4.1 Introduction

This chapter describes how government, organizations of men who have sex with men and private-sector providers can plan, deliver and scale up effective and comprehensive prevention, care and treatment services for men who have sex with men. In order to mobilize and support critical HIV interventions, the community, public-sector and private-sector partners must collaborate to build a network of biomedical, behavioural, social and structural interventions. This chapter presents a package of services and discusses innovative approaches to fill gaps and create better linkages and retention along the continuum of prevention, care and treatment.

HIV outcomes are significantly improved when services are community-led and community-supported.[1] It is vital that country programmes take stock of HIV prevention, care and treatment resources and identify and promote uptake of those that are respectful, appropriate and accessible for men who have sex with men. Services that were once thought of as being solely delivered at fixed clinical sites can now be delivered by the community, and vice versa.

The package of services described in this chapter is informed by the WHO 2014 Key Populations Consolidated Guidelines[2] and is organized in the following two sections:

- **combination prevention interventions** (Section 4.2)—sexual health and risk minimization, condom and lubricant promotion, voluntary HIV testing and counselling (HTC), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and screening/treatment of sexually transmitted infection (STI) services
- **care and treatment interventions** (Section 4.3)—antiretroviral treatment and care, tuberculosis, mental health, and alcohol and drug use programming.

This chapter also describes the different **service delivery approaches** that are needed (Section 4.4), including clinical approaches which engage community-led organizations, the private sector and the public sector to maximize reach and uptake and reduce loss to follow-up; community-led outreach and peer navigation; information and communication technology (ICT); and the use of safe spaces and drop-in centres.

This chapter discusses delivery of these components through programme implementation tips and case examples for a variety of delivery modalities. The context in which men who have sex with men live can change rapidly, and communities can be beset by crises. This is true not just in regard to HIV services—which are not always steadily and reliably funded—but also for the ways in which society behaves towards men who have sex with men. Political declarations or the introduction of laws against homosexuality are all too common, and present a particular challenge. The service-delivery approach must therefore depend on the circumstances in each setting.

4.1.1 The HIV prevention, care and treatment continuum

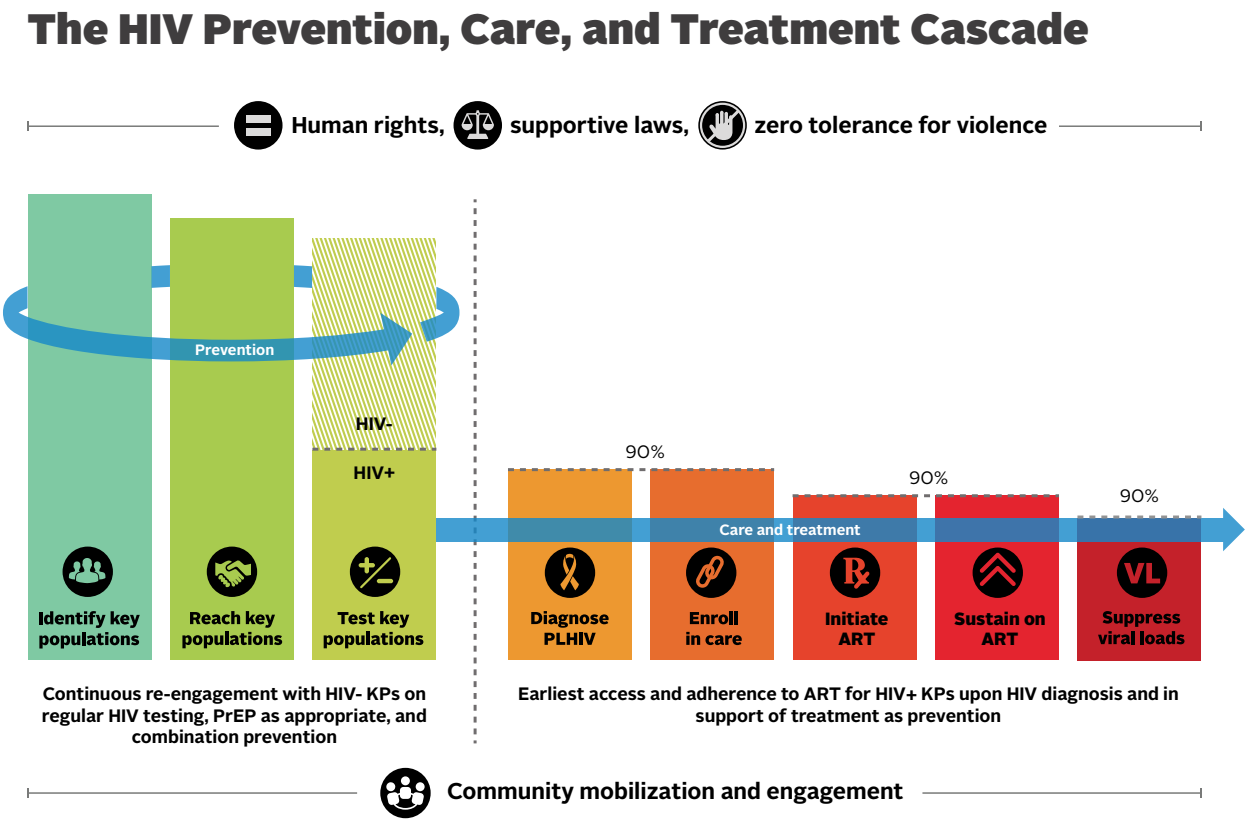
Figure 4.1 illustrates the HIV prevention, care and treatment continuum. It shows the essential steps for planning and measuring client flow through prevention, care and treatment services. It starts by emphasizing the importance of estimating the size and locations of the key population—in this case, men who have sex with men—followed by assessing their risk levels and needs and reaching them

1 In most contexts in this tool, "community" refers to populations of men who have sex with men rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to men who have sex with men, "community-led interventions" are interventions led by men who have sex with men, and "community members" are men who have sex with men.For further details, see the Glossary.

2 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2014.

with HIV prevention products and services through a combination of approaches. A major aim is to encourage uptake of HIV counselling and testing, following which HIV negative individuals should be continually re-engaged for regular repeat testing and combination prevention programmes. Men who have sex with men diagnosed with HIV infection are referred to care programmes until they are eligible to begin antiretroviral therapy (ART). Long-term sustained ART ultimately leads to a suppressed viral load.

Figure 4.1 Closing gaps in the prevention, care and treatment continuum



Source: USAID/LINGAKES. Note: this example is illustrative and not based on data specific to a key population or geographic area. PLHIV = people living with HIV.

The continuum is a powerful diagnostic, advocacy, planning and monitoring tool that can be easily understood and used by all actors in the HIV response. Mapping data to the continuum enables local stakeholders to:

1. identify "leaks" in the system where key populations are lost to follow-up or unable to access critical products and services in the comprehensive package
2. analyse the root causes of those gaps
3. identify the most effective solutions to improve the system's functioning
4. refine and focus interventions and services to reduce HIV transmission and impact.

Loss to follow-up along the HIV continuum is a major problem globally, especially among key populations because services are either unavailable or are often stigmatizing. The framework depicted in Figure 4.1 emphasizes the importance of "reach–test–treat–retain" to meet the proposed UNAIDS

prevention target of reducing the number of new HIV infections by 75% (to under 500,000 a year) by 2020, and the UNAIDS treatment target of 90-90-90 in 2020:

- 90% of all people living with HIV will know their HIV status
- 90% of all people with diagnosed HIV infection will receive sustained ART
- 90% of all people receiving ART will have durable viral suppression.

UNAIDS has also called for 90% coverage of key populations, including men who have sex with men, with combination prevention packages that include condoms, lubricant and PrEP.

4.1.2 Providing comprehensive health services to men who have sex with men

Figure 4.2 presents a blueprint or algorithm that can be used to provide holistic care to address the multiple clinical and support needs of men who have sex with men. It summarizes interventions recommended by the World Health Organization (WHO) at various points along the prevention, care and treatment continuum. It takes into account the HIV serostatus of men who have sex with men in indicating appropriate interventions.

Services begin by assessing the needs of men who have sex with men and reaching them with HIV prevention commodities and services through a combination of approaches. A major aim is to encourage uptake of HIV counselling and testing, following which HIV negative individuals should be continually re-engaged for regular repeat testing and combination prevention programmes. MSM diagnosed with HIV infection are linked to care programmes and should begin ART.

There are several overarching considerations and principles that should inform the planning, design and delivery of services to men who have sex with men:

Involving men who have sex with men in health-care provision: Wherever possible, community members should be involved in the design, implementation, management and evaluation of health-care services, whether these are delivered in community settings or in clinical settings. The considerations listed below apply particularly to settings in which providers have limited or no experience of serving men who have sex with men, but many of these considerations can be addressed by involving community members in service delivery, with appropriate training and support. Community outreach workers (see Section 4.4.2, Part A) and peer navigators (Section 4.4.2, Part C) are roles in which men who have sex with men can give information to community members, refer them to services and guide them through the experience of receiving health care. In addition, the presence of appropriately trained community members as clinic staff, e.g. receptionists, providers of HIV testing and counselling, managers, and nurses or doctors, will increase service uptake by helping to ensure that services are respectful of men who have sex with men, and acceptable to them.

Establishing a welcoming environment: For high-quality care to be provided, clients need to be welcomed into a safe space by respectful staff, followed by an opportunity to establish a trusting provider–client relationship. Taking clinical histories and conducting physical examinations may require additional insight and sensitivity on the part of health-care providers, since men who have sex with men often experience stigma and discrimination when seeking and accessing health services. Individual-level factors such as previous personal experiences, as well as societal factors including

attitudes and norms toward men who have sex with men, may create barriers to establishing a therapeutic relationship. Health-care providers need to be aware of and sensitive to such factors, as well as to their own biases. Creating a safe, supportive and therapeutic environment is the first step to providing appropriate care to men who have sex with men.

Figure 4.2 Blueprint of WHO-recommended package of prevention care and treatment services for men who have sex with men

	MEN WHO HAVE SEX WITH MEN	
	HIV-positive	**HIV-negative**
PREVENTION	✔ Outreach, distribution of condoms and condom-compatible lubricants, provision of safe spaces, community mobilization (Sections 4.2.5, 4.4.2, 4.4.4)	
		✔ PrEP for men at substantial ongoing risk of HIV infection (Section 4.2.7)
		✔ PEP following suspected exposure (Section 4.2.8)
	✔ Behavioural interventions to support risk reduction (Section 4.2.1)	
	✔ Brief sexuality counselling	
	✔ Anal cancer screening (Section 4.2.10)	
	✔ Prostate cancer screening	
	✔ STI screening (Section 4.2.9)	
	✔ Harm reduction for men who use drugs (needle and syringe programmes, opioid substitution therapy, other drug-dependence treatment and opioid overdose prevention and management) (Section 4.3.4)	
HIV TESTING	✔ For sexual partners (Section 4.2.6)	✔ Testing at least every 12 months and more frequently as needed, if at high ongoing risk; also for sexual partners (Section 4.2.6)
RETESTING & CONFIRMATORY TESTING	✔ Retest before ART initiation or when linked to care from community-based testing (Section 4.2.6)	✔ Retest at least every 12 months, before initiation of PrEP, and more frequently as needed, if at high ongoing risk (Sections 4.2.6, 4.2.7)
TREATMENT	✔ Antiretroviral therapy (Section 4.3.1)	
OTHER CLINICAL SERVICES	✔ Assessment and provision of vaccinations, such as HBV (Section 4.2.9)	
	✔ HBV and HCV testing and treatment (Section 4.2.9)	
	✔ Co-trimoxazole chemoprophylaxis	
	✔ Intensified TB case finding and linkage to TB treatment (Section 4.3.2)	
	✔ Provision of isoniazid preventive therapy (Section 4.3.2)	
OTHER SUPPORT SERVICES	✔ Mental-health services (Section 4.3.3)	
	✔ Psychosocial counselling, support and treatment adherence counselling	
	✔ Support for disclosure and partner	
	✔ Legal services	

Source: WHO, 2014; WHO, 2013; WHO, 2012; WHO, 2008.

Learning to interact with clients: Providers must understand how to interact appropriately with men who have sex with men as clients, and how to communicate appropriate health messages. A helpful strategy is to provide training on the clinical management of men who have sex with men, and on how to deliver services in a compassionate manner that encourages clients to feel safe, accepted and valued. A variety of high-quality training materials have been developed by practitioners experienced with providing health services to men who have sex with men (see Section 4.5).

Understanding fear of disclosing symptoms: Men who have sex with men may have highly symptomatic STIs before they are willing to present for care, because of the shame or fear that may be associated with disclosing sexual behaviour, orientation or the presence of sexually oriented symptoms. Clinicians should also be aware that emotional or psychological distress may not be freely disclosed, even though psychological symptoms, including depression, anxiety and suicidal ideation, are more common among men who have sex with men. Living in communities where blatant discrimination or more subtle forms of exclusion exist may be a part of the daily experiences of men who have sex with men. At a systemic level, health-delivery systems, including both community- and clinic-based settings, should be prepared to address the psychosocial needs of their clients.

Linking to ART: As provision of ART has been brought to scale, several programmatic challenges have emerged, including suboptimal rates of HIV testing, ART adherence and retention in care. HIV programmes face an additional challenge of delayed linkage to HIV and ART care and high pre-ART attrition among HIV-infected individuals, which hinders further scale-up and the attainment of universal coverage. Timely linkage to ART is critical to reducing HIV-related morbidity and mortality. These issues are coming to the fore as there is increasing interest in treating people earlier in the course of their infection, in order to increase the proportion of patients on ART who are virologically suppressed and thus at negligible risk of transmitting the virus to others. Community-led programmes can play a role in ensuring early linkage to and retention in care. They also play an important role in assisting with treatment adherence.

Taking a holistic approach: In the context of a health visit, or during follow-up care, the health of men who have sex with men should be addressed holistically. They should be encouraged to address issues such as nutrition, vaccinations, STI prevention, screening for chronic conditions and leading an emotionally balanced life. If available, health education programmes can be crafted to address self-care from the unique perspectives of men who have sex with men, including information about how to develop healthy coping mechanisms for dealing with minority stressors such as homophobia and heterosexism.[3] A secondary goal of all visits should be to encourage individuals to be proactive with their own health and to gain a sense of empowerment about using clinicians as advisors or consultants, alongside other resources such as the Internet (see Section 4.4.3 and Chapter 5). Strong partnerships between community programmes serving men who have sex with men and mainstream health clinics could ensure improved coordination toward addressing the holistic needs of this population.

3 Homophobia is an irrational fear of, aversion to, or discrimination against persons known or assumed to be homosexual, or against homosexual behaviour or cultures. Heterosexism is the imposition of heterosexuality as the only normal and acceptable expression of sexuality, resulting in prejudice or discrimination against people who are not heterosexual, or who are perceived not to be heterosexual.

Integrating services: HIV services are often compartmentalized and separated from other health-care services. Prevention is often divorced from HIV care and treatment sites, which may not be co-located with STI treatment, adherence support or other HIV care needs. Treating patients with HIV separately from other medical services can act as an impediment to keeping them healthy. One way to overcome this is to emphasize the holistic care of patients and to cross-train health providers to deliver multiple services to a single patient, such as hypertension services, stress counselling or routine STI screening. Engaging men who have sex with men and community members not just as recipients of services but also as providers and advisory bodies can help shape service delivery appropriately. (See also Section 4.3.1, Part D.)

Keeping up to date with expanding knowledge: Staying involved and participating in trainings with innovative, evidence-based information is highly relevant to providing optimal clinical care, no matter the patient. This includes up-to-date guidelines on the management of chronic conditions associated with HIV infection, ART and ageing. In countries with limited resources, creative strategies must be implemented in order to have access to such cutting-edge knowledge. Webinars such as those provided by The Fenway Institute in the USA offer a wealth of information from research and evaluation findings (see Section 4.5). In South Africa, Anova Health Institute uses a subscriber listserve, edited by a medical doctor, to disseminate newly published peer-reviewed papers and HIV news, with a subtle emphasis on men who have sex with men and other key populations. Started in late 2012, it serves over 170 clinicians, researchers and others in South Africa. An average of more than 20 articles a month are sourced and sent out with a brief introduction.[4]

Comprehensive health services should be designed and organized for implementation at scale: Achieving high coverage, ensuring high-quality services and linking or integrating to HIV, sexual-health and other services requires systematic, standardized approaches. Once established and scaled up, services may be expanded in scope to meet the broader health needs of men who have sex with men. A phased approach to scaling up services, moving from externally led services to community-led ones, is illustrated in Figure 4.3.

4.2 Combination prevention

Ensuring that men who have sex with men have accessible sexual-health services and appropriate risk minimization information and commodities is critical to an effective programme. Men who have sex with men have unique sexual-health needs beyond the issue of disease. When talking with them about their sexual health goals.

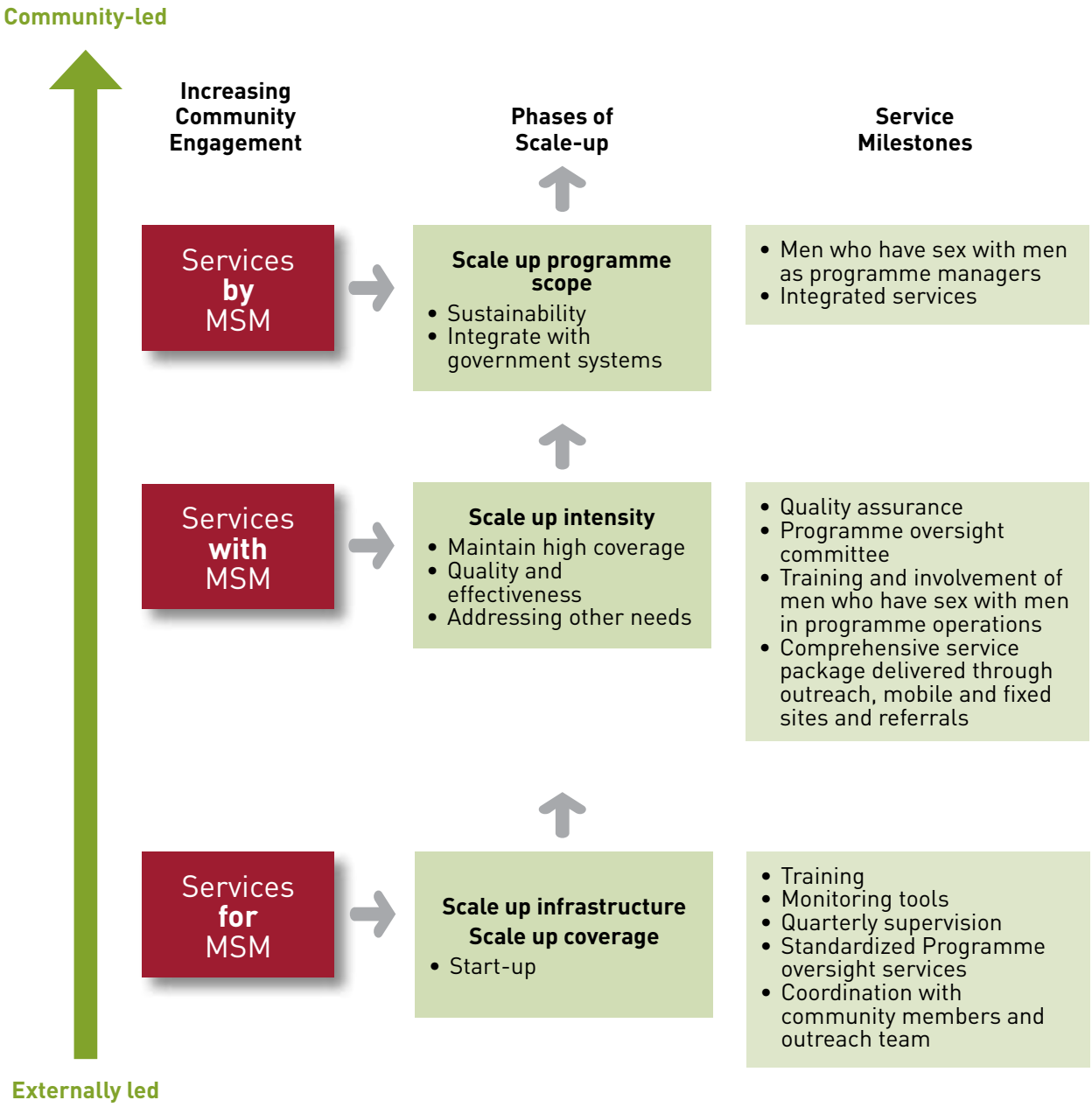
The use of combination prevention may ensure that diverse populations are offered prevention approaches appropriate to their lifestyles. The UNAIDS HIV Prevention Reference Group defines combination prevention programmes as "rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections."[5] Combination prevention programmes can include all the services described in this chapter. Programmes should:

- be tailored to national and local needs and conditions

4 More information is available at moderator@anovahealth.co.za or subscribe at http://lists.anovahealth.co.za/mailman/listinfo/hiv_clinician.

5 Combination HIV prevention: tailoring and coordinating biomedical, behavioural and structural strategies to reduce new HIV infections. Geneva: UNAIDS; 2010.

Figure 4.3 Scale-up of services for men who have sex with men



- focus resources on the mix of programmatic and policy actions required to address both immediate risks and underlying vulnerability
- operate synergistically and consistently on multiple levels (e.g. individual, relationship, community, society) over an adequate period of time
- mobilize community, government, private-sector and global resources
- incorporate mechanisms for learning, capacity-building and flexibility to permit continual improvement and adaptation to the changing environment.

Combination approaches should be viewed within the larger framework of the HIV prevention, care and treatment continuum, recognizing the interdependent relationship between prevention, care and treatment.

4.2.1 Individual and group-level behavioural interventions

2014 Key Populations Consolidated Guidelines

Implementing both individual-level behavioural interventions and community-level behavioural interventions is suggested. *(p.41)*

Men's health groups and organizations of men who have sex with men are essential partners in providing comprehensive training on human sexuality and delivering services and so should be actively engaged. They also can facilitate interaction with members of sexually diverse communities, thereby generating greater understanding of their emotional health and social needs and the cost of inaction against homophobia. *(p.103)*

Individual and group-level behavioural interventions should be welcoming, nonjudgemental and client-centred. Motivational mentoring and skills-building should focus on creating health safety plans with realistic goals. Topics can include negotiating safer sex with one's partner, decisions about open versus closed relationships, decisions about condom and lubricant use, lower-risk sexual practices (insertive versus receptive anal sex, oral sex versus anal sex, masturbation, use of sex toys etc), HIV and STI partner disclosure, couples HIV testing, considerations for biomedical prevention such as PrEP and PEP, and benefits of early and sustained HIV treatment.

For individual and group-level behavioural interventions to be successful, the necessary human resources, an enabling environment and adaptation to the local context are necessary.

Human resources

Many different professional cadres can implement behavioural interventions, such as nurses, social workers, psychologists, clinicians and counsellors. Trained non-professionals and community outreach workers can also effectively implement behavioural interventions.

The success of behavioural interventions requires high-quality and multi-faceted training to cover not only the technical content but key information on communication strategies, partner counselling techniques and motivational skills. Technical content should address syndemic factors (i.e. clusters of psychosocial health problems) that may contribute to HIV-related sexual risk, such as depression, substance use and psychosocial impacts of stigma and discrimination (see Sections 4.3.10 and 4.3.11).

Providers should receive training in the fundamentals of HIV, including basic definitions (e.g. HIV, AIDS, immune system, opportunistic infections etc), transmission modes and strategies to prevent becoming infected or transmitting HIV, and a minimum understanding of HIV treatment. Additionally, a referral system should be in place for services that are not readily available.

In resource-limited settings, highly trained individuals may not be available to implement such behavioural interventions. Task-shifting to other individuals such as trained counsellors and peer navigators (see Section 4.4.2, Part C) is therefore advised. In such cases, training programmes should be developed to provide a minimum level of knowledge and skills (e.g. HIV testing) prior to providing HIV services.

Behavioural curriculum content can be based on national strategic plans; however, recommendations from the WHO and the US Centers for Disease Control and Prevention (CDC) are available. Established programmes, such as that of the CDC's Division of HIV/AIDS Prevention, provide trainings on HIV prevention strategies, effective behavioural interventions and other topics targeting HIV prevention providers and administrators, and can serve as a model.[6] Other training materials are listed in Section 4.5.

Environment

Behavioural interventions can be implemented in a variety of settings: health facility, community-led, private home or mobile outreach. Health-care settings must pay particular attention to establishing environments inclusive of men who have sex with men, bearing in mind the numerous challenges they face. Stigma, discrimination and homophobia in the attitudes of health professionals and in the tone of the health-care or community setting—whether expressed verbally or nonverbally, implicitly or explicitly—create barriers to clients' access to, and use of, health care.

Diversity and sensitivity training for all staff who work in health-care facilities and community-based or community-led settings is needed. Establishing safe environments that maintain strict standards of confidentiality is essential. Providers should understand the heterogeneity of their communities and be trained to conduct health interviews from the perspective of sexual diversity, avoiding assumptions of heterosexuality, in order to gather a more accurate and informative assessment.

Adaptation to the local context

Men who have sex with men will appreciate intake forms, service signage and branding, posters, brochures and photographs and other visual elements that acknowledge and address their lives. While the use of visual tools openly displaying same-sex couples may not be possible in all contexts, strategies that communicate the principle of inclusion should be sought. Media can be designed with strategic ambiguity, where coded visual cues appeal to men who have sex with men without drawing adverse attention from other societal groups. Community input is critical in designing appropriate and non-threatening materials.

6 http://www.cdc.gov/hiv/training/programs.html