てセクシュアリティに起因する差別事例が存在する。

以上の結果から、MSM 陽性者への性的健康増進のための介入が必要であり、その資材形成、プログラム開発は急を要していることが明らかになった。

2.　陽性告知後支援資材開発

検査機関における陽性告知支援および告知直後のHIV陽性者支援を目的とし、支援団体等で使用されてきた治療準備支援ツール「治療と生活のアウトラインを知ろう・2003 年版」(日本HIV陽性者ネットワーク・ジャンププラス) を改訂し、検査機関においても活用可能な支援ツールとして開発を行った。

当プログラムは暫定版とし、医療情報等を定期的に更新し、さらに利用者の調査を実施し、より有効性の高いものへと改良を行うものとした。

3.　MSM陽性者性的健康向上プログラム開発と介入モデルの形成 (平成18・19年度)

平成17年度の研究成果より保健、医療分野におけるMSM陽性者のセクシュアリティへの理解が十分ではなく、陽性告知後に積極的な介入も行われていないことが分かった。そこで当研究グループのピア・サポート経験の豊富な当事者による資材およびプログラムの開発とその活用モデルの形成を行った。

3-1. MSM陽性者フォーカスグループインタビュー(FGI)調査

調査目的：MSM 陽性者セクシュアルヘルス向上阻害要因の調査

調査対象：MSM かつ HIV 陽性者
ゲイ自認有り
首都圏在住
年齢 20 代ー60 代

実施期間：平成 19 年 10 月

調査方法：MSM 陽性者 7 名を対象とした FGI を 2 回 (4 名、3 名) に分けて実施。インタビューガイドを作成し、逐語録を起し、これに複数の分析者による分析を加えた。

調査によって、次のような結果を得ることができた

検査前、検査後を通して MSM 陽性者の性意識および性行動の変化を見るとき、HIV 感染症予防の知識は備えているものの、行動変容を促すには十分ではない状況が明らかになった。特に予防情報や性的健康増進機会へのアクセスにおいて最大の障害になっているのは、HIV/エイズにまつわる偏見や、セクシュアリティに関する偏見が、最大の障害であると思われた。

以上のことより、性的健康増進のための介入においては、MSM 陽性者のセックスに対する否定的感情を軽減し、自己肯定感を高める作業が並行的に行われる必要があることが分かった。

3-2. 性的健康増進プログラムの開発

コミュニティベースで実施可能なMSM陽性者を対象とした、性的健康増進のためのプログラムを、諸外国の先行事例を参考に、すでに日本国内で新規陽性者向けに実施されているPeer Group Meetingの手法を用いて実施モデル (Workshop module) の開発、ファシリテーションマニュアルの作成を行った。

本プログラムはセクシュアルヘルスについて、HIV 陽性者自身がその必要性を認識し、行動変容の動機付けまでを目的として開発した。当プログラムおよびハンドブックともに同一のコンセプトに基づき、次の内容から構成されている。

【プログラム概要】

名称：Talking about Sex

目的：HIV 陽性者が自己のセックスに向きあい、現実的対応を行うよう意識と行動の変容に向けて働きかける

対象：陽性告知６ヶ月以上を経過した MSM 陽性者。参加者５名ー8 名を１グループ

とし、最大6名×2グループとする。
実施：休憩を含み4時間。ファシリテーターおよび共同ファシリテーターの計2名、グループが複数になる場合はグランドファシリテーターと2名の共同ファシリテーター計3名によって実施される。
内容：個別ワーク（ワークシートへの自記）と半構造化されたグループワークを組み合わせ自分のセックスをふり返る作業が中心となったプログラム
導入：テーマがセックスという極めて個人的な内容になるため、参加者のニーズアセスメントを慎重に行い、グループワークのためのダイナミズムを失わない範囲でピア性（同一性）を確保する。

以下、プログラムの概要を下記に示す。

1.セックスについて語ることへの抵抗感の軽減

2. セックスに対する認識の再検

3. 自分の性行動の振り返り

4. 現実的な自己の性行動のガイドライン作成（フレームの提示）

5.関連情報の提供

3-3.セクシュアルヘルス・ハンドブック

「セクシャルヘルスハンドブック」はMSM陽性者のための性的健康増進支援を目的とした小冊子で、前述のワークショップ・モジュールと同一の理念、内容で構成されており、双方のプラグラムは相互補完的に活用される。

【プログラム概要】

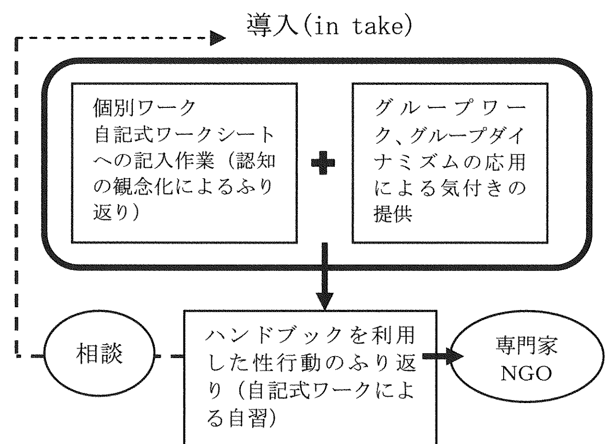
名称：Sexual Health Hand Book
Talking about SEX
体裁：A5版 右開き、中綴
内容：単なる知識の提供に留まらず、体験談やエッセーなどを交え、雑誌的な構成でリアリティを伝え、気付きを促すものとした。

・セックスって何だ？
・HIV陽性であることとセックス
・セクシュアルヘルスについて
・セックスの多様性とゲイセックス
・セーファーセックスは誰のため
・ファンタジーと現実
・セーファーセックス交渉術
・セックスのリスクを知っておこう
・自分のためのガイドラインを作る
・性感染症／原因、症状、予防
・困った時の情報源

3-4.MSM陽性者性的健康介入モデル

MSM陽性者の性に関する問題は極めて心理的、社会構造的に複雑な背景を有している。そこで、当研究に置いて開発、形成されたMSM陽性者向け資材およびプログラムは単独で利用されるべきではなく、その運用、実施に関してはその限界を認識した上で、さまざまなHIV陽性者支援と連動して行われる必要がある。そこで、当プログラムの実施についてはコミュニティの支援NGO等と協働のもと、参加者についてはプログラムとの親和性、適性を判断して導入（in take）されるべきものとした。さらに、プログラムの試行から参加者に対する継続的な支援と介入を行う必要があると判断された。

【介入モデル図】



D. 考察

当研究のMSM介入モデルは地域のゲイコミュニティにおいて少人数のグループ単位での実施を前提として開発された。しかし個別施策層としてのMSM集団は自らゲイであるという自認を持っている者は限られているために、その守備範囲が限られている。

そこで、当プログラムの実施にあたっては、医療機関、保健機関、HIV陽性者支援NGOとの連携の他、心理、教育、福祉など、他分野における実務家との協働を推進する必要がある。

また、MSM陽性者を対象とした当研究を進める過程において社会に横たわっているHIV/エイズ、性的少数者であるMSMのセクシュアリティに関する偏見や嫌悪感の問題とMSMの予防行動、受診行動が深く関連していることが明らかになった。

いっぽうで深刻な感染の広がりを見せているMSMコミュニティにおいて、予防情報が当事者によって形成される事が多く、地域のゲイコミュニティに根ざした活動やMSM対象のメディアの発達によって、予防情報へのアクセスは比較的良好であるものの、MSMが社会的認知を受けていないこと、可視性が低いことなどから、MSM自身にもこれらの情報を現実感をもって受け止められていないことが判った。また量的に十分とは言えない状況も明らかになった。

さらにわが国において性を扱う学問領域も限られており、それらの先行研究においても社会構造、心理、文化へのアプローチはあるものの、性行動そのものに関する先行研究は極めて少ない。特に実践的な介入、支援技術を有する専門家はほとんど育っていない。

このような背景の中でMSMの性的健康支援としてのHIV感染予防対策は極めて困難で、その結果、陽性告知を受けたMSMは検査、医療の現場で十分な心理的支援を受けにくい状況に追いやられている。つまり陽性告知後の性的健康に関する支援が実質的にはほとんど内情強にある。それどころか、一部には極めて差別的な対応を行っている検査機関、医療機関があることも判った。

大前提としてこの問題を改善しない限り、MSMの感染予防対策の根本的改善はできない。

E. 結語

私たちが生きる社会は多様であり、多重・多層の社会構造を有している。民主主義社会においては基本的人権がそのすべての人々に等しく保証されるべきことは自明の理だ。

しかし、現状ではゲイ、バイセクシュアルを含むMSMへの理解は進まず、社会的にも受容されていない。

性とは、性のありようとは人間の生き方の問題である。すなわち人間の尊厳の問題である。自らの性のありようを認めない社会においてHIV感染の現実に直面したMSMが保健や医療の現場で自らの健康を支援するべき立場の専門家が自らを否定していると感じたとき、個人としては為す術を無くし、さらなる性的健康の危険にさらされる。

偏見や差別がHIV感染対策の最大の障害となっていることは明らかだ。すべてのMSMが自らの性のありようを受け入れることができる社会が実現するとき、MSMにおけるHIV感染の広がりは初めて止まる。

当研究がそのための小さな一歩になる事を願い「男性同性間のHIV感染対策に関するMSM陽性者の視点からの提言」をこの報告の最後に加える。

男性同性間のHIV感染対策に関するMSM陽性者の視点からの提言
―個別施策層における予防、治療、ケア・サポートへの普遍的アクセスについて―

当研究の平成17年度、平成19年度において行ったMSM陽性者を対象とした聞き取り調査から個別施策層としてのMSM層の予防、治療、ケア・サポートへの普遍的アクセスの最大の阻害要因として社会に存在するHIV／エイズにまつわる偏見と性的少数者に対する偏見という二重のスティグマ（Stigma=汚名・差別的烙印）が最大の阻害要因として横たわっていることがうかがわれた。

HIV／エイズまつわる差別・偏見の解消についてはHIV感染症がわが国で問題になりはじめた当初からエイズ対策の重要な要素として挙げられながらも具体的には有効な戦略も見出し得ず、一般社会における意識はほとんど改善されていない。

これに加えわが国におけるMSMの可視性は低くその存在は未だ社会的認知を得ていない。ここでもまたエイズ問題が浮上してきた１９８０年当時の「エイズ＝ゲイの病」という偏見が残されたままである。

社会に存在するスティグマは当然MSM個々人の中にも内在化され、被差別不安や自尊感の極度な低下として現れる。これらのMSMに対する否定的社会心理が存在する以上、いかに予防情報や検査体制、医療制度へのアクセスを促進しても当事者の忌避的態度までは改善できない。

さらにMSM陽性者において医療機関におけるセクシュアリティ由来の被差別体験も少なくなく、これが原因となって医療者とのコミュニケーションを自主規制している事例も数多く見られた。これは検査機関や医療機関においてセクシャルヘルス向上への介入機会を自ら逸しているに他ならない。さらにMSM陽性者側にも被差別不安や自尊感情の低下に起因すると思われる過度な医療者不信が存在していることも否定できない。この患者と医療者のコミュニケーション不全が相互理解の欠如を生み、医療機関におけるMSM患者への差別事例も目立つようになってきた。

普遍的アクセスの最大の阻害要因として一般社会におけるHIV/エイズにまつわる偏見が存在することは改めて言うまでもない。

偏見や差別の原因となるスティグマは社会心理であり、知識普及型の啓発プログラムでは自ずと限界がある。これが存在する限り検査促進キャンペーンなどの一般人口対策の費用対効果も改善されず、継続的効果は期待できない。しかし、これは中長期計画の中で立案、実施されるべき課題であり、むしろ一般人口に対するアプローチの中で実施されなければならない。

ここで留意すべきは若年層（25歳以下）の感染例報告増加の背景にはその９割をMSMの若者の感染報告が占めていると言う事実である。つまり、現在個別施策層としてのMSM対策は主にコミュニティという既存の人的ネットワークへのアプローチが中心であり、ここに接触しない若年層MSMが現状のMSM対策の限界を超えて対象となっていない。これら若年層MSMに対してはむしろ一般人口へのアプローチあるいは個別施策層としての若者にMSMが存在していることを前提としたアプローチを行う必要がある。この若年層MSMはセクシュアリティの自認も未確立で、MSMに対する偏見や差別に対してはさらに脆弱な立場にある。このような不安定な状態で性行動が活発化するとそのHIV感染に対する脆弱性は倍加する。

このような背景をふまえつつ、ここでは個別施策層としてのMSM対策に焦点を絞り、以下の３点について施策提言を行う。

1. 検査、医療の現場でのMSMに対する理解促進と差別防止
2. セクシュアルヘルス支援に実践的な経験、技術を持つ専門家の育成
3. 予防啓発活動へのHIV陽性者の視点の導入

１．検査、医療の現場でのMSMに対する理解促進と差別防止

差別や差別的言動が社会的に許されないことは万人が理解しているところである。しかしながらこれらは常に無自覚に行われる所に問題がある。本研究のMSM陽性者への聞き取り調査から、検査機関や医療機関の専門職が自らの個人的価値観や嫌悪感などの感情に支配されたまま無自覚に差別的言動をとっていることが判ってきた。

MSMをはじめとする性的少数者に対する理解は近年進展を見せている。特に性同一性障害者に対しては一部戸籍変更が認められるなど制度上の改善も見られる。しかしながら男性同性愛者に対しては社会的認知も低く、当事者もまた男性同性愛者を含むMSMに対する否定的な社会心理を内在化させている場合が多い。このようなクライアント、患者の存在が重要な前提となるHIV感染症対策においては、まず職業人として保健、医療に従事する専門職がこの現実に対応する必要がある。

いっぽうで性社会学、性科学などの研究はわが国においても進展を見せている。MSMの社会的脆弱さがその自尊感情を低下させHIV感染の危険性を増加させている側面も明らかになってきた。(ゲイ・バイセクシュアル男性のHIV感染リスク行動と精神的健康およびライフイベントに関する研究/日高庸晴ら(2004)日本エイズ学会誌第6巻3号165-173, 日本エイズ学会)また、当事者による研究も欧米諸国に比して遅れているとはいえ、進展を見せている。しかしながらわが国におけるHIV抗体検査に携わる保健関係者、HIV診療にたずさわる医療関係者の育成に関わる専門家研修においてはこの問題が軽視されている。そのため一部医療機関においては独自に学習の機会を設けざるを得ない状況にある。この不存在が意図的であれ、無意識であれ、わが国におけるエイズ対策の中心的機関がこの努力を怠っていることはまさしく差別が制度化されつつあり、後天性免疫不全症候群に関する特定感染症予防指針(平成十一年厚生省告示第二百十七号、平成十八年三月二日厚生省告示第八十九号により改訂)の無視に等しいと言わざるを得ない。

MSM陽性者が安心してHIV抗体検査を受検し、高度な医療を誇るわが国のHIV診療体制に円滑にアクセスできる環境を整備するためには、クライアントおよび患者としてのMSM理解促進および差別的対応の改善のための研修を関係者に対して強く推進する必要がある。

2．セクシュアルヘルス支援に実践的な経験、技術を持つ専門家の育成

わが国において性行動に関する研究は欧米先進諸国に比較して大幅に遅れをとっている。精神科領域においてもセックス依存症に対応しうる専門医は極めて少なく、臨床心理分野においてもセックスカウンセリングに関する研究は未だ数少ない。さらに実践的経験を有する専門職は皆無に等しく、HIV陽性者の多くはセクシュアルヘルス向上のニーズを感じながらもその支援サービスへのアクセスをできない状況にある。

当研究の過程からも陽性告知後カウンセリングや医療現場において専門家の形式的理解による介入に反発を覚え性に関するコミュニケーションを自主規制している様子がうかがわれた。

この背景にはわが国の文化が社会構造的、社会心理的に性を卑しい存在とする性嫌悪症的傾向がある。しかしながらHIV感染症対策においてHIV陽性者のセクシュアルヘルス向上は現実的に最重要課題であり、この問題を回避してHIV感染症流行の流れは止めることは不可能である。特にMSMの性行動や心理を熟知した上で支援的対応が可能な専門家の育成は急務である。

3．予防啓発活動へのHIV陽性者の視点の導入

HIV陽性者は予防、検査、医療、ケア・サポートなどエイズ対策のすべての局面においてその対象となった経験を有している。そして、その経験を生かして予防活動、支援活動に積極的に参加しているHIV陽性者も少なくない。これらのHIV陽性者からは予防プログラムが時には自分を排除するメッセージとして感じるという指摘がなされている。

予防啓発の対象者は個別施策層として位置づけられそこに向けたメッセージが発信される。いっぽうで予防情報がHIV陽性者としての生活イメージ、つまり検査後の生活ビジョンが欠落したままHIV陽性者排除のイメージを感じ取らせるものであったならば、検査行動や受信行動を促す上で逆効果にもなりうる。

保健所など行政によって発信される予防メッセージが自らの職業上の使命を強く意識するあまりこの点への配慮が欠落しているケースが多々見られる。たとえば昨年日本ユニセフが作成したHIV陽性者の妊婦を加害者として位置づけるポスターはHIV陽性の女性をひどく傷つけるものであったし、エイズ予防財団が展開した「Living Together／大切な人を守るために」というキャンペーンテーマは、不用意に用いられた「守る」という言葉がHIV陽性者を感染源としてイメージさせるものであった。誰も自ら加害者の立場に立ちたいとは思わない。これらはさらにHIV陽性者を恐怖の対象として受け止めさせ、HIV/エイズのスティグマを拡大する可能性も大きい。

これらの予防メッセージはともに発信者の視点で形成されたもので、HIV陽性者の視点が導入されていればこのような結果は回避されたはずである。

また、HIV陽性者の視点はHIV感染が主にどこで、どのようにして起こっているのかという問題の解明にも貢献できる。個別施策層の中でも介入困難層はHIV陽性者として初めてエイズ対策の一環である医療にアクセスしてくる。つまりHIV陽性者は現行のエイズ対策が本来提供すべきセクシュアルヘルス向上のためのプログラムに不幸にもアクセスできなかった人々であり、その障害を解明することで今後重点的に実施すべき解決のための課題が浮かび上がってくる。この時、MSMをはじめとする社会的に脆弱な立場の人々への倫理的配慮が十分になされ、支援的な態度、体制が重要であることは言うまでもない。

厚生労働科学研究費補助金 エイズ対策研究事業（総合研究報告書）
男性同性間のHIV感染対策とその評価に関する研究

MSMに対するエイズ対策の国際比較研究
アジアとオーストラリアの経験から見えてきたこと
What can be learned from the Asian and Australian experience?

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研究要旨

The level of governments' leadership and commitment are critical factors in determining an effective response to HIV prevention and treatment provision for people with HIV[1)]. The aim of this research is to describe and analyze the epidemiology and response to HIV in a number of countries worldwide which have implemented successful and less successful policy. In 2006, analysis of the Australian experience shows that enabling gay men to be responsible for evaluating risk, through education and research feed back, with government funding and legally and socially supportive environments, has produced good outcomes in reducing HIV infections. Key to success has been strong links between affected communities, prevention specialists (ie AIDS educators in NGOs), and theoretically and methodologically strong epidemiological, behavioral and social research. In 2007, analysis on the epidemiology and response to HIV in Asia and Japan found a great deal of commonality and connectedness between Asia and Japan's HIV epidemic found that Japan shares a number of similar features with the Asian epidemic, including late appearance of HIV infection, previous assumptions of a heterosexual sexual epidemic due to lack of adequate HIV epidemiological surveys in homosexually active populations, diverse homosexual identities, high levels of stigma which have resulted in low levels of government funding and services for gay and bisexual men. More research is needed on travel related social and sexual networks, and drug using behaviors of MSM in Asia and Japan.
As the global HIV pandemic has grown, it has shown the dynamic and complex nature of dealing with health problems related to stigmatized behaviors such as drug use, sex work and homosexual and trans-gendered people. Despite what is clearly known to be effective, governments have various levels of success in halting the spread of HIV infections and providing support to HIV infected people[1)]. This report will present the aims, methodology, results, and discussion of the two reviews conducted in 2006 as 'HIV policy in Australia' and in 2007 as 'Epidemiology of HIV among MSM in Asia'. Research aims, methodology, results and discussion will be

A. 研究目的

1. HIV policy in Australia

Australia's HIV policy is internationally recognized as being successful in responding to HIV through effecting prevention at the community level[2]. The aim of this research is to describe and analyze Australia's policy and practice in relation to HIV prevention among MSM in order to inform community level and national HIV policy for MSM in Japan.

2. Epidemiology of HIV among MSM in Asia

In the 2007 funding year, an analysis was done on the situation regarding HIV among MSM in Asia, and assessment of the level of connectedness between MSM in Japan and Asia. Academic and NGO documents were collected on the epidemiology, risk factors, and prevention programs conducted in relation to MSM and HIV.

B. 研究方法

1. HIV policy in Australia

In the 2006 funding year, an analysis was done of the Australian response to HIV in relation to MSM. A literature search of academic, government and NGO publications was conducted and content was analyzed in relation to the epidemiology of HIV, history of the HIV policy development process, the national HIV policy and program structure, how HIV prevention and education is funded and implemented at the community level, behavioral and social research relating to MSM, and examination of why HIV infections have increased among MSM in Australia since 2000. Key findings are presented.

2. Epidemiology of HIV among MSM in Asia

Since 2000, more sophisticated HIV epidemiological data collected among MSM in Asia indicates high levels of infection rates in many countries including Thailand, Indonesia and China which have low infection levels among general populations[3]. This paper aims to present data on HIV risk and infection rates among MSM in Asia, in particular north eastern Asia, including Taiwan, Hong Kong, and Singapore, and compare it with data regarding the Japanese situation. Furthermore, travel and immigration data will be presented to elucidate the level of gay and bisexual men traveling between Asia and Japan.

C. 研究結果

1. HIV policy in Australia

Findings regarding the epidemiology, history, HIV program outline, funding of HIV prevention programs for MSM, local prevention and support for MSM, research regarding MSM, reason for the recent increase in HIV infections, and implications for Japan will be presented.

1-1) Epidemiology

Australia experienced a peak in HIV infections in 1984, followed by a rapid then gradual decline in annual reported HIV infections through the 1980s and 1990s. Since 2000, HIV infection rates have begun to gradually increase (See Figure 1).

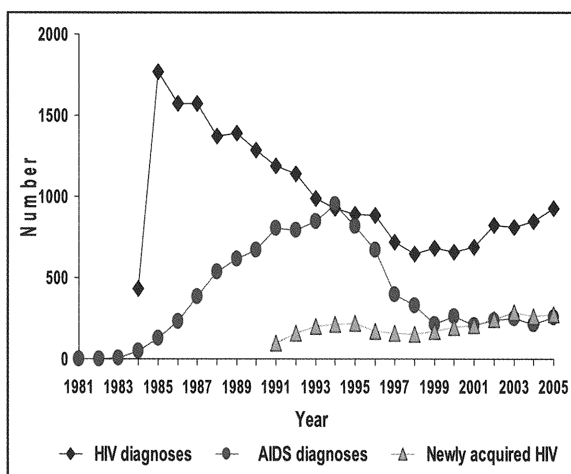

Figure 1. Annual reported HIV and AIDS diagnosis in Australia (HIV diagnoses adjusted for multiple reporting, AIDS diagnosis adjusted for reporting delays) Source: Sate and Territory health authorities[4]

In the early stages of Australia' s epidemic, 95% of HIV infections were among MSM. Since 2000, MSM make up 70% of HIV infections due to increasing HIV infections among immigrants from countries of high HIV prevalence. While HIV infections are reported through the whole country, the highest concentrations in the most populous states of NSW (capital city: Sydney) reporting an infection incidence rate of 6 per 100 000 people and Victoria (capital city: Melbourne) reports an incidence rate of 4.2 per 100 000 people[4].

1-2) History

Before the emergence of AIDS, gay and lesbians have been politically organizing, particularly in response to the decriminalization of homosexuality (anti-sodomy legislation is a commonality of British colonized countries). Since 1975, there has been an annual National Conference of Lesbians and Homosexuals convened. Before AIDS patients had been diagnosed in Australia, gay communities in Sydney and Melbourne had been holding community meetings and publishing articles in the gay press in relation to reports from the United States about a new disease dubbed 'gay cancer' affecting homosexually active men.

After the first AIDS patients were diagnosed in 1983, the initial government response focused on securing safe blood donations and HIV testing, as well as the establishment of AIDS councils in Sydney and Melbourne. Cooperation from the federal health minister was critical in providing funding to conduct education for gay men about AIDS and support for patients with AIDS within gay communities. In the early days, strong leadership by the government, combined with gay communities experience in community organizing laid the groundwork for success in facilitating a strong partnership approach to HIV policy development and program implementation. An approach emphasizing the public health benefits of working with affected communities, de-criminalizing prostitution and anal-sex, and provision of syringes, needles and support for drug users has been the philosophy behind the approach[5-7].

1-3) Program outline

HIV policy is developed and funded at the national level, with implementation of programs occurring at the state level, which is outlined as following:

National Level

- Coordination of national policy by the Australian National Council on HIV,

AIDS, Hepatitis C (Hepatides) and Sexual Health (ANCHAHS).

- Umbrella of state AIDS councils and AIDS related NGOS under the Australian Federation of AIDS Organisations (AFAO).
- Coordination of state People Living With HIV and AIDS through the National Organisation of People living with AIDS (NAPWA).
- Clinical, epidemiological, behavioral and social research is conducted primarily through 3 national AIDS research centers (Australian Research Centre in Sex, Health and Society, National Centre in HIV Epidemiology and Clinical Research, National Centre in HIV Social Research.

State Level

- Statewide NGOS providing prevention and support for sex workers, people with hemophilia, Aboriginals, IDU and migrants.
- State AIDS councils providing education and support for gay and bisexual men.

HIV policy and programming is developed in tri-annual National HIV/AIDS strategies which are externally evaluated. HIV policy has emphasized an 'enabling environment' for HIV prevention and support including the removal of legal and structural barriers to prevention including decriminalization of homosexual sex, removing barriers to condom accessibility, removing criminal sanctions on carrying drug injecting equipment, laws to guarantee confidentiality of HIV test results, anti-discrimination legislation and public education campaigns.

1-4) Funding of HIV/AIDS prevention and education for MSM

In 2006, the total annual funding for HIV/AIDS prevention education was around 40 million Australian dollars[8]. While MSM account for around 80% of total HIV infections, about one quarter of funding is targeted to programs for MSM (See Figure 2).

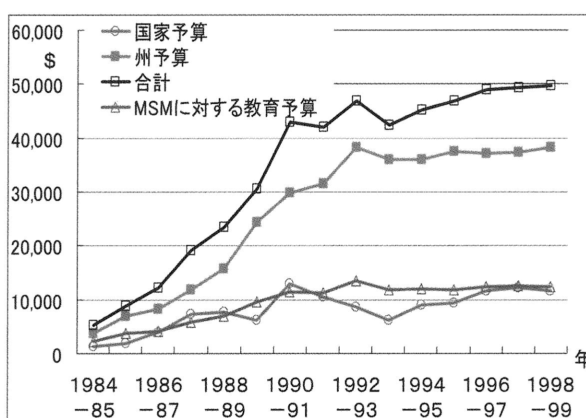

Figure 2. Funding allocations for MSM prevention activities according to funding sources[2]

Local level HIV prevention education and support for people with HIV and AIDS is provided at the state level through AIDS councils, PLWHA, drug user, sex worker, haemophilia, Aboriginal and migrant health organizations. An example of the level of funding for MSM at the local level is as follows.

1-5) Prevention education and support for MSM at the local level: The Victorian AIDS Council

HIV prevention education for MSM and support and care for PLWHA in Victoria is provided through the Victorian AIDS Council (which also incorporates the Gay Men's Health Centre and Positive Living

Centre in Melbourne). Outreach is conducted to rural areas through community health centers.

Funding is provided to conduct:

- HIV prevention education for MSM including programs on syphilis, Post-Exposure Prophylactics (PEP), outreach to provide clients of other organizations about VAC education campaigns.
- Counseling and support for MSM including behavioral change program, anxiety support group, 'Staying Negative' group as well as counseling for individuals and groups.
- Medical and social support for PLWHA including a medical clinic, support to improve the health goals of PLWHA (Health Coach Pilot Project), community support including day trips for isolated PLWHA, and financial support. Support for People with HIV including housing, and at home care.
- Needle Exchange Program, education and support for drug users and PLWHA.
- Volunteer program which supports volunteer participation.
- A fundraising program.
- A Policy development and strategic development committee.
- Finance and human resources management for VAC staff.

In 1983, VAC had 3 staff, and 21 years later in 2004, this had grown to 102 people including part and full time workers, and 300 volunteers. Funding is provided through federal and state health budgets, and in 2006 amounted to 2.7 million Australian dollars - See Table 1[9].

Table 1. Victorian AIDS Council funding in 2006

プログラム	Aust $	円
注射針の交換プログラム/教育	$ 396,822	3千6百万
HIV感染予防行動変容プログラム	$ 1,357,215	1億2千万
スタッフへのHIV予防、トレーニング	$ 651,345	5千9百万
HIV陽性者への住宅環境への支援/自宅介護	$ 288,180	2千6百万
HIV陽性者への注射針の交換プログラム/教育	$ 20,000	180万
HIV陽性者グループへの支援	$ 230,000	2千万
合計	**$ 2,693,562**	**2億4千万**

1-6) Research among MSM

According to the 2000 Sex in Australia random survey of 10,000 adults, 5.9% of men reported some sexual experience in their lives, and 2.6% identified as gay or bisexual[10].

HIV testing behavior among MSM in Australia is high in comparison with other industrial countries. Testing behavior has remained consistently high amongst all cities and HIV negative and HIV positive MSM samples since the beginning of the HIV epidemic[11] (See Figure 3). Research indicates that MSM who undertake HIV risky sexual behaviors and who have strong connection to gay communities are more likely to undertake HIV testing.

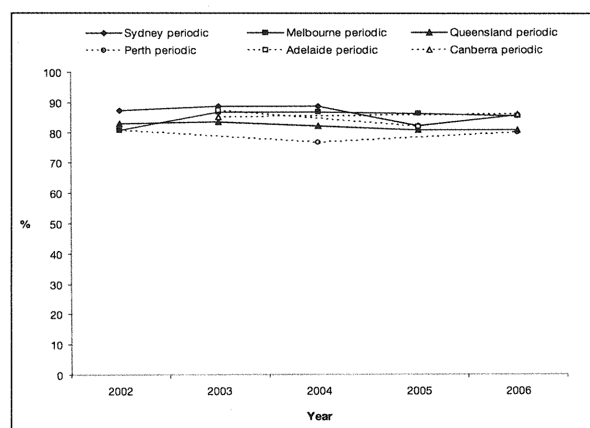

Figure 3. Proportion of MSM tested for HIV [11]

The behavior of community attached MSM and non-community attached MSM (as measured by level of physical an social contact with gay bars, dance parties, gyms, cruising spots, friends, media and organizations) is considerably different[12]. Non gay community attached MSM more likely to:

- Avoid unsafe sex with casual partners
- Not have a regular male partner
- Have mainly casual male partners
- Dress in women' s clothing
- Engage in group sex
- Use cruising venues and advertisements (rather than parties, friends and gay bars) to find sexual partners.

Annual behavioral surveys among MSM began in 1996, collecting data on with unprotected anal sex with casual partners experiencing a slight rise through the 1990s, and leveling out since 2000 (See Figure 4)[13].

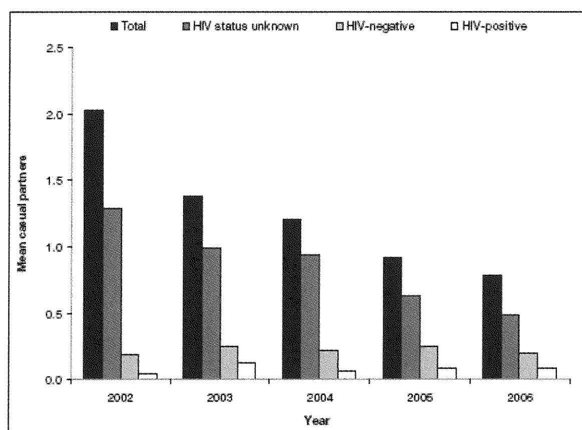

Figure 4. MSMs Mean number of casual partners over time according to HIV sero-status

Since 2000, the cohort study has been following the trends in the health and sexual behavior of HIV negative men Health in Men (HIM) and HIV positive men (The Positive Health study)[14]. Interim findings indicate:

- For the most part, HIV positive and HIV negative MSM report very similar patterns of sexual and drug use behaviors.
- The number of episodes of unprotected anal sex among casual partners is quite low. For the most part, most MSM use condoms with receptive anal sex with casual sex partners.
- HIV positive men are more like to have engaged in unprotected anal sex with casual partners.
- Even removing unprotected anal sex with casual partners among HIV positive MSM with HIV positive partners, unprotected anal sex among casual partners is high, although this has decreased between 2000 and 2005.
- The majority (90%) of unprotected anal sex acts with casual partners are carried by 10% of the MSM in the sample.

Investigation of the predictors of frequent risk takers, which is defined as more than 5 events of unprotected anal sex with a casual partner in the previous 6 months, has revealed the following relational factors[15]. Frequent risk takers were less likely to have a regular partner, dislike condoms, hold greater optimist about HIV treatments, were more likely to discuss HIV status with casual partners, and were more likely to engage in adventurous or esoteric sex practices. Since the late 1990s, research indicates that engaging in esoteric/ adventurous sexual practices is a predictor is unprotected anal sex with a casual partner[16]. Esoteric and adventurous sex,

whose behaviors include fisting, rimming, water sports, using sex toys and cock rings, engaging in bondage and discipline, sadomasochism, and dressing up in fantasy costume.

Research since the 1980s indicates that homosexually active men no longer have strong physical or social connections to gay community and no longer have primarily gay social networks[17]. This is probably due to the introduction of homophobia education and schools and strategies to deal with physical and verbal violence towards gays and lesbians. 'Post AIDS' has been used to describe the changing relationship that gay men have with HIV, in that young gay men have become sexually active in a time when AIDS is no longer a 'crisis' because HAART therapies have prolonged the lives of people with HIV[18].

1-7) Why the increase in new HIV infections?

The increase in HIV infections since 2000 has been subject of much discussion and debate among researchers, policy analysts and gay communities[17]. Research indicates that increasing infections are a result of increasing transmission, and not changes in testing rates[19]. Changes in the epidemiological picture and part of the cause, in that new infections are mainly among heterosexuals who were born overseas in countries with HIV infection rates. However, sharply increasing infections among gay men in Melbourne and Sydney has been blamed on 'policy drift and faltering of leadership' by Don Baxter from the Australian Federation of AIDS Organisations[20], and this has been acknowledged in the 2002 evaluation of AIDS policy conducted by the Department of Health and Aging[21]. Analysis of gay behavioral and social research[17] has concluded that public health and health promotions' focus on 'risk behavior' has limited effectiveness in that problematizing gay men's sexual behavior leads to less engagement by affected individuals, and suggests a greater focus on community development approaches.

1-8) Evaluation of current policy has concluded the following recommendations:

- Switching funding within the budget to have a stronger focus on gay men.
- Implementation of a new strategy which:
- Increases awareness about sexual health And HIV testing as well as:
  - Reinforces condom use.
  - Supports gay community activities and establish discourse around sex and the increase of new infections.
  - Involves HIV positive gay men and MSM in prevention efforts, and seeing this involvement to be crucial.
  - Understands the role of alcohol and drug use in gay men's sexual activity.

Responding to increasing infection rates will, given the fact that MSM have experienced consistent exposure to HIV prevention education programs for the last 20 years, is seen to be a complicated problem requiring a number of strategies. Widening the approach to one that involves sexual health, mental health, and sex

education programs, is seen as necessary.

2. Epidemiology of HIV among MSM in Asia

Until the late 1990s, HIV infection in Asia was presumed to be predominantly through sex work and infecting drug use[22]. However, recent epidemiological data indicates previously undocumented HIV epidemics among MSM through-out Asia[23][24].

2-1) The emergence of the epidemic among MSM in Asia

The first indications of an emerging epidemic among MSM came from epidemiological research conducted among MSM in Bangkok and Phuket in Thailand which observed a jump in reported HIV incidence from 17.3 % in 2003 to 28.3 % in 2005[25][26]. High increases in HIV infection rates among MSM in Thailand in the early 2000s are also consistent with hidden epidemics among MSM in other parts of Asia, including Cambodia, Vietnam, Indonesia, India, and northern Asian countries China, Hong Kong and Singapore [27-29] (See Table 2).

Table 2. HIV infection prevalence among MSM in a number of countries in Asia

Location	Year	Prevalence %	Study design
Bangkok Thailand	2003	17.3%	Time-location sample with sero-testing
Bangkok Thailand	2005	28.3%	
Singapore	2002	5.8%	I'net questionnaire
Singapore	2004	8.0%	I'net questionnaire
Hong Kong	2006	4.1%	Sero-testing with I' view
Beijing China	2004	0.4%	RDS with sero-testing
Beijing China	2005	4.6%	RDS with sero-testing
Beijing China	2006	5.8%	RDS with sero-testing
Taiwan	2006	8.0%	Sero-testing at bath house
Osaka Japan	2005	6.0%	Dance party questionnaire
Tokyo Japan	2005	4.0%	Gay-bar Questionnaire

(Action for AIDS 2004, Chen 2006, Kimura 2005, Kimura 2005, Ma 2007, PRiSM 2006, van Griensven 2005)

HIV testing among MSM in Asia is low in comparison with MSM populations in Australia, North America and Europe (See Table 3). This is partially related to low self-perceptions of risk, lack of accessible STI services, and low levels of knowledge of HIV among gay and MSM on individual and group levels[30].

Table 3. Life time rates of HIV testing among MSM in a number of countries in Asia

Location	Year	Testing rate	Study design
Beijing	2006*	32%	RDS/sero-testing
Bangkok	2005*	21%	RDS/sero testing
Hong Kong	2004*	14%	Random sample telephone I' views with adult men
Taiwan	2006*	76%	Sero-testing and I' view with bath house attendees
Singapore	2004*	50%	gay portal I'net survey
Tokyo	2005*	36%	dance-party survey
Osaka	2005*	28%	gay bar survey
Melbourne	2006#	84%	gay community survey
Sydney	2006#	63%	gay community survey
US	1999*	84%	Random sample of MSM, telephone I' view/Sero-testing
London	2004*	69%	Sero-testing

* life time experience
\# under-went testing in the previous 12 months
(Catania JA 2001, Dodds 2004, Frankland 2007, Ko 2006, Kimura 2005, Lau 2004, Ma 2007, van Griensven 2005, Zablotska 2007)

2-2) Factors contributing to HIV Risk among MSM

The literature identifies behavioral,

social and structural factors impacting on MSM' s risk for HIV infection. Behavioral factors include: wide-spread and diverse same sex behaviors and identities, high levels of unprotected anal sex, high levels of syphilis prevalence, and increasing levels of HIV infection among MSM as a population group. Social and structural factors include: stigmatization of same sex behaviors and government inactivity in providing MSM targeted organizational support, information and prevention activities.

2-2-1) High levels of male to male sexual behavior

Behavioral research from a number of Asian countries indicates high levels of male to male sexual activity among men. While many of the sexual behavior studies have been conducted on convenience samples, including military conscripts, and are primarily young populations of men, the figures of 3% of to 18% indicate high levels of male same sexual activity (See Table 4).

2-2-2) Unprotected anal sex

While population based studies have established that same sex behavior among men in Asia is high, MSM in Asia have a number of risk behaviors that make them vulnerable to HIV. These include: high levels of unprotected anal sex (See Table 5), lack of knowledge about associated risk, high levels of transactional sex, high numbers of sex partners and low perceptions of self risk[30].

Table 4. Prevalence of life-time same sex behavior among men in a number of countries in Asia

Location	Year	Prev %	Recruitment
Thailand	1993	3%	Interview survey with general adult population
Thailand	1993	16%	Military conscripts
Vientiane Laos	2004	18%	Young males
Hong Kong	2004	4.60%	Population based telephone survey with men 18 to 60
Japan	1999	1.2%*	Random sample Interview survey with adult general population

* Survey question asked the experience of same-sex sexual attraction (Kihara 1999, Lau 2004, Sittriai 1993, Toole 2006 2004)

Table 5. Prevalence of unprotected anal-sex among MSM in a number of countries in Asia

Location	Year	Prevalence %	Unprotected sex
China Beijing	2005	79%	Regular male partner/past 6 months
China Beijing	2007	68%	Unprotected sex with man/past 6 months
Taiwan	2005	22%	last bath-house visit
Hong Kong	2004	60%	Anal sex/last 6 months
Singapore	2004	30.8%	Unprotected anal sex with boy friend/ last month
		20.1%	Unprotected anal sex with casual partner/last month
Japan	2006	18.2%	Didn' t use condom with last anal sex/ regular partner
		8.6%	Didn' t use condom with last anal sex/casual partner

(Ruan 2005, Ma 2007, Chen 2005, Kimura 2005, Lau

2-3-3) Sexually Transmissible Disease

Data indicates high rates of syphilis among MSM through-out Asia. Syphilis prevalence among MSM is an indicator of unsafe sexual behaviour, as well as increased risk for HIV infection. Syphillis prevalence among MSM in Asia ranged from 5.5% in Phnom Pehn to 13.5% in Shiang Hai[3] (See Table 6).

Table 6. Prevalence of syphillis among MSM in a number of countries in Asia

Location	Year	Prevalence	Method
Beijing China	2006	9.9%	RDS/sero-testing (current syphilis infection)
Bangkok Thailand	2005	6.8%	Time-location sample/ questionnaire/ sero-testing
Pnom-Pehn, Cambodia	2004	14.4%	Questionnaire/ sero-testing
Ho Chi Minh, Vietnam	2000	7.0%	MSM attending clinic for voluntary testing
Singapore	2004	4.4%	I' net survey/ life-time syphilis infection
Hong Kong	2004	5.7%	Telephone survey/lifetime STD infection
Taiwan	2006	18.0%	Sero-testing at bath-house
Japan	2005	10.5%	I'net survey asking life-time experience

(Action for AIDS 2005, Cao 2002 in Colby 2004, Chen 2006, Girault 2004, Hidaka 2005, Lau 2004, Ma 2007, van Grensven 2005)

2-2-3) Sex Work

A number of local factors also impact on the vulnerability of MSM to HIV infection including sex work, drug use, and internal and cross border travel. Asian data indicates that payment for sex among MSM is quite prevalent[30]. For example, in Cambodia, 82.8% of Cambodian MSM reported being paid for sex by a male partner[28]. In the Cambodian survey, MSM reporting receiving money for sex one day, and paying for sex on another, indicating the difficulty in making clear definitions about who is the sex worker and client in MSM sexual exchanges. In Japan, 15.8% of MSM respondents an internet survey answered that they had paid money for sex, with 10.2% answering that they had received money for sex[31]. While female sex workers are often brothel based, and are the focus of prevention programs, male sex workers are often difficult to reach, and transactional sex is often infrequent, exchange of money of favors may be ambiguous making outreach and prevention programs to these groups difficult.

2-2-4) Drug Use

There is a large body of international data on the connection between drug use, MSM and unprotected sex. Drug use in Asia is highly implicated as a transmission route for HIV. Taiwan's situation indicates how dramatically the impact of injecting drug use can have on the increase in HIV infections in a short time span. In 2002, an increase in heroin importation into Taiwan, combined with an increase in needle sharing, led to a dramatic increase in HIV infections (See Figure 5).

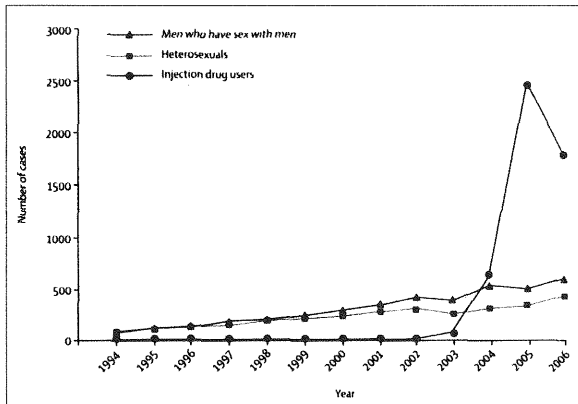

Figure 5. Annual numbers of HIV-1 infected persons according to infection route reported to the Taiwan Centers for Disease Control (Centers for Disease Control Taiwan 2006)

While the epidemiological data published by the Taiwanese CDC treats IDU and MSM as separate infection route categories, sentinel survey indicates drug use among MSM to be high[32]. The rapid increase in HIV infection in Taiwan is not implausable in Japan.

While little research exists on Asia in particular, the literature contains a large body of research on the connection between drug use and dance party attendance. Circuit dance parties, which are popular among MSM in Asia (For explanation see http://en.wikipedia.org/wiki/Circuit_party) have been associated with unprotected unsafe sex, increased risk of STIs, and drug use in the United States[33-35].

Data on drug use among MSM samples in Japan includes an internet survey among MSM in Japan[31] which found that 59% of respondents had a lifetime experience of drug use, as well as from gay community dance parties and gay bars in Osaka. In the 2005 survey among gay bar patrons in Osaka, 61.4% of respondents indicted they had used amyl nitrite, 21.1% 5Meo-DiPT, and 10.6% had used amphetamines during sex[36]. Of the respondents in this survey, only 36.9% reported never having using drugs during sex. Similarly, in a survey conducted at gay community and other dance parties in Tokyo, 48% of respondents reported using amyl nitrites, 8.8% 5MeO-DiPT and 5.3% reported using some other kind of drug[37]. In Japan, HIV sentinel surveillance is conducted among patients being treated for drug addiction in psychiatric hospitals and wards[38]. This data, along with HIV surveillance data, indicates that needle sharing and HIV transmission through needle use is increasing[39]. Despite increasing amounts of seizure of illegal narcotic drugs, particularly amphetamines in the Tokyo area, [40], there is a lack of behavioral and risk data among drug using populations and Japan' s criminal justice policy strictly opposing drug use creates a barrier to undertaking research and public health HIV prevention approaches.

2-2-5) Travel

Travel, migration and instability have been implicated in facilitating HIV infection within Asia, and globally. Asian countries are popular travel destinations for Japanese. Gay dance parties in Thailand, Singapore, Philippines and Japan attract gay travelers. While data collected on Asian MSM in San Francisco, and Asian students in Sydney include Japanese in survey respondents, findings indicate low levels of knowledge of the HIV situation and prevention in the (overseas) countries they are residing, as well high risk practices including drug taking[41]. While

little research has been conducted on the level of travel within Asia undertaken by MSM, a social survey conducted among HIV positive MSM in Hong Kong, indicated that half of the 198 participants had traveled overseas for commercial sex and circuit parties, with the most popular tourist destinations being Thailand, Taiwan and Japan[42]. Spatial linkage of the geographical sexual networks outside of Hong Kong of HIV positive MSM is represented in Figure 6.

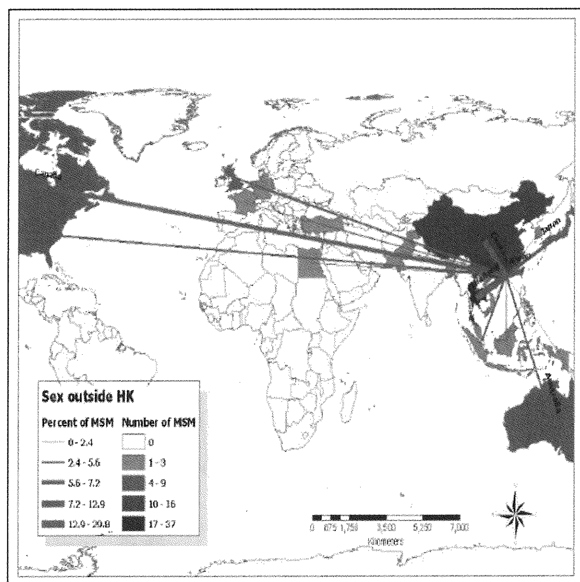

Figure 6. HIV positive MSM' s links with sex partners outside Hong Kong (Lee et al. 2007) (Line thickness represents proportion of survey respondents, and color indicating absolute number of respondents having sex in the country).

While the Hong Kong social network research indicates that MSM travel for the purpose of meeting and having sex with MSM, there is a lack of data on the connectedness between MSM in Asia and Japan. Examination of national travel data indicates that by year overseas tourists from Asia to Japan has increased exponentially due to the Japanese government' s tourist promotion campaigns and the low value of the Japanese Yen (See Figure 7).

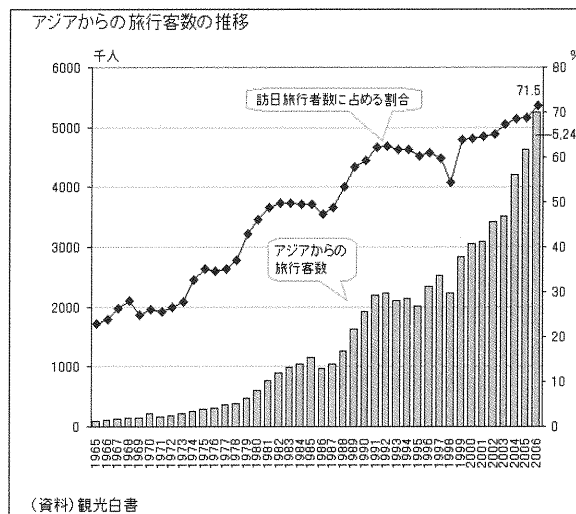

Figure 7. Annual numbers of Asian visitors to Japan (bars) and total number of visitors (line) to Japan

While Japanese travel overseas has been increasing year by year, For Japanese travelers, visits to and from nearby Asia are particularly numerous (Figure 8).

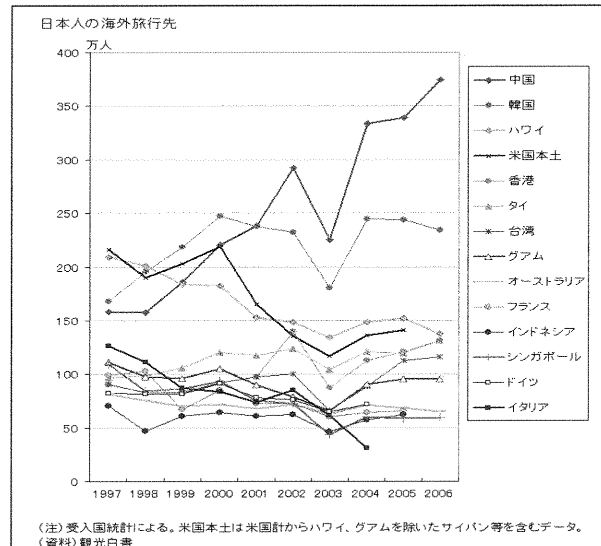

Figure 8. Annual number of Japanese travelers to most popular 14 countries of destination

Japan is a popular destination for foreign labor, particularly for workers from low income countries, who make up the majority of foreigners residing in Japan (See Figure 9).

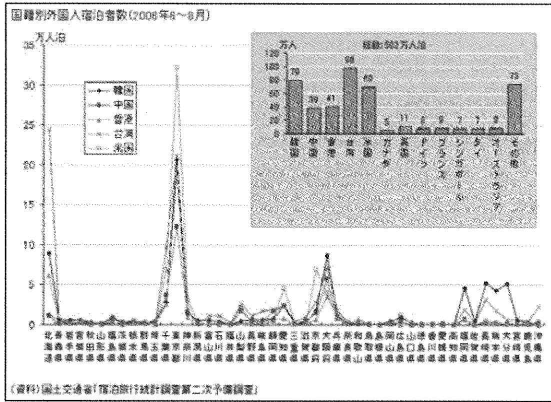

Figure 9. Location and nationality of registered foreign residents in Japan.

Foreigners in Japan face a number of problems regarding HIV prevention and support. Lack of multi-lingual information and NGOs providing health and HIV related support for foreigners in Japan, and the isolation of many foreign workers means that many people are not able to access information regarding HIV transmission, HIV testing and support in the case of a HIV positive diagnosis. The few NGOs providing support to foreigners are not necessarily able to deal with the specific needs of MSM[43]. Many workers do not have working visas or insurance, making them unable to access health services. While HIV infection rates among MSM in Japan have been quite low, in recent years, the numbers of foreign MSM diagnosed with HIV and AIDS has been slowly increasing indicating a need for HIV prevention information, outreach and support for foreign MSM.

As well as longer term visitors to Japan, anecdotal evidence from community center 'acta' in Shinjuku 2 chome in Tokyo, is that foreign gay and bisexual men, particularly from Asia, are more visible at gay bars and events in Tokyo. Similarly, since 2005, the number of foreign MSM in HIV and AIDS surveillance statistics have been increasing (See Figure 10 and 11).

b 外国国籍HIV感染者

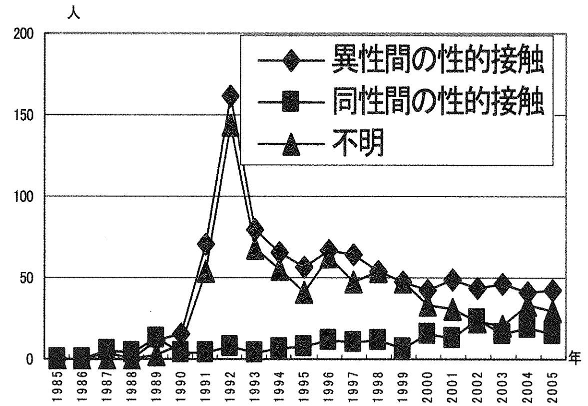

Figure 10. HIV Infection among foreign nationals in Japan (MHLW AIDS Surveillance Data)

d 外国国籍AIDS患者

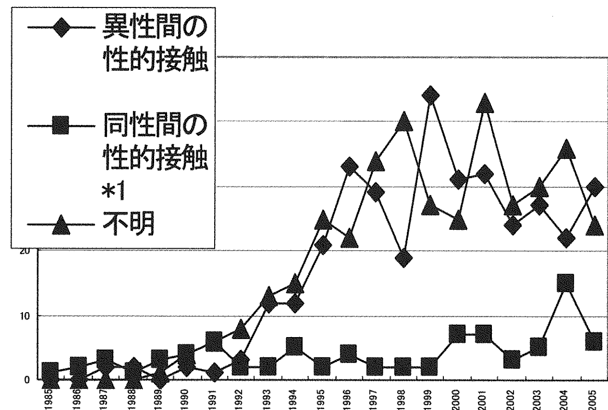

Figure 11. AIDS Infection among foreign nationals in Japan (MHLW AIDS Surveillance Data)

Increasing HIV infection rates among foreign MSM in Japan and the lack of adequate HIV prevention information and support for MSM will need to be addressed in interventions for MSM in Japan in the near future.

2-3. Why are Asian MSM disproportionately represented in HIV infection cases?

There are a number of reasons for the high

disproportion of MSM among national and city HIV/AIDS cases. Data presented in earlier parts of this party indicate that high levels of male to male sex, HIV transmissive risk behavior, and STIs among MSM account for how HIV infection has spread in MSM in Asia populations. However, it is clear that particularly in the case of countries such as Thailand and Cambodia, which have internationally recognized success in averting rapidly increasing HIV infection rates among sex workers and heterosexual populations, that social and policy factors have impeded a rapid and effective response to HIV infection among MSM.

A number of factors have been put forward to account for the delay in conducting adequate epidemiological surveys and implementing HIV preventive programs among MSM in Asia. While the government has been defended for its surveillance and prevention approach towards MSM[44], analysis of how the explosion of HIV infections occurred number reveals a number of criticisms of the Thai approach. A number of barriers have been identified as to why the 100% Condom Program did not translate into effective prevention for MSM in Thailand, These include: stigmatization of homosexual behavior within Thai society, changes in the political environment which were less accommodating of commercial venues for MSM, lack of a strong commitment to public health approach, lack of MSM' s inclusion in the Thai national AIDS plan, weak gay community organization, and lack of research on sexual and social research on Thai MSM' s behaviour and sexual networks[45)46]. A lack of surveillance and weak prevention efforts among Thai MSM allowed HIV to increase rapidly from 17. 3% among MSM in Bangkok to 28. 3%. Furthermore, low levels of HIV testing and unwillingness to disclose HIV status indicates the high amount of stigma in the Thai Department of Health and Thai society in creating a barrier to prevention, despite a successful national HIV prevention program[30].

Weakness in their approaches to MSM prevention and support is common to all countries in the Asian region. Examination of governments' HIV policy and program responses indicates that MSM have not been prioritized in national surveillance, AIDS plans and funding. A UNAIDS study among 20 countries in Asia found that although 60% of national surveillance included MSM in data collection, 15% did not collect behavioral and HIV infection data among MSM populations[47]. Furthermore, 40% of countries did not mention MSM in national AIDS plans, and 75% of countries did not have targeted funding for MSM programs (See Figure12). Positive aspects of governments' responses included the fact that 40% advocated for HIV interventions among MSM, and 100% had consultations between MSM communities, UN and governments. The study estimates that only 8% of the MSM population in respondent countries has access to comprehensive prevention services.

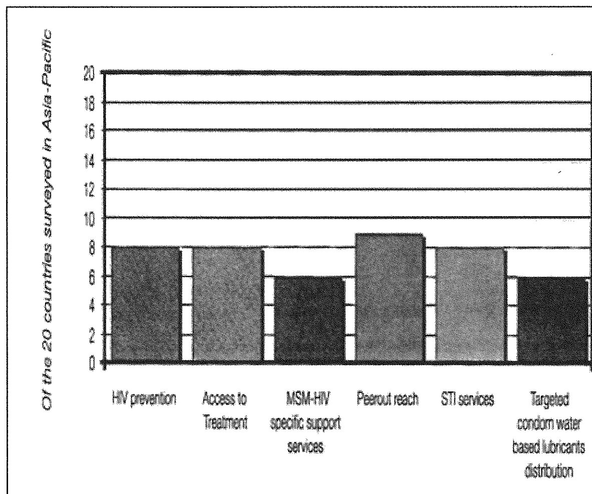

Figure 12. Number of country respondents with MSM specific programs/interventions in their National AIDS Plans (UNAIDS Response Survey 2006 conducted among 20 countries in Asia including Pakistan, India, Bangladesh, Nepal, Sri-Lanka, Bhutan, Maldives, China, Mongolia, Indonesia, Philippines, Thailand, Laos, Cambodia, Vietnam, Myanmar, Malaysia, Singapore, Papua New Guinea, Fiji.)

2-4. What is needed to improve MSM' s access to HIV prevention and support?

High and increasing prevalence among MSM populations necessitates scaling up of surveillance data on national MSM epidemics, inclusion of MSM in national plans, and increased funding and support to community organizations to provide prevention and support services. Furthermore, regional partnerships with MSM organizations bring visibility to MSM issues at a national level, encouraging the emergence of leaders within communities, legal and policy changes, and local advocacy are encouraged in order to foster advocacy for MSM.

D. 考察

HIV policy in Australia

1. HIV prevention policy and practice needs to be based on strong links between affected communities, prevention specialists (ie AIDS educators in NGOs) and researchers.
2. Prevention practice needs to be grounded in theoretically and methodologically strong epidemiological, behavioral and social research.
3. The Australian experience shows that enabling gay men to be responsible for evaluating risk, through education and research feed back, with government funding and legally and socially supportive environments, has produced good outcomes in reducing HIV infections.

Epidemiology of HIV among MSM in Asia

1. Lack of epidemiological data and stigma have resulted in lack of detailed epidemiological data on MSM populations in Asia, and while MSM specific NGOs are providing outreach to the most visible MSM populations, coverage of hidden MSM populations is poor.
2. There is a large amount of male to male sexual behavior with a large diversity of homosexual identities among MSM in Asia, which have dense and loose network characteristics.
3. There are generally low levels of community mobilization among gay and MSM communities.
4. Little is known about the numbers, characteristics and behaviors of gay travelers to and from Japan and Asia.

E. 結語

HIV policy in Australia

Evaluation of Australian policy and practice reveals that strong government