012), funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Referrals to medical and social services

The main idea of referrals is to establish a single point of contact for advice on diverse client services (including those not available within the organization making the referrals). After learning the client's details, staff members of this organization would refer a client to MSM friendly specialists.

Referral systems may have different names such as "support network" or "referral network." But providing non-stigmatizing treatment of clients with special needs or problems is something that all of them have in common. For example, for MSM this problem revolves around their fear of openly speaking about their sexual orientation or gender identity with specialists, whose assistance depends on their awareness of such aspects of their clients' lives (true for health specialists, especially those working with HIV or STI; psychologists; lawyers, etc.).

The following paragraphs summarize the state of referral services in the E&E countries:

In Ukraine, referral services are included in the basic package of services of HIV prevention projects, implemented with the Global Fund's support (in particular, the grantees are required to have signed agreements with relevant health facilities and other NGOs). In addition, the development of the support network for MSM was envisaged by the project of "Our World" Center in nine regions with the support of German government.

In Belarus[11] there is Vstrecha, the one large HIV-service NGO, which may refer MSM to HIV and STI testing/assessment services or to specifically trained medical specialists from the public health services available in the country's eight largest cities. It also has a functional telephone hotline; and MSM clients may ask questions and receive answers at the organization's website. As for legal assistance, the Belarusian Portal for Lesbians, Gays, Bisexual and Transgender People provides such services for MSM through the website http://www.news.gay.by/faq/. Vstrecha's site and the LGBT portal both cross-reference each other.

In Estonia there are about 10 functional HIV-service organizations; this report documents information from three of them – Estonian Network of PLWH, Estonian Sexual Health Association,[12] and the NGO network Association of Partners (with member NGOs Pealinna Abikeskus, Convictus Eesti, Women against AIDS, ESPO and others). All refer their clients to specialists, both verbally (as in case of ESPO), and by issuing coupons. For example, clients of the NGO "Suda-eesti Sotsiaalkeskus" receive a coupon in the office or counseling center, and then go to the specialist; the issuing staff member registers this referral. At the end of every week, they process the referrals, while both the consultant who issued the coupon, and the specialist who received a client with this coupon, are compensated appropriately). The Estonian Network of PLWH also provides remote counseling services, and MSM may apply to join self-help group son the organization's website (http://ehpv.ee).

In Lithuania, several LGBT initiatives exist[13] but the writers of this report could not find any meaningful data on HIV services and referrals.

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11 http://vstrecha.by/index.php?option=com_content&view=article&id=216&Itemid=12, as well as a telephone conversation on December 9, 2010.

12 www.amor.ee

13 E.g. www.gayline.lt, www.lygybe.lt, www.atviri.lt

In Kyrgyzstan, the NGO Labrys (www.labrys.kg) works with the LGBT community. The organization's health project is aimed at establishing a network of LGBT-friendly specialists in several regions/locations of the country.

In Georgia, the LGBT organization called the Inclusive Foundation (http://inclusive-foundation.org) collaborates with the HIV-service organization Tanadgoma Association (http://www.tanadgoma.ge). Both organizations offer online counseling, but materials in English sections of their websites do not clarify how the referral procedure works or who the clients are referred to.

In Armenia, the issues of LGBT, including health-related problems, are addressed by the NGO PINK (Public Information and Need for Knowledge) (www.pinkarmenia.org). Referrals to specialists are based on personal arrangements; no coupons are issued.

In Azerbaijan, the virtual initiative "Gay of Azerbaijan" (http://intergay.ru/article/232) does not deal with referrals. Participants can only recommend the specialist whom they know.

There exist two principal types of mechanisms in the referral networks. The first one is decentralized, where a number of organizations are linked to each other through bilateral agreements or contracts on referrals. A client comes to a specialist upon verbal referral (sometimes together with a social worker), or receives a coupon, which he has to turn in upon arrival. The organization which issues these coupons regularly collects information about visiting clients from these specialists, and this allows organizations to assess the functioning of this mechanism.

The second, centralized, approach gathers contact information for MSM-friendly specialists, who work within existing HIV-service or LGBT organizations (such as health professionals, lawyers, and psychologists). This is the responsibility of the referral network coordinator, who further communicates this information (by using the project's business cards, through the telephone helpline, via Internet) to representatives of target groups through social workers (employed by the network itself, or by member-organizations). In this way, local organizations join their efforts and resources, while representatives of the target group gain access to the range of various services.

Dissemination of information through outreach work with personal contacts requires certain amount of printed business cards with relevant contact information and descriptions of services, offered by the local specialists.

In terms of monitoring progress, essential data points that are worth tracking include: the number of contacts with MSM (e.g. the number of distributed business cards); the number of visits to specialists; the number of specialists involved in the project; the range of conditions/problems with which clients come to specialists (topics of consultations according to registration log). Optional data sources include: clients' social and demographic data (questionnaires filled by the outreach worker), and social and demographic data of clients who visited specialists (special sections of registration logs).

Component 2: Treatment, Care and Support to MSM Living with HIV

In order to develop treatment, care and support services at the country level, it is important to conduct needs assessment research. A description of an example of such work conducted in the Russian Federation may be found in Annex 4.

ARV and treatment of opportunistic infections for MSM living with HIV should be provided in accordance with WHO guidelines and country approved HIV treatment protocols.

Psychosocial Support of gay and bisexual men[14] living with HIV

Psychosocial support can be implemented through several methods which could be divided into group and individual level interventions.

Group level interventions:

Support Groups allow people who live with HIV to receive necessary information, to talk about critical issues and to share their personal experiences. One of the peculiarities of this type of group work is that a specialist – not group participants – bears responsibility for the organization and facilitation of group meetings. Such groups are particularly helpful for people in crisis. In the absence of any activity for PLWH in the region, support groups are the only method for group work. The inability of a facilitator to take into account the real needs of group participants and facilitator's attempts to impose his/her personal perceptions are barriers that can hinder group development.

Self-help Groups follow the same organizational pattern as support groups, but unlike the latter, the responsibility for group work and organization of meetings here lies on people living with HIV (but not on specialists). Creation of such groups is only possible upon the initiative of HIV positive activists. One of group members becomes the facilitator of the group, and is also responsible for observance of internal group rules. In addition possibly settling various personal problems of the participants, self-help groups encourage empowerment of group members; they offer opportunities to help other people and to involve them in active work. The success of a self-help group depends on the number of activists, their motivation and skills. One very effective form of assistance for the success of the group would be external support of HIV-service organization, including provision of technical resources and assistance to the group activists.

Psychotherapeutic Groups allow people living with HIV to develop new self-perception and awareness of their environment, as well as to develop communication skills. In addition, group participation encourages personal growth of every member. It is not recommended to invite people in crisis to the sessions of psychotherapeutic groups, since support and exchange of experience is not their goal. One specific feature of these groups is the setting of particular goals, and the professional psychotherapist guides the process toward its achievement. Development of group rules, participant selection and management of group processes depend on the specialist. The effectiveness of group work also depends on the professional competence of the psychotherapist, as well as on readiness of every participant to accept conditions of group membership.

[14] Gay and bisexual men indicated here as an key target group for care and support services for people living with HIV as they are in need for developing specially tailored services and hardly could be satisfied by general services for PLHA.

Individual psychosocial support methods:

In **Telephone Counseling** [15]of people living with HIV/AIDS, the level of anonymity is defined and controlled by clients themselves. Due to societal stigma and discrimination, PLWH are more likely to use telephone-based services instead of "face-to-face" ones. In the area of telephone counseling they distinguish "hotlines" and "telephones of trust". The objective of hotlines is often limited to provision of information and referrals to other services. Very often hotlines operate within group support services or services of personal counseling. Telephones of trust, however, may also offer clients psychological support in addition to information. For a client, it may be much easier to speak about his feelings while talking from home or another familiar environment. Moreover, a client is not distracted by the unfamiliar environment or appearance of the consultant – it is thus easier for him to focus on his own information. On the other hand, the absence of non-verbal communication limits opportunities for the establishment of deeper contact between a client and his consultant. As a rule, a consultant offering this service and his client talk only once; therefore the consultant knows nothing about future fate of the client.

Peer Counseling means provision of various (usually non-medical) services to people living with HIV by other PLWH (peers) who accept the role of consultants/assistants in the attempt to resolve issues. Related to life with HIV, for example:

- Acceptance of positive status; learning to live with HIV; psychological relaxation; self-assertion;
- How to talk about HIV; whom to tell about HIV;
- Rights of PLWH; development of activism skills;
- Treatment news; how to get medical assistance in city clinics;
- Therapy during pregnancy; child care; how to place a child in preschool institution or school;
- Skills of communication and interrelations with the nearest environment; relations within discordant couples (partners with different HIV status); sexual life;
- Peculiarities of communication between former and current drug users, etc.

Effectiveness of peer counseling: according to evaluation conducted within the "GLOBUS" project, of all respondents (121 individuals), 97.52% (or 118 respondents) were fully satisfied with the quality of peer counseling. Not a single respondent was dissatisfied with this service, while only 2.48% (3 individuals) found difficult to answer the question. 90.08% (109 respondents) would use this service once more; 85.12% (103 participants) would recommend peer counseling to their friends and other contacts. Client Satisfaction Index of all projects, implemented in various cities of the Russian Federation, registers at 1.90 out of 2, reflecting high loyalty/commitment of clients to the project. Maximum value of this Index (2.00) was reached by the projects "Information Center for PLWH – Krasnoyarsk," "Information Center for PLWH – St. Petersburg," "Information Center for PLWH – Kazan," "Information Center for PLWH – Orenburg." Minimum value (1.69) was observed in the project "Alternative," implemented in Tver, meaning that client satisfaction with the abovementioned projects is much higher than that in Tver. Clients mention convenient working hours, friendly (informal) climate, comfortable conditions of service provision, high level of support, large volumes of accessible information about services, wide selection of services, and professional competence of specialists.

[15] Support of People Living with HIV. INFO-Plus Educational Center. Authors: Nikolai Nedzelsky, Yelizaveta Morozova

An effective counseling process needs to be based on the following key stages:

1. Establishment of relations between consultant and client
2. Individual situation assessment
3. Provision of support and information
4. Assistance with decision-making and planning
5. Referral and completion of the counseling process

Practical experience of psychosocial support for gay and bisexual men in the Russian Federation

This experience is documented in "Free Choice," the self-help group for HIV positive MSM from Yekaterinburg supported by the NGO Ural-Pozitiv Movement with additional support from ECCF "Sodeystviye 2000" from 2008-2010 (gay-ekt.ru).

Why people came to the group: to meet each other (to settle the problem of the absence of partners); to receive information about ARV therapy; to discuss problems of personal relations and psychological issues or related to life with positive diagnosis.

Why people refused to come: unwillingness to reveal their diagnosis to other HIV+ gay men (probable leakage of information, high levels of stigma in gay community); unwillingness to meet other positive gay men with whom they failed to develop normal personal relations; reluctance to discuss personal problems in an open forum with other people (self-stigmatization, the absence of culture of group psychotherapy).

Lessons learned: Absence of group rules during initial sessions was a mistake – they could have prevented situations that may be uncomfortable for many participants. It is important to offer peer counseling through Internet (web chats, personal communication), via the telephone (calls from group participants), and in the group.

Key preconditions for the implementation of self-help work without funding are as follows:

1. There is a leader who is ready to organize the group
2. The leader has an experience of participation and facilitation of self-help group
3. Availability of comfortable and safe public catering facility for meetings

Pre-conditions for the implementation of model with the funding of services:

1. There are trusted specialists who are ready to provide necessary services for a fee/compensation
2. There are partners to fund the printing of media materials
3. There are social partners who are ready to assist in dissemination of information at their premises (with the use of their resources)
4. Availability of measurable indicators and project performance monitoring

Pre-conditions for the implementation of model with the funding of services and public events:

1. The presence of a leader, who is ready to organize the group; the leader has an experience in participation and facilitation of self-help group
2. Availability of comfortable public facility for meetings
3. The presence of trusted specialists who are ready to provide necessary services for fee/compensation

4. The presence of partners-manufacturers of print media materials
5. The presence of social partners, who are ready to assist in dissemination of information at their premises (with the use of their resources)
6. The presence of a team of like-minded people to develop and implement a series of public events, aimed at the reduction of stigma and discrimination of HIV+ MSM within LGBT community
7. Availability of measurable indicators and project performance monitoring

Minimum Package of Services of All-Ukrainian Network of PLWH for MSM living with HIV

Program activity

1. Counseling of specialists:
   • peer consultant
   • psychologist
2. Selection of clients in cooperation with a drop-in center or facility that offers VCT services.
3. Promotion of HIV, CD4, TB and VL testing.
4. Development of individual follow-up plan for every client.
5. Information sessions regarding life with HIV/AIDS, ARV-therapy and sexual behavior.
6. Self-help groups, trainings on the principles and methods of independent group facilitation.
7. Organization of leisure time (cinema club, drama studio, library, hobby groups, gym, dating club, evening parties, Internet browsing, attending cultural and public events – cinemas, theatres, excursions, concerts and shows).
8. Assistance in receiving specialist consultations regarding life HIV/AIDS (infectious diseases specialist, lawyer)
9. The school of volunteers

Palliative Care for GBT[16]

The term "care services" implies the provision of non-medical assistance to individuals with HIV-associated diseases and medical problems.

The objective of this service is to create conditions in which critically ill or dying patients will receive necessary care. Non-medical care includes training, as well as social, psychological, spiritual, physical and material assistance. Unlike treatment, assistance of this kind is not included (and should not be included) in the standard package of services of health care facilities; this is a task of services of support to people living with HIV/AIDS.

Psychological support: Both the HIV positive individual and those who are closest to him/her require support in such situations. Client's emotional problems can be effectively addressed if he/she has an opportunity to discuss his/her concerns, if there are people who understand these difficulties. Psychological support helps the patient to overcome isolation and to make medical care more effective.

Spiritual and religious support: The period of crisis for many people living with HIV – including illness and dying – is the time to revise their life values and to seek spiritual "anchor" in the life. Therefore, spiritual support should be based on views and needs of the client.

[16] Support of People Living with HIV. INFO-Plus Educational Center. Authors: Nikolai Nedzelsky, Yelizaveta Morozova

Social support: Illness leads to the loss of working capacity and ability to take care of oneself. Consequently it undermines the social well-being of an individual. The organization involved in care provision needs to determine the following: what social services may help the client; whether the patient's rights are violated in the area of social security; whether they need legal support. If necessary, such assistance may also include material help such as the provision of food, care products, clothes.

Nutrition: Good nutrition is one of "remedies" in the area of HIV/AIDS treatment. Nutrition replenishes energy and supports the immune system in the human body. It may be difficult for an individual for adhere to appropriate dietary regime because of difficulties with cooking, loss of appetite, financial problems or difficulties with food intake. Therefore, care may include trainings for caregivers on the basics of well-balanced nutrition, as well as cooking and assistance in food intake.

Assistance in case of physical disabilities: Some people suffering from AIDS have physical pain and/or many other unpleasant symptoms, such as nausea and diarrhea. Very often traditional medicine fails to address these issues. In addition, many seriously ill patients cannot maintain a comfortable life, because they are unable to take care of themselves and their housing. Addressing these issues is one of the key objectives of palliative care services.

Education: Care for the dying is a separate area of activity which requires specific skills. It is not necessary to be an advanced specialist, but one should possess relevant information and basic skills. The organization involved in care provision needs to organize special trainings for caregivers. Even though required skills often go beyond the medical sphere, effective education still requires active involvement of highly qualified doctors and nursing specialists as trainers (especially if they have experience in palliative care).

Home-based care: If an individual can stay at home, most likely his/her family members, sexual partners, or friends will be his/her caregivers. It is necessary to take into account this home-based care system, and to view the abovementioned caregivers as "colleagues" and "clients".

Planning assistance: It is absolutely natural for seriously ill individuals to worry about things that will happen after his/her death. Therefore, it is very important to help such person with legal matters, including the last will, testament, childcare, debts, etc.

Three main types of palliative care services

- **Program for caregivers.** Within these services, people who care for their HIV positive relatives or friends receive relevant support, information and skills to make this care effective to the maximum possible extent, as well as to improve the quality of life for the person living with HIV.
- **"Buddy System" program.** Not all people have close relatives or friends to see them through times of illness. Within the framework of the "buddy system" program organizations may train volunteers who become "buddies" of the patient, visit him/her regularly, and provide the kinds of assistance which are usually provided by relatives/friends.
- **Hospice.** If a dying patient cannot stay at home, a hospice may become a place where this individual may spend the last days of his/her life. People prefer hospice care not necessarily because they want to die there, but because it offers comfortable conditions.

Positive Prevention

The draft National LGBT Glossary in Ukraine defines the term "positive prevention" as a set of measures aimed at the prevention of repeated infection of HIV positive people with human immunodeficiency virus and exclusion of the spread of HIV infection beyond the group of HIV positive people. Specific areas in the positive prevention are:

- motivation of HIV positive individuals towards adoption of healthy lifestyles and prevention of HIV-associated risky behavioral and sexual practices, which may lead to re-infection of PLWH with human immunodeficiency virus, or infection of other people
- assistance in granting HIV positive individuals access to HIV/AIDS treatment
- provision of HIV positive individuals with comprehensive information about life with HIV
- psycho-social support of PLWH
- influence on persons, who may have an effect on psycho-emotional and health condition of PLWH (e.g. influence on the immediate environment of PLWH, health workers, psychologists and decision-makers – politicians, public officials, etc.), in order to improve prevention, treatment, care and support services for PLWH.

In a broader sense, positive prevention for HIV positive men who have sex with men aims to promote healthy relations with sexual partners; strengthen mental, physical and sexual health and wellbeing; reduce the likelihood of HIV transmission to one's sexual partners; and prevent one's own re-infection with other strains of HIV and other sexually transmitted infections.

Positive Prevention in the Russian Federation
Project implemented by RO "Center+" in Moscow (Eugene Sorokoumov, the project coordinator)

The service project for HIV positive MSM was launched in 2008 (Charity Aid Fund: from April 15, 2010 through December 31, 2010). Currently the project covers (HIV+ MSM) through:

- self-help groups – approx. 300 clients.
- individual consultations – 1,000 clients
- workshops – 50 participants
- thematic events – 50 participants
- movie groups – 100 clients.

Methods of involving MSM in the project include leaflets, business cards, Internet, thematic meetings, and "jungle telegraph." Project activities and events include:

1. Information workshops:
   - Substance dependence and addictive behaviors among MSM
   - Problems of discordant couples and ways of HIV transmission
   - Adherence to ARV therapy
2. Self-help group for both HIV+ MSM and general positive populations (including issues of adherence to ARV therapy).

Needs assessment of the target group is conducted through client questionnaire/surveys as well as Internet surveys. Project staff does not see any obstacles in terms of attraction of new clients to the project. Annual number of requests for project services always exceeds planned indicators. Key issues include: the lack of funding (project staff basically work as volunteers; no opportunities for organizational development and expansion); the center, where the services are provided is administered by third-party organization.

Principles for Conducting Positive Prevention Work

Shared Responsibility for Prevention: Development of prevention programs for, and inclusive of, HIV positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people with HIV. A culture of shared responsibility that encourages communication and equality in relationships should be a goal for HIV prevention programming.

Complexities of behavior change -- addressing social determinants of health: Prevention work must take into account the complexities underlying behavior change. This includes, but is not limited to the interplay of individual life experiences, personal perspectives on sexuality and HIV and any social, economic and cultural conditions. In addition, recognition must be given to the influences of stigma and discrimination on community environments and personal decision-making.

Health promotion and risk/harm reduction: Coercion and criminalization are not the solution to the risk-taking activities of gay men with HIV, and certainly are not the first answer. This approach creates a climate in which trust and honest engagement of people, cornerstones of effective HIV prevention, are unlikely. Rather, programs rooted in health promotion and risk/harm reduction will ensure that individuals and communities are actively engaged.

Disclosure of HIV status – a lifelong process: Disclosure is not always the answer and is not a magic solution to HIV transmission. There is no single HIV prevention intervention or solution that will work for all people in all circumstances. Disclosure does not guarantee safer activities. Disclosure must be considered within an environment of stigma and discrimination; it may result in both risks and benefits to people with HIV. Helping people assess their readiness to disclose and developing the skills to do so is different than telling people they must disclose.

Sexual health and wellbeing: POZ prevention programs can best support a reduction in new HIV infections by ensuring that the sexual health and wellbeing of HIV positive gay men is a primary focus of the work.

Evidence must inform actions: POZ prevention programs should be evidence-informed, timely, and relevant to HIV positive gay men.

Programs should be evaluated: All HIV prevention programs should be evaluated to ensure that they are having the intended outcomes for gay men with HIV. Evaluations should consider both the intended and potential unintended impacts that HIV prevention programs can engender. For example, HIV prevention campaigns may have the unintended impact of not being relevant to HIV-positive gay men if they do not include messages relevant to those who already have HIV.

Diversity of needs must be addressed: Gay men with HIV have the right to sexual health programs that address their unique needs, while recognizing that HIV positive gay men are a heterogeneous group.

Source: Poz Prevention Definition, Values and Principles. Developed by the Poz Prevention Working Group and Approved by the Provincial Advisory Body of the Ontario Gay Men's HIV Prevention Strategy. Version: January 25, 2008

Positive Prevention in Moldova
According to Vyacheslav Mulear, the Moldovan project "Health and Social Well-being of LGBT Community in Moldova," implemented by the organization Genderdoc-M, offers support to HIV+ LGBT (as a rule, gay men). Within the project they discuss the issues of safe sexual relations, adherence to ARV therapy, healthy lifestyles and similar issues. These activities are not funded through the main grant of the Global Fund. There exist certain problems with involvement of representatives of this target group in the project. In addition, it is difficult to raise funds for the project, aimed at positive prevention.

Positive Prevention in Belarus
According to Oleg Yeremin, the director of Vstrecha – which has been implementing MSM-specific prevention projects in Belarus for many years – it is planned to establish a self-help group in Vitebsk. It is possible that similar group will be created in Minsk. Previous attempts to establish such group in the capital city failed. People with HIV+ status are afraid to disclose it even in the presence of other positive people. All positive prevention work is generally limited to individual social follow-up. The head of the organization or social worker conduct individual consultations on the particularities of life with HIV; provide psychosocial assistance and accompany clients to the infectious diseases specialist. They also help the clients to address typical questions, such as initiation of ART and so on.

Unfortunately, these activities lack scale and size, and the reasons for that are numerous. They include insufficient knowledge on this type of prevention among the organization's staff, and fears of clients regarding disclosure. All attempts to attract someone from the HIV+ MSM community to work in the area of positive prevention have failed. Positive MSM may disclose their status to the staff member of Vstrecha, but they just don't want to work in this area. For example, there is one activist – a Vstrecha board member who is an MSM individual with positive status – but he has no internal motivation, and all previous efforts to motivate and encourage him to work on positive prevention were wasted. Information for HIV positive MSM is posted in the organization's website (www.vstrecha.by), in other Byelorussian gay sites and in the Vstrecha newspaper, but the work is still conducted on ad hoc basis.

Positive Prevention in Ukraine
The data from 11 regions were collected during the training "Positive Prevention among HIV positive MSM," that was organized on November 25-29, 2010 in the city of Kamianets-Podilskyi by the All-Ukrainian Network of PLWH.[17] The training brought together 19 participants. Cities of Ukraine:

1. Vinnytsia oblast, the city of Vinnytsia
2. Donetsk oblast, the cities of Donetsk and Mariupol
3. Zhytomyr oblast, the city of Zhytomyr
4. Kyiv oblast, the city of Kyiv
5. Odessa oblast, the city of Odessa
6. Kherson oblast, the city of Skadovsk
7. Kharkiv oblast, the city of Kharkiv
8. Khmelnytskyi oblast, the city of Khmelnitskyi
9. Lviv oblast, the city of Lviv
10. AR Crimea, the city of Simferopol
11. Mykolayiv oblast, the city of Mykolayiv

[17] The author would like to express his gratitude to Petr Polyantsev (All-Ukrainian Network of PLWH), and Vladimir Medil (East Europe and Central Asia Union of PLWH) for information.

All services were subdivided into four categories: services available in all regions; services available in the selected regions; insufficient services and missing services.

I) Minimum package of services, offered by HIV service organizations and initiative groups in all regions of Ukraine:

1. Self-help groups
2. Peer counseling
3. Consultations of psychologist
4. Information (IEC) materials

II) Services, available in the selected regions of Ukraine:

1. Services of professional community centers
2. Means of individual protection
3. Information workshops or trainings (educational programs)
4. Services of different medical specialists (infectious diseases specialist, urologist, proctologist, Dentist, STI specialist, etc.)
5. Work with deaf and mute HIV positive MSM
6. Work with HIV+ MSM with the disabled (diabetes, poor vision, patients with locomotor system disabilities)
7. Sports and recreational activities (hiking and picnics, saunas, gyms, pools)

III) Insufficient services:

1. Drugs to treat co-infections – antifungal medications (ointments and sprays), oxolinum (in the period of epidemics of flu), and ointments to treat herpes, hepatoprotectors
2. HAART
3. Means of individual protection (condoms, lubricants, cleansing products for hands).
4. Medical products/disposables (syringes, bandages, spirit, cotton, latex gloves, flu masks)

IV) Missing services and services, often requested by HIV-positive MSM:

1. Diagnostics of opportunistic infections and co-infections (tests, CT and MRI)
2. STI diagnostics and treatment
3. Treatment and health improving activities (recreation centers, summer camps, SPA facilities, health resorts both general and specialized)

In June 2010 All-Ukrainian Charitable Organization "Tochka opory" (Foothold)[18] launched the project "Your Foothold," funded by the Elton John AIDS Foundation. Project objectives include:

- Establishment of primary contacts with HIV positive MSM, identified during HIV rapid testing – immediately after the test or during post-test counseling.
- Organization of groups on Positive Prevention and Adherence Reinforcement (PPAR).
- Motivation of new MSM towards testing through the system of rewards.
- Establishment of contacts with new HIV positive MSM and encouragement of the most active of them to join the project.

[18] The author would like to express his gratitude to Alexey Zavadskiy (AUCO «Tochka opory») for information on project activities.

- Follow-up of HIV positive MSM, identified during rapid testing within the framework of the project of International HIV/AIDS Alliance in Ukraine.

The project consists of two activity components: (1) PDI (Peer Driven Intervention), and (2) PPAR (Project Performance Assessment Report). Activities within the first component (PDI) cover Donetsk, Zaporizhya, Lviv, Odessa, Kharkiv and Khmelnitskyi.

A four-step system of social follow-up of HIV positive MSM includes the following:

- **Primary follow-up:** All HIV positive MSM with established initial contact receive information, peer counseling, and assistance in having confirmatory HIV test in AIDS center. Clients receive full information about HIV services in the region, contacts of gay-friendly specialists, as well as data on services of AUCO "Tochka opory" in this and other regions of the country.
- **Secondary follow-up:** Monitoring of client's results of confirmatory HIV test in AIDS center; there can be several contacts until the client agrees and comes to testing; motivating the client to diagnose CD4 and viral load.
- **Tertiary follow-up:** Peer counseling; discussions of results of CD4 and viral load diagnostics; planning for the future together with the client.
- **Fourth stage of follow-up:** Peer counseling; discussion of the quality of client's life and his needs in 6 months after completion of the tertiary follow-up.

Conclusions and Recommendations regarding Positive Prevention:

1. In Russian-speaking professional circles, the information on positive prevention in general is scarce; moreover, there is almost no data on the work with HIV+ MSM.
2. Positive prevention is not included in the majority of projects working with MSM as one of the basic and mandatory services.
3. In HIV service organizations, where they do implement positive prevention activities of some kind, such measures are of non-systematic and non-structured nature.
4. Specialists working in the area of HIV/AIDS prevention report about problems with involvement of HIV positive MSM in the projects; HIV+ MSM fear disclosure of their status within LGBT community due to HIV-associated stigma (double stigma).
5. Donor organizations do not view positive prevention as their priority, allocating the lion's share of their resources towards primary prevention (that is, working with uninfected people). This limits organizational and service potential of grantees and their beneficiaries.
6. Positive prevention is relatively "young" concept (as compared to primary prevention); therefore it is necessary not only to introduce new services in the existing projects, but also to train specialists on how to develop this activity area.
7. Positive prevention should be implemented in LGBT community together with campaigns, aimed at overcoming internal homophobia, stigma and discrimination. These phenomena, especially in small towns, hinder effective interventions on the one hand, and also reduce the opportunities for people directly affected by HIV/AIDS epidemic, to "come out to the light" and to establish a circle of like-minded people with much needed support.

Component 3: Social Support and Community Mobilization

Psychosocial support services in Community Center settings

One of the most successful fields of prevention work with MSM/LGBT is establishing special centers where MSM/LGBT can communicate and get HIV/STI prevention counseling. Such centers constitute a convenient basis for offering a comprehensive package of services.

The Community Centers' premises are to be shared by MSM and LGBT community members with a view of spending leisure time there, or holding social or cultural arrangements. In terms of HIV/AIDS prevention, the Community Center's task is to offer comprehensive HIV prevention services to the most vulnerable groups and their significant others. In addition to offering the above services, the Community Center allows for a safe place for community members' communication, information sharing, mutual support; the centre tightly cooperates with a number of organizations that can endorse clients with legal advice, health care services and arrangements to improve centre clients' life quality. Stemming from target group needs, institutional and financial capacities, every centre sets up its own set of services to be offered to clients.

In Ukraine, the first community centre for MSM appeared in 2004 as a project of the non-governmental organization of the Mykolayiv Association of Gays, Lesbians and Bisexuals (LiGA) with the support of the Tides Foundation (USA). Since 2005 this center has flung open the doors for both the MSM and LGBT communities. LiGA is a non-profit organization registered with the Mykolayiv city executive committee on December 26, 1996. The Association was founded in order to unite people of homosexual and bisexual orientation with a view of their integration into the Ukrainian society through lobbying interests of the LGBT community, awareness-raising activities on the basis of healthy life-style promotion and services rendering to the LGBT community in Southern Ukraine.

The main purpose of the establishment of harm reduction centers for MSM is advocacy of interests and protection of target group rights, including rights for safety, protection from stigmatization and discrimination on the basis of sexual orientation and HIV status as well as acceleration of activities for MSM by means of engaging them into training, educational, prevention programs. Great attention is also paid to issues of mobilization of the LGBT community.

The Kherson Community Centre for LGBT was opened in 2007. Centers for MSM have been operating in Kyiv (by the NGO Gay Alliance) and Odessa (by the youth public movement "Partner") since 2008. A specific feature of community centers for MSM is their focus on mobilization of the community, consolidation of its members (including consolidation with other groups discriminated on the basis of sexual orientation and gender identity) and transfer to a stronger LBGT community. Prevention programs in such centers are built on both delivery of protection means as well as information on HIV and overcoming other factors having an impact on the epidemic prevalence such as homophobia, stigmatization of homosexual behavior and homosexual identity, non-visibility of homosexuals in the society.

The information center "GenderDoc-M," in Chisinau, Moldova is a non-governmental organization registered with the Ministry of Justice of the Republic of Moldova on May 8, 1998. It is the only organization in the country that deals with protection of rights of sexual minorities. Although it was set up with a view of gathering, processing, storing and distributing gender-themed information, it rather

quickly it started providing other services for the LGBT community in Moldova. Now, thanks to persistent work of Center volunteers and workers as well as partners and fund providers, it has grown to be one of the best-developed organizations on protection of rights of sexual minorities in countries of the former USSR and became acknowledged at national and international levels.

In 2003 the community center PULSAR-Omsk was opened in Omsk, the Russian Federation, and it turned into a center where MSM and other representatives of the Omsk LGBT community can participate, twice weekly, in various activities, and receive psychological assistance and counseling on sexual health matters. This community center has become a place where one can get friendly support and merely communicate with others by having a cup of tea in an informal setting.

A nine-year history of the project is a unique chronicle of continuous search, development and implementation of innovative forms, methods and instruments of effective work which foster both HIV/STI prevention among MSM in Omsk and development of the regional LGBT community. In nearly a decade of intensive, everyday work, the center has managed to organize and hold some 900 various activities including trainings, workshops, debates, campaigns, etc.

Social services on the basis of Community Centers for MSM/LGBT

The goal of community centers for MSM is to change the risk behaviors of men having sex with men. Thus, the must-have set of services provided by the community centre for MSM includes counseling of beneficiaries on safe sex and HIV/STI transmission, provisioning with safe-sex packages (condoms and lubricants), dissemination of information materials and awareness-raising arrangements on HIV/AIDS matters. It also covers counseling of doctors (e.g., skin and STI specialists, urologists, andrologists) in the community centre (or referral to friendly specialists at health care institutions). In order to render such services the community center staff must carry out preparatory work with doctors and clarify special health care needs of MSM/LGBT as well as find a tolerant specialist free from prejudice on homosexuality. Also there is a popular service when a beneficiary goes to a test accompanied by a social worker. At community centers operating with the assistance of Alliance-Ukraine tests for HIV, syphilis and hepatitis B are carried out. Client management is ensured in case of positive test results.

Psychological problems related to social condemnation of homosexuality force people to have unprotected sex, due to self-stigmatization, internal homophobia, difficulties in adaptation within the society. In order to ameliorate such problems, psychologists are brought in both for individual counseling and self-support group meetings. These specialists must have the skills to work with stigmatized groups. Group methods such as discussion clubs, workshops on homosexuality matters, are also common. Subjects of psychosocial and social counseling for LGBT can vary: safe behavioral matters, sexual and gender identity, coming-out, counseling for family pairs and their significant others, counseling for mature LGBT, counseling for LGBT having children.

Indirect methods work well, such as watching movies about homosexuality or offering library services with books about homosexuality, and these can also foster positive role models and, thus, help people overcome negative mindsets imposed by social homophobia.

Among services offered by community centers for MSM, a special place is held by group arrangements targeted at consolidating the community. In this aspect, good outcomes are shown by educational arrangements (trainings) and efforts to organize clients' leisure time through theme parties, camping trips, sports competitions, etc. Participation in such arrangements fosters positive feelings among

homosexuals, a sense that they are a part of the society, and makes it possible to spend time with people having similar problems and find support.

The community centre for MSM is, first and foremost, a safe harbor for communication and awareness-raising of the socially stigmatized group. The centre where one can get support and help is a compulsory pillar of HIV/AIDS prevention among men having sex with men.

Community centers may also offer these kinds of support:

- Arranging the work of trained personnel and volunteers for the re-socialization of MSM who been raped or who have substance abuse issues, as well as transgender people who went through a gender reassignment operation;
- Referral to specialists/organizations or to effective programs (of rehabilitation and substitution therapy), care and support for people living with HIV;
- Social assistance in employment and house hunting;
- Establishing a social-entrepreneurial network of services for the community: a cafe, a hair studio, a massage room, a gift shop, an art atelier, etc.
- Legal advice services. The main purpose of such services is to raise target group's awareness of protection of rights of MSM/LGBT. As a rule, for such activities community center workers engage MSM friendly specialists (lawyers, attorneys) from legal organizations.

A stand-alone component of Community Center activities can be these additional social services:

- Providing homeless clients with overnight accommodation (as a temporary stay center).
- Satisfying homeless clients' basic hygienic needs (shower, laundry, clothing ironing and repair).
- Providing low-income MSM/LGBT community members with humanitarian aid (clothes, hot meals, etc.)

The main achievement of operating community centers for MSM/LGBT is that they managed to earn the confidence of target group representatives which is evidenced by a continuously increasing number of center visitors and participants of group sessions.

Some cases of successful forms of community centre activities:

Project PULSAR-Omsk (Russia)
"Safe games" is a cycle of interactive sessions focusing on male sexual health matters. At the meetings, vital problems that may arise in lives of both men and women are discussed, i.e. intestinal infections that can be transmitted through unprotected sexual contact as well as other diseases of rectum and genital organs that may lead to greater troubles. Within the cycle "Safe games" such subjects as prostate problems, adenoid tumors, cancer and various inflammatory diseases of the rectum are discussed. Also session attendees obtain information on available treatments for such diseases, names of specialists, and prevention measures.

Movie clubs (movie discussions). Project PULSAR-Novosibirsk (Russia)
Movie discussions "LGBT TV series."LGBT subjects are covered in many present-day TV series. In some soap operas, homo- and bisexual characters have lead roles, in others only minor ones. In many TV series, sooner or later, episodes somehow dealing with LGBT appear. Also there are TV series that are fully devoted to lives of LGBT community representatives and their significant others. They are basically targeted at the very LGBT audience. At some community center MSM meetings,

the most popular LGBT-themed series are discussed: main characters, the most beloved characters and their relationships, best-remembered moments and episodes. Attendees will learn about different TV series on this subject and will be able to watch some popular episodes. Similar activities are also held in the majority of community centers serving MSM/LGBT both in Ukraine and Moldova.

Literary soirees and poetry readings. NGO Gay-Alliance, (Ukraine)
Since October 2008, the NGO Gay-Alliance in Kyiv, with the support of ICF "International HIV/AIDS Alliance in Ukraine" has been operating a community center for gays and homosexuals located nearly in the heart of the city. It is open every day from 11 am to 9 pm except on Mondays. In this safe environment, MSM can find people to talk to, spend time with friends, have a cup of tea or coffee, read information booklets or magazines, and meet and make friends with new people. Weekend activities here include self-help groups, discussion clubs, educational sessions and training classes. Week day activities include leisure groups (for movie viewing), literary soirees in which the founders of *One of Us* Magazine take part.

The primary objective of these events is to familiarize the audience with publications by well-known authors which touch upon many problems: discrimination and stigmatization along the lines of gender, ethnicity and race as well as the problems of freedom, self-actualization, creative pursuits, speaking about the right to be one's self. Similar events are also held at most of the community centers for MSM/ LGBT communities in Ukraine, Moldova, and Kyrgyzstan.

Providing legal support to the clients detained by law enforcement agencies or facing disciplinary charges or financial liability. **NGO "Donbas-SotsProekt" (Ukraine)**
Nineteen years after the abolition of criminal prosecution for male homosexuality in Ukraine was passed (the Criminal Code of Ukrainian SSR, Article 121, Section 1, 1991), the negative and prejudiced attitude in society toward homosexual and bisexual people has not been reversed. They are still being persecuted for homophobic reasons. This category of people has a great need for the protection of their fundamental human rights, recognition of their civic rights, and legal services.

In July 2010, the first hearing of a case against ex-policeman Sergey Markov was held; motivated by his victim's homosexuality, Markov was charged with beating and robbing Roman Zujev in January 2010. At the hearing, the victim and his representative (Elena Vasylyeva, legal adviser of the NGO Donbas-SotsProekt) requested that the case be classified not only as a criminal offense (infliction of moderate bodily injury), but also as a crime connected with the defendant's homophobic views.

In October 2010 criminal proceedings against ex-policeman Sergey Markov were completed. The court passed a two-year sentence with suspension and the defendant's commitment to make restitution for the material and moral damage caused to the victim. The second part of the indictment, i.e. the hate motivation, was handled as an individual case and referred for further investigation to the public prosecution office (http://1.bp.blogspot.com/_YUiRzU09AZc/TKg_cWMB6jI/ AAAAAAAAAlY/ dBvUkOf2aek/ s1600/reszenije-suda_2010-10-01.jpg).

It should be noted that this is the first case of this type in Ukraine where a gay victim set aside his embarrassment and brought the matter to court and had it validated as a hate crime (in the past, there had been two cases linked to homophobia but they were not criminal ones).

Social and legal support: Experience of Regional Organizations

Social integration is currently a challenging issue for LGBT living in Eastern Europe and Central Asia. At the same time, one of the most important tasks for this group is to ensure their full involvement in the social and community life where they will not be facing intolerant attitudes, discrimination and violation of their rights. Responding to this issue is the key mission of many LGBT organizations in the Eastern Europe and Central Asia region, including the following ones:

- GenderDocM, Moldova – Social integration of lesbian, gay, bisexual and transgender people through the advocacy of their interests, provision of information, social, psychological, health, legal and other services, and through the development of partnerships with governmental and social organizations at the national and international levels.

- LiGa, Ukraine – a voluntary association of people with gay and bisexual orientation aimed at their integration in the Ukrainian society through the advocacy of LGBT community interests, provision of access to information, psychological and legal services, implementation of educational activities to promote healthy life styles, and development of partnerships with governmental and social organizations at the national and international levels.

- For Equal Rights, Ukraine – Equitable and democratic Euro-integration and creation of a healthy society without discrimination based on gender identity or sexual orientation.

- We - for Civil Equality, Armenia – Social involvement of LGBT community members in society through the protection of sexual, reproductive and mental health, HIV/AIDS and STI prevention, social and community awareness raising about human rights, lobbying and advocacy of LGBT community interests.

One of the primary factors towards the implementation of these organizations' missions is to ensure provision of social and legal services to the LGBT community representatives. At the same time, the service package should be as comprehensive as possible, and not only include such basic services as counseling, group activities etc., but also the broader services that may include monitoring and documenting the cases of violations of human rights of LGBT, and the use of these documents as advocacy tools to facilitate legal reforms.

In 2006, thanks to PRECIS operation, the first LGBT organizations were established in Caucasian countries – Armenia (We for Civil Equality), Georgia (Inclusive Foundation), and Azerbaijan (Gender and Development). PRECIS contributed to the development of several groups in the region and to their establishment as officially registered organizations, such as Amulet in Kazakhstan, and Ukraine's For Equal Rights and Insight. The PRECIS program has five key activity areas:

1. Capacity building
2. Consolidation of LGBT movement
3. HIV/AIDS prevention
4. Monitoring sexual behavior
5. Lobbying and advocacy

VI. Recommendations for Implementation

While this package of services has been primarily developed to assist USAID missions in determining MSM programming needs, the package also has wider implications for the region. The package supports the efforts of UNDP, WHO and UNFPA in raising the profile of MSM issues. WHO and UNDP regional offices have expressed interest in cooperating further to develop and implement the package, and this interest needs to be pursued.

In order to effectively implement the package of services, consistent and quality programs need to be developed across the region. A way to achieve this is via the establishment of a regional center of best practice for MSM programming. This center would be able to provide appropriate technical support and develop standards of programming and implementation

As Central Asia countries historically and linguistically are closely connected with post soviet Eastern Europe and have similar health and social care systems, a natural extension of the development of the package of services would be to include coverage of Central Asia in its application. This interest and need has already been expressed at the UNDP led regional MSM consultation. In order to include Central Asia in the package, complementary MSM assessments in select countries would be needed to validate the packages applicability for that region. This is something that USAID may want to consider.

For each of the countries covered by the original assessment, upon which this package of services is based, further work needs to be done to map current programming against the package of services, identify gaps in service provision and develop implementation plans for the package. This should be done as part of the in country stakeholder and mission meetings to explain and validate the package. USAID country missions need to identify specific elements of the package they can support during this process.

Annexes

Annex 1. Goal, Objectives and Team for Service Package Development

According to the assessment findings, an appropriate combination of action and investment by all relevant stakeholders can make a dramatic difference in HIV prevention, treatment, care and support. Indeed, many of the earliest and most dramatic HIV prevention successes around the world involved men who have sex with men.[19] Most of the activities for MSM are conducted by local CBOs and NGOs without any state or local authorities support. Last year, thanks to the support from GFATM, programs on prevention among MSM appear in most of the selected countries as well as mentioning of this vulnerable group in National AIDS program.

The goal of the development of package of services is building the regional consensus around the comprehensive package of prevention, care and support services for MSM based on regional best practices. As well as capacity assessments and subsequent capacity building plans need to be developed for MSM organizations in order that they can implement relevant components of the comprehensive package of services.

Objectives of the development

During October-November, 2010 the Team for development of the Package of prevention, care and support services for MSM in Eastern Europe Region consisting of 9 regional experts worked on the structure of the package to present for review and recommendation during the Review committee meeting in November 2010.

Countries for the regional package of services coverage

Package of services consultation will cover 12 Eastern Europe and Central Asia such as: Albania, Azerbaijan, Armenia, Georgia, Russia, Belarus, Moldova, Tajikistan, Uzbekistan, Kazakhstan, Kyrgyzstan and Turkmenistan.

Responsibilities and Tasks of the team

Team leader is responsible for:

1. Development of a draft concept of regional package of services for HIV/STI prevention, care and support among MSM
2. Presentations of the analytical report and draft concept of service packages for MSM/LGBT to organizations, leaders and experts during Vienna conference in July 2010, ILGA-Europe conference in October 2010.
3. Organizing/coordinating the work of the consultants team in October, 2010
4. Facilitation of the discussion and building consensus on the of regional package of services during the Eastern Europe and Central Asia regional consultations on HIV and MSM, Kyiv in November 2010
5. Facilitating the meaningful and active review committee meeting
6. Finalization of the package using results of Regional and Review Committee consultation.

[19] Merson H M et al., "The history and challenge of HIV prevention", The Lancet, HIV Prevention, August 2008, pp. 7–20.

Consultants on human rights protection, reducing stigma and discrimination, community mobilization and other structural interventions:

1. Review international and regional recommendations and best practices for the components and structure of essential package of human rights protection, reducing stigma and discrimination, community mobilization and other structural interventions.
2. Review of relevant programmatic report of organizations piloting/implementing different components of package of services to draft operational description of services.
3. Support presentation of relevant components of regional package of services during the Eastern Europe and Central Asia regional consultations on HIV and MSM, Kyiv in November 2010
4. To take active part in Review committee meeting 24-25th of November, 2010 in Kyiv to review Package of services document.
5. To provide comments and recommendation on the final draft of the service package document.

Consultants on HIV and STI prevention services for MSM:

1. Review international and regional recommendations and best practices for the components and structure of essential package of services for HIV/STI prevention for MSM.
2. Review of relevant programmatic report of organizations piloting/implementing different components of package of services to draft operational description of services.
3. Support the presentation of relevant components of regional package of services during the Eastern Europe and Central Asia regional consultations on HIV and MSM, Kyiv in November 2010
4. To take active part in Review committee meeting on November 24-25, 2010 in Kyiv to review Package of services document.
5. To provide comments and recommendation on the final draft of the service package document.

Consultants on care and support services for HIV-positive MSM:

1. Review international and regional recommendations and best practices for the components and structure of essential package of care and support services for HIV-positive MSM.
2. Review of relevant programmatic report of organizations piloting/implementing different components of package of services to draft operational description of services.
3. Support presentation of relevant components of regional package of services during the Eastern Europe and Central Asia regional consultations on HIV and MSM, Kyiv in November 2010.
4. To take active part in Review committee meeting on November 24-25, 2010 in Kyiv to review Package of services document.
5. To provide comments and recommendation on the final draft of the service package document

Peer Review committee meeting objectives

Building the regional consensus around the comprehensive package of prevention, care and support services for MSM based on regional best practices becomes one of the key priorities for the project implementation stage. As well as capacity assessments, subsequent capacity building plans need to be developed for MSM organizations so that they can implement the relevant components of the comprehensive package of services. During October-November, 2010 the Team for development of the Package of prevention, care and support services for MSM in Eastern Europe Region consisting of 9

regional experts worked on the structure of the package to present for review and recommendation during the Review committee meeting:

1. To present concept and structural components of Regional package of prevention, care and support services;
2. To get country level and regional review and recommendations for developed package by specific of services, by key target groups and age sub-groups of the target community;
3. To specify essential and additional package of prevention, care and support services;
4. To build the regional consensus on key advocacy and implementation steps for the regional package of services.

Annex 2. International Approaches and Recommendations Summary

A comprehensive approach to HIV and sexual health among MSM requires foundational activities to create an enabling environment, supportive interventions for the effective operation of the prevention and care package (e.g. capacity building), and a complete prevention and care package. Given the unique needs of MSM in the post-Soviet/Eastern European social and cultural environment it is necessary to adapt a package of services for this region that focuses on stigma/discrimination, drug/alcohol use, care for HIV-positive MSM and organizational networking.

A summary of the key elements of effective prevention programs for MSM could be developed from a series of articles in The Lancet in 2008, which reviewed evidence for efficacy in a broad range of HIV prevention programs, including those for most vulnerable populations, including MSM.[20] Key findings from the reviews were:

- Combined, multiple approaches to prevention are essential since HIV prevention is neither simple nor simplistic. To achieve significant reduction in HIV transmission, widespread and sustained efforts and a mix of communication channels is needed to disseminate messages to motivate people to engage in a range of options to reduce risk. Success in HIV prevention results from a complex combination of strategies and several risk-reduction options, with strong leadership and community engagement that is sustained over a long period of time.

- Interventions derived from behavioral science have a role in HIV prevention, but are insufficient when used by themselves to provide substantial and lasting reductions in HIV transmission between individuals or in communities. Behavioral strategies need to be combinations of approaches at multiple levels of influence. Behavioral HIV prevention also needs to be integrated with biomedical (including condom promotion) and structural approaches, promotion of social justice and human rights, and treatment for HIV and STI infections. Top-down approaches can be adept at packaging and branding replicable strategies such as behavior change communication and social marketing, while bottom-up approaches are useful for supporting local innovation and ownership. Both approaches have experienced successes and limitations.

- Local engagement, using the creativity and energy of the people who are most affected to develop messages and strategies to motivate behavior change, is important. It is necessary to create an enabling environment that allows members of a community to act on their own behalf in response to their perceived needs.

- Peer education is especially effective if it involves participation and collaboration with vulnerable groups who are often alienated from formal service providers and government structures. Peer education has been demonstrated to be effective in increasing condom use and reducing STIs in Asia. Peer education can be successfully coupled with network-based interventions which involve gaining access to social and sexual networks through key individuals,

[20] Coates, T.J. et. al., Behavioural strategies to reduce HIV transmission: how to make them work better. Lancet 2008; 372: 669-84. Gupta, G.R. et. al., Structural approaches to HIV prevention. Lancet 2008; 372: 764-75. Imrie, J. et. al., Biomedical HIV prevention – and social science. Lancet 2008; 370: 10-11. Merson, M.H., The history and challenge of HIV prevention. Lancet2008; 372: 475-88.

identifying members of the networks, training network leaders as peer educators, disseminating risk reduction messages, and assessing effects.

- Community mobilization is an essential component of effective HIV prevention. A United States Centers for Disease Control and Prevention (US CDC) assessment of well-received HIV prevention programs in the USA demonstrated that community-based programs succeeded only if there was strong institutional support through organizational development, and capacity to implement and sustain the program.

- HIV prevention programs cannot succeed in the long-term without addressing the drivers of HIV risk and vulnerability in different settings. Structural approaches therefore need to be incorporated into HIV prevention. Structural factors include the physical, social, organizational, cultural, community, economic, legal and policy features of the environment that affect HIV vulnerability. The defining aspects of structural approaches is that they aim to change the social, economic, political, or environmental factors that determine HIV risk and vulnerability in specific contexts. Structural approaches can result in activities or services being delivered to individuals. However, the approach is different from individually oriented behavior change because it addresses the factors affecting individual behavior, rather than targeting the behavior itself.

- There is increasing evidence, including among sex workers and MSM, that community structures and systems (e.g. social support networks) can make populations less vulnerable to HIV.

- Investments in HIV prevention should be integrated with health system strengthening and training of community health workers who can generate and respond to community responses that are essential to HIV prevention.

- National level prevention successes have been associated with government leadership and community activism. Leadership and activism are also essential for sustaining and renewing prevention responses.

Defining key interventions, when informed by the key findings above, makes it possible to identify gaps in current responses to HIV and STI epidemics among MSM[21] and provides a basis from which regional stakeholders can determine opportunities to address these gaps. It is possible to outline two broad categories of interventions and services, as described below:

1. Enabling environment and supportive interventions:

Enabling environment interventions include stigma and discrimination programs, policy and legal frameworks, advocacy, community development and mobilization, relations with gatekeepers and structural interventions. Supportive interventions include strategic information, capacity building and organizational development.

Key documents supporting this work were developed to enhance regional and national HIV responses and LGBT human rights protection activities:

[21] David Lowe Scoping exercise: Options for AusAID support for comprehensive approaches to address HIV infection among men who have sex with men in the Asia Pacific Region, 3 June 2009

- ***UNAIDS Action Framework "Universal Access for Men who have Sex with Men and Transgender People."*** The goal of this framework is to enable UNAIDS to facilitate and support the achievement of universal access to appropriate HIV prevention, care, treatment and support for men who have sex with men and transgender people. The UNAIDS Secretariat and the UNAIDS Cosponsors recognize that universal access to appropriate HIV programs for men who have sex with men and transgender people is a crucial part of achieving universal access to HIV prevention, treatment, care and support as a whole. This approach aims to reduce the incidence of HIV everywhere, while protecting the health and rights of not only these marginalized groups but also their female sexual partners and the rest of the population. ***The Global Fund to Fight AIDS, Tuberculosis and Malaria in its GENDER EQUALITY STRATEGY*** supports the UNAIDS approach: "Towards a comprehensive package[22] of measures to address HIV-related issues among men who have sex with men and transgender people. UNAIDS' recommended conducive legal, policy and social environment requires:

    - The promotion and guarantee of the human rights of men who have sex with men and transgender people, including protection from discrimination and the removal of legal barriers to access to appropriate HIV-related prevention, treatment, care and support services for them, such as laws that criminalize sex between males;
    - An assessment and understanding of the numbers, characteristics and needs of men who have sex with men and transgender people regarding HIV and related issues, including risks associated with injecting drug use, sex work, prison confinement, etc.;
    - Ensuring that men who have sex with men and transgender people are appropriately addressed in national and local AIDS plans, that sufficient funding is budgeted for work, and that this work is planned and undertaken by suitably qualified and appropriate staff;
    - The empowerment of men who have sex with men and transgender communities to participate equally in social and political life;
    - Ensuring the participation of men who have sex with men and transgender people in the planning, implementation and review of HIV-related responses, including the support of nongovernmental and community-based organizations, including organizations of people living with HIV;
    - Public campaigns to address homophobia and transgender discrimination;
    - Training and sensitization of health-care providers to avoid discriminating against, and ensure the provision of appropriate HIV-related services for, men who have sex with men and transgender people;
    - Access to medical and legal assistance for boys, men and transgender people who experience sexual abuse;
    - The promotion of multisectoral links and coordinated policy-making, planning and programming, including health, justice (including the police), home, social welfare, similar and related ministries, at the national, regional and local levels.

[22] UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People "UNAIDS/09.22E / JC1720E". Based on the recommendations from the WHO consultation meeting on men who have sex with men, HIV and other STIs, held in Geneva, 15–17 September 2008, WHO's.

- ***Yogyakarta Principles*** is the document developed on the basis of the Universal Declaration of Human Rights in 2006. It establishes international principles regarding the application of human rights to sexual orientation and gender identity. These address issues of extrajudicial executions, rape, torture, access to justice, integrity of private life, non-discrimination, denial of free speech and assembly, as well as a range of discriminatory actions in work, health, education, housing, immigration and status of refugees, participation in the state administration and other human rights issues related to LGBT.

- ***United Nations General Assembly (UNGA) Statement on human rights, sexual orientation and gender identity*** supported by 68 countries from five continents and unanimously supported by EU December 2008. The Statement reaffirms the principle of non-discrimination and condemns executions, arbitrary arrest or violations of human rights on the basis of sexual orientation or gender identity.

- ***Toolkit to Promote and Protect the Enjoyment of all Human Rights by Lesbian, Gay, Bisexual and Transgender (LGBT) People.*** This document, prepared by the intergovernmental EU body in consultation with civil society organizations, outlines what the European Union should be doing abroad to defend the human rights of LGBT people. Among other recommendations, the toolkit calls on EU diplomats, the future European External Action Service (EEAS) and EU Member States to actively work towards the decriminalization of same-sex relations throughout the world; to further denounce discrimination on grounds of sexual orientation and gender identity; and to support human rights defenders in repressive areas. The toolkit is a welcome development in the European Union's external action. Although not binding, it provides the European Union's institutions with a blueprint for positive action in favor of LGBT people's human rights abroad.

2. Prevention and care package

UNAIDS recommend all interventions should be evidence-informed, developed with, and protect the rights of men who have sex with men and transgender people and should include safe access to:

- Information and education about HIV, other sexually transmitted infections, and safer sex and safer drug use, provided through appropriate service delivery models (including peer-led, -managed and -provided services);
- Condoms and water-based lubricants;
- Confidential, voluntary HIV counseling and testing;
- Detection and management of sexually transmitted infections through the provision of clinical services (by staff members trained to deal with sexually transmitted infections as they affect men who have sex with men and transgender people);
- Referral systems for legal, welfare and health services, and access to appropriate services;
- Safer drug-use commodities and services;
- Appropriate antiretroviral and related treatments, where necessary, together with HIV care and support;
- Prevention and treatment of viral hepatitis;
- Referrals between prevention, care and treatment services;
- Services that address the HIV-related risks and needs of the female sexual partners of men who have sex with men and transgender people.

Annex 3. MSM Service Delivery Approaches

There are a variety of issues to consider when determining MSM service delivery approaches, including:

- **Safety.** The facility where health services are provided must be safe, clean, inviting, and be appropriately designed and equipped to care for patients. It must be located in a place that is easily reached by the target population, whether urban, semi-urban or rural. Ideally, it should be on or near public transportation lines and have adequate parking. Access to the facility must be well lit, well maintained, and clients should not be required to wait in, or pass through isolated or unsafe areas to reach the clinic. The entry to the facility should be secure and allow for a locked door, a security guard, and/or a double-door entry, as appropriate. Given the stigma associated with MSM in most Eastern Europe Region countries, uninvited individuals should not be allowed to freely enter the building or the clinic. Security personnel must be trained to be sensitive to the needs and concerns of MSM. Staff should be trained to protect the safety of clients and fellow staff. Ideally, clinic staff should have identification badges that they wear during clinic hours, but depending on the location of the clinic/center, requirements should not be made that may compromise the safety of staff. If possible, a security system might be obtained that limits the entry to sensitive areas to appropriate staff only.
- **Permits and licenses.** Given the stigma that might be leveled against a clinic that treats gay men and other MSM, each program must assure that all laws are adhered to and all permits for the operation of a health facility have been obtained and updated. This might include permits from the building owners in accordance with city, state, and federal mandates. Sufficient insurance must be purchased to protect the clinic, the staff, and/or the Board of Directors.
- **Confidentiality.** An environment that respects the confidentiality of each client is critical for a facility that cares for MSM. Confidentiality must be emphasized at all levels, including leadership, staff, contractors, and anyone else associated with the clinic. A confidentiality policy statement must be developed and each staff member must sign a confidentiality agreement, which is kept on file. Anyone with potential access to client information and/or files must also sign an agreement as well. Individuals will agree to hold confidential a client's presence at the clinic, verbal communication, and the contents of medical records, including laboratory results, studies, and other communication.
- **Medical records.** A medical records system must be in place to ensure that client medical information is safely and securely organized and stored. Records must be kept away from client and visitor traffic and be available only to those staff involved in the care of the clients and client scheduling/intake. Records should not be accessible to unauthorized individuals either during clinic hours or after hours.
- **Payment for services**. Many clinics are grant funded, some are fully funded by the government and there is no fee charged, while others have some form of fee-for-service payment. Whether services are free, covered by insurance, offered on a sliding fee scale, or require a co-payment, the payment policy should be transparent and consistent. Detailed records of financial transactions must be kept, money should be handled by a limited number of staff, and clients should feel comfortable that their funds are being handled carefully. A client who perceives that his funds are being handled in a cavalier fashion may feel as if that same attitude may be directed toward his health services.
- **Infection control**. Clients and staff at a health center may be at risk for infections that are transmitted in the health care setting. Every health care facility must take special precautions to

protect everyone from exposure to pathogens while working in, or receiving services at the facility. The main types of exposures likely to be encountered in the health center include those organisms transmitted through the air (tuberculosis [TB] and influenza) and those transmitted via hand-hand contact or via contaminated surfaces. Each health facility must develop an infection control policy, which is reviewed annually. Provisions should be made to ensure that clients and staff can wash their hands after using the bathroom and between contacts with each client. Staff and clients should be trained on how to manage acute or chronic respiratory symptoms in the health center, including considerations for a preliminary phone call prior to the visit, a separate entrance, a designated room, and the use of masks for patients with cough syndromes. Staff should be instructed to avoid reporting to work when acutely ill, and a work culture must be developed that does not discourage or punish absence due to illness.

- **Linkages to other resources.** A clinic providing services to MSM may be required to refer clients for additional services that are not available through the clinic. Health outcomes and client satisfaction are likely to be improved if relationships have already been developed with key providers of other services. Clinic leadership should plan to invest time creating these relationships and work to ensure that MSM clients are treated respectfully and professionally. Programs that do not meet the needs of referred clients can be dropped in favor of programs that are receptive to MSM clientele. Other resources might include: emergency care, medical and surgical specialists, addictions specialists, mental health and counseling specialists, shelters and food aid, advocacy organizations for MSM, and the law enforcement community. Certainly any relationships that can be created between clinic management and political, civic, and spiritual leaders would likely be helpful in reducing stigma and in improving services in general for MSM.

Promotion. The health facility may wish to promote itself and its services in the community in order to reach MSM in need of services. Promotion efforts might need to strike a balance between reaching the target audience and avoiding inflaming the broader community, and increasing stigma in the environs of the clinic. Word of mouth promotion by members of linked or affiliated organizations is often the most effective and confidential means of attracting new clients.

Annex 4. Regional consultation recommendations

[Note to USAID: We are waiting for the regional consultation report to be finalized and translated into English, which is expected to be delivered to AIDSTAR-Two by the end of February. Recommendations will be inserted into this document as soon as they are available.]

Annex 5. The Needs of HIV Positive LGBT in the Russian Federation

Needs and for All-Russian Public Association of PLWH at Different Levels[23]

Meeting the majority of needs will have positive impact on both target group (HIV positive homosexuals) and on other groups within PLWH community, since the majority of needs are not specific to the former. The only specific need concerns attitudes towards HIV+ LGBT, who are stigmatized both on the part of the rest of PLWH community, and on the part of staff of HIV service organizations (HSO), the society and the state. At the same time, HIV+ LGBT suffer from stigma, demonstrated by other representatives of LGBT community, who are HIV negative.

ARCC (All-Russian Committee of the Community) of PLWH has identified the following basic needs:

Need #1: Respect towards needs of LGBT+

Need #2: Belonging to the community

Need #3: Equal attitudes towards all participants of informal associations and unions, regardless of sexual orientation and gender identity

Need #4: Acceptance of LGBT+ by the specialists of HIV service organizations, taking into account their self-regulation

Need #5: Non-discrimination of LGBT+ in government, commercial and non-commercial institutions that provide services to representatives of LGBT communities

Need #6: Receiving reliable information from the specialists, regardless of their attitudes towards LGBT, knowledge and experience of work with these groups

Need #7: Psycho-emotional support of LGBT+ in difficult life circumstances

Need #8: Accessibility of all LGBT services for LGBT+

Need #9: Availability of services for the nearest social environment

Need #10: Accessibility of services for LGBT+, who are substance dependent and co-dependent

Need #11: Accessibility of information about functioning services for LGBT+

Need #12: Support of family traditions

Need #13: Recognition of the need in sexual relations

Need #14: Necessity to ensure legal protection against homophobia

Need #15: Decriminalization of human-to-human transmission of HIV

[23] Unpublished report by V. Revin, N. Nedzelsky, E. Pisemsky

Phase 2.2. Operational plan

1. Organizing the 2-3 hour pre-consultation with MSM/LGBT community to develop preliminary view on package implementation plan.

2. Conducting these presentations and stakeholder meetings in the various countries could help to fulfill the key project objectives for each meeting:

- Gathering the key HIV response stakeholders in the country, consisting of national health and social work authorities, MSM-service and LGBT NGOs, service providers for MSM, UN agencies, the USAID Mission, and GFATM program PRs, to discuss the topic of MSM targeting services. This objective is extremely important for countries where the target group is still hidden for HIV response, for example Azerbaijan and Russia.
- Overview of AIDSTAR-Two assessment results, including at the country and regional levels (aim of project, regional findings, country level data). This provides an opportunity for the participating stakeholders to have an overview of all existing epidemiological, behavioral and programmatic data.
- Presentation and discussion of the concept and draft package of prevention, care and support services for MSM in Eastern Europe Region. This will allow all stakeholders to see the full spectrum of services possible for MSM and to analyze the existing mapping of available services for MSM in their country. It is important to get several outcome from the discussion:
    - Additional best practices from country level
    - Building consensus for the development of services on prevention, care and support for MSM on a country and regional level
    - Development of agreement of next steps for service planning on the country level.

1. Conducting negotiation/ separate meetings with USAID, UNDP and key donors on their possible support of developed plan for services package implementation.

Possible agenda of country visit

1 day Arriving
    2-3 hour meeting with LGBT/MSM community
2 day Stakeholders meeting
3 day Negotiations with USAID, UNDP and other donors
    Departure.

Outputs

The output of every country level meeting will include:

- Recommendations for improvement and implementation plan of the regional package of services;
- A common negotiated agreement (in line with last bullet under objectives above) on the development of further services by the USAID Mission as well as other donors and experts.

Deliverables

- A trip report for each trip
- A meeting report on each meeting, detailing the results of the country level discussions
- The final package of services with all added best practices, comments and recommendations incorporated.

Organization

The meetings will be one day events and up to 15 stakeholders will be invited to each.
From From the project team the local consultant will present the assessment results and the team leader will present and facilitate discussion on the package of services. The AIDSTAR Two MARPs expert, Elden Chamberlain, will also participate in each meeting.

Schedule of country visits
18-27 of April – Armenia, Georgia, Azerbaijan
12-20th of May – Moldova, Belarus, Russian Federation