Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men

PRACTICAL GUIDANCE FOR COLLABORATIVE INTERVENTIONS

UNFPA MSMGF UNDP Empowered lives. Resilient nations. UNAIDS World Health Organization USAID FROM THE AMERICAN PEOPLE PEPFAR WORLD BANK GROUP

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Contents

Acknowledgements . . . vii

Acronyms and abbreviations . . . x

Glossary . . . xi

Introduction . . . xv

❶ Community Empowerment . . . 1
- 1.1 Introduction . . . 5
  - 1.1.1 Power and health . . . 6
- 1.2 Key elements of community empowerment . . . 10
  - 1.2.1 Working with communities of men who have sex with men . . . 11
  - 1.2.2 Fostering programmes led by men who have sex with men . . . 12
  - 1.2.3 Developing cohesive communities . . . 13
  - 1.2.4 Strengthening community systems . . . 15
  - 1.2.5 Promoting a human-rights framework . . . 17
  - 1.2.6 Shaping policy and creating enabling environments through advocacy . . . 19
  - 1.2.7 Adapting to local needs and contexts . . . 20
  - 1.2.8 Supporting community mobilization and sustaining social movements . . . 21
- 1.3 Monitoring progress . . . 22
- 1.4 Resources and further reading . . . 26

❷ Addressing Violence against Men Who Have Sex with Men . . . 29
- 2.1 Introduction . . . 33
  - 2.1.1 Contexts of violence . . . 36
  - 2.1.2 Values and principles for addressing violence . . . 38
- 2.2 Promising interventions and strategies . . . 39
  - 2.2.1 Building capacity and self-efficacy . . . 40
  - 2.2.2 Working for legal and policy reforms . . . 41
  - 2.2.3 Fostering police accountability . . . 43
  - 2.2.4 Promoting safety and security . . . 45
  - 2.2.5 Providing health services . . . 46
  - 2.2.6 Providing psychosocial, legal and other support services . . . 47
- 2.3 Management, monitoring and evaluation . . . 50
- 2.4 Resources and further reading . . . 53

❸ Condom and Lubricant Programming . . . 57
3.1 Introduction . . . 61
3.1.1 Principles of condom and lubricant programming . . . 62
3.2 Steps in effective condom and lubricant programming . . . 64
3.2.1 Establishing accessible supplies . . . 67
3.2.2 Condom and lubricant social marketing programmes . . . 70
3.2.3 Creating demand . . . 71
3.2.4 Creating an enabling environment for condom and lubricant programming . . . 74
3.2.5 Lubricant programming . . . 76
3.2.6 Other considerations in condom and lubricant programming . . . 78
3.3 Programme management, monitoring and evaluation . . . 79
3.3.1 Roles and responsibilities . . . 80
3.3.2 Programme monitoring . . . 81
3.3.3 Evaluation . . . 82
3.4 Resources and further reading . . . 82

❹ Health-Care Service Delivery . . . 85
4.1 Introduction . . . 89
4.1.1 The HIV prevention, care and treatment continuum . . . 89
4.1.2 Providing comprehensive health services to men who have sex with men . . . 91
4.2 Combination prevention . . . 94
4.2.1 Individual and group-level behavioural interventions . . . 96
4.2.2 Sexual or other risk history-taking . . . 98
4.2.3 Adaptive strategies (serosorting, strategic positioning) . . . 100
4.2.4 Voluntary medical male circumcision . . . 101
4.2.5 Condom and lubricant promotion . . . 101
4.2.6 Voluntary HIV testing and counselling . . . 104
4.2.7 Pre-exposure prophylaxis (PrEP) . . . 109
4.2.8 Post-exposure prophylaxis (PEP) . . . 115
4.2.9 Sexually transmitted infection services . . . 116
4.2.10 Other sexual-health services . . . 124
4.3 Care and treatment . . . 127
4.3.1 Antiretroviral treatment and care . . . 127
4.3.2 Tuberculosis . . . 130
4.3.3 Mental health . . . 131
4.3.4 Drug and alcohol use . . . 135
4.4 Service delivery approaches . . . 137
4.4.1 Clinical approaches . . . 137
4.4.2 Community-led approaches . . . 141
4.4.3 Using information and communication technology . . . 154
4.4.4 Safe spaces . . . 155
4.5 Resources and further reading . . . 157

5 Using Information and Communication Technology 165
5.1 Introduction 169
5.1.1 Background 170
5.2 ICT programme planning and integration 171
5.2.1 Is ICT the appropriate solution? 171
5.2.2 Assessing the ICT landscape and identifying online leaders 171
5.2.3 Designing a behavioural intervention for ICT 172
5.2.4 Safety and ethical concerns 174
5.3 ICT and programme implementation across the HIV continuum 175
5.3.1 Increasing reach and promoting HIV prevention and testing 175
5.3.2 Promotion of commodities and services 177
5.3.3 Strengthening service quality 178
5.3.4 Virtual supportive communities 179
5.4 ICT for the enabling environment 180
5.5 Engaging the private sector 181
5.6 ICT and programme management 181
5.6.1 Data collection 181
5.6.2 Monitoring and evaluation 181
5.7 Resources and further reading 183

6 Programme Management 185
6.1 Introduction 189

PART I.
6.1.1 What are the challenges for programme management? 190
6.1.2 Managing programmes with men who have sex with men 190

6.2 Planning and implementing comprehensive sexual-health services for men who have sex with men 193
6.2.1 Define programme and standards 194
6.2.2 Establish a data system for programme design and routine management 197
6.2.3 Plan the programme evaluation 204
6.2.4 Define the management structure 207
6.2.5 Progressively ensure full participation of men who have sex with men 209
6.2.6 Prioritize 209
6.2.7 Implement in a staged manner 210
6.2.8 Establish a supportive supervision system 219
6.3 Capacity-strengthening and programme learning 221
6.4 Staff development 222

PART II.

6.5 Strengthening the capacity of organizations of men who have sex with men . . 222
6.5.1 Forming a registered organization . . . 223
6.5.2 Organizational capacity-building . . . 226
6.5.3 Governance . . . 226
6.5.4 Project management . . . 227
6.5.5 Technical support and capacity-strengthening . . . 228
6.5.6 Resource mobilization and financial management . . . 229
6.5.7 Networking . . . 230

PART III.

6.6 Programming in difficult or dangerous contexts . . . 231
6.7 Resources and further reading . . . 233

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Acronyms and abbreviations

ART	Antiretroviral therapy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention (USA)
CHTC	couples-based HIV testing and counselling
CRT	crisis response team
eCrCl	creatinine clearance rate
ED	erectile dysfunction
GPS	global positioning system
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICT	information and communication technology
LGBT	lesbian, gay, bisexual and transgender
LMIS	logistics management information system
M&E	monitoring and evaluation
MSM	men who have sex with men
NGO	nongovernmental organization
NSP	national strategic plan
PEP	post-exposure prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PrEP	pre-exposure prophylaxis
SMS	short message service
SRH	sexual and reproductive health
TasP	treatment as prevention
TB	tuberculosis
TMA	total market approach
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VMMC	voluntary medical male circumcision
WHO	World Health Organization

Glossary

Agency has two distinct meanings: 1) an organization; and 2) the choice, control and power that an individual has to act for himself. In chapters where "agency" is used with the second meaning, the definition is given in a footnote at the first occurrence.

Capacity-building: In Chapter 6, the term "organizational capacity-building" is used. However, "capacity development", "organizational development" or a number of other terms would serve equally well.

Community: 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.

In many contexts, community empowerment and an organized response to HIV among men who have sex with men have initially involved those who self-identify in terms of their sexual orientation or behaviour, e.g. as gay, bisexual, MSM, or another term specific to their language or culture. But it is important to remember that men who have sex with men, while sharing a range of sexual behaviours and attractions, do not all necessarily share an identity related to those behaviours (i.e. they do not all identify as gay). Men who have sex with men are also diverse in terms of age, ethnicity, class background, religion, gender identity, gender expression, family background and HIV serostatus. We therefore recommend an open-minded, sensitive and thoughtful consideration of what "community" might mean when conceptualizing interventions that are "community-based" for men who have sex with men.

Community outreach is outreach to men who have sex with men in order to provide services such as education, commodities and other forms of support. Wherever possible, outreach is best done by empowered and trained community members, i.e. men who have sex with men (referred to in this tool as community outreach workers - see definition below). However, people who are not men who have sex with men can also be effective outreach workers, especially in contexts where community members are not yet sufficiently empowered to do outreach.

Community outreach worker: In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.[1]

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.

Homophobia is an irrational fear of, aversion to, or discrimination against persons known or assumed to be homosexual, or against homosexual behaviour or cultures.

Implementing organization is an organization delivering a prevention, care or treatment intervention to men who have sex with men. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

Safe space (drop-in centre) is a place where men who have sex with men may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 4, Section 4.4.4 for details.

Sex workers: The UNAIDS *Guidance note on HIV and sex work* (updated 2012) defines sex workers as female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work may vary in the degree to which it is "formal" or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities.

Young men and **young people** are those in the age range 10–24 years, in accordance with the Interagency Working Group on Key Populations's *HIV and young men who have sex with men: a technical brief* (Geneva: World Health Organization; 2015).

1 See: Inter-Agency Steering Committee (IASC). Guidelines for gender-based violence interventions in humanitarian settings: Focusing on prevention and response to sexual violence in emergencies (field test version). Geneva: IASC; 2005 (p.7). Betron M, Gonzalez-Figueroa E. Gender identity, violence, and HIV among MSM and TG: a literature review and a call for screening. Washington (DC): Futures Group International, USAID Health Policy Initiative, Task Order 1 (p.vi); 2013; Betron M. Screening for violence against MSM and transgenders: Report on a pilot project in Mexico and Thailand. Washington (DC): Futures Group, USAID Health Policy Initiative, Task Order 1; 2009; Wong CM, Noriega S. Exploring gender based violence among men who have sex with men (MSM), male sex worker (MSW) and transgender (TG) communities in Bangladesh and Papua New Guinea: Results and recommendations. FHI 360; 2013.

Introduction

Introduction

Men who have sex with men are disproportionately affected by human immunodeficiency virus (HIV) compared to the general population in nearly all countries collecting reliable surveillance data. In low- and middle-income countries they have 19.3-fold greater odds of being infected with HIV compared with the general population. HIV prevalence among men who have sex with men across North, South and Central America, South and Southeast Asia and sub-Saharan Africa ranges from 14% to 18%. Even as HIV incidence is in decline worldwide, the rate of new HIV infections among men who have sex with men remains unchanged and is increasing in some high-income countries like the United States.

In 2011 the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Development Programme (UNDP) and The Global Forum on MSM & HIV (MSMGF) developed a guidance document on *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*.[1] The document sets out technical recommendations on interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) among men who have sex with men. In 2014, WHO released the *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*.[2] These bring together all existing guidance related to key populations, including men who have sex with men, with updates on selected guidance and recommendations. The recommendations of these two publications are summarized in Table 1 at the end of this Introduction.

Following the dissemination of the 2011 Recommendations and the 2014 Key Populations Consolidated Guidelines describing effective, evidence-based interventions (the *what*), a need was expressed for guidance focused on implementation (the *how*). This publication responds to that need by offering practical advice on implementing HIV and STI programmes for men who have sex with men, aligned with the 2011 Recommendations and the 2014 Key Populations Consolidated Guidelines. It contains examples of good practice from around the world that may support efforts in planning programmes and services, and describes issues that should be considered and how to overcome challenges.

The need for this tool

The health and prevention benefits of antiretroviral therapy (ART) in the management of HIV are now strongly supported by research. Behavioural prevention programmes including use of condoms and lubricant, early diagnosis, prompt linkage to sustained care and ART, and viral suppression constitute points along a comprehensive continuum of HIV-related services. When services are easily accessible, implemented effectively and delivered in close partnership with their intended beneficiaries, this comprehensive continuum of health services reduces morbidity, mortality and onward transmission of HIV.

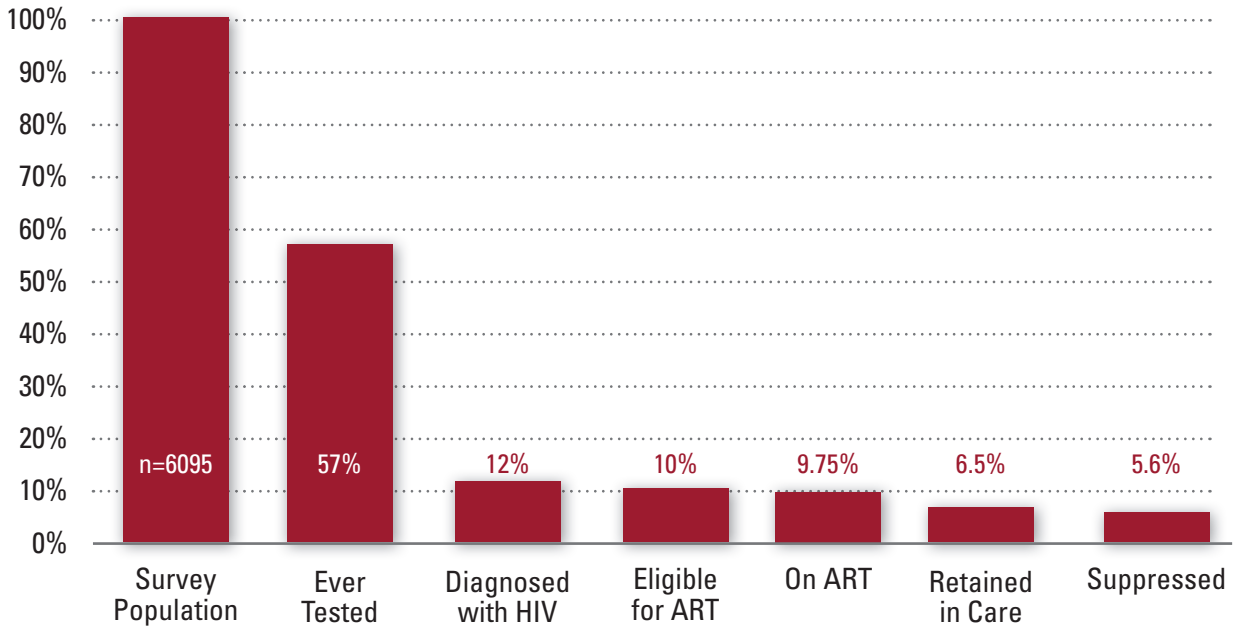
However, current service delivery models are not as effective as they should be in linking and retaining men who have sex with men to the services they need, resulting in a failure to fully realize the health and prevention benefits of all interventions currently at our disposal. A 2012 study by MSMGF explored

1 Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. Geneva: WHO; 2011.

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

drop-off from the continuum of HIV prevention, testing and care in a global sample of men who have sex with men. The findings revealed a drop-off in service retention at every point along the continuum (Figure 1). Difficulties in retention in HIV services were associated with experiences of homophobia and stigmatizing behaviours and attitudes expressed by health-care providers. Conversely, comfort with a health-care provider, participation in community-led risk reduction programmes and engagement in gay communities were associated with better linkage to and retention in care.

Figure 1. Drop-offs in service retention along the continuum of HIV testing and care



Note: Denominator = survey population. Eligibility for ART was based on WHO criteria.

Source: Based on Ayala G, Makofane K, Santos GM, Arreola S, Hebert P, Thomann M, et al. HIV treatment cascades that leak: correlates of drop-off from the HIV care continuum among men who have sex with men worldwide. Journal of AIDS and Clinical Research; 2014:5:331. DOI: 10.4172/2155-6113.1000331.

For men who have sex with men, HIV responses at the country level continue to be seriously hampered by daily experiences of homophobia, discrimination, violence and criminalization, which can have severe and damaging effects on the physical and mental health of men who have sex with men and limit their access to and use of vital services. For example, men may choose to conceal their sexuality or sexual behaviour from their families, friends, neighbours and health-care providers. Addressing homophobia, stigma and discrimination is central to implementing evidence-informed and rights-based HIV prevention, care and treatment services. This tool describes how services can be designed and implemented to be high-quality, acceptable and accessible to men who have sex with men. To accomplish this, respectful and ongoing engagement with communities of men who have sex with men is essential.

Men who have sex with men have played a central role in designing and implementing HIV prevention, treatment, care and support programmes since the start of the HIV epidemic. For more than 30 years, their expertise, creativity, energy and fortitude have shaped the global response to the epidemic in

important and indelible ways. This tool seeks to honour and support the legacy forged by men who have sex with men at the community level and which they continue to create. It therefore gives particular attention to programmes run or led by men who have sex with men themselves, in contexts where this is possible.

This tool is itself the product of collaboration among men who have sex with men, advocates, service-providers, researchers, government officials and nongovernmental organizations (NGOs) from around the world, as well as United Nations agencies, and development partners from the United States.

Definition of men who have sex with men

"Men who have sex with men" and the corresponding acronym "MSM" refer to all men who engage in sexual and/or romantic relations with other men or who experience sexual attraction towards the same sex. As used in this publication, the term is inclusive both of a variety of patterns of sexual behaviour by males with members of the same sex, and of diverse self-determined sexual identities and forms of sexual and social associations ("communities").

"Men who have sex with men" can include men who identify as gay or bisexual, transgender men who have sex with men, and men who identify as heterosexual. Some men who have sex with men also form relationships with, or are married to, women. Some men sell sex to other men, regardless of their sexual identity. Some men who have sex with men do not associate themselves with any particular identity, community or terminology.

Despite this diversity of identities and experiences, many men who have sex with men do share common experiences of social exclusion, marginalization, stigma, discrimination or violence. They may also have common experiences of support, affinity, friendship, love and community.

In this publication, "men who have sex with men" should be understood to include young men, i.e. those in the age range 10–24 years, according the to the United Nations definition of young people.[3] Including younger men in programming is important because young people in general, and young men who have sex with men in particular, are especially vulnerable to HIV and subject to violence.

"Men who have sex with men" is used throughout this publication wherever possible; "MSM" is used as its equivalent only when quoting other published material that uses this term, or to avoid phrasing that would otherwise be ambiguous or awkward.

3 Interagency Working Group on Key Populations. HIV and young men who have sex with men: a technical brief. Geneva: WHO; 2015.

How to use this tool

This tool is designed for use by public-health officials and managers of HIV and STI programmes; NGOs, including community and civil-society organizations; and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates. It is meant to cover implementation of interventions across the full HIV services continuum, including prevention, treatment, care and support interventions. Each chapter explicitly or implicitly addresses one or more of the 2011 Recommendations or 2014 Key Populations Consolidated Guidelines.

The first two chapters describe approaches and principles to building programmes that are led by men who have sex with men. These community-led approaches are themselves essential interventions. Chapters 3, 4 and 5 describe approaches to implementing recommended interventions for HIV prevention, care and treatment. Chapter 6 describes how to manage programmes and build the capacity of organizations of men who have sex with men. (See Figure 2.)

Chapter ❶ Community Empowerment is the foundation of the tool. This chapter describes how empowerment of men who have sex with men is both an intervention in itself, and also essential to effective planning, implementation and monitoring of all aspects of HIV and STI prevention, treatment and care.

Chapter ❷ Addressing Violence focuses on one of the most urgent needs of men who have sex with men: to be protected from violence, discrimination and other forms of human-rights violation. The effectiveness of HIV and STI prevention interventions is often compromised when interventions to address violence are not implemented concurrently.

Chapter ❸ Condom and Lubricant Programming presents a detailed description of how to plan and implement the provision of condoms and lubricants, using the approaches outlined in the previous chapters. The chapter covers planning for and managing adequate supplies, multi-level promotion of the commodities and creating an enabling environment.

Chapter ❹ Health-Care Service Delivery presents detailed descriptions of fundamental prevention, care and treatment interventions, incorporating the approaches outlined in the previous chapters. The services described include sexual and risk minimization, anal health and STIs, voluntary HIV testing and counselling, pre- and post-exposure prophylaxis, antiretroviral therapy, and treatment of STIs and of co-infections such as tuberculosis and viral hepatitis, mental health, and substance use. The chapter also addresses community-led service delivery and safe spaces.

Chapter ❺ Using Information and Communication Technology (ICT) describes the ways in which men who have sex with men currently use ICT, and how ICT can be used for outreach, support and advocacy for men who have sex with men.

Chapter ❻ Programme Management and Organizational Capacity-Building provides practical guidance on planning, starting, scaling up, managing and monitoring an effective programme from two perspectives: (1) a large multi-site programme with centralized management and multiple implementing organizations, and (2) local community groups seeking to start or expand services.

Figure 2. Structure of the tool

Key elements of each chapter

Each chapter begins with an introduction that defines the topic and explains why it is important. The introduction presents one or more of the 2014 Key Populations Consolidated Guidelines, where relevant. Interventions are described in detail, broken down into stages or steps, wherever possible, to make them easy to follow. Topics or points of particular interest are presented in text boxes. Case examples from programmes around the world are presented in shaded boxes. These examples do not describe an entire programme in detail but highlight specific aspects related to programming with men who have sex with men that have worked well in their contexts. The purpose of the case examples is to illustrate how an issue or challenge has been addressed, and to inspire ideas about approaches that could work in the reader's own context. The forms, charts etc presented from various

programmes have the same purpose. Each chapter ends with a list of resources—tools, guidelines and other practical publications—available online; and further reading—journal articles and other publications—that provide a research or academic perspective on some of the points made in the chapters.

Navigating within and between chapters

Although each chapter is subdivided to make it easier to find and use information, the reader is urged not to view the various services and interventions described in a chapter as separate and independent of one another. In the same way, the content areas of each chapter are also linked and should not be considered in isolation. Cross-referencing is provided in each chapter to assist the reader in making these connections. It is important to remember that no single, standalone service modality or intervention will suffice when designing and implementing programmes tailored to the needs of men who have sex with men. HIV programmes should be comprehensive, accessible, acceptable, affordable and tailored to the specific concerns and needs of men who have sex with men at the local level.

Table 1. Recommendations for all key populations from the 2014 Key Populations Consolidated Guidelines and the 2011 Recommendations

HIV prevention
The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs). • *Condoms and condom-compatible lubricants are recommended for anal sex.* • *Adequate provision of lubricants needs to be emphasized.*
Where serodiscordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral pre-exposure prophylaxis (PrEP, specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner. • *Among men who have sex with men, PrEP is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package.*
Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
Implementing individual-level and community-level behavioural interventions for the prevention of HIV and STIs among men who have sex with men is suggested.
Offering targeted internet-based information to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among men who have sex with men is suggested.
Using social marketing strategies to increase the uptake of HIV and STI testing and counselling and HIV services among men who have sex with men is suggested.
Implementing sex venue-based outreach strategies to decrease risky sexual behaviour and increase uptake of HIV testing and counselling among men who have sex with men is suggested.
HIV testing and counselling (HTC)
Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.

HIV treatment and care
Key populations living with HIV should have the same access to antiretroviral therapy (ART) and to ART management as other populations.
Prevention and management of co-infections and co-morbidities
Key populations should have the same access to tuberculosis prevention, screening and treatment services as other populations at risk of or living with HIV.
Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.
Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve their adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies.
Substance use and prevention of bloodborne infections
Men who have sex with men with harmful alcohol or other substance use should have access to evidence-based brief psychosocial interventions involving assessment, specific feedback and advice.
Men who have sex with men who inject drugs should have access to needle and syringe programmes and opioid substitution therapy.
Sexual health
Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.
People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options, including family planning services.
Critical enablers
Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations.
Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations. • *Countries should work toward developing policies and laws that decriminalize same-sex behaviours.* Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health. • *The following strategies are recommended to increase safer sexual behaviours and increase uptake of HIV testing and counselling among men who have sex with men:* *targeted Internet-based information* *social marketing strategies* *sex venue-based outreach.*
Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations. • *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.*
Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Guiding principles for implementing comprehensive HIV and STI programmes with men who have sex with men

Several principles underlie the 2011 Recommendations and 2014 Key Populations Consolidated Guidelines and the operational guidance given in this publication. These principles are described in the 2014 Key Populations Consolidated Guidelines (pp.11–12) and are articulated in more detail in this tool. They may be summarized as follows:

Human rights: Fundamental to development of these guidelines is the protection of human rights for all members of each key population, including men who have sex with men. Legislators and other government authorities should establish and enforce antidiscrimination and protective laws, derived from international human-rights standards, in order to eliminate stigma, discrimination and violence faced by men who have sex with men and to reduce their vulnerability to HIV.

Access to quality health care is a human right. It includes the right of men who have sex with men to appropriate quality health care without discrimination. Health-care providers and institutions must serve men who have sex with men based on the principles of medical ethics and the right to health. Health services should be accessible to men who have sex with men. HIV programmes and services can be effective only when they are acceptable and high quality and widely implemented. Poor quality and restricted access to services will limit the individual benefit and public-health impact of the recommendations contained in this guidance document.

Access to justice is a major priority for men who have sex with men, due to high rates of contact with law-enforcement services and the current illegality of their behaviours in many countries. Access to justice includes freedom from arbitrary arrest and detention, the right to a fair trial, freedom from torture and cruel, inhuman and degrading treatment and the right, including in prisons and other closed settings, to the highest attainable standard of health. The protection of human rights, including the rights to employment, housing and health care, for men who have sex with men requires collaboration between health-care and law-enforcement agencies, including those that manage prisons and other closed institutions. Detainment in closed settings should not impede the right to maintain dignity and health.

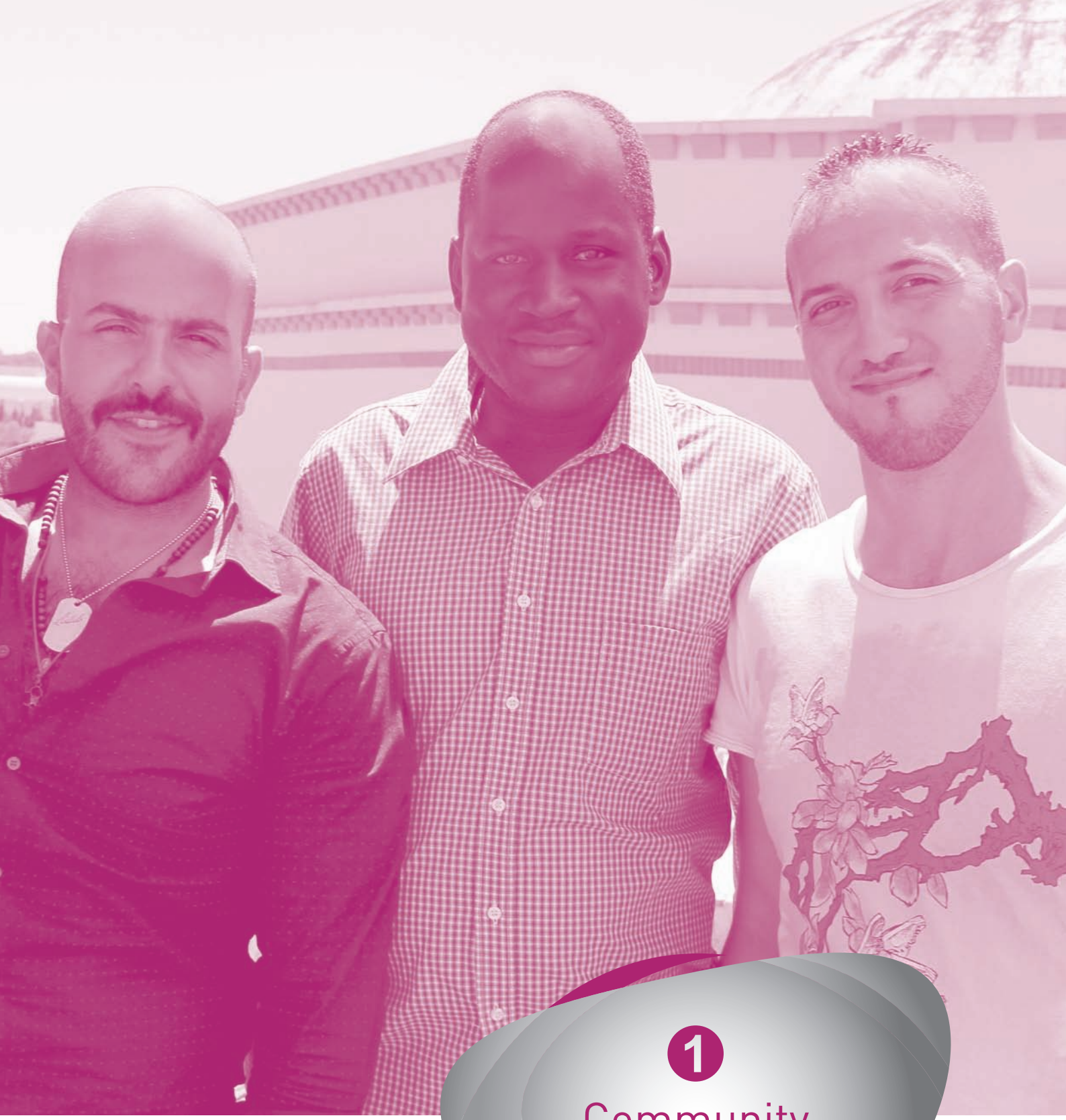
Acceptability of services is a key aspect of effectiveness: Interventions to reduce the burden of HIV among men who have sex with men must be respectful, acceptable, appropriate and affordable to recipients in order to enlist their participation and ensure their retention in care. Services for men who have sex with men often employ appropriate models of service delivery but lack expertise in HIV. Conversely, men who have sex with men may not find specialized HIV services acceptable. There is a need to build service capacity on both fronts. Services that are acceptable to men who have sex with men are more likely to be used by them in a regular and timely way. Consultation with organizations led by men who have sex with men and including community outreach workers in service delivery are effective ways to work towards this goal. Mechanisms of regular and ongoing feedback from beneficiaries to service-providers will help inform and improve the acceptability of services to men who have sex with men.

Health literacy: Men who have sex with men often lack sufficient health and treatment literacy. This may hinder their decision-making on HIV risk behaviours and their health-seeking behaviour. Health services should regularly and routinely provide accurate health and treatment information to men who have sex with men. At the same time health services should strengthen providers' ability to prevent and to treat HIV in men (including young men) who have sex with men.

Integrated service provision: Men who have sex with men commonly have multiple co-morbidities and poor social situations. For example, HIV, viral hepatitis, tuberculosis, other infectious diseases and mental-health conditions are common in men who have sex with men and often linked to stress associated with persistent social stigma and discrimination. Integrated services provide the opportunity for patient-centred prevention, care and treatment for the multitude of issues affecting men who have sex with men. In addition, integrated services facilitate better communication and care. Thus, wherever feasible, service delivery for men who have sex with men should be integrated. When this is not possible, strong links among health services working with men who have sex with men should be established and maintained.

Community empowerment is the process whereby men who have sex with men are empowered and supported to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services to reduce the risk of acquiring HIV. Community empowerment is an essential approach that underlies all the interventions and programme components described in this tool, and is inseparable from them.

Community participation and leadership in the design, implementation, monitoring and evaluation of programmes are also essential. Participation and leadership help to build trust with those whom programmes are intended to serve, make programmes more comprehensive and more responsive to the needs of men who have sex with men, and create more enabling environments for HIV prevention.



1

Community Empowerment

Contents

1.1 Introduction 5
1.1.1 Power and health 6

1.2 Key elements of community empowerment 10
1.2.1 Working with communities of men who have sex with men 11
1.2.2 Fostering programmes led by men who have sex with men 12
1.2.3 Developing cohesive communities 13
1.2.4 Strengthening community systems 15
1.2.5 Promoting a human-rights framework 17
1.2.6 Shaping policy and creating enabling environments through advocacy 19
1.2.7 Adapting to local needs and contexts 20
1.2.8 Supporting community mobilization and sustaining social movements 21

1.3 Monitoring progress 22

1.4 Resources and further reading 26

What's in this chapter?

Community empowerment is the foundation for all of the interventions and approaches described in this tool. This chapter:

- **defines community empowerment** and explains why it is fundamental to addressing HIV and STIs among men who have sex with men in an effective and sustainable way (Section 1.1)
- **describes elements of community empowerment,** with examples from a number of programmes (Section 1.2).

The chapter also presents:

- examples of **indicators** to measure community empowerment and mobilization (Section 1.3)
- a list of **resources and further reading** (Section 1.4).

1.1 Introduction

2014 Key Populations Consolidated Guidelines: Community Empowerment [1]

Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations.

Programmes should be put into place to provide legal literacy and legal services to key populations so that they know their rights and applicable laws and can receive support from the justice system when aggrieved.

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. *(pp.102–103)*

In all countries where there is reliable epidemiological data, men who have sex with men shoulder a disproportionate burden of HIV infection compared to the general population. In the context of HIV programming, men who have sex with men play a critical role in addressing the social and structural factors responsible for this inequity. They are also important in ensuring more urgent and more responsible national HIV responses. It is therefore essential that communities of men who have sex with men are well resourced and able to take individual and collective ownership of the HIV response.

Empowered communities are best positioned to reach their members, rally support and lobby their respective governments to tailor national HIV responses to the needs of key populations. Empowered men who have sex with men are best positioned to challenge societal homophobia as well as the internalized homophobia that may lead to self-hatred, poor self-esteem, depression and drug use. Empowered communities start with empowered individuals. Empowered individuals, groups and communities are best positioned to successfully counter stigma and discrimination by changing hearts and minds.

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

Box 1.1

A note on community

In most sections 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.

It is important to remember that while men who have sex with men have a range of shared sexual behaviours and attractions, they do not necessarily share an identity related to those behaviours. They are also diverse in terms of age, ethnicity, class background, religion, gender identity, gender expression, family background and HIV serostatus. Those that do express an identity related to sexual behaviours may call themselves "gay" or may adopt other terms specific to their cultural, language or country contexts.

In many places and situations, men who have sex with men choose not to disclose their sexual orientation or behaviour to members of their family, friends, neighbours, co-workers or health-care professionals, for fear of harsh or even violent reactions. Cohesive or identifiable communities of men who have sex with men may not exist or may not be immediately apparent because of repression. Individual empowerment and empowerment of small groups are pre-conditions to community empowerment.

In many contexts, community empowerment and an organized response to HIV among men who have sex with men have initially involved those who self-identify in terms of their sexual orientation or behaviour, e.g. as gay, bisexual, MSM, or another term specific to their language or culture. Men who do not identify in these terms may not identify with community empowerment initiatives or participate readily in them. However, the services, rights and protections that may result from community empowerment should be made available to all men who have sex with men, regardless of how they self-identify.

Given these realities, we recommend an open-minded, sensitive and thoughtful consideration of what "community" might mean when conceptualizing interventions that are "community-led" for men who have sex with men. See also the definition of community outreach worker in the Glossary.

1.1.1 Power and health

Community empowerment can only be fully understood by considering the social contexts in which power is exercised. Power relations between two or more people are always linked to how societies are structured and how they allocate resources. Both power and community empowerment should therefore be considered across the many social contexts in which people live, work and play. They are social, political, economic and cultural phenomena: each of these factors determines who has what kind of power and how much of it they have.

The relationship between power and health is also mediated by different social contexts: those of the individual, family/community and wider society. Health and well-being are brought about by conditions that promote:

1. **Choice and control** (the personal dimension of perceived and actual power)
2. **Community and community integration** (through social support, networking, identity formation, learning and adopting important social roles, and enhancing participation in community life)
3. **Access to essential resources** (work, education, housing, health care, nutrition, personal safety, security and other material and non-material conditions linked to the quality of life).

These are the pillars of empowerment. Table 1.1 outlines some of the empowering qualities of social contexts that are likely to impact the health of men who have sex with men.

Table 1.1 A model for understanding the relationship between power and health

Key dimensions of power	Qualities of social contexts that promote power	Health impact
Choice and control	Social policies and laws that protect and promote the human rights of men who have sex with men	Reduced prevalence of violence, discrimination, stigma, blackmail, suicide, depression, anxiety and risk for HIV
	Governmental and nongovernmental organizations (NGOs) that provide opportunities for self-development and leadership training	Men who have sex with men develop leadership competencies, strong communications skills and self-efficacy
	Support for individual expression and personal decisions about same-sex friendships and sexual relationships	Men who have sex with men are self-accepting and retain active roles within their families and social networks
Community and community integration	Governmental organizations and NGOs that provide men who have sex with men with a voice and choices in social and civic affairs	Men who have sex with men have a voice and are actively engaged in social and civic affairs, including national HIV planning processes
	Organizations and community-based programmes that provide opportunities for leadership and meaningful participation	Men who have sex with men have influence in the organizations and programmes in which they are involved
	Family members and friends who are accepting of homosexuality and roles for men who have sex with men	Men who have sex with men experience improved relationships with family members and friends
Access to essential resources	Social policies and laws that reduce inequality and facilitate access to health services	Adequate income, steady employment, stable and affordable housing, food, personal safety and security, education and health care, including HIV services
	Robust community infrastructure, including civil-society groups with strong technical and organizational capacities	Programmes and services are easily available, accessible, acceptable and tailored to the needs of men who have sex with men
	Strong bonds and communications between family members and within social networks	Social support from family members and friends

Source: Adapted from articles in the Journal of Community & Applied Social Psychology's Special Issue: Power, control and health. 2001;11(2):75–165.

Interventions delivered through a community empowerment framework implicitly recognize the role of power in producing population-level health and wellness. Community empowerment interventions therefore engage with local men who have sex with men to raise awareness about their rights, the establishment of community-led safe spaces (drop-in centres),[2] and the formation of organizations that determine the range of services to be provided, as well as outreach and advocacy.

Powerful communities have been the backbone of the HIV response for 30 years. In many places, men who have sex with men have led the response from the beginning by taking charge of community processes, mobilizing with other men who have sex with men to develop solutions to the issues they face, and advocating for their rights as members of a community and as human beings.

Community empowerment is more than a set of activities in the service of linking men who have sex with men into prevention, treatment and care. It can also contribute to positive self-esteem and peer norms as well as a sense of urgency, altruism and fellowship. In this sense, community begins with the individual in order to leverage stronger and more involved responses to HIV. It is an approach that should be integrated into all aspects of health and HIV programming.

Box 1.2

Case example: The Mpowerment Project

This community-level intervention is for young men who have sex with men of diverse backgrounds. It mobilizes men to reduce risky behaviour and to get HIV testing frequently.

The Mpowerment Project offers a comprehensive manual (in both English and Spanish), three-day trainings, phone and web-based technical assistance and 10-minute audio-slideshows for executive directors, supervisors, coordinators and funders. These materials focus on lessons learned from real-world implementation in diverse communities. Materials are available at www.mpowerment.org

Community empowerment is also linked to a broader social movement that supports the self-determination of men who have sex with men. It requires governmental, nongovernmental, public, private, political, cultural, health and religious institutions and organizations to address and remove the social exclusion, stigma, discrimination and violence that violate the human rights of men who have sex with men and heighten associated HIV risk and vulnerability. Community empowerment includes working towards the decriminalization of sex between males and the elimination of the unjust application of any laws and regulations used against men who have sex with men.

Investing in community empowerment is critical to achieving impact because choice, control, community integration and access to essential resources produce positive health outcomes. Strategies for delivering comprehensive HIV services are more effective and sustainable when

2 A safe space or drop-in centre is a place where men who have sex with men may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 4, Section 4.4.4 for details.

carried out by empowered individuals, groups and communities. Programmes led by men who have sex with men have resulted in improved reach, access, service quality, service uptake, condom use and engagement of men who have sex with men in national policies and programmes. Scaling up comprehensive, community empowerment-based HIV services helps prevent significant numbers of new HIV infections, particularly in settings with high rates of HIV. Community empowerment is the cornerstone of a human-rights-based approach to HIV and, as such, underpins all the recommendations and components presented in this tool.

Box 1.3

What does a community empowerment framework for men who have sex with men mean?

- Men who have sex with men coming together for affirmation, mutual assistance and support
- Addressing individual and community needs in a supportive and safe environment
- Facilitating connectedness and affinity with others who share similar experiences around sexuality and gender expression
- Being sex-positive—affirming and nonjudgemental of sex, sexuality and gender expression
- Respecting each individual's self-determination and control of his own body
- Meaningfully and respectfully engaging men who have sex with men in all aspects of programme design, implementation, management and evaluation, and removing barriers and creating opportunities for their participation and leadership
- Acknowledging and using the strengths and abilities of men who have sex with men as individuals and communities, recognizing and leveraging their diversity
- Trusting that men who have sex with men know best how to identify their priorities and the context-appropriate strategies to address those priorities
- Strengthening partnerships among communities and groups of men who have sex with men, government, civil society and local allies
- Promoting and supporting mobilization of financial, technical and other resources for organizations and communities of men who have sex with men, which become responsible for determining priorities, activities, staffing and the nature and content of service provision. Ultimately, community-led organizations may become the employers of relevant staff (doctors, nurses, social workers, outreach workers), rather than men who have sex with men being solely volunteers, community outreach workers[3] or employees.

3 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers", "peer navigators" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

1.2 Key elements of community empowerment

The process of community empowerment is, by definition, driven by men who have sex with men themselves. It is therefore impractical to adopt a prescriptive, inflexible approach to implementing community empowerment initiatives. However, some key elements of community empowerment have been found relevant by groups of men who have sex with men across the world (Figure 1.1).

Figure 1.1 Key elements of community empowerment among men who have sex with men

The approach is flexible and adaptable to individual community needs. There is no fixed order in which the elements should be addressed; the process may flow from working with communities of men who have sex with men to fostering community-led outreach, to the development and strengthening of organizations and networks led by men who have sex with men and, consistent with local needs and contexts, to shaping human rights-based policies and creating an enabling environment for a sustainable movement.

This process represents a paradigm shift, away from men who have sex with men being recipients of services and towards the self-determination of communities of men who have sex with men. Community empowerment builds a social movement where the community collectively exercise their rights, are recognized as an authority, and are equal partners in the planning, implementation and monitoring of health services.

1.2.1 Working with communities of men who have sex with men

Community empowerment is a process that takes significant time and effort, especially since in many contexts homosexual identity or behaviour is stigmatized and criminalized. Trust, empathy and respect are important for all partners. Building trust involves treating all men who have sex with men, regardless of HIV serostatus, with dignity and respect, listening to and addressing their concerns, and working with them throughout the process of developing and implementing an intervention.

The meaningful participation of men who have sex with men is essential to building trust and establishing relationships and partnerships that have integrity and are sustainable (see Box 1.4). This may be challenging for service-providers who are more accustomed to establishing the parameters within which services are provided, and prescribing how relationships or partnerships are to be conducted. As men who have sex with men and the organizations they may form become more empowered, there will be greater expectations of power-sharing and power-shifting (see Chapter 6, Section 6.2.5). In the initial stages of community empowerment, men who have sex with men may have less experience in organizing as a group. National, regional and global networks of men who have sex with men are able to provide essential technical assistance and support (see Chapter 6, Section 6.5.1). Allies also have an important role in facilitating meaningful participation of men who have sex with men, by intervening on behalf of men who have sex with men in places and situations in which men who have sex with men have no voice.

Box 1.4

Meaningful participation

Meaningful participation in service delivery and in national policy processes means that men who have sex with men:

- choose how they are represented, and by whom
- choose how they are engaged in the process
- choose whether to participate
- have an equal voice in how partnerships are managed.

Stigma towards men who have sex with men encourages discriminatory civil and criminal laws which perpetuate social and political exclusion. Every aspect of the lives of men who have sex with men is adversely affected by this stigma because it encourages negative attitudes on the part of family, community and policy-makers. Negative societal attitudes about homosexuality may become internalized, resulting in self-hatred and peer stigma (or stigma from within communities of men who have sex with men). All partners should share the responsibility for supporting the shift from disempowerment of men who have sex with men to their empowerment. Especially in countries

where same-sex sexual practices and relationships are criminalized, safeguards need to be built into programmes and partnerships to ensure that men who have sex with men do not face a backlash for organizing, do not fear that identifying themselves as men who have sex with men will lead to blackmail, arrest, harassment or violence, and do not experience further stigmatization from health-care providers.

1.2.2 Fostering programmes led by men who have sex with men

There is a difference between programmes that are done *for* men who have sex with men and those led *by* men who have sex with men. Table 1.2 summarizes these approaches. Programmes that are done *for* men who have sex with men are likely to result in services that are viewed with apprehension and therefore underused. Programmes done *with* or *led by* men who have sex with men are likely to result in earlier service engagement and improved retention in services, yielding better health outcomes.

Initiatives led by men who have sex with men operate under the principle that men who have sex with men are best equipped to help each other learn to protect themselves from risks to their health and safety and from human-rights violations. Men who have sex with men should therefore be the driving force in targeted programmes addressing HIV. It is not enough to consult with them before creating a programme. Rather, programmes should be based on their needs, perceptions and experiences.

This element in the community empowerment process requires service-providers to reflect on how they can move from providing services to men who have sex with men, towards a situation where organizations of men who have sex with men are themselves the employers of service-providers.

Table 1.2 Characteristics of programme approaches

Done for men who have sex with men	Done with or led by men who have sex with men
Prescriptive: Programmes sometimes focus on telling men who have sex with men what to do and how to do it.	**Collaborative:** Programmes listen to men who have sex with men's ideas about what to do and how to do it.
Paternalistic: Often assume that knowledge, skills and power reside with the programme staff and managers and not with community members.	**Participatory:** Honour and actively seek to leverage the knowledge, skills and power that reside with the community of men who have sex with men.
Tokenistic: Involve men who have sex with men in programme implementation mainly as volunteers, not as equal partners.	**Inclusive:** Involve men who have sex with men as equal partners in programme design, implementation and evaluation, more commonly as paid employees working with the community, not for an external organization.
Commodity-oriented: Monitoring mainly focuses on goods and services delivered and targets to be achieved.	**Quality assurance-oriented:** Monitoring mainly focuses on quality, safety, accessibility and acceptability of services and programmes, community engagement, community cohesion and community connectedness, as well as adequacy of service coverage.
Top-down: Focus on building relationships mainly within the health system with health-care providers. Less emphasis on building relationships among groups of men who have sex with men.	**Bottom-up:** Focus on building relationships within communities of men who have sex with men as well as between men who have sex with men and other organizations, service-providers, human-rights institutions and similar groups.

In order to ensure the trust and confidence of men who have sex with men, it is important to also employ health-care workers, HIV service staff, health educators and outreach workers who are themselves men who have sex with men. As service planners and providers, men who have sex with men:

- share a common experience that may decrease internalized stigma and increase self-worth and collective solidarity
- have knowledge about and access to networks and communities of men who have sex with men that can inform sensitive outreach and programme activities.

As service recipients, men who have sex with men:

- are likely to be more comfortable discussing intimate details of their lives with someone who is experienced and knowledgeable about their issues
- are more likely to follow up on referrals to services, adhere to treatment and engage in health-seeking behaviours if they trust the person providing the advice.

However, men who have sex with men should not be limited to these roles in community-led programmes. Rather, they should participate in all other levels of the programme, including decision-making on programme implementation, management, resource mobilization and governance. Capacity-building and mentoring should be a priority to enable them to take up these positions.

1.2.3 Developing cohesive communities

Developing cohesive communities of men who have sex with men will only be successful if the process is initiated and led by men who have sex with men. A common first step is to provide a safe space where men who have sex with men can come together to socialize and discuss issues (see also Chapter 4, Section 4.4.4). This can be an empowering exercise in and of itself (see Box 1.5) and helps men who have sex with men identify common issues and a sense of purpose and connectedness. In addition to protecting the safety and respecting the anonymity and confidentiality of the individuals using safe spaces, establishing a regular schedule of meetings and events is important for building expectations, cohesiveness and a sense of continuity.

Activists and organizers of such spaces and meetings should remember that most individuals who participate will not have an immediate awareness of issues that affect them at the community or country level. New participants may not have a sense of involvement or a desire to participate in activism. Those who use safe spaces should not be expected or pressured to participate in group activities immediately.

Group and community processes start with the individual. Before individuals can feel that they belong to a group, they must have their own needs attended to. In stigmatizing and hostile environments, the most important gains from group interactions for men who have sex with men are feeling listened

to, having the chance to share individual concerns, and knowing that they are not alone. Where possible, concrete needs may also be addressed, especially for men who are in danger, unemployed or without stable housing.

After a group or safe space has addressed individual issues, such as self-acceptance and experiences of societal stigma, discrimination or violence, a typical next step can involve men who have sex with men meeting together more regularly to discuss key topics or issues that affect them individually but that require a group response, such as rejection by the family, discrimination at school or in the workplace, violence, blackmail or harassment; or they may identify common needs such as seeking sexual and romantic partners or places to get evidence-based sexual-health information.

Box 1.5

Bringing men who have sex with men together

- Organize group activities at safe spaces (drop-in centres) based on the interests of the group members.
- Plan activities for special occasions.
- Invite men who have sex with men who are activists or community outreach workers from neighbouring areas to speak at a gathering of local men who have sex with men.
- Facilitate coalition-building with allies.
- Use the Internet to create virtual "safe spaces"

A third step in developing communities is formally establishing an organization. This is covered in detail in Chapter 6, Section 6.5.1. There are multiple paths to community empowerment and the formation of community organizations, given the diversity of political and cultural contexts of men who have sex with men. Organizations and networks have varying developmental trajectories and may function in many different ways. However, it is crucial to note that community-*led* organizations (i.e. those led by men who have sex with men) are not synonymous with generic community-*based* organizations. In community-led organizations, power and decision-making lie in the hands of community members, whereas in a community-based organization power may reside only with some members of the community, or with non-community members who act as administrators. It is the self-determining and self-governing nature of an organization, and its commitment to pursue the goals that its own members have agreed upon, that characterize community-led processes.

Box 1.6

Case example: Community building in Romania

Population Services International in Romania began the programme *I am! You?* by inviting visible and well-connected local men who have sex with men to a series of meetings. Those attending extended social support to one another and shared experiences of discrimination, challenged self-stigma, and discussed health, romantic and sexual relations and social equality. Following these initial discussions, the participants were invited to explore issues that they felt negatively impacted their local lesbian, gay, bisexual and transgender (LGBT) "community", and to brainstorm ideas for activities to address these issues. Several discussion groups were established by local volunteers who participated in the original group. Volunteers received funding and organizational support to design, implement and document small projects addressing issues of concern.

Volunteer teams were then convened for two days to share their projects in a competition. The winning project was awarded funding for a second round to implement the interventions they had designed. Additionally, members of the local groups were trained and given the opportunity to conduct social inclusion and anti-discrimination workshops in local high schools.

By motivating and supporting more influential informal opinion leaders, supporting the groups to carry out small projects of their choosing, and then bringing groups together to build a sense of belonging on a national scale and constructive competition, *I am! You?* laid the foundation for sustainable community-building and empowerment in 10 Romanian cities.

Evaluation baseline and post-intervention questionnaires administered to men who have sex with men nationally showed significant increases in self-reported condom use, HIV testing, HIV knowledge, peer support and interpersonal disclosure of one's sexuality among men exposed to the intervention, compared to men who did not participate.

To learn more visit www.psi.org/contact-us/

1.2.4 Strengthening community systems

Building community is challenging, but maintaining and strengthening it is even more difficult. Organizations and networks of men who have sex with men, like many community-led movements around the world, face significant barriers, including inadequate funding, too few paid staff, diverse and complex needs, political opposition to their existence, competition for resources from within and outside their communities and lack of recognition of the importance of their populations. In most countries, the marginalization and lack of visibility of men who have sex with men within legal, social and economic structures at all levels of society means that their organizations and networks are typically underfunded and undervalued.

When implementing an HIV response, governments, donors, the broader civil-society movement, local organizations and multilateral agencies have a responsibility to provide sustainable support to organizations and networks of men who have sex with men to ensure their capacity. Such support should not be tied to particular donor-driven ideologies that may conflict with the needs and priorities determined by the community. This risk can be mitigated—and more productive funding strategies negotiated—if a community empowerment process is pursued.

A strong community-led organization is characterized by vibrant membership, increasing ability to responsibly manage finances, greater political power and wider social engagement. For example, a well-functioning, community-led organization or network is:

- participatory in the approaches it takes
- accountable to its core constituency
- able to respond to and communicate with constituents quickly
- well-connected with policy-makers and donors
- transparent, with well-articulated ways for constituents to be involved
- analytical—able to understand the impact of bad policies
- flexible and adaptable—able to change with shifts in the policy landscape
- financially stable, organizationally strong and well-managed
- influential—able to foster change.

In 2009, the Global Fund to Fight AIDS, Tuberculosis and Malaria introduced the concept of community systems strengthening to its model. It actively encourages applicant countries to budget and plan for interventions that engage systematically in community mobilization, community-led service delivery and strengthening accountability, in order to increase the scale and impact of responses to disease at the population level. The six core components of the Global Fund's community systems strengthening framework are summarized in Box 1.7, with cross-references to the parts of this tool that cover these components.

Box 1.7

The community systems strengthening framework: six core components of community systems

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal and governance environments, and for affecting the social determinants of health (Section 1.2.6).
2. **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships (Chapter 4, Section 4.4 and Chapter 6, Sections 6.5.1 and 6.5.7).
3. **Resources and capacity-building** – including human resources with appropriate personal, technical and organizational capacities; financing (including operational and core funding); and material resources (infrastructure, information and essential commodities, including medical and other products and technologies) (Chapter 6, Sections 6.2.8, 6.4, 6.5.2–6.5.7).
4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs (all chapters).
5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems (Chapter 6, Section 6.5.2).
6. **Monitoring and evaluation (M&E) and planning** – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management (Section 1.3 and Chapter 6, Section 6.2) .

When each of these components is strengthened and functioning well, they will contribute to:

- improved outcomes for health and well-being
- respect for people's health and other rights
- social and financial risk protection
- improved responsiveness and effectiveness of interventions by communities
- improved responsiveness and effectiveness of interventions by health, social support, education and other services.

In strengthening community systems, it is important to invest time and resources in building leadership among men who have sex with men through mentorship and by involving them in:

- trainings
- conferences
- project design, implementation, evaluation, research, reporting and fundraising activities
- the wider LGBT rights movement.

It is also essential to develop the organizational skills and capabilities of community members, including those of young men who have sex with men. This may involve enhancing the M&E, business and management skills of members. Peer-to-peer mentorship and coaching may assist with the process.

Developing a wider base of skills and leadership can help ensure the sustainability of organizations of men who have sex with men in the face of changing donor funding or policy environments at the country and local levels.[4]

1.2.5 Promoting a human-rights framework

2014 Key Populations Consolidated Guidelines: Law and Policy

Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations. *(p.91)*

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against people from key populations. *(p.96)*

Countries should work toward developing policies and laws that decriminalize same-sex behaviours. *(p.91)*

Countries should work toward developing non-custodial alternatives to incarceration for drug users, sex workers and people who engage in same-sex activity. *(p.94)*

It is important that countries secure political commitment, with appropriate investment in advocacy and adequate financial resources for HIV-related key population programmes and health services. *(p.95)*

Promoting and protecting the human rights of men who have sex with men is central to all community empowerment processes. The 2014 Key Populations Consolidated Guidelines specifically address the

4 See also the policy brief on Community systems strengthening and the HIV response: http://www.stopaidsnow.org/sites/stopaidsnow.org/files/filemanager/General_Policy_Brief_CommunitySystemStrengthening-SAA.pdf and the web page of the International Council of AIDS Service Organizations (ICASO) containing resources on community systems strengthening: http://www.icaso.org/community-systems-strengthening

human rights of men who have sex with men. Two further documents also contribute fundamentally to understanding the human rights of men who have sex with men, including in relation to HIV.

The report of the Global Commission on HIV and the Law, *Risks, Rights & Health*, published by the United Nations Development Programme in 2012, notes that laws in many countries, rather than providing protection, frequently make men who have sex with men and other key affected populations more vulnerable to HIV. Eighty-three countries—mainly with governments influenced by conservative interpretations of religion—make same-sex sexual activity a criminal offence, with penalties ranging from whipping to execution.[5] Among its recommendations, the report calls for governments, civil society and international bodies to:

- outlaw all forms of discrimination and violence directed against those who are vulnerable to or living with HIV
- repeal punitive laws and enact laws that facilitate and enable the effective responses to HIV, including access to services for all who need them
- decriminalize private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.

The *Yogyakarta Principles: Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2007) were developed by human-rights jurists and scholars. They are intended to help interpret human-rights treaties by applying international human-rights legal standards to address violation of the human rights of lesbian, gay, bisexual and transgender people. There are 29 principles along with recommendations to governments, regional intergovernmental institutions, civil society and the United Nations.

Challenging stigma and discrimination, mobilizing support, educating community members on the universality of human rights and changing the attitudes of the wider community are activities that test the most robust of organizations and networks. The strength of community-led organizations, mobilization efforts and alliances is crucial to promoting a human-rights framework. Law-enforcement authorities must be involved in the promotion and protection of the human rights of men who have sex with men, and programmes to create enabling legal and policy environments, including training of law-enforcement officers, judges and parliamentarians, should be funded and supported (see Chapter 2, Sections 2.2.2 and 2.2.3).

In many social and political contexts, men who have sex with men face stigma, discrimination, blackmail, violence and criminalization. Despite these challenges, it remains both necessary and feasible to deliver HIV services in ways that protect the safety, confidentiality and well-being of men who have sex with men. Service-providers have an ethical obligation to serve men who have sex with men impartially and equitably and to prevent human-rights violations when they can. Access to health is a human right. Empowered communities play a key role in demanding and monitoring high-quality, accessible, acceptable, affordable and safe services. For more information, see Chapter 2, especially Sections 2.2.1 and 2.2.5.

5 Based on the list of countries and political entities with criminal laws against sex between males compiled by the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), May 2014.

1.2.6 Shaping policy and creating enabling environments through advocacy

Community empowerment processes reach beyond the community to influence policy and create enabling environments through advocacy. Advocacy is how rights are realized and respected and is the consequence of empowered communities. It involves community organizing, educating policy-makers, raising public awareness, documenting the lived experiences of community members, training, demonstrations, litigation and lobbying. Advocacy can use communications strategies including mainstream media and Internet-based communications technologies to issue public statements or raise awareness (see Chapter 5, Section 5.4).

Advocacy can result in substantive changes in law, policies, funding, treatment costs and HIV service access. For example, communities can influence:

- HIV programmes to affirm and promote the universality of human rights for men who have sex with men, including their rights to health, dignity and lives free from violence, discrimination and stigma. Programmes should also design and implement "Know Your Rights" campaigns to raise awareness among men who have sex with men. (For details on addressing violence, see Chapter 2.)
- national strategic health plans to recognize the heightened HIV risk and vulnerability of men who have sex with men and to ensure that integrated, high-quality health services are safe, available, affordable, acceptable and accessible for them. Where pre-exposure prophylaxis (PrEP) is not available, this may include advocacy for its provision as an HIV prevention option, while also safeguarding the availability of treatment to those who are already living with HIV (see Chapter 4, Section 4.2.7, Part E).
- health professionals, including HIV service-providers, through regular training and sensitization to the needs of men who have sex with men, including training on human sexuality, informed consent, confidentiality and the ethical obligations of health professionals to deliver care.
- economic security of men who have sex with men, by providing opportunities for stable housing and employment. Economic security is undermined by violence, stigma, discrimination and consequent mobility; this may be particularly true for young, poor, ethnic-minority, trans-identified and HIV positive men who have sex with men (see also Chapter 2).
- access to education for men who have sex with men (many are denied education because of bullying or lack of support from educational systems).
- donor organizations to fund organizational development by making the case for the importance of community empowerment and strengthened organizations led by men who have sex with men (see Chapter 6).

Advocacy designed to influence law and policy must consider the safety and security of community members. This includes protecting the confidentiality of individuals and data collected for advocacy purposes. Programmes serving men who have sex with men in criminalized settings should have safety and security protocols in place to respond quickly to violence, blackmail or arbitrary arrests.

The Robert Carr Civil Society Networks Fund (RCNF)

Launched in Washington, DC, USA in July 2012, RCNF aims to support civil-society networks in addressing critical factors for scaling up access to HIV prevention, treatment, care and support and to protect the rights of inadequately served populations across the world.

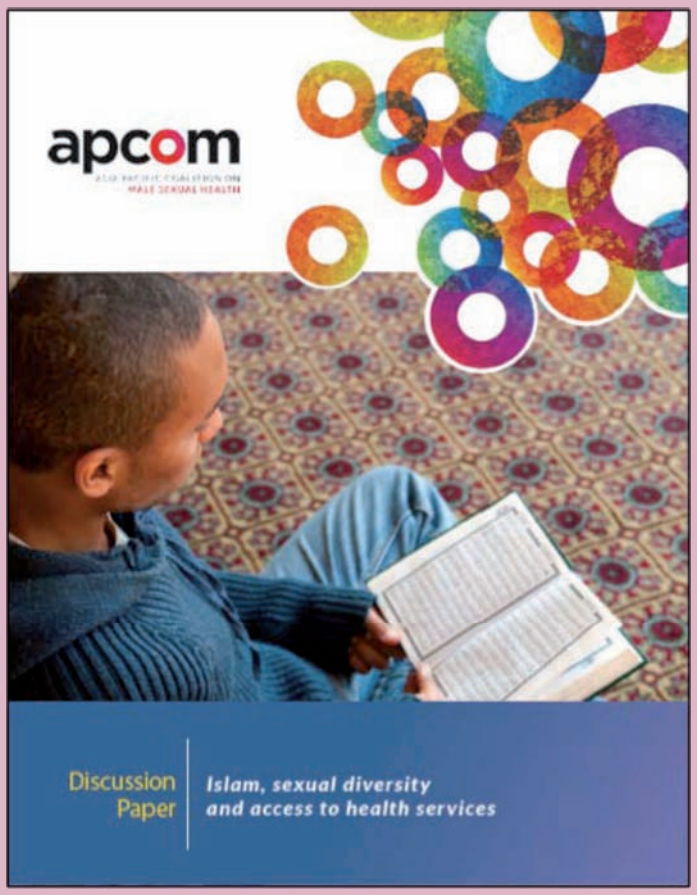
http://www.robertcarrfund.org/

1.2.7 Adapting to local needs and contexts

Men who have sex with men are not a monolithic group. They live, work and play in diverse legal, political, social and health environments and identify themselves in many ways or none (see Box 1.1). As a result of this diversity, different communities of men who have sex with men have varying needs and challenges that may be addressed through community empowerment initiatives. HIV programmes need to be sensitive to the diversity that exists among men who have sex with men. Flexibility, responsiveness and adaptability are essential in implementing community empowerment initiatives. Intervention goals need to be aligned with and address the needs of men who have sex with men, even if these change over time.

Box 1.8

Case example: Islam, sexual diversity and access to health services



At the 10th International Congress on AIDS in Asia and the Pacific in Busan, South Korea in 2011, a Faith and Sexuality Working Group, formed by the Asia Pacific Coalition on Male Sexual Health (APCOM) and consisting of representatives from faith-based organizations and men who have sex with men, discussed faith, sexual diversity, the impact of stigma and discrimination, and access to health. The group formulated context-specific strategies to address discrimination and human-rights concerns in Muslim contexts. Recommendations were published by APCOM and launched at a session on HIV programming in Islamic contexts at the 7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention in Kuala Lumpur, Malaysia, in 2013.

See http://www.apcom.org/printpdf/18952

1.2.8 Supporting community mobilization and sustaining social movements

Community mobilization is intricately linked to community empowerment. Community mobilization is the process by which men who have sex with men use their knowledge, strengths and competencies to address shared concerns through collective action. Community mobilization efforts should be seen as legitimate structural-level or social interventions by HIV advocates, policy-makers and donors because they alter the power relations between marginalized and dominant groups that can in turn lead to important legal and policy changes. Community mobilization involves:

- raising consciousness among men who have sex with men about their rights and strategies for demanding them
- engaging in advocacy with stakeholders, including policy-makers and donors
- identifying barriers to and facilitators of HIV service access (e.g. availability of condoms, lubricants, antiretroviral therapy)
- reducing health risks, including sexual-health risks, and promoting health-seeking behaviours
- extending mutual, peer-led support in coping with and challenging stigma, discrimination and violence
- responding to human-rights crises and incidence of violence and acting to deter future incidents
- developing leadership with a focus on engaging younger men who have sex with men who might subsequently take on management roles within organizations serving men who have sex with men
- monitoring and educating media in their coverage of issues related to HIV and men who have sex with men
- facilitating activities to enhance networking and information exchange
- monitoring funding trends and the enactment of policies.

When communities of men who have sex with men are mobilized over time and across geographic areas, they form movements. To sustain themselves, movements of men who have sex with men should operate in solidarity with other social movements, particularly those that also advocate for human rights. This may include international LGBT movements, youth movements, women's rights movements and movements of other key populations with similar experiences of social exclusion, such as sex workers, people who use drugs, and transgender people, some of whom are men who have sex with men. Organizations led by and working on behalf of men who have sex with men should also be linked with organizations and networks of people living with HIV. Collaboration between movements strengthens the collective response and ensures that communities are at the centre of that response.

Community advocates should be viewed as respected partners in policy-making, regardless of the legal status of sex between males. That said, it is unreasonable to expect any group to grow from a small collection of individuals to a movement whose members actively contribute to the national HIV response unless it receives sustained support. It is therefore essential that development partners working in low- and middle-income countries, governments and other stakeholders actively support the sustainability of programmes, organizations, networks and movements led by men who have sex with men.

B-Change

B-Change is a social enterprise group whose mission is to promote social change through the use of Internet-based technologies. It accomplishes this by designing and sharing digital ideas that stimulate real-world action. It works with community groups to design their own tech-based programs for HIV prevention, care, treatment and support.

http://www.b-change.org/

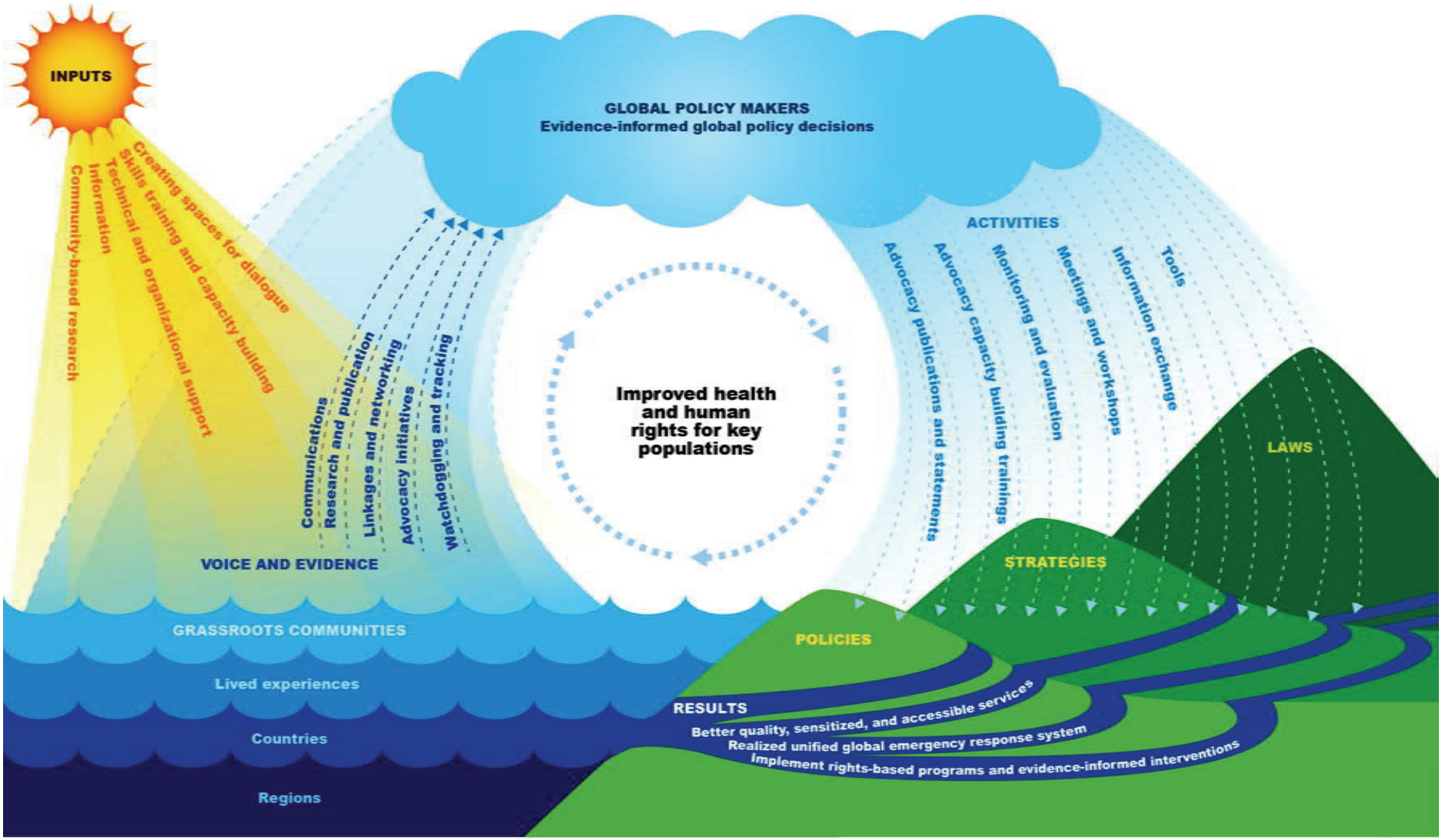
1.3 Monitoring progress

In a programme based on community empowerment, monitoring and evaluation should not only include services provided and health outcomes achieved, but should also attempt to monitor and evaluate whether and to what extent the community empowerment process is occurring. Frequently, programme indicators measure quantitative outputs, such as individuals contacted and condoms distributed, rather than documenting organizational progress and social inclusion.

Short- and long-term objectives and goals should be established to specifically address the community empowerment process. As an example, monitoring community empowerment in relation to HIV prevention, treatment, care and support and health services would measure the involvement of men who have sex with men in each of the following: how services are run, quality assurance, funding allocations, training of health personnel to address stigma, and advocacy to address discrimination.

Monitoring progress towards community empowerment requires early and methodical planning. Community-led programmes and organizations should consider partnering with trusted evaluators or researchers who are knowledgeable about organizational development processes and structural or social interventions and experienced in measuring them. Advocates should also consider developing theories of change or using logic models or log frames to evaluate their processes and intended outcomes (see Figure 1.2).

Figure 1.2 A theory of change for advocacy focused on the health and human rights of key populations



Source: Global action with local impact: why advocacy matters. Global Forum on MSM & HIV (MSMGF) in partnership with the Global Network of People Living with HIV (GNP+), the International Network of People Who Use Drugs (INPUD), the Global Network of Sex Work Projects (NSWP) and the International Treatment Preparedness Coalition (INPC); 2014.

Indicators for monitoring community empowerment should be selected with care to ensure that they are appropriate for the national context. Table 1.3 describes some approaches.

Table 1.3 Monitoring indicators for empowerment of men who have sex with men

Level	Empowerment activities	Empowerment indicators
Central	• Work to decriminalize same-sex sexual behaviour • Strengthen and expand rights networks to promote the rights of men who have sex with men at a global level • Prioritize and invest in community-led HIV prevention approaches • Include men who have sex with men in policy, programming and funding decisions	• Inclusion of MSM movement in national policies and programmes • Amount of funding allocated to programmes led by men who have sex with men • Inclusion of groups led by men who have sex with men in policy-making on such issues as HIV prevention • Recognition of organizations led by men who have sex with men at the national level
State/ provincial level **District/ county level**	• Incorporate participation of men who have sex with men in formation of local/district/state-level policies and programmes • Train health-care providers, police and social-service agencies in rights and needs of men who have sex with men • Involve men who have sex with men in planning, implementation and delivery of health, legal and social services	• Inclusion of MSM movement in state/district policies and programmes • Number of health-care providers, police and social-service agents trained in rights and needs of men who have sex with men • Level of involvement of men who have sex with men in service design and delivery, including health care, legal services and social services • Changes in attitudes and practices of health-care providers, police and social service agents towards men who have sex with men • Changes in degree of discrimination perceived by men who have sex with men from health-care providers, police and social-service agents
Municipality/ sub-municipality	• Raise wider community's awareness of rights of men who have sex with men • Forge relationships with organizations led by men who have sex with men and other community groups	• Level of participation of men who have sex with men in public life (i.e. public office) • Degree of social acceptance of men who have sex with men by members of the general community • Number of outside organizations that report contact and partnering with organizations led by men who have sex with men
Frontline worker	• Create safe communal spaces (physical and virtual) • Identify common priorities, needs and goals • Establish and sustain organizations led by men who have sex with men • Hold meetings, marches and rallies for rights of men who have sex with men, to the extent the legal context allows • Train legal advocates to document and challenge human-rights violations	• Number of safe spaces created • Percentage of men who have sex with men who report reduced self-stigma • Degree of social cohesion among groups of men who have sex with men • Number of organizations/groups led by men who have sex with men established • Number of meetings, marches or rallies held to promote rights of men who have sex with men • Percentage of men who have sex with men who report participation in an organization/group of men who have sex with men • Number of men who have sex with men trained as legal advocates • Documentation of human-rights violations

While community empowerment, mobilization and movement-building are increasingly acknowledged as important interventions in the HIV response at national, regional and global levels, few studies have investigated how these interventions contribute to improving conditions for men who have sex with men, including improved HIV outcomes. A 2013 study in Andhra Pradesh state, India, assessed community mobilization using indices that measure collective efficacy, collective agency and collective action. It also measured participation in public events among men who have sex with men at the risk of being "outed" (identified as homosexual). The study found strong positive relationships between community mobilization on the one hand and consistent condom use and use of government health facilities among men who have sex with men at high risk for HIV infection.[6] Inspired by this study, Table 1.4 presents some additional domains to consider when supporting and monitoring community empowerment.

Table 1.4 Empowerment and mobilization domains and their measures

Domain	Definition	Measure *(individual items when asked together make a scale)*
Collective efficacy	A community's belief in its power to work together to bring about positive change.	How confident are you that your community can work together to: keep each other safe from harm; increase condom use; speak up for your rights; improve your lives?
Collective agency	The choice, control and power communities have to act for themselves to claim their rights and to hold others accountable for their rights.	How often in the past XX months have you negotiated with or stood up against: police; neighbours, family members, friends, co-workers, employers—in order to help other men who have sex with men?
Collective action	Strategic and organized activities by mobilized community members to increase the community's visibility in wider society and present or enact its agenda for change (e.g. through rallies, demonstrations or meetings with stakeholders).	Did your group or organization come together to demand: equitable access to HIV services; introduction of PrEP; lower HIV drug pricing; decriminalization of same-sex behaviours or relationships; legal protections against violence; services that are more sensitive to the needs of men who have sex with men; improved funding for community-led services; inclusion in national AIDS planning processes?
Participation in public events	Participation in public events.	In the past 6 months, how often did you participate in: a public rally; demonstration; meeting with policy-makers; consultation; marches or parades; health fairs—at the risk of revealing that you are a man who has sex with other men?

6 Saggurti N, Mishra RM, Proddutoor L, Tucker S, Kovvali D, Parimi P, et al. Community collectivization and its association with consistent condom use and STI treatment-seeking behavior among female sex workers and high-risk men who have sex with men/transgenders in Andhra Pradesh, India. AIDS Care. 2013;25(1):55–66.

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2

Addressing Violence

Contents

2.1 Introduction . . . 33
2.1.1 Contexts of violence . . . 36
2.1.2 Values and principles for addressing violence . . . 38

2.2 Promising interventions and strategies . . . 39
2.2.1 Building capacity and self-efficacy . . . 40
2.2.2 Working for legal and policy reforms . . . 41
2.2.3 Fostering police accountability . . . 43
2.2.4 Promoting safety and security . . . 45
2.2.5 Providing health services . . . 46
2.2.6 Providing psychosocial, legal and other support services . . . 47

2.3 Management, monitoring and evaluation . . . 50

2.4 Resources and further reading . . . 53

What's in this chapter?

This chapter explains:

- the **different kinds of violence** that men who have sex with men may experience, and how violence increases vulnerability to HIV (Section 2.1)
- the **places and contexts** in which violence occurs, and the social and legal conditions that make men who have sex with men vulnerable to violence and other human-rights violations (Section 2.1.1)
- **core values and principles** for effective programmes to address violence (Section 2.1.2)
- **promising interventions and strategies** to address violence, including how to implement these strategies (Section 2.2)
- approaches to the **monitoring and evaluation** of interventions (Section 2.3).

The chapter also provides a list of resources and further reading (Section 2.4).

2.1 Introduction

2014 Key Populations Consolidated Guidelines[1]

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations. *(p.96)*

Men who have sex with men face high levels of violence, stigma, discrimination and other human-rights violations. Research indicates that experiencing violence and trauma is associated with an increased risk for HIV and other sexually transmitted infections (STIs). This risk is due to physiological exposure to HIV during the violent or traumatic event (e.g. via open wounds, torn mucous membranes, or transmission of bodily fluids that carry HIV). In addition, the psychological burdens that may result from violence or trauma (such as depression, decreased self-esteem, fear of further threat, fear of isolation, denial of risk) can interfere with one's ability to protect oneself consistently from HIV transmission. Repeated exposure to unsafe sex within violent relationships also heightens the risk of HIV transmission. Physical or emotional abuse within such relationships often contributes to an inability to negotiate safe sex.

Men who have sex with men may face violence because of the stigma associated with same-sex sexual behaviour, a stigma which is reinforced in the many countries where such behaviour is criminalized. Violence may be a manifestation of homophobia—an irrational fear of, aversion to, or discrimination against persons known or assumed to be homosexual, or against homosexual behaviour or cultures. Homophobic stigma and discrimination may be experienced at an early age in educational settings, causing significant trauma well before adulthood.

Men who have sex with men are often perceived as failing to conform to gender expectations, and this gives rise to much of the violence to which they are subject. This violence can therefore be understood on a spectrum of gender-based violence.[2] International advocates for human rights analyse gender-based violence to include sexual violence, physical violence, emotional and psychological violence, and structural violence—discriminatory social policies or social practices that can negatively impact health and well-being. Although stigma and discrimination cause violence, in their most aggressive forms they may also themselves be acts of violence (see Box 2.1 for a detailed list of the forms of violence faced by men who have sex with men). Violence may also be experienced due to discrimination based on race, class, HIV status, drug use or other factors.

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

2 Gender-based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.

For men who are HIV positive, experiencing violence or trauma can complicate health management on multiple levels and reduce the ability to limit onward viral transmission. On a physiological level, research on other populations indicates that HIV positive individuals who have experienced significant trauma may show a more rapid decline in their CD4 counts, which weakens their immune system.[3] HIV positive survivors of violence who experience symptoms comparable to post-traumatic stress disorder also report more late or missed doses of anti-retroviral medicines or missed medical appointments, and this is also correlated to worse health outcomes. Individuals who experience multiple traumas can develop anxiety disorders, and these can create additional barriers to taking care of their health.

Violence, whether threatened or actual, and fear of being a target, can deter men who have sex with men from accessing HIV information and services. It can also prevent clinics and community-led organizations from providing information and services to them.[4] Many health services designed for men who have sex with men are provided by organizations led and staffed by local men who have sex with men. Those who provide these services, along with grassroots advocates for funding and policy changes to support these services, are among the most visible members of their communities, making them especially vulnerable to violence.

The United Nations has noted that incidents of violence based on sexual orientation and gender identity tend to be especially vicious, and are carried out with a high degree of cruelty and brutality.[5] Governments have a central role to play in addressing violence and ensuring the safety and security of all persons, including men who have sex with men. Although there is abundant anecdotal evidence of violence against men who have sex with men, and against those who provide services to them, such violence is seldom documented systematically. Where documentation does occur, it is often by community-led organizations that lack dedicated funding and have no access to police report databases.

HIV prevention and treatment programmes must include strategies to document and address violence against men who have sex with men and protect their human rights. Addressing violence can make it easier for men who have sex with men to access information and services and make their own choices about their long-term health and welfare. Building coalitions with potential allies working in areas of health, human rights and empowerment can assist in reducing violence against men who have sex with men (see also Chapter 1, Section 1.2.8 and Chapter 6, Section 6.5.7).

This chapter provides practical suggestions for how HIV programmes can implement strategies that address violence.

3 Kimerling R, Calhoun KS, Forehand R, Armistead L, Morse E, Morse P, et al. Traumatic stress in HIV-infected women. AIDS Educ Prev. 1999;11(4):321–330.

4 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.

5 United Nations General Assembly. A/HRC/19/41. Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity: report of the United Nations High Commissioner for Human Rights. New York (NY): United Nations; 2011.

Box 2.1

Forms of violence faced by men who have sex with men

Physical violence: Being subjected to physical force which can cause death, injury or harm. It includes having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g. gun, knife or other weapon). Other acts that could be included in a definition of physical violence are biting, shaking, poking, hair-pulling and physically restraining a person.

Sexual violence: rape (e.g. completed or attempted oral or anal penetration with the penis or other body part or object without consent), gang rape (i.e. rape by more than one person), sexual harassment (i.e. unwanted sexual attention, advances or requests for sexual favours), being physically forced or psychologically intimidated to engage in sex or subjected to sex acts against one's will (e.g. undesired touching, being forced or coerced into sex when drunk, high, drugged or unconscious and unable to consent) or being forced or intimidated to engage in sex that one finds degrading or humiliating. Sexual violence can also take the form of "corrective rape", which is rape of one man by one or more other men with the purpose of punishing the victim and "curing" him of his homosexuality.

Emotional or psychological violence: being insulted (e.g. called derogatory names) or made to feel bad about oneself; being humiliated or belittled in front of other people; being threatened with loss of custody of one's children; being rejected or isolated from family or friends; being bullied or threatened with harm to oneself or someone one cares about; repeated shouting, inducing fear through intimidating words or gestures; controlling behaviour; the destruction of possessions.

Socioeconomic violence: being refused or cheated of salary, payment or money that is due to the person, or being severed unfairly from employment; having money extorted; being unfairly restricted in access to social services or social benefits; being excluded from housing (denied housing opportunities or rejected or evicted from housing); being excluded from property rights and inheritance; being denied access to education which would increase one's socioeconomic stability; being subject to unfair fines or unjust criminal penalties.

Structural violence: policies that refuse to acknowledge sexual-health needs (such as not teaching about sexual harm reduction for men who have sex with men); laws that criminalize sexual relationships; laws that require a person's family, friends and social circles to report him to the authorities for incarceration or punishment.

Other human-rights violations that should be considered in conjunction with violence against men who have sex with men include forms of stigma or discrimination such as:

- being denied or refused food or other basic necessities
- being harassed by landlords and neighbours or forced from one's home
- being denied employment or discriminated against in one's job
- being arbitrarily detained, subjected to invasive body searches or incarcerated in police stations, detention centres and rehabilitation centres without due process
- being arrested or threatened with arrest for carrying condoms
- being refused or denied health-care services
- being subjected to coercive health procedures such as forced STI or HIV testing
- being publicly shamed or degraded (e.g. stripped, chained, spat upon, put behind bars)
- being coerced or forced into "reparative" treatment or therapy for homosexuality
- being forced to subscribe to religious doctrine in order to obtain services
- being expelled from school based on real or perceived homosexual orientation.

2.1.1 Contexts of violence

Numerous contexts, dynamics and factors put men who have sex with men at risk for violence. It is also important to distinguish between the different types of perpetrators of violence. Understanding the various contexts and perpetrators is key to designing appropriate programmatic responses to protect and serve men who have sex with men.

Laws and policies, especially those criminalizing same-sex relationships, may increase the vulnerability of men who have sex with men to violence. In addition, laws punishing the "promotion of homosexuality to minors" can be interpreted as outlawing any kind of education about homosexuality and same-sex behaviour. Research suggests that violence against men who have sex with men increases when a law of this kind is passed because its effect is to undermine education and tolerance for sexual diversity and to promote homophobia.

Violence against men who have sex with men is not always defined or perceived as a criminal act. For example, laws may not recognize attacks against men who have sex with men as a serious offence (in some jurisdictions sexual assault laws only envision women as victims of sexual assault or rape), or the police may refuse to prevent—or may even encourage—attacks against men who have sex with men, especially where sexual relations between men are illegal. Men who have sex with men are often reluctant to report violent incidents to the police for fear of police retribution or of triggering negative media attention. Laws criminalizing HIV exposure may prevent MSM living with HIV from seeking support in cases of sexual violence, for fear of being prosecuted. Even where sexual relations between men are not explicitly criminalized, the police may use administrative law, religious law or executive orders to stop, search and detain men who have sex with men, increasing the risk that they will experience violence.

Violence against men who have sex with men may be committed by the following types of perpetrator:

- **Violence by representatives of the state:** Men who have sex with men most commonly face violence from the police, but also from military personnel, border guards and prison guards. Criminalization or punitive laws against homosexual behaviour may provide cover for violence. Violence by representatives of the state compromises the access of men who have sex with men to justice and police protection, and sends a message that such violence is not only acceptable but socially proper.
- **Violence by perpetrators at large:** Research suggests that stigma against same-sex behaviour leads some people to commit violent acts against men who have sex with men in order to "punish" them for deviating from societal expectations of masculinity and heterosexuality, or perhaps in an effort to mask their own sexual or gender insecurity.
- **Violence in institutional contexts:** Men who have sex with men may face violence from individuals in a position of power, e.g. employers, health-care providers, bankers or landlords. Young men who have sex with men are particularly subject to violence, including jokes, hostile remarks and bullying in educational institutions. This is usually perpetrated by other students, but in some cases also by teachers and other staff. Schools can be among the most homophobic social spaces. Studies in a range of countries show that young men who have sex with men are more likely to experience homophobic bullying at school than in the home or the wider community. Yet it is also in schools and through education that the foundation for combating violence and bullying can be constructed in the minds of young people (see Box 2.2).

- **Violence from intimate partners and family members:** A growing research literature documents the significant prevalence of intimate partner violence among men who have sex with men. Men who have sex with men may also be at risk for violence from family members, especially when they disclose that they have sexual or emotional relationships with other men.
- **Organized non-state violence:** Men who have sex with men may face violence from extortion groups, militias or religious extremists.

Box 2.2

Addressing homophobic violence in educational institutions

Tackling homophobic violence requires action both to prevent it and to address it when it happens. Many countries have measures in place to deal with school-related violence, which can be adapted to respond to homophobic violence. Evidence and experience suggest that an effective education-sector response to homophobic violence includes interventions in the following areas:

1. ***Policy.*** Where there are no education-sector or school policies that specifically address homophobic violence and prohibit discrimination against lesbian, gay, bisexual or transgender (LGBT) students, policies to address bullying and violence in schools in general can be used to prevent and address homophobic violence.
2. ***Curriculum and learning materials.*** Depending on the local context and what is feasible and practical in each country, it may be possible to address issues relating to sexual diversity and homophobic violence in life skills-based sexuality education, sexual and reproductive health classes, or human-rights, citizenship or civics education; it may also be possible to mainstream them across a range of subjects.
3. ***Staff training and support.*** Some educational staff may consciously or unconsciously convey negative messages that legitimize homophobic violence. If well trained and supported, they can become part of the solution to the problem. Training can include raising issues of their responsibility as mentors to ensure a safe and healthy environment for all students, to support diversity and social inclusion.
4. ***Support for all learners.*** Relevant support needs to be provided for all learners, including those who experience homophobic violence as well as bystanders or witnesses to violence and perpetrators. This includes psychological support for those who experience violence and protection from retaliation; support for perpetrators including counselling, cooperative learning and development of social skills; and support for bystanders to encourage them to be helpful not hurtful, empowered to intervene and report, with protection from retaliation.
5. ***Partnerships and coalitions.*** It can be valuable to build coalitions to address homophobic bullying with constituencies including parents and parent–teacher associations, teacher and other staff unions, student unions and youth organizations, LGBT organizations and the media.

Based on United Nations Educational, Scientific and Cultural Organization (UNESCO). Education sector responses to homophobic bullying. Good Policy and Practice in HIV and Health Education. Booklet 8. Paris: UNESCO; 2012. http://unesdoc.unesco.org/images/0021/002164/216493e.pdf

2.1.2 Values and principles for addressing violence

To be effective, programmes for preventing HIV and supporting the health of men who have sex with men must address violence, stigma and discrimination. The following principles should be fundamental to all programmes. Emphasis can be given to either or both of the first two principles when advocating with policy-makers for programming or funding, in accordance with the national or local context.

Addressing violence against men who have sex with men is a public-health imperative. Violence based on sexual orientation operates on a systemic level, and its impacts on health are both direct (by causing grievous bodily harm) and indirect (by impeding provision of and access to vital health services). As such, violence against men who have sex with men needs to be addressed as a public-health issue affecting an entire population group. Public-health principles and models can be used to understand violence against men who have sex with men and its numerous causes and effects, so that public-health funding and resources can be mobilized to address it accordingly. (See Section 2.4 for documentation of the relationship between violence and the increased risk of HIV infection, and the necessity of reducing violence against men who have sex with men on public-health grounds.)

Men who have sex with men are entitled to the full protection of their human rights. The relevance of international human-rights laws to sexual orientation and gender identity has been clearly outlined in the Yogyakarta Principles (see Chapter 1, Section 1.2.5). These provide a useful lens for addressing violence against men who have sex with men, and policy recommendations for how the rights of men who have sex with men should be respected.

Programmes should not be stigmatizing, prejudicial or discriminatory in any way. This means that they should:

- **Reject interventions based on the requirement or belief in reparative treatment or therapy for same-sex behaviour.** Some programmes addressing violence against men who have sex with men are founded on a belief that these men would be at less risk of violence if they stopped their same-sex behaviours. However, not only have all credible professional medical and mental-health associations rejected the effectiveness or healthfulness of these programmes, but such programmes have also been shown to subject men who have sex with men to additional emotional and psychological trauma. (See Section 4.4 for statements by health bodies on reparative treatment.)
- **Respect the right of men who have sex with men to make their own choices** about their lives, including their health and their sexuality. This may involve seeking assistance and services for redressing violence, or choosing not to report or seek redress for violence. Research indicates that individuals may remain in violent or abusive relationships for numerous reasons, including that they may not perceive a viable option to leave. Men who have sex with men should have the right to make their own informed choices about their relationships, and resources and support must be available to help such individuals understand what choices are available to them.

Further principles for programming are listed in Box 2.3.

Box 2.3

Programming principles

- **Understand local patterns of violence** against men who have sex with men and the relationship of violence to HIV, as the basis for designing programmes (see Section 2.2.1).
- **Use participatory methods.** Men who have sex with men should be invited to engage in processes to identify their problems, analyse causes, identify priorities and develop solutions. Such methods strengthen programme relevance, build life and relationship skills and help ensure the long-term success of programmes.
- **Use an integrated approach in designing interventions.** Broad-based programmes that include the provision of information and holistic health services (including mental-health services), that work with the legal and justice sectors and are community-led can have a greater impact on violence against men who have sex with men and the risk of HIV. It is also important to incorporate social protections from bullying and harassment and provide equal access to educational resources. Such interventions would benefit all, but would particularly support younger men who have sex with men. Designing programmes like these requires establishing partnerships with a wide range of groups and institutions.
- **Build capacity of programme staff** to understand and address the links between violence against men who have sex with men and HIV. Programme staff should be able to respond sensitively to men who have sex with men who experience violence, without further stigmatizing or blaming them. (See also Chapter 4, Section 4.3.3, Part D.)
- **Recognize that programmes may have unintended harmful impacts** for men who have sex with men, such as retaliatory or "backlash" violence. Prepare for this possibility and monitor programmes for such unintended consequences.
- **Evaluate programmes** to identify strategies that reduce risk factors and levels of violence faced by men who have sex with men, in order to build the evidence base and ensure that resources are directed to the most beneficial strategies. Include measurable objectives that articulate results to reduce violence against men who have sex with men.

2.2 Promising interventions and strategies

This section identifies a number of strategies to prevent and respond to violence against men who have sex with men. Many of these strategies were developed as good practice by groups of men who have sex with men, and should serve as examples for programmatic design. All of the strategy domains listed should be implemented together because they are complementary and in combination can have a powerful effect in addressing violence against men who have sex with men.

Although many of these strategies were led by and at the initiative of groups and organizations of men who have sex with men, the onus to implement such strategies lies as much with government actors such as health and law-enforcement departments as with community groups.

It should be noted that many of these strategies have not been formally evaluated for their impact on reducing risk factors or levels of violence against men who have sex with men. Monitoring and evaluation will be important for producing evidence of violence reduction and rationales for programme expansion.

2.2.1 Building capacity and self-efficacy

Several kinds of activities support men who have sex with men in building knowledge of their rights and their confidence to claim these rights. This process also builds capacity for action, and strengthens the self-efficacy of men who have sex with men (i.e. their belief in their ability to act) to address and respond to contexts of violence.

Documenting violence faced by men who have sex with men and defending their human rights

An important process for building the capacity of men who have sex with men around rights is to document the violence that they face. The knowledge produced can be useful for developing strategies for appropriate community responses. Data on violence faced by men who have sex with men can also be used to advocate with police, local authorities, media, and national and international policy-makers about the extent of the problem and the need to change laws and policies that encourage or condone violence against men who have sex with men. However, care should be taken that collection of data or documentation of incidents of violence does not itself stigmatize or endanger the safety of men who have sex with men.

Documenting activities could include:

- gathering data or information on the different forms of violence faced by men who have sex with men
- documenting abuses and incidents of violence faced by men who have sex with men
- facilitating their access to justice and redress through legal services
- documenting innovative and effective efforts that have reduced violence towards men who have sex with men.

For the uses of information and communication technology (ICT) in documenting violence, see Chapter 5, Section 5.4.

Box 2.4

Case example: Documenting violence against men who have sex with men in the USA and Australia

In some settings, systematic documentation of violence against men who have sex with men has been used to develop resources to promote their safety. For example, the Anti-Violence Project in the USA (www.avp.org) has used expertise in counselling LGBT survivors of violence and trauma to create and disseminate resources for LGBT persons (including men who have sex with men who do not identify as LGBT) to understand better the experiences they have survived, and what steps might be useful for subsequent healing and legal recourse. Similarly, ACON and Laurel House in Australia have created phone and online reporting mechanisms, and psychological and legal resources for men who have sex with men who are survivors of assault.[6]

Raising awareness about human rights and legal redress

Training men who have sex with men about their human rights and the options for legal redress against violence raises their awareness of rights and laws that may protect them, and can encourage

6 see http://www.acon.org.au/lgbti-health/safety/ and http://laurelhouse.org.au/?page_id=22

them to report and challenge violence. Awareness-raising activities for men who have sex with men may include training and advocacy workshops, the production and dissemination of written and visual materials about violence and the human rights of men who have sex with men, community meetings and face-to-face counselling from community outreach workers.[7] Topics covered in these workshops, meetings or materials may include:

- the sources of, and reasons for, violence faced by men who have sex with men
- laws that affect men who have sex with men (e.g. municipal statutes, laws related to homosexual behaviour, drug use)
- a person's rights when arrested, charged or detained by the police, and correct police procedures
- available legal services
- resources for filing grievances and seeking justice.

Since men who have sex with men have literacy levels and learning needs that are as diverse as any population's, materials and curricula should be engaging and accessible to those with a layperson's understanding of law and policy.

A possible process for raising awareness and facilitating action could include the following elements:

1. Provide a process (such as a meeting or a series of workshops) for men who have sex with men to reflect critically on the full range of problems that they face (which may include, but not be limited to, violence) and the root causes of these problems.
2. Build collective solidarity among men who have sex with men to mobilize and advocate to challenge and change the behaviours of powerful groups or institutions that deny them their rights and perpetuate violence and other abuses, including obtaining redress in cases of violations. An important aspect of this solidarity and community empowerment would be institutionalizing at least one method or venue for documenting the violence faced by men who have sex with men.
3. Build alliances with other civil-society groups and, where appropriate, other sectors of society that can be allies in ensuring long-term change, such as public-interest campaigns, trade unions, religious institutions and traditional structures such as village assemblies.

2.2.2 Working for legal and policy reforms

Advocacy for legal and policy reforms can contribute to preventing or reducing violence (including stigma and discrimination) against men who have sex with men by:

- changing law-enforcement practices that harass or abuse men who have sex with men and deny them their human rights, including the deployment of general public-nuisance, vagrancy or public-order laws against men who have sex with men
- repealing and reforming laws and policies, and opposing new laws, that criminalize homosexuality or same-sex sexual activity, as well as laws that are used to harass, abuse or deny the rights of men who have sex with men (see Box 2.5). An important element of this strategy is to educate lawmakers on the harms of such laws, or to challenge their validity before the judiciary.
- building the institutional accountability of government stakeholders such as the police for the proper implementation of existing laws and policies that uphold the human rights of men who have sex with men. This includes institutionalizing strategies within government mechanisms (such

7 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

as national human-rights institutions and ombudspersons) to monitor and report on violence and other human-rights violations against men who have sex with men.

- building the knowledge and skills of the civil and criminal judicial system on HIV, sexual orientation, gender expression and identity and the law, and on the discriminatory experiences faced by men who have sex with men in housing, education and employment contexts
- countering stigma, discrimination and violence against men who have sex with men through sensitization workshops on sexuality, sexual orientation, gender expression and identity, human rights and the law
- disseminating print and multimedia materials about violence against men who have sex with men
- working with journalists and other members of the media to promote positive narratives and language use about men who have sex with men, sexual orientation, gender expression and identity
- supporting collective action by men who have sex with men and LGBT groups to seek redress for violence faced by their community members
- in organizations that provide services to men who have sex with men, building programme managers' understanding of laws affecting the rights of men who have sex with men.

Advocacy efforts may need to strike a balance between targeting frontline staff in different sectors (e.g. police or health workers) and higher-level decision-makers (e.g. administrators and managers), as frontline staff may respond best to pressure from decision-makers.

Box 2.5

Case example: Community-based advocacy in the Philippines

With the rate of HIV transmission in the Philippines dramatically increasing among men who have sex with men and transgender people, the need for a strengthened response through community-based groups was prioritized by the Health Action Information Network and TLF-SHARE Collective, supported by the United Nations Development Programme.

This initiative developed a range of services for men who have sex with men and transgender populations, based on a review of existing community-based responses to HIV among these groups. It also helped civil-society organizations engage effectively with local governments in HIV responses. These processes led to the training of 18 community-based groups and 200 men who have sex with men and transgender people in Metro Manila, Cebu and Davao on sexual health and rights, and organizational and programme development, as well as the formation of three new community-based organizations and the foundation for developing a national community network.

After three years of implementation, the initiative saw community-based groups assuming key roles in the HIV response through self-organization and peer-based collaborations. Community collectivization and leadership led to dialogue, coordination and collaboration with local government officials on HIV, gender and human-rights issues. This engagement led to greater local-government awareness of the specialized development, health and human-rights needs of men who have sex with men and transgender populations. For the community-based groups, it promoted a better understanding of government planning processes and increased participation in them.

One concrete outcome of this process of engagement was the passage of an anti-discrimination ordinance by the City Council of Cebu in October 2012, which prohibited discrimination on the basis of sexual orientation, gender identity and health status (HIV), among other grounds.

Source: United Nations Development Programme

Box 2.6

Case example: Working to reduce stigma and discrimination against men who have sex with men in Kenya

An LGBT organization provides support to men who have sex with men and other communities in Kenya on HIV-related prevention, treatment and care services. It also undertakes human-rights and security trainings for LGBT community members, and includes a staff lawyer to assist in cases of harassment or arrest.

Since 2010, the organization has worked with religious leaders to address stigma and discrimination against men who have sex with men and the LGBT community. It aims to equip leaders with skills and knowledge to reduce stigma and discrimination, in order to improve the access of men who have sex with men to HIV prevention and treatment and other health services. Meetings include discussion on sexuality, understanding stigma and discrimination, myths and facts about HIV, and community health. Trainings, which are held in Mombasa and led by the organization's staff who are themselves men who have sex with men, are conducted in English and Kiswahili and have reached 130 religious leaders from coastal Kenya.

Invitations to participate in the training were initially made by a partner organization, Kenya Medical Research Institute, but now invitations are made through direct contact by the LGBT organization and its trainers. Over time the training has increased acceptance by religious leaders and helped them to develop personal relationships with men who have sex with men and to address homophobia. Such work with key stakeholders who influence public opinion and perceptions helps reduce prejudice against men who have sex with men and fosters a safer environment for them.

2.2.3 Fostering police accountability

Working with the police has been a key element of efforts to reduce violence against men who have sex with men. Activities may include:

- **Advocacy** to reduce police harassment of men who have sex with men. This can include regular meetings with the police and using events and occasions to demonstrate solidarity between MSM groups and the police force (see Box 2.7).

Box 2.7

Case example: Advocacy with the police in Papua New Guinea

In Papua New Guinea, the Poro Sapot Project of Save the Children did advocacy with the police to build understanding on human rights and HIV to reduce violence against key populations.

The project staff and volunteers, who comprised mainly men who have sex with men, sex workers and people living with HIV engaged with police in 46 stations in three provinces. Trainings included education on the basics of HIV, and legislation and policies related to key populations, including how human-rights violations faced by men who have sex with men increase their vulnerability to HIV. Since January 2011, over 500 police officers have attended trainings and meetings. This led to the police providing security escorts to key populations and showing public solidarity by marching together with key populations on World AIDS Day.

- **Sensitization with the police** to raise awareness of human rights and HIV issues related to men who have sex with men. Bandhu Social Welfare Society in Bangladesh conducted regular face-to-face information sessions at police stations and provided the police with a list of outreach workers to protect them from harassment. In Senegal, a multi-partner project including the local NGO Enda Santé and the health ministry undertook sensitization and education of the media as a way to reach other key stakeholders such as the police and community leaders.

Training topics covered in sensitization workshops with the police may include: basic introduction to HIV, HIV programming, sexual orientation, gender expression and identity; stigma, discrimination and violence as they impact men who have sex with men (including physical, sexual, and emotional and psychological violence); laws and law-enforcement practices that affect the rights of men who have sex with men; the role of the police in HIV prevention and mitigation of stigma, discrimination and violence; and human-rights sensitization more generally.

Box 2.8

Case example: Sensitizing the police in India

Based on the experience of the NGO Sangama in Bangalore, India, some promising approaches to police education were identified, including:

- Provide legal literacy courses to police which discuss the rights of high-risk groups, common instances of police abuse, and preferred treatment for high-risk groups; and develop platforms for cooperation, for example to decide cruising and solicitation spots acceptable to both police and men who have sex with men or sex workers.
- Add HIV prevention to the curriculum at police training schools and academies for low-level and high-level officers. This can be an entry point to build respect for high-risk individuals who are working as community outreach workers.
- Have community outreach workers' ID cards endorsed by the police department, with a signature from the highest-ranking officer possible. This can be shown to officers on the street to prevent harassment and allow uninterrupted outreach.
- Institute monthly meetings between key population members and the police for ongoing discussion and resolution of grievances. Ideally, contact persons should be appointed within the police force to deal with HIV-related issues on a routine basis.
- Advocate for police departments to adopt workplace policies that encourage provision of HIV-related information and services within the police force; discourage arbitrary and inhumane treatment of people living with HIV; and prohibit mandatory testing of and discrimination against HIV positive personnel.
- Recognize officers who are supportive through formal ceremonies at the community-led organization.

- **Building institutional accountability** with police to uphold the rights of men who have sex with men. Orientations on HIV and key populations can be built into the procedures of law enforcement and prisons in order to make these topics a sustained, routine part of police training and prisons reform. For example:

HIV programmes have been institutionalised within the Nepal police force in collaboration with the NGO Blue Diamond Society. This has included setting up an HIV/AIDS Advisory Team at police headquarters, developing an HIV strategy, work plan and curriculum, conducting awareness and training programmes at all levels of the police force, and establishing a voluntary counselling and testing centre at the Nepal Police Hospital.

The Penitentiary Initiative implements HIV prevention and psychosocial support for men who have sex with men in prisons in Ukraine. This project includes training to reduce stigma and discrimination directed against men who have sex with men by prison staff. It also provides psychosocial support and HIV prevention activities to male prisoners. A training manual has been has been accepted by the National Penitentiary Service for use in all prisons in Ukraine as well as in other parts of Eastern Europe.

2.2.4 Promoting safety and security

Strategies to promote the safety and security of men who have sex with men may be formal or informal. The following should be considered:

- **Disseminate information or tips about safety to men who have sex with men,** e.g. advising men who have sex with men to carry a mobile phone and to have at least one emergency number that they can call if they find themselves in a dangerous situation. Such advice can also be disseminated effectively through the Internet.
- **Maintain and share lists or reports of aggressors** or incidents of violence against men who have sex with men. The list can include physical descriptions of perpetrators. Reporting sheets can be made available online, by fax, e-mail, mail or at safe spaces (see next bullet point). The reports can be compiled and distributed to men who have sex with men through monthly bulletins, SMS or e-mails so that they know to avoid potentially dangerous individuals.
- **Create safe spaces (drop-in centres)** or shelters that allow men who have sex with men to come together and discuss common issues and problems they face, including violence, and develop and exchange solutions. Such spaces require a security plan, and staff should undertake security training. (See Chapter 4, Section 4.4.4.)
- **Establish and maintain links between nongovernmental organizations (NGOs), community-based and community-led and international non-partisan institutions,** such as United Nations (UN) agencies, which can be beneficial in times of crises. When staff members of an organization providing safer sex information to men who have sex with men were arrested in Senegal in 2008, a crisis committee of local organizations and UN agencies coordinated a response based on relationships developed over time. UN senior staff talked with senior government officials, highlighting the negative impact of the arrests on the HIV response. The committee provided guidance on hiring lawyers to defend the arrested individuals, and supported civil society in providing safe homes and shelters to men who have sex with men who faced threats during the crisis.
- **Creating "hearts-and-minds" change through anti-homophobia campaigns in the mass media,** such as that which took place in Mexico in 2004-05. This campaign arose from the need to address stigma, discrimination and violence against men who have sex with men, which was impeding the HIV response in their communities. The campaign was designed to make it easier for men who have sex with men to get tested for HIV and follow up with appropriate care and treatment. This required addressing homophobia within families, health-care services and in employment. A multilateral partnership led by the national AIDS programme, with the support of the Pan American Health Organization, Mexico's health ministry, its anti-discrimination council,

and civil-society NGO partners, addressed homophobia by basing the campaign on scientific and legal foundations, which were successfully used to counter the strong opposition that emerged as anticipated.

2.2.5 Providing health services

Men who have sex with men who experience physical, sexual and psychological violence may need medical care in both the short and long terms. In most settings there are few, if any, specialized medical services for those who experience violence. The point of entry to immediate health care may be through the emergency services, so wherever possible, emergency-service providers should be trained and sensitized in appropriate provision of emergency care to men who have sex with men who experience violence. For longer-term care, it may be useful to consider integrating services into the broader set of HIV prevention, treatment and care and other health services for men who have sex with men.

In many cultural contexts men who have sex with men may not have enough trust in clinical providers to share their personal history, especially where same-sex behaviour is criminalized or strongly stigmatized. Local organizations of men who have sex with men may be able to help develop strategies for service-providers to build trust in clinical care settings; and to determine the most culturally appropriate ways to provide supportive services, which could include referral to legal and support services or developing safety plans.

Recommendations for clinical care, psychological support and health services for those who experience violence and sexual assault include:

- Provide immediate support to those who experience violence who present at a health facility. Providers should ensure confidentiality, be nonjudgemental and provide practical care, including treatment of physical injuries, and in the case of those who experience sexual assault, HIV and STI post-exposure prophylaxis. (See Section 2.4 for a USAID Health Policy Initiative training manual for health providers on identifying violence against men who have sex with men.)
- A clinical recommendation is to ask about the history of violence, listen carefully without pressuring the person to talk, facilitate access to social support, resources and services (e.g. legal if needed) and, in the case of intimate partner violence or the threat of aggression following discharge, help develop a safety plan.
- Provide psychological care, including information about the importance of mental health, and the symptoms of trauma and stress as a reaction to surviving violence and trauma. The World Health Organization (WHO) offers this information, as well as clinical protocols for care provision if the survivor of violence experiences symptoms such as depression, inability to carry out daily functions, or suicidal feelings. (See Section 2.4 for WHO's 2014 factsheet on mental health and its 2013 *Guidelines for the management of conditions specifically related to stress*.)

Health-care providers should be trained to provide services to those who experience violence (see Box 2.10 for recommended training topics). A directory of medical, legal and social services for men who have sex with men who experience violence should be compiled with input from local community organizations, where they have identified medical, legal or social-service providers who are trusted and provide services of the highest quality available. Once these providers are identified, arrangements should be established with them to accept referrals.

Health-service providers should document examples of resilience demonstrated by local men who have sex with men, in spite of violence and trauma. Numerous factors within an individual's personality and his environment can contribute to resilience for survivors of violence, and those factors vary by geographic and social context. By understanding and documenting these factors, providers can also consider how to encourage resilience in all of the men who have sex with men whom they serve. Raising and maintaining collective resilience for local men who have sex with men is likely to support their outcomes for mental and physical health.

Box 2.9

Topics for training health-care providers in addressing violence against men who have sex with men

- Types of violence that men who have sex with men may experience.
- Laws and policies that make men who have sex with men vulnerable to violence, and laws and policies applicable to men who have sex with men that prohibit violence, including human-rights law.
- The obligation of health-service providers not to discriminate, stigmatize or perpetrate violence against men who have sex with men.
- Identifying those who may be experiencing violence based on physical or psychosocial symptoms (e.g. depression, anxiety, post-traumatic stress disorder, suicidality or self-harm, substance use, injuries).
- When and how to inquire about violence.
- Collecting forensic evidence for investigating sexual violence.
- Providing clinical and psychological care and treatment.
- Where to refer for support services in the community.
- Providing nonjudgemental care that does not stigmatize those who experience violence.
- Implications of mandatory reporting of violence.

2.2.6 Providing psychosocial, legal and other support services

Men who have sex with men who experience violence often need a further range of immediate and longer-term services. Services that may be provided according to local need and capacity include:

Community response to violence

- Crisis response teams, such as those devised by Pehchan-supported interventions in India (see Box 2.11), can increase the sense of security and confidence of men who have sex with men, and increase uptake of HIV-related services. Longer-term approaches such as media campaigns can also be planned in conjunction with the programme's advocacy team.
- Community-led organizations in India such as Sangama and Samara have distributed cards that provide helpline numbers for men who have sex with men (and transgender people) who have experienced violence or harassment from the police, family members, gangs, the general public or at the workplace.

Training in these types of activities may be led by knowledgeable men who have sex with men and may cover: listening and communication skills; prioritizing the safety of men who have sex with men; advocacy skills to work with the police, social and health services and media; knowledge of the rights of men who have sex with men; dealing with police and local government officials; counselling those who may be under psychological duress; and assessing risks of harm. Training should take into account different learning needs and the diversity (e.g. ethnicity, migrant status) of men who have sex with men.

Box 2.10

Case example: Pehchan's crisis response system in India for men who have sex with men

To address the frequent violence faced by men who have sex with men and transgender people in India, the Pehchan programme, implemented by India HIV/AIDS Alliance and partners, developed crisis response teams (CRTs) in 200 CBOs across 18 states. These teams enable the programme to act quickly, provide support and document incidents of violence and discrimination. Trained staff members in each CBO are "on call" 24 hours a day to respond immediately when an incident occurs. Community members in crisis call a dedicated phone number to reach the CRT, and more than 90% of incidents are responded to within 24 hours. CRT staff have access to experienced legal advisors and health-care providers who can address each specific situation.

Each CRT is composed of programme staff, outreach workers, community volunteers, and a legal resource person familiar with violence and discrimination in sexual minority populations. The team has 5–15 members, depending on factors such as context, frequency of incidents and size of the area to be covered. With training and guidance from Pehchan, each CRT establishes detailed protocols for staffing and handling each crisis. Funding for emergency legal aid is available during a crisis situation and as a part of post-crisis response.

Familiarizing community members with the programme's crisis response services has been essential to success. Awareness-building activities with men who have sex with men and transgender people in the local community have been undertaken through events, regular meetings and education, including sessions on legal literacy and basic human rights. CRTs also get support through networking with other civil-society organizations, activists, community volunteers, human-rights organizations, bar associations and media.

The crisis response system has several steps:

1. When an incident occurs, the on-call CRT member appraises the situations and gets in touch with team members as needed.
2. The CRT ensures that at least one team member goes to the site of the incident and meets the person concerned. It is important to provide immediate attention, including facilitating emergency medical or legal support, and to affirm that the person is not alone in this situation and has support.
3. If a person reports any physical injuries or sexual assault, a community-friendly health-care provider is immediately contacted to provide first aid or assist with hospitalization.
4. If a police report needs to be filed or if the situation involved any kind of police or legal action, a team member and a lawyer go to the local police station immediately.
5. Every crisis is documented and recorded in the programme's register. This information is used both to improve crisis response services and for public advocacy by the programme.
6. A meeting of the CRT takes place within 24 hours of each incident to review the situation and evaluate the response.

Legal support

This may require engaging or linking with lawyers or trained paralegals (who may themselves be community members) who can help negotiate with legal and judicial authorities about incidents of violence, advocate on behalf of men who have sex with men and support training on laws related to homosexuality. For example, in Macedonia, STAR-STAR, a sex worker-led organization that includes male and transgender sex workers, links with other organizations, such as the Health Education Research Association (HERA) and the Healthy Project Options Skopje (HOPS), that offer legal advice services. This has been done by setting up a telephone information line that provides community members with referrals to medical, social and legal services provided by HERA and HOPS. This facility is also made available during emergencies when sex workers are experiencing violence or abuse from clients or seeking psychological support.

In Mumbai, India, Humsafar Trust runs a male sexual-health centre, which also assists men who have sex with men with links to legal aid and support. Humsafar has supported individuals in seeking redress for blackmail and robbery related to Internet dating sites. Such extortion occurs in a context where same-sex sex is still criminalized. Humsafar helps individuals to file reports with the police and refers them to legal aid groups such as the Lawyers Collective, which has ensured the arrest of blackmailers. Humsafar is using such cases as supporting documentation in its continued challenge to India's anti-sodomy law in the courts.

Support service models vary in terms of their complexity, the amount of financial and human resources required to operate them (see Box 2.12), and whether they have been evaluated and shown to work. Support services should also be based on assessments of informal practices already established by men who have sex with men themselves, and on their existing priorities. Some models, such as comprehensive crisis response systems, are resource-intensive, while others may require fewer resources.

Managing support services

The following activities should be considered in order to support these services:

- **Provide necessary infrastructure:** This may include local mobile phone numbers and/or hotlines staffed by trained community members. The availability of support services may need to be advertised through word of mouth, fliers and other communication channels.
- **Document incidents of violence:** Recording incidents of violence enables programme staff to analyse the incidents, ensure follow-up, monitor efforts and improve services. For men who have sex with men who want to file legal cases in response to violence, such documentation helps to provide necessary evidence for courts. Data on violence faced by men who have sex with men may also be used for advocacy with local, state and national policy-makers and for planning services to address violence against men who have sex with men.

Box 2.11

What are the potential resources needed for providing legal, psychosocial and other support services?

Resource people:

- Designated and trained men who have sex with men to operate helplines or hotlines
- Community outreach workers
- Trained community and/or professional counsellors for psychological support
- Lawyers or paralegals (could be trained men who have sex with men) who can provide legal support

Materials and venue:

- Mobile phones and time credit
- Hotlines
- Internet access
- Print materials to advertise services
- Data collection and reporting forms
- A space to operate hotlines, conduct trainings and meetings
- Safe space (drop-in centre) or shelter

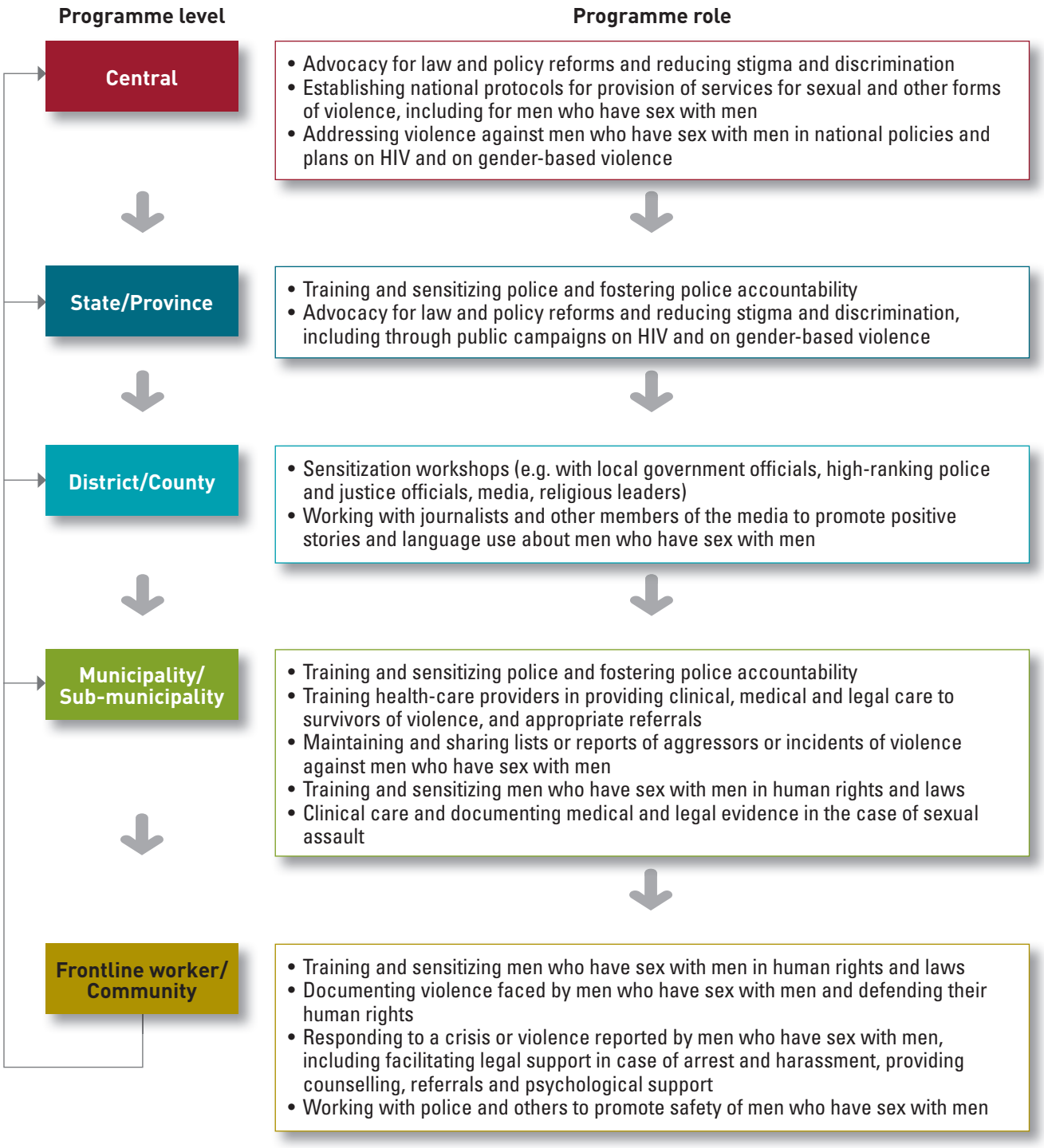
Costs:

- Remuneration for staff (including lawyers if not working pro bono)
- Start-up and maintenance costs for mobile phones, hotlines
- Advertising the services
- Transport costs
- Training

2.3 Management, monitoring and evaluation

The interventions described in this chapter are not only implemented at a local level but also require engagement at subnational and national levels. This is particularly true for sensitization and advocacy work. Figure 2.1 shows the roles of each of the levels of implementation. It should be noted that in many contexts, specific interventions may be required across multiple levels.

Figure 2.1 Illustrative multi-level approach to addressing violence against men who have sex with men



Note: programme roles shown are not exhaustive.

Monitoring and evaluation of violence prevention and response efforts are important because:

- Data on the specific forms of violence faced by men who have sex with men, and the contexts in which they occur, provide a basis for planning and designing appropriate strategies.
- Including indicators on violence faced by men who have sex with men in the routine monitoring framework allows programmes to monitor whether there are any unintended consequences of programmes and interventions, e.g. backlash violence.
- Evidence on violence faced by men who have sex with men is a powerful tool for advocacy efforts to change laws and policies related to homosexuality and create an enabling environment for promoting the rights of men who have sex with men.

There are currently no validated and internationally agreed-upon population-based impact indicators or programmatic indicators that are specific to violence faced by men who have sex with men. Indicators for monitoring and evaluating interventions that address violence against men who have sex with men may be developed or adapted and validated based on existing indicators for women. In India, where the Avahan AIDS Initiative included crisis response systems to address violence, programmes have also collected data on reported incidents of violence faced by men who have sex with men. These indicators include:

- number of men who have sex with men who report incidents of physical violence
- number of men who have sex with men who report incidents of sexual violence
- perpetrators of any violence reported by men who have sex with men, by category (e.g. police, intimate partner, client).

Programme monitoring data that rely on self-reported incidents of violence are sensitive to bias. It may therefore be challenging to interpret monitoring efforts that track increases or declines in reported incidents over time. Some forms of violence may be more likely to be reported when programme monitoring systems are established than others, and this will vary across different contexts over time.

Evaluation of violence prevention and response strategies with men who have sex with men is necessary before most of the options presented in Section 2.2 are scaled up. Gathering accurate information about violence requires that men who have sex with men be comfortable disclosing their experiences of violence. In contexts where same-sex sexual behaviour is highly stigmatized or criminalized, gaining trust takes time and requires consistent integrity, respect and honesty in relationships with men who have sex with men. Once relationships have been established, it is important to seek regular feedback on how to improve service provision, build trust and collect information that could serve as data for programme evaluation.

Care should be taken that collecting data or documenting incidents of violence does not further endanger the safety of men who have sex with men or stigmatize them. Building trust depends on the ethical and safety measures included in data collection, and the skills of data collectors in sensitively asking relevant questions. Prior research on violence against men who have sex with men can provide guidelines for researching violence and gathering data. Men who have sex with men must be equal partners in the design, implementation and dissemination of results from any data collection activity related to violence and other human-rights violations against them.

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3

Condom and Lubricant Programming

Contents

3.1 Introduction 61
3.1.1 Principles of condom and lubricant programming 62

3.2 Steps in effective condom and lubricant programming 64
3.2.1 Establishing accessible supplies 67
3.2.2 Condom and lubricant social marketing programmes 70
3.2.3 Creating demand 71
3.2.4 Creating an enabling environment for condom and lubricant programming 74
3.2.5 Lubricant programming 76
3.2.6 Other considerations in condom and lubricant programming 78

3.3 Programme management, monitoring and evaluation 79
3.3.1 Roles and responsibilities 80
3.3.2 Programme monitoring 81
3.3.3 Evaluation 82

3.4 Resources and further reading 82

What's in this chapter?

This chapter explains:

- why condom and lubricant programming is essential to HIV prevention interventions (Section 3.1)
- three steps in effective condom and lubricant programming (Section 3.2):
  - establishing accessible supplies of condoms and lubricants
  - multi-level promotion
  - creating an enabling environment
- other considerations for programming (Section 3.2)
- programme management (Section 3.3)

The chapter also provides a list of resources and further reading (Section 3.4).

3.1 Introduction

2014 Key Populations Consolidated Guidelines[1]

The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs. *(p.26)*

People from key populations, including people living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options. *(p.81)*

Condoms and condom-compatible lubricants are recommended for anal sex. *(p.26)*

Adequate provision of lubricants needs to be emphasized. *(p.26)*

The effective supply, distribution and promotion of condoms together with condom-compatible lubricants is essential to successful HIV prevention among men who have sex with men. Condoms and lubricants have been recommended as an HIV prevention method since the mid-1980s. With compatible lubricant, condoms offer greater protection from HIV and other sexually transmitted infections (STIs) including chlamydia, hepatitis B, syphilis and gonorrhoea. Female condoms are also used by some men who have sex with men to provide protection during receptive anal intercourse.

Historically, condoms and lubricant have been at the centre of the response to HIV. Condom and lubricant use has had a transformative impact on the trajectory of HIV epidemics worldwide, and today they are a fundamental component of HIV prevention programming for all populations. Condoms are also widely used to prevent other STIs and unintended pregnancies, making them one of the most versatile and cost-effective health commodities. For men who have sex with both men and women, only condoms provide the advantage of dual protection against both unintended pregnancy and acquiring HIV and other STIs.

With the development of pre-exposure and post-exposure prophylaxes (PrEP and PEP), along with advances in HIV prevention and treatment technologies, men who have sex with men now have more options for protecting themselves and their partners from HIV transmission. People from all key populations, including those living with HIV, should be able to experience full and pleasurable sex lives (see Box 3.1). Having access to a range of options for protection makes this possible, and for many people, condoms and lubricant remain the most convenient and cost-effective choice. Condom and lubricant programming therefore remains fundamental to any package of HIV and STI prevention, treatment and care services for men who have sex with men.

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

Box 3.1

A sex-positive approach to condom and lubricant programming for men who have sex with men

Condom and lubricant programming should reflect a rights-based approach to men's sexual health that honours and protects individual choice and bodily autonomy. Effective programming recognises the full spectrum of human sexuality, sexual orientations and gender identities and is grounded in respect for each individual's sexuality.

Increasingly, programmes led by men who have sex with men are moving away from a narrow focus on risk behaviour and infection, and embracing an approach to HIV and STI prevention that is more holistic and sex-positive. The sex-positive view recognizes that sex and sexuality are intrinsic to people throughout their lives. In this view, all consensual sexual activity is regarded as a healthy and pleasurable aspect of life that all individuals are entitled to express according to their personal choice. This can be supported through medically accurate safer-sex and sexuality education.

Within a sex-positive and identity-affirming framework, condom and lubricant use is promoted as a means for individuals to take control of their own health and to exercise their own agency[2] in preventing HIV and STI transmission. This normative shift is reflected in this publication and is the framework for the approaches to condom and lubricant programming discussed in this chapter.

Recent trends indicate that condom use among men who have sex with men has levelled off or declined in some countries. Research suggests a correlation between increased access to newer HIV pharmaceuticals and higher rates of self-reported risk behaviour. Thirty years into the epidemic, there is some evidence of "condom fatigue" among men who have sex with men, and reports of reduced acceptability of condoms.[3] While these trends are primarily evident in countries with greater access to new prevention methods, there is concern that condom fatigue could also increase in low- and middle-income countries. In order to reverse these trends and encourage new prevention technologies to complement, rather than supplant, condom and lubricant use, greater effort is needed to create sexual-health programming that actively promotes condom and lubricant knowledge, skills and use. Achieving global prevention goals will require bringing condom and lubricant programming to scale and enhancing the effectiveness and cost-efficiency of condom and lubricant promotion.

3.1.1 Principles of condom and lubricant programming

Condom and lubricant programming for men who have sex with men is a complex process with multiple steps. It requires partnerships between national government, local governments, local nongovernmental organizations (NGOs) and organizations of men who have sex with men, and involves:

- establishing accessible supplies of condoms and condom-compatible lubricants that adhere to internationally accepted standards for quality through:
  - forecasting and procurement planning
  - procurement and stock management
  - distribution
  - quality assurance

2 Agency is the choice, control and power that an individual has to act for himself.

3 Adams BB, Husbands W, Murray J, Maxwell J. AIDS optimism, condom fatigue, or self-esteem: explaining unsafe sex among gay and bisexual men. J Sex Res. 2005;42(3):238–48.

- multi-level promotion of condoms and lubricants
- creating an enabling environment for condom and lubricant programming. This includes increasing the understanding of the indispensability of lubricants as a part of effective condom use (see Box 3.2).

Through each stage of programme planning, the meaningful involvement and leadership of the community[4] is essential. This is particularly important in identifying which brands and types of condoms and lubricants to procure in order to meet the needs and preferences of specific communities and populations. Partnerships with the private sector through social marketing initiatives and direct engagement with local business owners can increase options for condom and lubricant procurement, distribution and marketing and broaden access for men who have sex with men (see Section 3.2.2).

When condom and lubricant programming is successful, men who have sex with men are provided with stable, ongoing and adequate supplies of condoms and lubricants that are acceptable to them in material, design and pricing. Yet ensuring access to condoms and lubricants alone is not sufficient to maximize opportunities for comprehensive sexual-health promotion. Condoms and lubricants should be distributed along with medically accurate and relevant information about their correct use and effectiveness in preventing HIV and other STIs. Comprehensive condom and lubricant programmes that address individual and structural barriers to condom and lubricant use and that respond to the overall sexual-health needs of men who have sex with men may have a stronger and more sustainable impact on improving community health in general.

Programmes also need to create an enabling environment for condom and lubricant access by addressing social and legal barriers to their use, such as criminalization of same-sex behaviour or expression, and extra-legal punitive practices such as public shaming and social exclusion, which cause men who have sex with men to fear carrying condoms and lubricants. Even in countries where laws criminalizing same-sex sexual relations are either not in place or not enforced, limited investment of human, financial and technical resources in the public health-care system presents another set of challenges to programme design and roll-out. Consequently, implementing effective condom and lubricant programmes for men who have sex with men requires creative strategies for working both within and outside public health-care systems.

Programming guidance in this chapter reflects a health systems strengthening approach that is based on increasing the capacity of local organizations and using local expertise so that comprehensive condom and lubricant programming can be led, supported and sustained by the communities being served. While the steps in programme implementation (Table 3.1) and supply planning (see Section 3.2.1) reflect conditions where local procurement and supply chain systems exist, this chapter also addresses strategies for acquiring and distributing supplies of condoms and lubricant in contexts where such systems do not (see Box 3.3).

4 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 futher details, see the Glossary.

Box 3.2

Lubricants for sexual health and well-being

Lubricants improve the effectiveness of condoms in penetrative sex, and anal sex in particular. Neither the anus nor the rectum has secretion glands and they do not produce lubricant on their own. Reported condom breakage during anal sex has been shown to decrease from 21% to 3% when condoms are used with compatible lubricants, rather than without them. Lubricants are therefore essential to condom use by men who have sex with men for protection from HIV and other STIs. Water-based lubricants are compatible for condom use, but oil-based ones may damage the condom and cause it to break.

Lubricants are a feature of healthy, empowering and affirming sex lives for many individuals. While lubricants used alone do not protect against transmission of infections, most types appear to make it possible for individuals to have penetrative anal sex without damaging delicate rectal skin and tissue. Although lubricant is often associated with anal sex, and is often stigmatized, lubricants make all forms of penetrative sex easier, more comfortable and more enjoyable. By expanding the range of possibilities for intimate expression between consenting partners, lubricants can make sex more enjoyable and fulfilling as well as safer.

Some research indicates that water-based lubricants, when used alone without a condom, could be harmful to the tissue lining the anus, and further research on lubricant use is needed to fully understand its relationship to risk for infection. In the meantime, however, WHO-recommended lubricants should be made broadly available to men who have sex with men, both to enhance their sexual health and well-being and to reduce condom breakage or slippage. Condoms and lubricants should be co-packaged or distributed together whenever possible. In addition, whenever condoms are mentioned in the context of HIV prevention with men who have sex with men, the words "and lube" must follow.[5]

3.2 Steps in effective condom and lubricant programming

Strategic partnerships among all stakeholders are essential to improve access to condoms and lubricants and increase their use. Partners should include organizations of men who have sex with men at a minimum, as well as NGOs, community-led organizations, the ministry of health or national AIDS programme, department of reproductive health, United Nations agencies, the private sector, social marketing organizations, donor agencies, lawmakers and law-enforcement ministries.

At the central management level, the national AIDS programme, national government and national-level civil-society organizations have important roles to play in condom and lubricant procurement and supply, national-level promotion and creating an enabling environment for condom and lubricant programming. Local implementing organizations,[6] including social marketing organizations and health clinics, play essential roles in commodity forecasting, distribution, community-led promotional strategies and advocating for an enabling environment for condom and lubricant programming at the local level. These roles are outlined in Table 3.1 as well as in Section 3.3 and Figure 3.2, where additional information is provided on the various levels of planning and execution of strong partnerships for condom and lubricant programming.

5 For further details on guidance for procurement of lubricant, please see World Health Organization (WHO). Use and procurement of additional lubricants for male and female condoms: WHO/UNFPA/FHI360 advisory note Geneva: WHO; 2012. A webinar on lubricant safety and access around the globe is available at http://www.msmgf.org/html/webinars/LubeFeb26/lib/playback.html.

6 An "implementing organization" is an organization delivering a prevention, care or treatment intervention to men who have sex with men. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

Table 3.1 Implementation of high-quality condom and lubricant programming with men who have sex with men

Activity	Role of national HIV programme and national implementing organizations	Role of local implementing organizations, local government and health clinics
Establishing accessible condom and lubricant supplies for men who have sex with men	• Carry out accurate forecasting of condom and lubricant supply needs.	• Use monitoring of supply and demand conducted by local community-led organizations to inform national condom and lubricant forecasting.
	• Define the procurement plan and funding source; ensure sufficient funding is available for needed orders, including lubricant.	• Conduct market research through focus groups and surveys with men who have sex with men to understand condom and lubricant brand and type preferences, including sizes, colours, flavours etc. • Provide input into market research and procurement planning processes at the national/central level.
	• Place condom and lubricant orders on a timely basis, securing an uninterrupted supply of products that: 1. meet World Health Organization (WHO) recommendations 2. respond to community needs for variety and comfort. 3. adhere to internationally accepted quality standards.	• Map the potential distribution outlets in the community for condom and lubricant distribution. • Assess the size and quality of the distribution outlets (existing and new) to ensure that condoms and lubricants are stored in optimum conditions to prevent deterioration over time.
	• Consult with men who have sex with men, including young men who have sex with men, to plan condom and lubricant distribution points that meet their needs. • National social marketing organizations may carry out large-scale distribution, sales and promotion of branded condoms and lubricants.	• Manage supply chain of condoms and lubricants, including proper product storage and a complete management information system on condom and lubricant distribution patterns. • Provide free condoms and lubricants through targeted distribution points including clinics, drop-in centres etc as well as through community outreach workers. Sensitize outlet owners and depot holders. • Distribute branded social marketing condoms and lubricants through traditional and non-traditional social marketing outlets.
	• Carry out regular monitoring of central condom and lubricant stocks to ensure timely ordering and avoid stock-outs.	• Carry out regular monitoring of local condom and lubricant stocks to ensure timely ordering and avoid stock-outs.
	• Request feedback on condom and lubricant product needs and distribution system and make changes accordingly.	• Collect regular feedback from users on condom and lubricant product needs and preferences and distribution system, and provide this information to national programme.

Activity	Role of national HIV programme and national implementing organizations	Role of local implementing organizations, local government and health clinics
Multi-level promotion of male and female condoms and lubricants	• Build the capacity of NGOs and community-led networks and organizations of men who have sex with men in community-driven promotional strategies (if needed).	• Implement community-driven promotional strategies for condoms and lubricants, such as promotion of condoms and lubricants through community outreach workers. • Tailor promotion to include young and married men who have sex with men. • Integrate condom and lubricant promotion into broader sexual-health strategies that discuss self-perception and overall health and well-being of men who have sex with men.
	• Destigmatize condoms and lubricants through promotional efforts in the general population, including talk shows and radio programmes, or condom and lubricant cartoons in popular magazines and newspapers.	• Integrate community-driven promotional strategies for condoms and lubricants with other community outreach activities. • Develop online strategies for promotion.
	• If necessary, provide funding or technical assistance to develop tailored behaviour change interventions for correct and consistent condom and lubricant use.	• Provide condom and lubricant demonstrations and skills-building as part of broader sexual-health and wellness campaigns. • Provide education on which available lubricants are condom-compatible and safe. • Develop tailored individual and community-level interventions to address sexual health of men who have sex with men.
	• Provide additional commodities and training supplies such as penis models to local organizations, as needed.	• Develop and promote condom and lubricant interventions that promote the benefits for individual users. Foster a culture that normalizes condom and lubricant use.
	• Train health-care workers and counsellors to provide condom and lubricant demonstrations and skills-building.	• Build capacity of men who have sex with men to negotiate condom and lubricant use and sexual risk reduction.
	• Destigmatize condoms and lubricants through high-level, well-publicized political support for condom and lubricant use.	• Provide routine reinforcement of condom and lubricant use negotiation skills. • Train outreach workers to carry out condom and lubricant promotion activities using a motivational approach that is exploratory, nonjudgemental, and respectful of choices of men who have sex with men.
Creating an enabling environment for condom and lubricant programming	• Challenge laws and regulations that penalize possession of condoms and lubricants.	• Implement condom and lubricant promotion and distribution as part of a broader package of health services. • Solicit ongoing feedback from community members and programme participants to determine adequacy of quality, type and quantity of condoms and lubricant.
	• Stop law-enforcement practices of confiscating condoms and lubricants and using condoms and lubricants as evidence of illegal sex or sex work.	• Advocate to remove laws and practices that penalize possession of condoms and lubricants.

3.2.1 Establishing accessible supplies

An effective supply chain ensures that the right quality product, in the right quantity and right condition, is delivered to the right place at the right time, for a reasonable cost. A supply chain typically has the following major components:

- forecasting to ensure a reliable supply of condoms and lubricants
- procurement of high-quality condoms and lubricants, consistent with the needs and wants of men who have sex with men, through internationally established quality assurance mechanisms
- quality assurance at all levels[7]
- warehousing and storage of condoms and lubricants in a way that maintains the integrity of the commodities and their supply chain
- distribution to providers and other outlets to serve the needs of men who have sex with men
- logistics management information system to support informed decision-making and planning.

Effective, comprehensive condom and lubricant programming can be achieved under the following conditions:

- There is governmental commitment to collaboration with implementing partners and organizations of men who have sex with men, and efforts are coordinated through sound leadership at the national level.

  Where stock-outs or sporadic access to commodity deliveries are caused by inconsistent government coordination, partnerships with nongovernmental agencies or government foreign mission offices may offer channels for improving access to condoms and lubricants (see Box 3.3).
- Government-led efforts are designed in collaboration with condom and lubricant users, including men who have sex with men.
- Demand for condoms and lubricants is created and sustained.
- Adequate supplies of high-quality condoms and lubricants are available and distributed widely. Advocacy, skills-building and knowledge-sharing are carried out at all levels to ensure the sustainability of the programme over the long term.

Box 3.3

Access and distribution in repressive environments

In countries where homosexuality is criminalized, and where local organizations of men who have sex with men may be forced to operate covertly due to restrictive laws, accessing condoms and lubricants through ministries of health and other public sources may not be possible. The potential for social marketing programmes aimed at men who have sex with men is also limited as high visibility may make individuals and organizations vulnerable to police action or subject to criminal charges. However, some organizations have found ways to meet the critical needs of their constituents within repressive environments. One commonly used strategy is to partner with NGOs engaged in HIV prevention among the general population, and who have existing procurement and distribution systems in place. Through such collaborations, organizations of men who have sex with men can have their sites integrated into delivery systems and can help plan and execute distribution strategies that will expand reach to men who have sex with men. By determining which international NGOs or foreign government mission offices are locally involved in condom and lubricant supply chain management, and identifying ways to coordinate, organizations may be able to tap into these alternatives to improve service delivery.

7 For more information on quality assurance testing as well as proper storage of condoms in warehouses, see the WHO/UNFPA/FHI publication Male latex condom: specification, prequalification and guidelines for procurement, 2010, listed in Section 3.4.

Accurate condom and lubricant supply planning requires forecasts based on regular consumption data, supplemented with data on service provision, demographic and morbidity data, estimates of population mobility and programme plans. (See Section 3.4 for guidance on condom and lubricant forecasting.)[8] National condom and lubricant programmes should work closely with organizations that serve men who have sex with men to request regular (monthly, bimonthly or quarterly) reports of condom and lubricant consumption, defined as the actual quantities of condoms and lubricants that have been distributed to men who have sex with men within a specified period.

It is important to be aware that multiple condoms and lubricant sachets may be used during a single sexual encounter. For this reason, asking men who have sex with men about the frequency of their sexual activity may not yield accurate information about the quantity of condoms and lubricant each individual may require. Where there is a functioning logistics management information system, organizations working with men who have sex with men should be incorporated into it to report condom and lubricant consumption data and changing needs.

Government condom and lubricant distribution programmes should actively involve organizations of men who have sex with men and civil-society organizations in condoms and lubricant supply forecasting, market segmentation, condoms and lubricant distribution and product promotion. Men who have sex with men should be engaged throughout the process of planning and mapping condom and lubricant distribution points.

Empowering organizations of men who have sex with men to distribute condoms and lubricant to communities is essential to increase their accessibility and use at the community level. With direct access to the population being served, organizations of men who have sex with men are key distribution points for condom and lubricants, providing condom and lubricants in "safe spaces" (drop-in centres),[9] through community outreach workers and as part of other health services.

Table 3.2 provides key questions that implementing organizations should ask in planning for adequate supplies of condoms and lubricants.

Condom and lubricant distribution programmes should work with men who have sex with men to understand their preferences for condoms and lubricants, including material (latex/polyurethane), condom size, colour, scent and branding preferences. While female condoms and lubricants are not approved by WHO or the United Nations Population Fund for use in anal sex, in practice many community-led organizations procure and distribute female condoms to men who have sex with men based upon the preferences of the community (Box 3.4).

8 Guidance on contraceptive forecasting is used for all condom programming because condoms are usually included as part of national contraceptive commodities programmes.

9 A safe space (drop-in centre) is a place where men who have sex with men may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 4, Section 4.4.4 for details.

Table 3.2 Condom and lubricant supply planning questions

Questions	Potential answers
From what types of outlets do community members prefer to obtain condoms and lubricants? (Place strategy)	• "Safe spaces" (drop-in centres) • Community outreach workers • Shops, pharmacies • Medical clinics, doctors, hospitals • Workplaces • Truck stops, bus stops, bars, saunas, clubs, cruising areas
What types of condoms and lubricants do men who have sex with men prefer? (Community members should be consulted to determine colour, scent, size and price preferences.)	• Free public-sector condoms and lubricants • Socially marketed condoms and lubricants (See Section 3.2.3) • Commercial condoms and lubricants • Others?
How close are condom and lubricant outlets to the community? (Accessibility)	• Very close (1-5 minute [min.] walk) • Close (10-20 min. walk) • Far (30-45 min. walk) • Very far (1 hour or more)
Do these outlets always have condoms and lubricants to provide? (Availability)	Condoms: Yes/No Water- or silicone-based lubricants: Yes/No
How many condoms and how much lubricant do men who have sex with men have access to weekly? (Current level)	Male condoms: Lubricants:
How many do they need to access? Unmet need (Right quantity?)	Number of condoms and lubricants required per man who has sex with men monthly
What are the most common problems men who have sex with men report with male condoms and lubricants (Right quality?)	• Breakage • Slippage • Condom has bad smell • Condom and/or lubricant is expired • Condom and/or lubricant package is damaged • Condom is wrong colour/flavour

Distributing low-priced social marketing condoms and lubricants in outlets close to locations where men who have sex with men gather, in combination with free distribution of generic condoms and lubricants through community outreach workers, is often the most effective way to ensure broad-based accessibility of condoms and lubricants.

Programmes working with men who have sex with men require penis models for condom and lubricant demonstrations and should incorporate these and other commodity needs identified above into their procurement planning and product distribution efforts.

Box 3.4

Case example: Empowering men who have men to have safer sex: promoting the female condom and lubricant in Myanmar

The TOP programme—with funding from PEPFAR, the Global Fund, and other donors and operated by Population Services International—has been providing HIV and other health services for female sex workers and men who have sex with men in Myanmar since 2004. One of its most important interventions is the marketing and distribution of female condoms along with water-based lubricant for use in anal sex between men. The risk of HIV transmission during anal sex is much higher than during vaginal sex, so promoting safer anal sex is a critical part of the response to HIV in Myanmar, as elsewhere. TOP had originally focused on increasing the acceptability and use of the female condom among female sex workers. But programme staff gradually noticed that it was also being used by men who have sex with men. In response, TOP used social marketing techniques to increase demand for the female condom for anal sex between men, and to promote its correct use. (TOP continues to promote the correct and consistent use of male condoms and lubricant.)

A team of TOP community outreach workers regularly meets with men who have sex with men to show them how to use the female condom correctly for anal sex, along with water-based lubricant to reduce condom breakage. The TOP outreach workers, who are themselves community members, share tips and information. Because the female condom used with lubricant offers the insertive partner a "bareback" feel, it is particularly popular among men whose partners may be reluctant to use condoms. The freedom and discretion that men who have sex with men can exercise in using the female condom with their partners has quickly made it a popular and effective alternative to the male condom for HIV and STI prevention.

TOP outreach workers promoting the use of female condoms for anal sex among men who have sex with men

3.2.2 Condom and lubricant social marketing programmes

In many countries, government- or donor-provided free condoms and lubricants are distributed with limited or no branding, with minimal branded marketing support, and without specialty aspects (i.e. different colours, sizes, flavours etc). This creates a complementary market for branded and specialty condoms and lubricants sold by the private and social marketing sectors on a cost-recovery basis. Condom and lubricant social marketing programmes sell lower-priced, subsidized condoms and lubricants to individuals who can afford to pay only some of the total commodity cost. They also carry out a variety of branded and generic marketing campaigns that destigmatize condom and lubricant use overall.

Working with both the public and private sector simultaneously can increase the options for obtaining condoms and lubricant for individuals across all socioeconomic levels, and can significantly improve access to essential commodities for key populations in particular. By involving the private sector in

condoms and lubricant distribution, governments can reduce the overall budget needed to procure sufficient condoms and lubricants for free distribution and broaden options for condom and lubricant procurement, distribution or marketing.

While there are advantages to social marketing programmes, they should not be a substitute for the distribution of free condoms and lubricant in sufficient quantities to key populations, including men who have sex with men. A primary objective of country ownership of HIV prevention, treatment and care programmes is to strengthen health systems so that sexual and reproductive health commodities are included as essential medicines in all public health programmes and clinical services.

Public, private and social-marketing sectors can coordinate efforts at the national level to institute a total market approach (TMA) to condom and lubricant programming. A strong TMA with broad reach emphasizes segmentation of the marketplace, coordination with manufacturers and distributors in the private sector, and development of branding strategies tailored to specific groups of consumers.[10]

Box 3.5

Case example: Social marketing of condoms and lubricant in Thailand: the SWING Revolving Fund

In 2004 the Service Worker in Group Foundation (SWING), a community-based non-profit organization, began a revolving fund to supply male sex workers in Bangkok's red-light areas with condoms and lubricant. Until then, condoms and condom-compatible lubricants were scarcely available in "hotspots" around Bangkok, and those for sale in local shops were unaffordable for most male sex workers, who required regular supplies. HIV prevalence among men who have sex with men in Bangkok was estimated at 31% in 2007.

SWING faced significant challenges in setting up an effective mechanism to increase access to affordable condoms and water-based lubricants. These included a shortage of condoms from donors and the government, and difficulty complying with the policies of an international NGO regarding a social marketing strategy for condoms and lubricants because of SWING's limited organizational capacity.

In response, SWING partnered with FHI 360, who provided a grant of 3,000 Thai baht (US $120) to purchase an initial stock of condoms and water-based lubricant sachets. SWING started selling the commodities to four establishments as well as to individual male and trans sex workers. Prices were determined through informal discussions with beneficiaries and stakeholders. Condoms were sold for just 20% of their price in private stores, and lubricant sachets at 40% of the private price. SWING's profit was 0.25 Thai baht (US$ 0.01) per item sold.

By June 2009, the project was operating in 54 establishments in 6 hotspot areas of Bangkok. It also reached a significant number of freelance male and transgender sex workers in places such as parks, streets and cinemas. A total of 119,000 condoms, 47,300 sachets of water-based lubricants, 42 large cans of water-based lubricant and 460 safer sex packages have been sold since the beginning of the project. From the initial capital of 3,000 baht, total assets have risen to more than 400,000 baht (around US $12,000), allowing SWING to maintain its commodity stock over time and to continue meeting the needs of the community.

3.2.3 Creating demand

Condom and lubricant use should be promoted as part of a broader approach to the sexual health of men who have sex with men that does not simply focus on the prevention of disease.

10 For more information on a total market approach to condom social marketing, see Barnes J, Armand F, Callahan S, Revuz C. Using total market approaches in condom programs. Bethesda (MD): Strengthening Health Outcomes through the Private Sector Project, Abt Associates; 2015. http://abtassociates.com/Reports/2015/Using-Total-Market-Approaches-in-Condom-Programs.aspx

Nonjudgemental, sex-positive and medically accurate communication at the individual, group and community level is an essential component of programmes to motivate men who have sex with men to incorporate condoms and lubricant in their sex life. Acknowledging that men practise anal sex because they enjoy it is a necessary precursor to motivating them to care for their health when doing so. Behaviour change communication strategies should be designed to help individuals understand and take charge of their health in the context of having better sex. This includes providing basic information about the anatomy of the anus and rectum and their role in sexual pleasure, and how a man should protect his anal health (see Chapter 4, Section 4.2.10, Part A). In the context of counselling between a health-care provider and an individual man, a discussion of these topics can be a bridge to exploring the individual's understanding of and attitude towards HIV risks, and the advantages and disadvantages of reducing those risks, including by using condoms and lubricant.

A condom and lubricant promotion strategy should be based upon a situation analysis and/or formative research with populations of men who have sex with men and should use relevant behaviour change theories. A successful strategy will incorporate individual, community and mass-media interventions. Individual interventions include one-to-one counselling from health-care providers and interpersonal communication with community outreach workers. At the community level, group activities can provide opportunities for discussion as well as for making condoms and lubricants available. Condoms and lubricants should also be available and promoted in health centres used by men who have sex with men as well as in community spaces frequented by them (i.e. drop-in centres, entertainment venues etc).Television, the Internet and other electronic media can be part of a mass-media promotion strategy. For details of community-based promotional activities, see Chapter 4, Box 4.2.

Box 3.6

Case example: Increasing appeal and sustaining demand in The Russian Federation

menZDRAV Foundation found that conducting outreach and community-led education directly in gay clubs, bars and saunas in Moscow where men who have sex with men are already gathered, and where they are most likely to engage in condomless sex, is an effective strategy for condom and lubricant promotion if it is kept fresh with new approaches.

For several months, volunteers distributed condoms and lubricant along with information about HIV testing at a popular nightclub with a regular clientele. Initially, patrons were enthusiastic about receiving free condoms and lubricant from menZDRAV's community outreach workers. However, after some time, interest and demand for condoms and lubricants fell, as visitors said that they already had condoms and no longer needed information.

To change this dynamic, menZDRAV invited the dancers and drag queens who worked at the club to be trained as outreach workers. Once trained, the dancers greeted guests at the door with menZDRAV materials. The dancers easily captured the patrons' attention, and their presence and rapport with the nightclub regulars made condom and lubricant outreach sexually appealing. The dancers also conducted brief counselling sessions on HIV, sexual health and condom use, and a physician was invited as a volunteer to conduct brief counselling sessions at the nightclub. By using this creative approach to motivate individuals to choose safe sex, menZDRAV was able to substantially increase condom and lubricant use and rates of HIV testing.

A menZDRAV outreach worker provides communication skills training on safe sex to a dancer working at a night club. Photo by Denis Aleksandrov.

Mass media promotion of condoms and lubricant

Broad social support for condom and lubricant use is needed in order for them to be used consistently. Condoms and lubricant cannot be stigmatized or viewed as only for high-risk sex, or only for men who have sex with men. It is essential that social values encourage the acceptance of condom and lubricant use as a "sexual-health" tool in both casual and regular sexual partnerships. Where possible, condom and lubricant promotion programmes should expand activities for the general population in order to create overall social support for condom and lubricant use in all types of sexual relationships.

Media campaigns may be used to promote condom and lubricant use, decrease demand for condomless sex and change social norms. Campaigns should provide consistent and complementary messaging through mass media, health-service providers and entertainment venues. Ideally, media promotional efforts are delivered through a partnership of organizations, including the national government, relevant NGOs and private-sector condom and lubricant companies. When these partnerships are successful, they create high-quality campaigns that reach men who have sex with men and the general population with messages grounded in behavioural theory. These messages will motivate individuals to use condoms and lubricants, while also influencing social norms and "normalizing" condom and lubricant use among the general population.

ICT and condom and lubricant promotion

As Internet access expands, individuals interested in casual and commercial sex often meet online. The anonymity afforded by social networking apps and websites can make them an effective platform for health promotion. Condom and lubricant promotion programmes should expand to online venues, particularly those where commercial and casual sex contacts are made. Social media messaging should reinforce and complement condom and lubricant promotional messages in other mass media and inform individuals about condom and lubricant outlets. Online condom and lubricant promotion is most effective within a broader sexual-health framework to promote access to other HIV and STI prevention services such as HIV and STI testing and counselling. For examples, including the use of social media, see Box 3.7 and Chapter 5, Section 5.3.2.

Box 3.7

Case example: Using social media to promote condoms and lubricants

Using social media, apps and dating sites to promote condom and lubricant use has been a successful strategy used by numerous local organizations of men who have sex with men. In Kampala, Uganda, Spectrum Uganda Initiatives uses websites such as Planet Romeo, Adam 4 Adam, and the Grindr phone app to post messages about their Safe Space meetings where men who have sex with men can drop in and receive free condoms and lubricants from trained community outreach workers. Since these social media platforms are popular among Spectrum's constituents, who may be reluctant to obtain HIV and STI prevention commodities on their own, this messaging allows Spectrum to maximize its reach and increase condom and lubricant use among a high-risk group.

The Australian organization Ending HIV (www.endinghiv.org.au) distributes free condoms and lubricant to sex-on-premises venues, gay clubs and bars, and health clinics. Each distribution site is identified on a searchable Google map embedded on the organization's website so that men who have sex with men anywhere in the country can find the nearest location to access condoms, lubricant and sexual-health services.

3.2.4 Creating an enabling environment for condom and lubricant programming

An enabling environment for strong condom and lubricant programming ensures that:

- policy, legal and regulatory frameworks are supportive of condom and lubricant programming
- these frameworks are properly enforced
- key organizations and individuals support condom and lubricant programming and access for men who have sex with men.

Legal and policy issues

As a prerequisite for effective HIV and STI prevention programming with men who have sex with men, national governments should establish laws and policies that protect their rights. The laws, regulations or law-enforcement practices of some countries still penalize possession of condoms and lubricant. To enable effective distribution programmes and ensure individual freedoms, these should be revised to permit personal possession of condoms and lubricants by all individuals and to ensure that possession is not used as evidence of a crime. In countries where law-enforcement officials use condoms and lubricant as evidence of sex work, governments should act to end this practice. Neither condoms nor lubricants should be considered evidence of specific sexual behaviours or a specific sexual orientation, and these items should never be confiscated from men who have sex with men or male sex workers.

In many contexts where sexual activity between people of the same sex is criminalized, promoting or distributing condoms and lubricant among men who have sex with men may be viewed as promoting criminal behaviour. However, public-health imperatives must take precedence over moral arguments for the continued criminalization of same-sex sex, particularly given that criminalization can force same-sex activity underground, making it harder to reach men who have sex with men. The overarching aim of policy reform and advocacy efforts should be to remove laws that criminalize the behaviour of men who have sex with men.

Box 3.8

National policies and advocacy initiatives to promote condom and lubricant use among men who have sex with men

- Decriminalize sex between people of the same sex to ensure the effective implementation of condom and lubricant distribution.
- Remove laws that penalize possession of condoms and/or lubricant.
- End the practice of law-enforcement officials using condoms and lubricant as evidence of sex work or confiscating condoms and lubricant from individuals.
- Develop national legislation to protect the rights of men who have sex with men and of lesbians, gay, bisexual and transgender people.
- Reform obscenity laws that are used to prevent health promotion and sexual-health education activities by civil-society organizations.

Community support

Condom and lubricant programming should never be an isolated activity. In order to be successful, promotion and distribution should always be conducted as part of a broader package of health services and activities and should be by carried out by men who have sex with men themselves. At the local level, community-led condom and lubricant programmes can best achieve health promotion goals by working directly with men who have sex with men to understand situations and social factors that compromise condom and lubricant use. For example, drug use, violence, group and casual sex should be addressed by community members who are involved in programme planning and development in order to develop effective harm reduction and intervention strategies. Depending upon the local context, either advocacy or programmatic solutions, or both, could address these situations.

Box 3.9

Case example: Engaging communities in national condom and lubricant programme planning and implementation in Kenya

LVCT Health, an HIV and SRH service-provider and referral organization, advocates for increased access to sexual-health services for men who have sex with men in Kenya. It works closely with national coordinating agencies and key stakeholders, including local groups of men who have sex with men, to implement condom and lubricant programming, HIV testing and counselling and other HIV prevention interventions that are relevant and useful to men who have sex with men.

The Kenya National AIDS Strategic Framework on HIV/AIDS gives priority to prevention programming among key populations, including men who have sex with men. During the programme-planning phase, LVCT Health conducted focus group discussions with local organizations for men who have sex with men to collect their views on how the framework should address their issues. In addition, they determined the most useful avenues to distribute condoms and lubricant and identified "hotspots" frequented by men who have sex with men. The owners of businesses in hotspots promote condoms and lubricants by providing convenient locations for dispensers. Ongoing monitoring of condom and lubricant access and distribution for men who have sex with men is conducted in collaboration with local communities, and condom and lubricant forecasting is made more accurate by measuring consumption at designated hotspots.

Advocacy and media support

Effective condom and lubricant programming includes advocacy to engage the media in creating an enabling environment for condom and lubricant programming. One way to do this is to identify and support condom and lubricant "champions" (advocates) within government, civil society and the health-care system. A champion can be any individual who rejects laws and regulations that negatively influence condom and lubricant use, and is able and willing to publicly advocate for such laws to be overturned. In some cases, it may be necessary to strengthen the technical and advocacy skills of these champions through training. Training materials on creating an enabling environment for condom and lubricant promotion can be developed or adapted from existing models. Condom and lubricant champions can also be provided with guidance on developing communication strategies to engage the media, and following a "train-the-trainer" model, can facilitate sensitization trainings and skills-building for journalists and members of the mass media.

Box 3.10

Local strategies for creating an enabling environment for condom and lubricant programming

- Ensure that condoms and lubricant are widely available through distribution outlets in locations where men who have sex with men may meet, such as bars, nightclubs, cruising zones etc.
- Train local police to promote and protect the human rights of men who have sex with men and HIV and STI prevention knowledge, including the need for condom and lubricant promotion and distribution.
- Provide community outreach workers with identification cards signed by local police authorities to prevent them from being harassed while they are conducting outreach work.
- Advocate for the removal of local practices that penalize or stigmatize condom and lubricant use among men who have sex with men.
- Conduct advocacy for government ownership of condom and lubricant procurement and programming through specific government policies, strategies and budgets.
- Conduct training for service-providers to carry out sexual-health and condom and lubricant promotion communications within health services for men who have sex with men.
- Train "condom and lubricant champions" who will work to educate and advocate with the media and other key stakeholders.

3.2.5 Lubricant programming

Figure 3.1 Lubricant programming opportunities

Advocate for increased lubricant availability

- Incorporate lubricants into national HIV strategic planning documents
- Incorporate lubricants into national procurement systems

Increase accessibility of safe, condom-compatible lubricants

- Distribute lubricants through NGOs and clinics working with men who have sex with men
- Make lubricants available in packages that are consumer-friendly

Educate men who have sex with men and providers regarding lubricant use

- Emphasize the importance of lubricant use to prevent condoms slipping and breaking during anal and vaginal sex
- Educate men who have sex with men regarding the dangers of using non-condom-compatible lubricants such as household products

Lubricants are a feature of healthy, empowering and affirming sex lives for many individuals (see Box 3.2). Research shows that in the absence of affordable and accessible condom-compatible lubricants, some individuals will choose to use other types of lubricant (e.g. body lotion, soap, cooking oil) which can damage the condom. In order to prevent this, condom-compatible lubricants must go together with condoms in every aspect of programme planning and facilitation.

Wherever condoms are distributed, water- and silicone-based lubricants should also be made available, according to the preferences of men who have sex with men for either type of lubricant or for a specific brand of lubricant. All lubricant products should meet WHO recommendations (see Section 3.4 for information on WHO recommendations for procurement of lubricants). The forecasting, procurement, supply chain management and distribution of lubricants should be integrated with those processes for condoms and other related health commodities. Lubricants should be made available in tubes, sachets or other convenient packages according to the preference of the community in that locality. Social marketing organizations often package lubricants together with condoms, which can be an effective approach to lubricant distribution.

Box 3.11

Case example: Co-packaging of condoms and lubricants

In Laos, Population Services International distributed a co-packaged condom and lubricant, branded as Number One Deluxe Plus. The co-packaged condom and lubricant was distributed by community outreach workers to men who have sex with men, transgender individuals and sex workers, along with an informational pocket card that emphasized that condoms and lubricants should be used together to prevent disease transmission and minimize condom and lubricant breakage.

In Thailand, TestBKK's *Suck, F*#K, Test, Repeat* campaign (www.testbkk.org) combines condom and lubricant promotion with HIV testing messages marketed primarily to young men who have sex with men. Two condoms and a 5 ml sachet of water-based lubricant are contained in a package that is branded with the campaign logo, along with instructions for correct condom and lubricant use and information about HIV testing. This links sexual-health information to service delivery.

The primary focus of condom and lubricant distribution programmes is on increasing condom and lubricant use, and therefore product communications should focus on the benefits of using both products together.

Advocacy at the national and community levels is needed to ensure that affordable condoms and condom-compatible lubricants are made widely available nationally. Lubricants are often associated with anal sex between men and are therefore highly stigmatized. Effective lubricant advocacy involves removing the stigma around lubricant use and asserting the need for lubricants as a critical component of risk reduction for HIV and other STIs and of pleasurable, healthy sex in general. It is crucial to frame the message about increased lubricant access in terms that encompass the needs and concerns of the general population, in order to generate support from a wider range of constituents, policy-makers and private-sector stakeholders. By emphasizing that lubricant is important to prevent condoms from tearing in both anal and vaginal sex, it is possible to demonstrate that it is a necessary preventive commodity whether people have sex with members of the opposite or same sex. Some advocacy activities that can be carried out to improve access to safe, affordable condoms and lubricant-compatible lubricants include the following:

- Review the National Strategic Plan for HIV and determine if it includes a provision on lubricant availability. If it does, follow up with relevant government agencies and donors to include lubricant as a line item in the government or a donor's HIV prevention budget. If it does not, advocate for it to be included in the next revision of the NSP.

- Integrate the need for availability of condoms and condom-compatible lubricants into all community trainings, government sensitization sessions and workshops.
- Document the need for individuals to access affordable condoms and condom-compatible lubricants. Document the needs of individuals engaging in sex with opposite-sex partners, as well as those who practise male-to-male sex, in order to avoid any stigmatization of lubricants.
- Encourage donors to advocate with governments for inclusion of lubricants in programming.
- Urge researchers carrying out HIV-related studies to include questions on lubricant access and availability.
- Access the "Global Lube Access Mobilization" Toolkit online for further ideas. (See Section 3.4 for a link to this document.)

3.2.6 Other considerations in condom and lubricant programming

Condom and lubricant programming for young men who have sex with men

The first sexual experience with another person can be complex, especially for young men who have sex with men. Family pressures, social exclusion and homophobia may compromise their ability to negotiate protected sex with condoms and lubricant. Condom and lubricant programming for young men who have sex with men can only be effective if they are involved in programme design and execution. Through focus groups, surveys and unstructured interviews and meetings young men who have sex with men can identify their own needs and preferences and shape programmes to better address these. Once youth have participated in the initial programme planning stages, they should be involved in executing the programme as educators, outreach workers and in day-to-day operations. Wherever possible, after-school, part-time and full-time paid positions should be created for young people in the condom and lubricant programme.

Framing condom and lubricant promotion messages and instructional information using language and images that reflect the way young people actually express themselves is one step in this process. Beyond simply using "youth-friendly" language, it is important to provide physical meeting spaces or youth-exclusive drop-in centres in community settings, wherever possible. Establishing consistent spaces where young people can safely gather, connect with mentors and community outreach workers, and confidentially access condoms and lubricant in an accepting environment can increase receptivity to condom and lubricant promotion.

While safe spaces exclusively for young men who have sex with men (and LGBT youth in general) are necessary in most environments, it is just as important to ensure that mainstream youth-friendly spaces are inclusive of sexual and gender minorities. Working with existing youth centres and other programmes that provide sexual-health and HIV prevention programming for young people can create accepting and affirming environments where all youth, regardless of sexual orientation, gender identity or gender expression can feel safe and supported. Sensitization workshops and sexual-health education discussion groups that promote knowledge about the spectrum of human sexuality are demonstrated measures of creating such environments.

Condom and lubricant programming with male sex workers who provide services to men

The types of sexual services provided to men by male sex workers vary, and condom and lubricant distribution and promotion programmes should take these differences into account and ensure that

male sex workers have access to the commodities they need. Programmes serving male sex workers should work with them to understand their information and commodity needs, and tailor promotion and information accordingly.

Male sex workers should be served by community outreach workers who are themselves current or former sex workers, in order to maximize understanding, minimize stigma and discrimination and facilitate sharing ideas between the men and the community outreach workers. Community outreach workers should discuss relevant topics with male sex workers, such as how to negotiate condom and lubricant use with clients, and how to put on a condom with their mouth or in other attractive ways.

Effective condom and lubricant distribution for male sex workers relies on a harmonized approach to HIV programming among the health, commercial and judicial sectors. Condoms and lubricant should be widely promoted and available in the commercial sector, particularly in convenience stores, small-scale vendors and non-traditional outlets near entertainment areas. Most importantly, condoms and lubricant must be available in the locations where commercial sex takes place and where men who have sex with men gather to contact one another. When condoms and lubricant are more or less within arm's reach during a commercial sex act, it is much more likely that they will be used. It is therefore absolutely necessary that proprietors of venues where sex services are provided, and men who have sex with men themselves, should not be hampered, punished or detained by police or others for possessing condoms and lubricant.

Box 3.12

Strategies for increasing condom and lubricant use among male sex workers and their clients

- Distribute condoms and lubricants in locations convenient to clients of male sex workers, including convenience stores, workplaces and sex work/contact venues.
- Discuss topics relevant to sex workers such as condom and lubricant negotiation with clients and how to make condoms and lubricant sexy for their clients.
- Use community-led education to develop skills and promote knowledge from a sex worker perspective. Peer-to-peer sexual-health education enhances sex workers' ability to use condoms and lubricants consistently in situations where there are power imbalances.

3.3 Programme management, monitoring and evaluation

Box 3.13

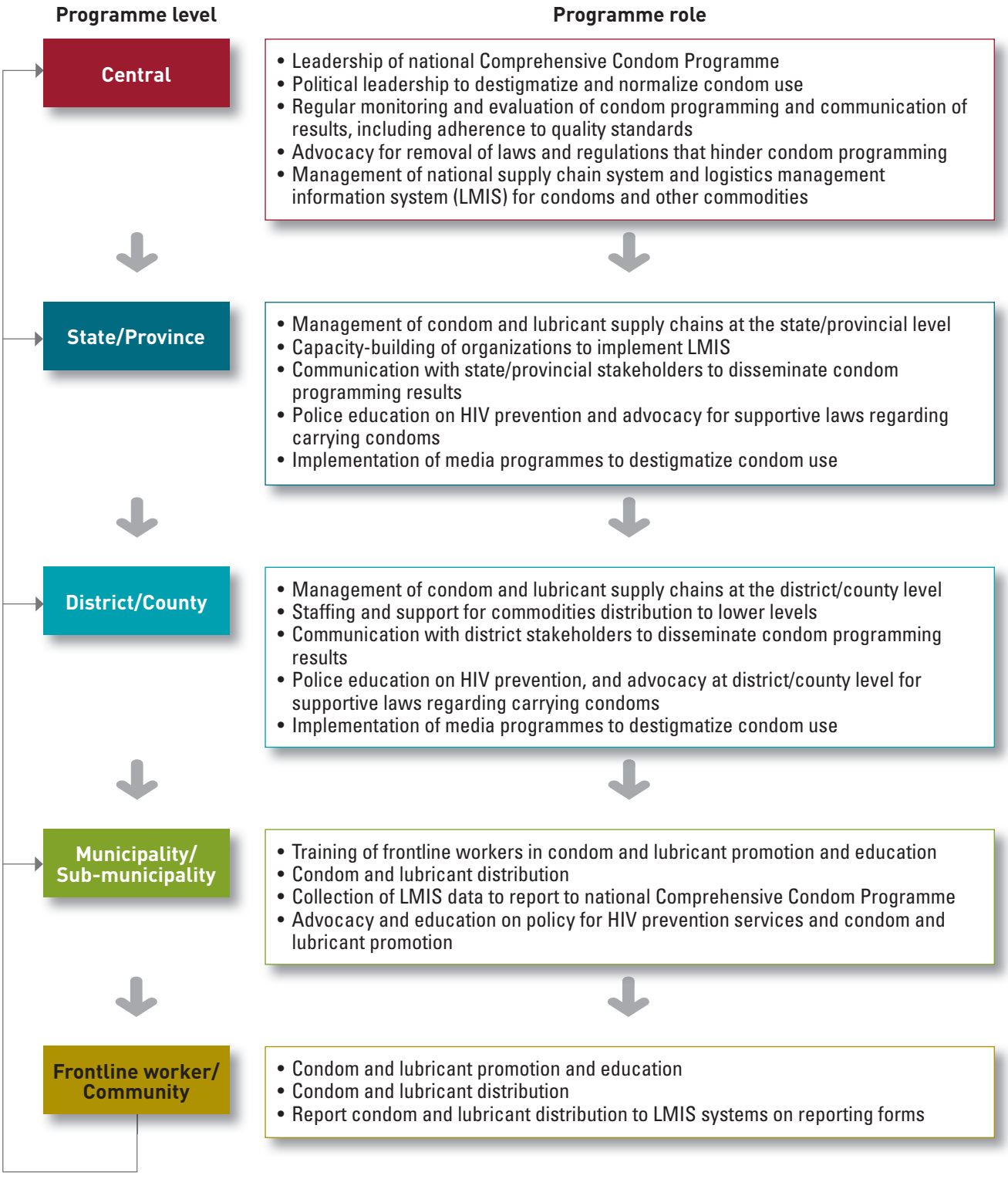
Guiding principles for programme monitoring and evaluation

- Use a rights-based approach based on the meaningful participation of men who have sex with men in every aspect of programming.
- Effective condom and lubricant programming must be evidence-based, but a lack of data should not deter coordinating efforts among stakeholders in the public, private and NGO sectors.
- Encourage efficiency and sustainability by openly engaging the general public and encouraging the sharing of knowledge and information.
- Apply relevant indicators to capture the availability, coverage, quality and impact of condom and lubricant programming.

3.3.1 Roles and responsibilities

Figure 3.2 shows how condom and lubricant programming is managed through partnerships and coordination among organizations at multiple levels of government and implementing organizations.

Figure 3.1 Roles and responsibilities in condom and lubricant programming



Note: programme roles shown are not exhaustive.

3.3.2 Programme monitoring

Table 3.3 shows illustrative examples of state-level and service-level indicators. For national-level indicators, please refer to the WHO *Tool for setting and monitoring targets for prevention, treatment and care for HIV prevention, diagnosis, treatment and care for key populations* (2015 – see Section 3.4).

Table 3.3 Condom and lubricant programming monitoring indicators

Activity	Target	Indicator	Data sources
Establishing accessible condom and lubricant supplies for men who have sex with men	1	Ratio of condoms and lubricant distributed to estimated monthly requirements	Micro-planning tools Condom and lubricant stock registers Enrolment questionnaires Other condom and lubricant gap assessments
	0	Number of implementing organizations service delivery points reporting any condom stock-outs for free distribution in the last month	Implementing organization or service delivery point condom stock registers
	0	Number of implementing organizations service delivery points reporting any lubricant stock-outs for free distribution in the last month	Implementing organization service delivery point lubricant stock registers
	90%	Number of men who have sex with men provided with condoms and lubricant by implementing organization service delivery points	Implementing organization service delivery point records
	90%	% of enumeration areas where condoms and lubricant are available for sale within a 10- or 20-minute walk	Social marketing condom and lubricant coverage survey
	95%	% of men who have sex with men who agree with the statement: "Condoms and lubricant are available when I need them."	Behavioural surveillance surveys
Multi-level promotion of condoms and lubricants	90%	% of men who have sex with men reporting condom and lubricant use during last anal sex	Enrolment questions (quasi-baseline) Routine questions in clinic encounter
	5%	% of men who have sex with men reporting condomless receptive anal sex at last sex with a male partner	Behavioural surveillance surveys
	Increase	% of men who have sex with men reporting identified motivational factors for condom and lubricant use	Behavioural surveillance surveys
	Decrease	% of men who have sex with men reporting identified barriers to condom and lubricant use	Behavioural surveillance surveys
	Increase	% of men who have sex with men reporting correct knowledge of which lubricants are safe	Behavioural surveillance surveys
Creating an enabling environment for condom and lubricant programming	0	Number of reported incidents of confiscation of condoms and lubricants	Programme reports
	90%	% of implementing organizations reporting condom and lubricant needs to the national condom and lubricant programme	Logistics management information system

3.3.3 Evaluation

Evaluating the effectiveness of condom and lubricant promotion and distribution with men who have sex with men supplements regular programme monitoring. Evaluation helps to ascertain whether programmes have effectively changed condom and lubricant use by men who have sex with men. While a variety of evaluation methodologies and tools may be used, the most common include routine collection of condom and lubricant distribution and sales data, behavioural surveillance surveys, condom and lubricant coverage surveys and process evaluations using routine monitoring data.

Behavioural surveillance surveys are conducted at regular intervals (every 2–4 years) with men who have sex with men to determine the effect of interventions on health outcomes. These surveys measure changes in self-reported condom and lubricant use as well as changes in identified motivations and barriers to condom and lubricant use. Some behavioural surveillance surveys may also incorporate biomarkers that measure HIV and/or STI prevalence.

Condom and lubricant coverage surveys are generally employed by social marketing programmes. These surveys use lot quality assurance sampling to measure levels of condom and lubricant coverage and quality of coverage in mapped enumeration areas.

A process evaluation using routine monitoring data may be an instructive way to measure progress on condom and lubricant programme outputs. In particular, condom and lubricant supply indicators may be measured through routine programme reporting and use of a logistics management information system. Review of these data at regular intervals helps understand whether condoms and lubricant are sufficiently available to men who have sex with men.

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4

Health-Care Service Delivery

Contents

4.1 Introduction . . . 89
4.1.1 The HIV prevention, care and treatment continuum . . . 89
4.1.2 Providing comprehensive health services to men who have sex with men . . . 91

4.2 Combination prevention . . . 94
4.2.1 Individual and group-level behavioural interventions . . . 96
4.2.2 Sexual or other risk history-taking . . . 98
4.2.3 Adaptive strategies (serosorting, strategic positioning) . . . 100
4.2.4 Voluntary medical male circumcision . . . 101
4.2.5 Condom and lubricant promotion . . . 101
4.2.6 Voluntary HIV testing and counselling . . . 104
4.2.7 Pre-exposure prophylaxis (PrEP) . . . 109
4.2.8 Post-exposure prophylaxis (PEP) . . . 115
4.2.9 Sexually transmitted infection services . . . 116
4.2.10 Other sexual-health services . . . 124

4.3 Care and treatment . . . 127
4.3.1 Antiretroviral treatment and care . . . 127
4.3.2 Tuberculosis . . . 130
4.3.3 Mental health . . . 131
4.3.4 Drug and alcohol use . . . 135

4.4 Service delivery approaches . . . 137
4.4.1 Clinical approaches . . . 137
4.4.2 Community-led approaches . . . 141
4.4.3 Using information and communication technology . . . 154
4.4.4 Safe spaces . . . 155

4.5 Resources and further reading . . . 157

What's in this chapter?

This chapter explains:

- The **HIV prevention, care and treatment continuum and comprehensive health services** (Section 4.1)
- **Combination prevention interventions for men who have sex with men** (Section 4.2), including sexual health and risk minimization, condom and lubricant promotion, voluntary HIV testing and counselling, pre- and post-exposure prophylaxis, and diagnosis and treatment of sexually transmitted infections
- **Interventions that make up the care continuum** (Section 4.3), including antiretroviral treatment and care, treatment of tuberculosis, mental-health assessment and services, and drug and alcohol treatment
- **Service delivery approaches,** including clinical approaches, community-led approaches, using information and communication technology, and safe spaces (drop-in centres) (Section 4.4)

The chapter also provides a list of **resources and further reading** (Section 4.5).

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

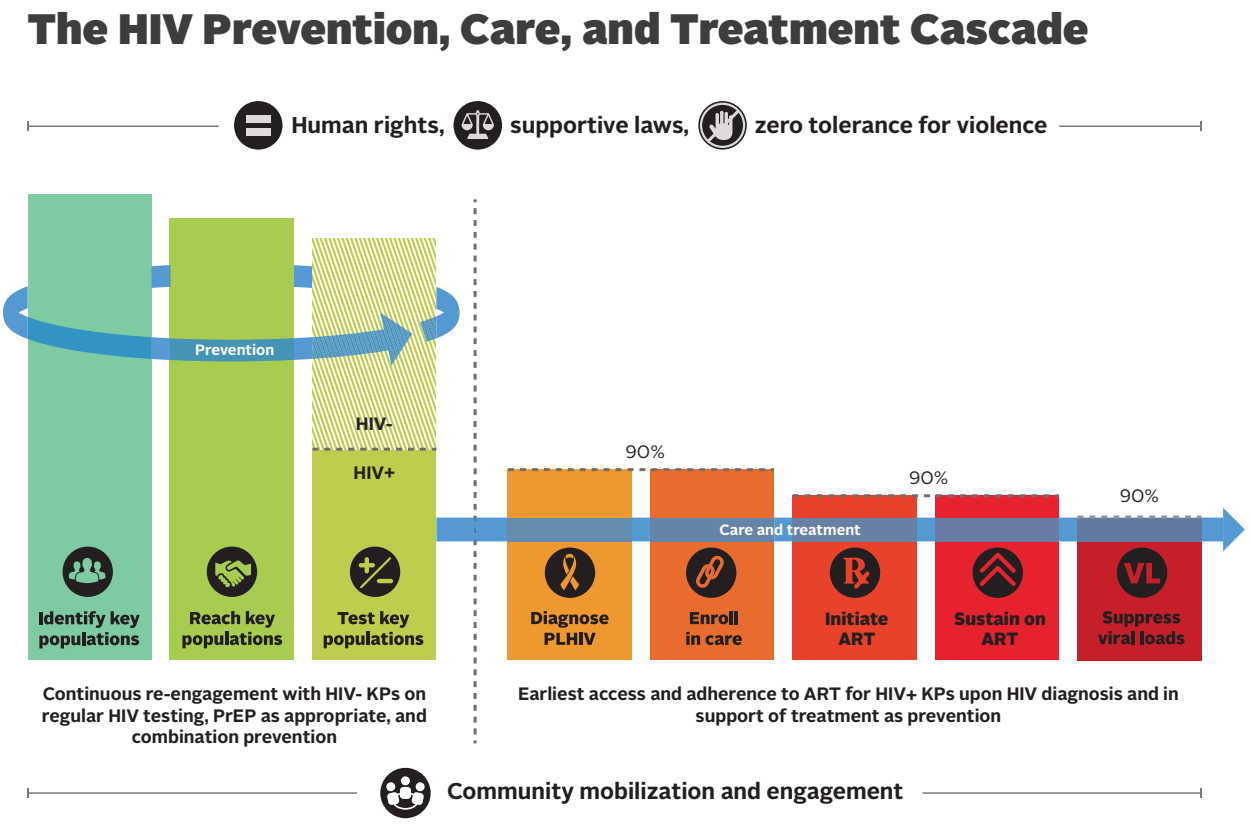
Figure 4.1 illustrates the HIV prevention, care and treatment continuum. It shows the essential steps for planning and measuring client flow through prevention, care and treatment services. It starts by emphasizing the importance of estimating the size and locations of the key population—in this case, 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.

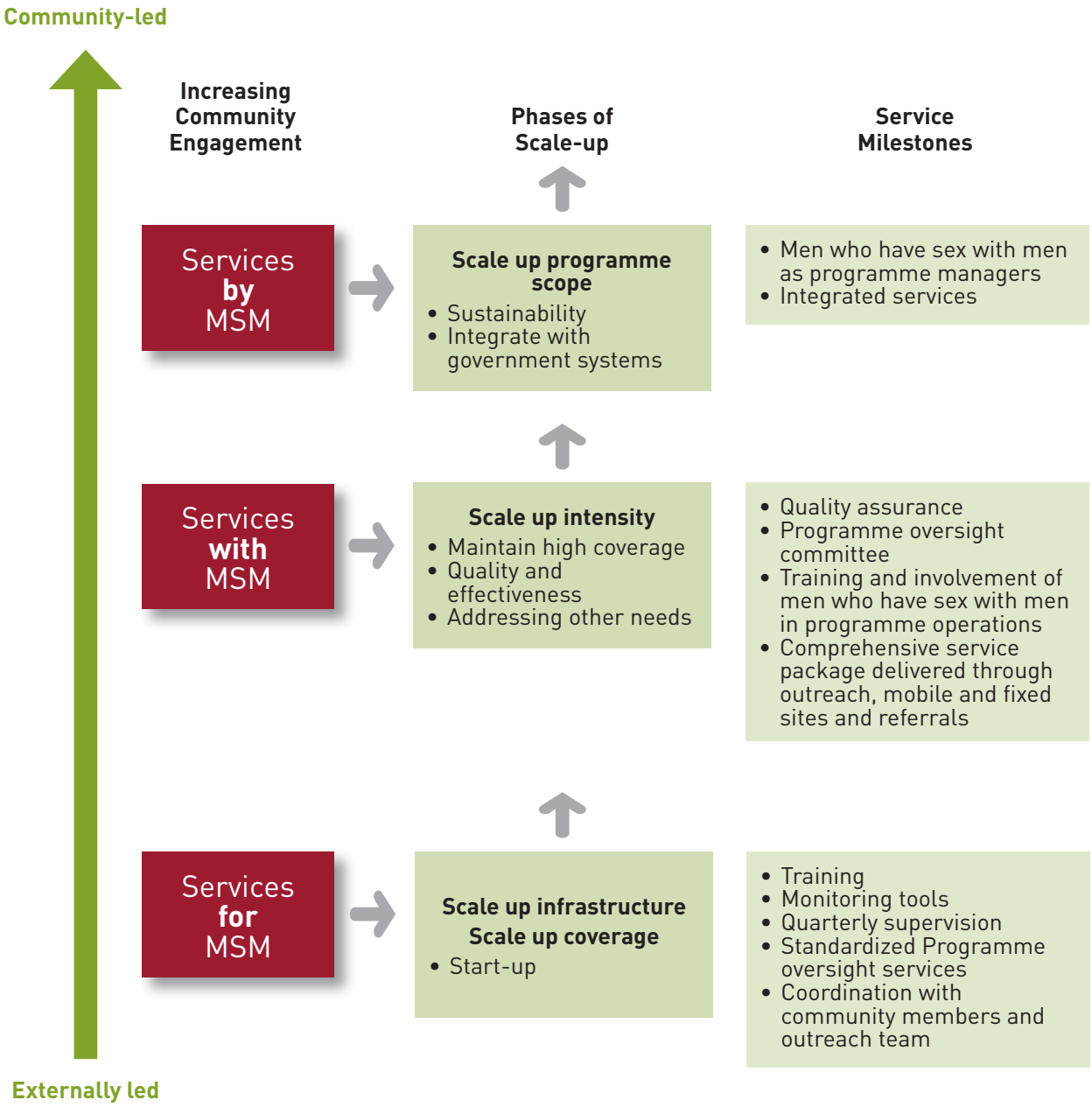
The use of combination prevention may ensure that diverse populations are offered prevention approaches appropriate to their lifestyles. The UNAIDS HIV Prevention Reference Group defines combination prevention programmes as "rights-based, evidence-informed, and community-owned programmes that use a mix 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

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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

Box 4.1

Case example: Training health-care workers in nonjudgemental service provision in Kenya

In May 2013, in collaboration with the District AIDS and STI Coordinator for Mombasa and two community-based organizations (CBOs) working with men who have sex with men, the LVCT Training Institute trained 23 health workers from 12 Ministry of Health facilities in Mombasa and its environs to provide nonjudgemental services to men who have sex with men. Two months after the training, a follow-up assessment was conducted in nine facilities. In four of them there was an increase in the number of men who have sex with men accessing services, from an average of 10-12 beneficiaries a month before the training to 15-20 beneficiaries after the training.

The involvement of CBOs in the training and assessment improved the ability of health-care workers not only to deliver services, but also to refer patients to LGBT-led organizations when appropriate. One nurse commented: "Prior to the training and the assessment, we used not to know how to mobilize for MSMs, where to refer the few that came here or even where to get such commodities like condoms and lubricants. We now have a comprehensive referral directory ... and we are in constant supply of condoms and lubricants."

4.2.2 Sexual or other risk history-taking

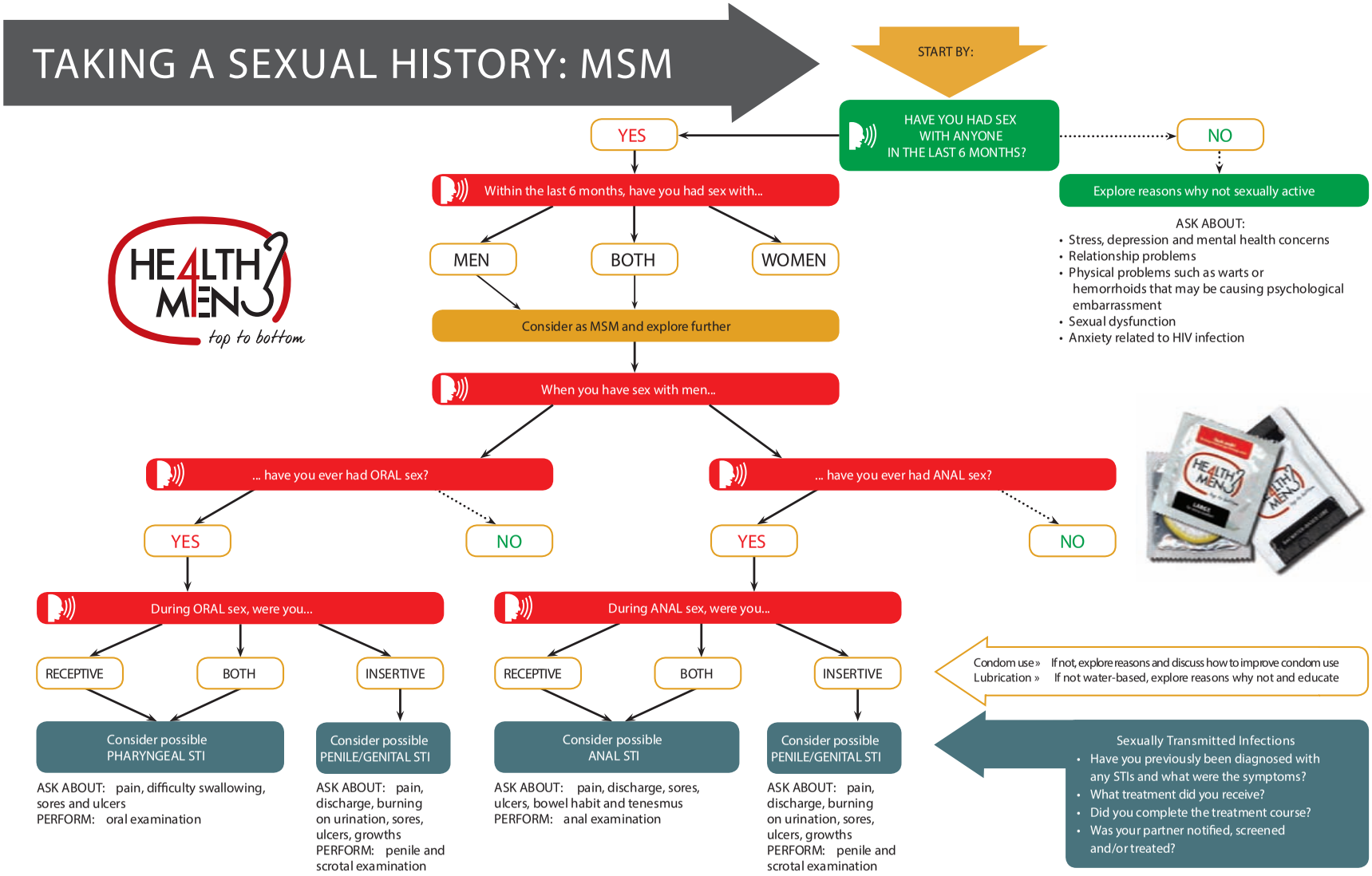
In safe settings, an assessment of sexual history and drug use history is necessary to inform risk minimization counselling. However, men who have sex with men may fear that disclosure will result in stigma, discrimination or criminalization, particularly in contexts where same-sex sexual activity or HIV non-disclosure are criminalized. In order to create an environment in which men are comfortable disclosing details of their sexual behaviours or use of drugs, sexual or other risk history-taking should:

- take place only once during a clinical visit, and after rapport has been established with the client and an explanation given about why the sexual history is required
- occur in a private room, with a trained provider or a self-completed questionnaire
- be conducted by a male service-provider if this is the preference of the patient
- provide an explanation of why the information is required, and how confidentiality will be maintained
- move from neutral to more specific questions, and offer sample response options (e.g. ranges of sexual partners)
- inquire about a clinically relevant time frame for risk behaviours (e.g. "since your last HIV test…")
- approach sexual behaviours as a normal part of a healthy life, without expressing an assumption that the client is heterosexual, and allowing the client to indicate whether he has engaged in sexual activity with men, women or transgender people
- inquire about drug use during sex and sharing of injection equipment for drugs or hormones.

Providers should:

- use their judgement about what to record, particularly in hostile environments where that information could jeopardize the rights and safety of clients
- reinforce that the information provided is confidential
- reassure the client that the provider is not there to pass moral judgement, and say that honesty can result in better care; but also emphasize that the client is not required to answer any questions.

Figure 4.4 Flowchart of sexual history taking for men who have sex with men

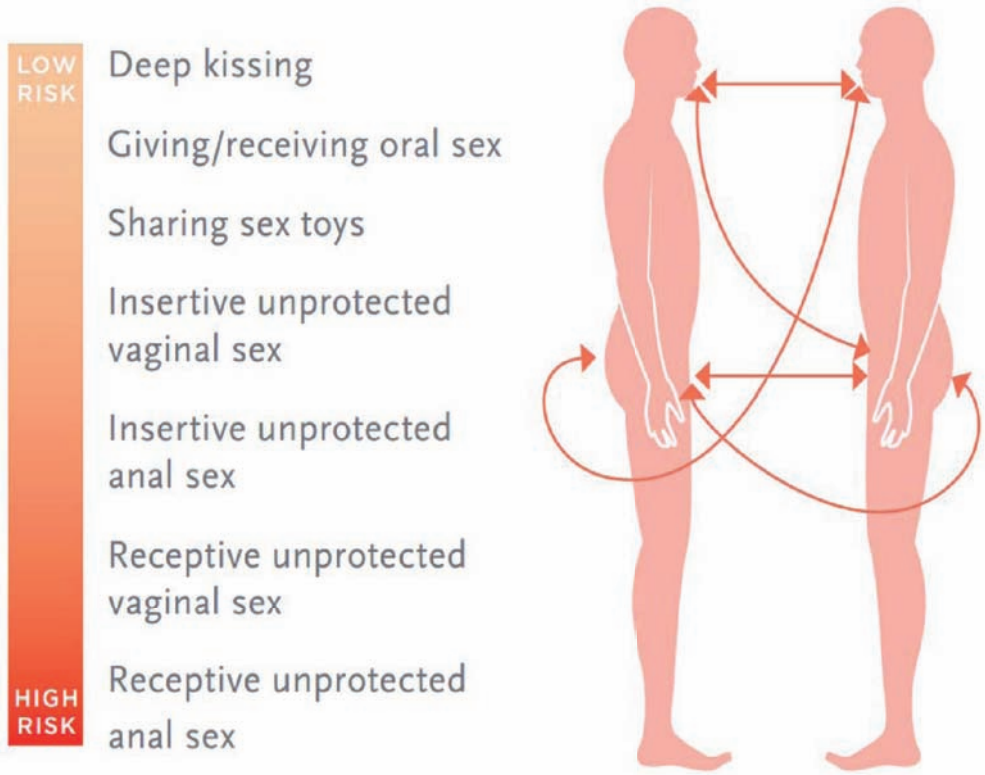


Source: Anova Health Institute

Taking a sexual risk history can be followed by brief sexuality-related communication, in which the provider uses open-ended questions to ask the client about his sexual health, provides information and supports the client in building his self-confidence and skills to take steps towards protecting his sexual health and well-being, including condom and lubricant use and negotiation. For further information see the WHO publication *Brief sexuality-related communication: recommendations for a public health approach* (2015) (see Section 4.5).

Figure 4.4 presents a flow chart on sexual history-taking: its purpose is to help health-care providers identify symptoms of possible STIs. Men who have sex with men who report any of these symptoms or other symptoms associated with the penis, anus or genital area during HTC should be referred for clinical management. Figure 4.5 shows a range of sexual activities and their relative risk for transmitting HIV and other STIs.

Figure 4.5 Hierarchy of STI/HIV transmission risk



Source: Promoting the health of men who have sex with men worldwide: a training curriculum for providers. The Global Forum on MSM & HIV and Johns Hopkins University; 2014.

4.2.3 Adaptive strategies (serosorting, strategic positioning)

Serosorting is a strategy in which a person chooses a sexual partner known to be of the same HIV serostatus, often to engage in condomless sex, in order to reduce the risk of acquiring or transmitting HIV. Strategic positioning is a strategy in which HIV negative men may choose only to be the insertive partner in anal sex, or HIV positive men choose to be the receptive partner with partners who are serodiscordant or of unknown HIV status.

For men who have sex with men who do not use condoms, these strategies may reduce the risk of HIV transmission. However, many men who have sex with men are unaware of the level of risk associated with different sex acts, and in contexts of high HIV incidence and low HIV testing, serosorting and strategic positioning may carry significant risk of HIV transmission, since these strategies rely on accurate knowledge of a sex partner's status.

Although the extent to which men who have sex with men adopt adaptive strategies is unclear, health-care providers should be aware that some clients do use them. Discussion of adaptive strategies can be introduced during one-on-one counselling, couples counselling and group-level counselling. Information should be provided about the benefits and risks and providers should make it clear that adaptive strategies are an approach to risk reduction, not risk elimination. Counselling should include decision-making skills about when to use and not use this approach and how to couple it with other behavioural and biomedical interventions (e.g. condoms and lubricant, PrEP, partner viral load testing etc).

4.2.4 Voluntary medical male circumcision

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Voluntary medical male circumcision is not recommended to prevent HIV transmission in sex between men, as evidence is lacking that it is protective during receptive anal intercourse. *(p.54)*

Although voluntary medical male circumcision (VMMC) is not recommended as an intervention to prevent HIV transmission in sex between men, men who have sex with men may still benefit from circumcision if they also engage in vaginal sex. Because circumcision is not completely protective, condoms and lubricant should still be used.

Men who have sex with men should not be excluded from VMMC services in countries in east and southern Africa where VMMC is commonly offered for HIV prevention. Although data are not available, there is a concern that exclusion might lead to their being publically identified as men who have sex with men and expose them to greater stigma and discrimination. In addition, VMMC provision may also serve as an entry point for additional services.

4.2.5 Condom and lubricant promotion

Promoting condom and lubricant knowledge and use through nonjudgemental, sex-positive and medically accurate communication at the community, group and individual levels is essential to successful programmes with men who have sex with men. Meaningful communication around the use of condoms and condom-compatitble lubricant explores the sexual risks of men who have sex with men, their attitudes towards those risks and the advantages and disadvantages of reducing those risks. Men who have sex with men should be provided with counselling to explore their feelings around condom and lubricant use and their risk reduction options. This counselling may include discussion of whether they have themselves experienced any "fatigue" around using condoms and, if so, how they can work around it to reduce their HIV risk.

Condom and lubricant behaviour change communication strategies should be designed with the primary goal of motivating individuals to understand and take charge of their sexual and reproductive health. They should be delivered as part of a broader approach to the sexual health of men who have sex with men that goes beyond a focus on condoms and lubricants alone. Sex-positive approaches to behaviour change communication are likely to be most effective. Sex-positive messaging emphasizes pleasurable, romantic and enjoyable aspects of sexual expression, removes the stigma around condoms and lubricants, and associates condoms and lubricants with the broader realm of healthy sexuality and sexual expression. For more information on sex-positive messaging, see Chapter 3, Box 3.1. For more information on condom and lubricant promotion, see Chapter 3, especially Box 3.2 and Section 3.2.3.

Community-led condom and lubricant promotion

The condom and lubricant promotion strategy may be developed in a workshop setting that should be led by men who have sex with men who represent relevant sub-groups. Providing men who have sex with men with a space to engage in and lead this process ensures a realistic understanding of their current practices and preferences regarding condoms and lubricant, as well as barriers to condom and lubricant access.

Community-level and group promotion strategies should apply an holistic approach. Led by (or in consultation with) men who have sex with men, behavioural interventions and materials may be developed in order to build needed skills and reinforce condom and lubricant promotion messages. Meaningful, community-led activities accompanied by high-quality tools and illustrative materials have proven effective in ensuring targeted promotion messaging and building condom-related skills. Approaches can include group discussions and role-plays, tools can include flip charts, posters, video testimonies etc. Behavioural interventions should be designed to address a variety of personal barriers to condom use, including:

- Knowledge of the health benefits of condoms and where they are available
- Safer sex negotiation abilities[7]
- Skills building for the correct and consistent use of condoms
- Appropriate use of condom-compatible lubricants

Demonstrations of correct condom use by community outreach workers[8] may increase the skills of men who have sex with men in using condoms as well as their self-efficacy (i.e. their belief in their ability to use a condom even under challenging circumstances). Approaches should also facilitate the ability of men who have sex with men to build support systems in their community in order to collectively identify ways to encourage consistent condom and lubricant use. Box 4.2 lists strategies for community-led condom and lubricant promotion.

7 See *Making sex work safe* (NSWP, 2011), pp.67–68 for condom negotiation strategies.

8 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers", "peer navigators" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

Box 4.2

Condom and lubricant promotional and educational strategies with men who have sex with men

- Involve men who have sex with men in the design of evidence-based promotional and educational strategies and messaging that reflect their experiences of condoms and lubricants, and their needs.
- Explore messaging that promotes condoms and lubricants in the context of positive, appealing messaging about sexual pleasure, relationships and health.
- Educate men who have sex with men regarding the importance of lubricant use in preventing condoms from slipping or breaking, and increasing sexual pleasure.
- Offer condom and lubricant skills-building for men who have sex with men and for service-providers.
- Provide information on choosing safe, effective lubricants and avoiding unsafe lubricants.
- Provide training in advocacy to make lubricants broadly available.
- Offer individual, open and nonjudgemental counselling on risk reduction options and challenges in using condoms consistently and correctly.
- Train men who have sex with men in safer sex negotiation skills, including how to negotiate condom and lubricant use and strategies for reducing risk when no condom and lubricant is available.
- Discuss the use of the female condom by men who have sex with men and its potential benefits (for more information, see Chapter 3, Box 3.4).

Condom negotiation

Decisions about whether or not to use condoms during sex are usually made in the context of a specific interaction between two individuals, and navigating this interaction successfully can require particular skills. In order for condom and lubricant promotion programmes to be successful, they should discuss safer-sex negotiation strategies with men who have sex with men, to enable them to negotiate condom use with a variety of types of partners, whether casual or primary (see below). For example, some men who have sex with men have reduced their risk of HIV transmission by creating community norms of condom and lubricant use, deciding to engage in non-penetrative sex and refusing to have sex with a potential partner unless he agrees to use a condom and lubricant.

Condom use with primary partners

In a primary partnership,[9] it can be difficult to acknowledge one's own need to use condoms, or to use condoms with a partner who may be unwilling or reluctant to do so. By nature, primary partnerships imply trust, and a man may fear that introducing a condom will be seen as a lack of trust in his primary partner, or as an indication that he himself is not trustworthy. However, there are degrees of risk even in many trusting primary partnerships. Men who have sex with men should receive education to understand the risks of condomless sex in all types of partnerships, including primary partnerships. Because negotiating condom use within such relationships is a critical skill for preventing HIV and other STIs, it should be central to health education and condom promotion programmes for men who have sex with men.

In some programmes, experienced community outreach workers have developed effective behaviour change communication strategies based on navigating issues of trust within relationships, and

9 In this publication, a primary partnership means an ongoing relationship that typically involves the partners' greatest commitment of time and emotional attachment.

equipping people with the knowledge and skill to candidly discuss using condoms and lubricants with their primary partners, as well as the option of non-penetrative sex. In the wider community of men who have sex with men, normalizing condoms by fostering a culture where condoms and lubricants are constantly visible and accessible and discussed without stigma will assist men in negotiating condom use in all of their relationships, including primary partnerships.

4.2.6 Voluntary HIV testing and counselling

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Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services is recommended in addition to provider-initiated testing and counselling. *(p.57)*

HIV testing and counselling (HTC) is an essential entry point to HIV prevention, and to care and life-sustaining treatment for people with HIV. By combining personalized counselling with knowledge of one's HIV status, HTC can motivate behaviours to prevent HIV transmission, and persons living with HIV can access supportive counselling, community care, clinical care, ART and treatment for opportunistic infections.

Voluntary HTC services should be part of an integrated programme of HIV prevention, care and treatment, so that men who have sex with men have access to HTC—ideally free of charge or easily affordable—as frequently as required, at times and locations that are convenient. Testing and counselling services should adhere to the principles of the "5 Cs"—consent, confidentiality, counselling, correct test results and connection to follow-up services. They should be delivered respectfully and without coercion, judgement, stigma or discrimination.

A. Types of HIV testing

Voluntary HIV counselling and testing

HIV testing can be passively offered, whereby the client seeks out the HTC service. This can be located in a variety of settings (community, clinic, mobile and home). Voluntary HIV testing and counselling may be a preferred method for hidden populations and more cost-effective in settings with low HIV prevalence.

Provider-initiated HIV testing and counselling (PITC)

PITC means that a health-care provider offers HTC as part of a routine clinic visit. The intent is to reach greater HIV testing coverage and to normalize HIV testing behaviour. PITC is recommended so long as it is not compulsory, is not coercive, and is linked to treatment and care, in line with WHO guidelines. Particular attention should go to providing accurate information; informed consent must always be obtained; and results should remain confidential.

Couples-based HIV testing and counselling

A third type of testing is couples-based HIV testing and counselling (CHTC). CHTC has been provided primarily for heterosexual couples but may also be a strong intervention for men who have sex with men and is an option when trained couples counsellors are available. CHTC differs from standard HTC in that the couple receives pre- and post-test counselling—including the results of HIV tests—together. CHTC seeks to interrupt HIV transmission in sero-discordant couples, help sero-negative couples negotiate plans to remain negative, and link sero-positive couples to care. It also facilitates communication and partner support. Advantages to testing couples together include:

- CHTC provides a safe environment for couples to discuss risk concerns.
- Partners hear information together, enhancing likelihood of a shared understanding.
- The counsellor can ease tension and diffuse blame for a positive test result.
- Counselling messages are based on the test results of both individuals rather than only one.
- An individual who receives a positive test result is not burdened with the need to disclose the result to their partner or persuade their partner to be tested.
- Counselling facilitates the communication and cooperation required for risk reduction.
- Care and treatment and other decisions about the future can be made together.

HIV testing and counselling for couples or partners should be offered to anyone, regardless of how they define their relationships. The principle and the policy should be that providers support all people in a sexual relationship to receive testing as a couple or as partners, irrespective of their sexual orientation or the length or stability of their relationship.

Self-testing

HIV self-testing is a process whereby an individual either sends a sample away for diagnostic tests, with results given by a service-provider, or tests the sample with a kit and interprets the results himself. HIV self-testing enables individuals to test themselves for HIV in private settings, such as their own home. By providing an opportunity for people to test themselves discreetly and conveniently, self-testing may increase testing among people not reached by existing HTC services. Rapid diagnostic tests are primarily whole blood-based (such as finger-prick/capillary) or oral fluid-based tests. Most have a 6- to 12-week window period (the period between suspected infection with HIV and the time when the test can detect HIV antibodies). However, several factors may affect the length of the window period.

HIV self-testing does not provide a definitive HIV diagnosis. Instead, it is a screening test for the presence of HIV-1/2 antibodies or HIV-1 p24 antigen. A reactive self-test always requires further confirmatory testing according to relevant national testing algorithms.

Policy development regarding HIV self-testing is at varying stages across countries. A few, such as Kenya, have developed national HTC policies that include HIV self-testing. Other countries, including Malawi, South Africa and Zimbabwe, are considering the introduction of self-testing. WHO has not yet issued normative global guidance on HIV self-testing. However, WHO and UNAIDS have issued *A short technical update on self-testing for HIV* to inform stakeholders who are considering or already implementing HIV self-testing (see Section 4.5).

Box 4.3

HIV testing for young men who have sex with men

Accessible and acceptable HTC services must be available to young men who have sex with men in all epidemic settings and provided in ways that do not put them at risk. Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to access and uptake of HTC and to linkages to prevention, treatment and care following testing. Young people should be able to obtain HTC without parental or guardian consent or presence. HTC with linkages to prevention, care and treatment is recommended for young people from key populations in all settings (generalized, low and concentrated epidemics). Young people should be counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine when, how and to whom to disclose.

B. Preparing to deliver voluntary HTC services

Community awareness and building demand

Community members should be informed about the benefits of knowing one's HIV status and about the availability and benefits of treatment if they are infected with HIV. Even with awareness-raising activities for the general public or key populations, men who have sex with men may not know about the availability of services that are respectful of men who have sex with men and provided by trained and qualified providers sensitive to their needs.

As part of awareness-raising campaigns, men who have sex with men should be informed of their right to confidentiality and consent and their right to refuse HIV testing if they choose.

Training providers and community outreach workers

Training for HTC providers should follow national and international standards (see Section 4.5).

Location and timing of services

Both the location and the timing of voluntary HTC services should be responsive to the needs and requests of men who have sex with men. In some settings, particularly for MSM who are sex workers, this might mean providing services during evening hours or at weekends.

For details on possible community settings for HTC which may be more attractive than health-care institutions, see the information on mobile service delivery in Section 4.4.1 Part A.

Box 4.4

Case example: Targeting networks and building trust in Ghana

In Greater Accra, staff of FHI 360 identified six establishments where male sex workers were providing services to male clients, as well as a network operated by two managers via telephone. Because sex work and same-sex behaviour are illegal in Ghana, the owners of these establishments and one of the managers were initially reluctant to work with the programme. After months of discussion to build trust with these networks, each of the six establishments agreed to discreet outreach efforts. Between December 2012 and March 2014, FHI 360 staff and selected health-care providers of the Ghana Health Service provided an outreach session to male sex workers and clients in each of the six establishments, and a session for those connected to the telephone network operated by the manager. Each session of the USAID-supported programme included the following activities:

- group counselling on HIV and STI prevention and HIV testing
- HIV testing (rapid HIV test) and STI screening
- provision of condoms and water-based lubricants
- referral to HIV care, support and treatment and STI services when needed.

The owners of the establishments and the manager were in charge of inviting the participants from their networks. The number of invitations for each event was limited in order to keep the logistics manageable. In the first four of the eight sessions (conducted between November 2013 and March 2014), 135 male sex workers participated, and two-thirds opted to have an HIV test and counselling. About one-quarter of these tested HIV positive and all were enrolled in HIV care, treatment and support services.

Procuring essential supplies

Procurement of supplies to conduct HIV testing is usually done by the agency or organization providing the services. A programme serving men who have sex with men that wishes to provide voluntary HTC on-site should work with local health authorities to obtain training and authorization to provide HTC, as well as the needed supplies. Procurement should be guaranteed for quality-assured (WHO pre-qualified) diagnostics. It may be helpful to obtain handouts or other informational material about the importance of HIV testing to distribute to men who have sex with men.

Data tracking

HTC providers should receive standardized training on data capturing, including logbook and other form completion, aggregating totals and frequency of data transfer, data and personal information safety and security, how to make referrals and follow-up linkages, and data quality checks.

Quality assurance/quality improvement

As part of provider training, providers should learn about HTC quality standards: what they are, why they are important and how to implement them in their daily work. Topics such as proficiency testing, use of algorithm diagrams, timer battery backup supplies etc should be incorporated. Ideally the programme partner should conduct routine quality monitoring visits with immediate onsite feedback to HTC providers so that quality improvement plans are developed on the spot.

Management

For general programme management approaches, see Chapter 6. For information specific to the management of voluntary HTC services, please refer to the WHO *Handbook for improving HIV testing and counselling services* (see Section 4.5).

C. Delivering HTC services

Adequate training, ongoing performance support and monitoring are essential for all staff performing HIV testing at the community level, including health workers, programme staff and community outreach workers. For more information, see the WHO *Consolidated guidelines on HIV testing services: 5 Cs: Consent, Confidentiality, Counselling, Correct results and Connection* (2015). Voluntary HTC may be more acceptable to men who have sex with men when the testing and counselling are performed by a trusted peer (i.e. another man who has sex with men), and community outreach workers can be an effective part of the voluntary HTC workforce. Community outreach workers who provide HTC should receive certified training in line with national HTC guidelines. Opportunities for professional development and promotion to supervisory, management and leadership roles should always be available for community outreach workers.

Pre-test information

Counselling is provided prior to the test. The pre-test dialogue should focus on basic HIV information and information about the HIV testing process, and ensure that testing is voluntary. A risk or sexual history assessment may be taken. This should be voluntary and should only be done if the HTC provider has received training on how to conduct the discussion.

Post-test counselling

Counselling is provided when the client receives his test results. HTC offers a valuable opportunity to provide accurate information about safer sex and harm reduction that is relevant to the person being tested, reflecting the test result.

For men who have sex with men who are found to be HIV negative, post-test counselling is important. Risk-reduction information specific to their individual risks and based on a voluntary risk or sexual history assessment may be offered. They should also be given access to condoms and lubricant, and to other potential preventive services such as behavioural interventions and PrEP, as appropriate (see Section 4.2.7). Providers should ensure post-test counselling for individuals who test HIV positive. Post-test counselling must include support concerning disclosure of HIV status.

Men who have sex with men who are found to have HIV infection should receive immediate care, confirmatory testing as appropriate or according to national guidelines, and additional screening and treatment at the clinic or at a referral hospital or other clinical site whose staff are respectful and trained in the clinical management of men who have sex with men. They should also receive supportive counselling about how to avoid transmitting HIV to others and information on how to access community care resource organizations.

Programmes serving men who have sex with men should take extra efforts to support links to care, such as identifying a trusted peer (or community outreach worker) to accompany HIV positive men who have sex with men to care, support and treatment services. However, this should only be done with the individual's consent.

Mental-health issues, such as anxiety and depression, should be assessed if the counsellor has been trained in these areas. Referral to a clinician with training in mental health may be helpful. (See also Section 4.3.3.)

Repeat testing

Sexually active men who have sex with men should seek re-testing at least annually (more frequently if there is the possibility of having been exposed to the virus). Situations and settings where re-testing is warranted in all epidemic types include:

- men who have sex with men who engage in high-risk behaviours, have a partner who is known to be high-risk or HIV positive, or have clinical indications for re-testing, such as a newly acquired STI
- if an individual can identify a specific incident of HIV exposure in the three months prior to HIV testing (e.g. occupational exposure, unprotected sex with a person known to be HIV positive, sharing injecting equipment with a person known to be HIV positive).

WHO specifically recommends repeat testing after four weeks for men who have sex with men who test HIV negative, if they believe they may have been exposed to HIV within the past three months, to ensure that they are truly HIV negative. (For more information, see the WHO publication *Delivering HIV test results and messages for re-testing and counselling in adults*.)

4.2.7 Pre-exposure prophylaxis (PrEP)

2014 Key Populations Consolidated Guidelines

Among men who have sex with men, pre-exposure prophylaxis (PrEP) is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package. *(p.44)*

Findings from clinical trials of pre-exposure prophylaxis (PrEP)—a daily oral fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg (labelled as Truvada)—have demonstrated safety and a substantial reduction in the risk of acquiring HIV infection for men who have sex with men.[10] PrEP is therefore recommended as an HIV prevention option for sexually active adult men who have sex with men at substantial risk of acquiring HIV, as part of a combination prevention approach (see Section 4.2).

The use of other antiretroviral medications for PrEP (i.e. medication other than the two-drug regimen of TDF/FTC) has not yet been recommended by WHO, and nor has the use of PrEP timed around sex acts. Other medication regimens and other delivery methods (e.g. rectal microbicides) will continue to evolve and may become an option for prevention programmes.

WHO has issued technical guidance on PrEP and will publish updated and consolidated guidelines on antiretroviral medications at the end of 2015. The US Centers for Disease Control and Prevention (CDC) has also issued guidelines on the use of PrEP, including among men who have sex with men (see Section 4.5).[11]

10 Most recently, data from the PROUD study, as reported at the 2015 Conference on Retroviruses and Opportunistic Infections, indicated an 86% reduction in HIV risk for men who have sex with men when taking daily PrEP. For more information, see http://www.avac.org/sites/default/files/u3/PROUDfeb24.pdf. See also Section 4.5.

11 The clinical recommendations on PrEP in this tool are drawn primarily from the US Public Health Service Centers for Disease Control and Prevention (CDC), Preexposure prophylaxis for the prevention of HIV infection in the United States – 2014, a clinical practice guideline. Atlanta (GA): CDC; 2014.

Clinicians providing PrEP should:

- prescribe medication regimens that are proven safe and effective for uninfected clients who meet recommended criteria to reduce their risk of HIV acquisition
- educate clients about the medications and the regimen to maximize their safe use
- provide support for medication adherence to help clients achieve and maintain protective levels of medication in their bodies
- provide HIV risk-reduction support and prevention services or service referrals to help clients minimize their exposure to HIV
- monitor clients to detect HIV infection, medication toxicities and levels of risk behaviour in order to make indicated changes in strategies to support their long-term health.

Training for PrEP providers should follow national and international standards (see Section 4.5).

Box 4.5

Recommended indications for PrEP use by men who have sex with men

Adult man without acute or established HIV infection who:

- has had any male sex partners in the past six months
- is not in a monogamous partnership with a recently tested, HIV negative man

and has had at least one of the following:

- any anal sex (receptive or insertive) without condoms in the past six months
- any STI diagnosed or reported in the past six months
- is in an ongoing sexual relationship with an HIV positive male partner

A. Assessing risk of HIV acquisition

Because offering PrEP is currently indicated for men who have sex with men at substantial risk of HIV acquisition, national programme planners will need to develop eligibility criteria for PrEP based on screening questions. Health-care providers should ask brief questions designed to identify same-sex behaviours and to assess a key set of sexual practices that are associated with the risk of HIV acquisition. The following questions should be explored:

In the past six months:

- Have you had sex with men, women or both?
- How many men have you had anal sex with?
- How many times did you have receptive anal sex (you were the bottom) with a man without a condom?
- How many times did you have receptive anal sex (you were the bottom) with a man where the condom broke or slipped off?
- How many of your male sex partners were HIV positive?
- How many times did you have insertive anal sex (you were the top) without a condom with a man who was HIV positive?
- How many times did you have insertive anal sex (you were the top) where the condom broke or slipped off with a man who was HIV positive?

In addition, for all sexually active patients, clinicians may want to consider reports of diagnoses of bacterial STIs (chlamydia, syphilis and gonorrhoea) during the past six months as evidence of sexual activity that could result in HIV exposure. Clinicians should also briefly screen all patients for alcohol use (especially before sexual activity) and the use of non-injection drugs (e.g. stimulants), especially substances that can impair thinking and decision-making. The use of these substances may affect sexual risk behaviour, hepatic or renal health or medication adherence, any of which may affect decisions about the appropriateness of prescribing PrEP medication.

In addition to good clinical judgement, tools that facilitate easy and efficient ways to identify men who have sex with men who are at risk for becoming HIV infected are needed. Figure 4.6 is a risk index to briefly and systematically screen for key information about factors that are predictive of very high HIV acquisition risk. This index, while not necessarily applicable in every context, may help to identify men who have sex with men who could benefit from combination prevention interventions such as high-impact intensive behavioural interventions (e.g. risk reduction counselling) and/or biomedical interventions (e.g. PrEP).

Figure 4.6 Risk index for men who have sex with men

		Score
1. How old are you today?	If <18 years, score 0 If 18–28 years, score 8 If 29–40 years, score 5 If 41–48 years, score 2 If 49 years or more, score 0	
2. In the last 6 months, how many men have you had sex with?	If >10 male partners, score 7 If 6–10 male partners, score 4 If 0–5 male partners, score 0	
3. In the last 6 months, how many times did you have receptive anal sex (you were the bottom) with a man without a condom?	If 1 or more times, score 10 If 10 times, score 0	
4. In the last 6 months, how many of your male sex partners were HIV positive?	If >1 positive partner, score 8 If 1 positive partner, score 4 If <1 positive partner, score 0	
5. In the last 6 months, how many times did you have insertive anal sex (you were the top) without a condom with a man who was HIV positive?	If 5 or more times, score 6 If 0-4 times, score 0	
6. In the last 6 months, have you used methamphetamines such as crystal or speed?	If yes, score 6 If no, score 0	
* If score is 10 or greater, evaluate for intensive HIV prevention services, including PrEP. If score is below 10, provide indicated standard HIV prevention services.	Add down entries in the right column to calculate total score	TOTAL SCORE*

Adapted from: US Centers for Disease Control and Prevention (CDC). Preexposure prophylaxis for the prevention of HIV infection in the United States – 2014 clinical providers supplement. Atlanta (GA): CDC; 2014.

Note: This index is based on results from the United States HIV Behavioral Surveillance used to inform predictive risk among men who have sex with men; it may not be applicable in all other settings.

B. Choosing an HIV prevention method

After assessing the risk of HIV acquisition, providers should discuss with the client which of several effective prevention methods (e.g. PrEP, behavioural interventions, condoms and lubricants) can be pursued in combination. For clients who use condoms consistently and correctly, high levels of protection against both HIV and several STIs are afforded without the side-effects or cost of medication. If consistent condom use is not achievable, additional risk reduction strategies should be considered, such as using PrEP or selecting lower-risk sexual behaviours. Health-care providers should discuss all options and tailor their counselling sessions to the needs of their clients. It is important to explain to clients that while PrEP can provide effective protection against HIV, it does not by itself protect against other STIs.

If a client reports having a regular sex partner who is HIV positive, providers should determine whether the partner is receiving ART and whether a recent evaluation indicates an undetectable viral load. Supporting the HIV positive individual to achieve an optimally suppressed viral load will benefit him and his partner. In addition to the known health benefits of viral load suppression, preliminary data from the PARTNER study indicate that viral load suppression is highly protective against HIV transmission to a receptive partner in anal sex between men (96% reduction in transmission risk).[12]

Box 4.6

Case example: The right time, place and client for PrEP

A 20-year-old man sought PrEP at a primary-care clinic. He had a primary partner, and numerous additional sexual partners with whom he engaged in unprotected receptive anal intercourse. He used condoms inconsistently as he did not feel empowered to ask his partners to do so and feared rejection. He had had rectal gonorrhoea twice in the past 12 months but had repeatedly tested HIV negative.

As part of PrEP, the client was engaged in discussion about negotiating condom use and self-empowerment. He developed a vocabulary for insisting on condom use, and was able to successfully integrate both sero-status inquiry and condom use into his repertoire of sexual-health tools. This was accomplished over time while under the "protective cover" of PrEP treatment. The client did not find it difficult to adhere to the daily PrEP medication, as he simply took the pill with his morning multivitamin. He found that the comfort provided by the protection of daily oral PrEP reduced a persistent anxiety about his sexual health which had been further compromising his ability to negotiate safer sexual practices. After around 18 months he discontinued PrEP when he felt he had no further need due to consistent condom use.

This example illustrates how PrEP can be used to protect the individual during periods of sexual risk, and can provide an opportunity to explore a range of HIV prevention options. A context for conversations concerning sexual decision-making and empowerment might not ordinarily arise, and an opportunity to provide information, training, perspective and resources in an unbiased and destigmatized environment should be welcomed as a part of PrEP services. The cessation of PrEP when sexual risks decrease to low levels is an example of how patients can be expected to cycle on and off PrEP in accordance with their changing sexual behaviours and risk profile.

Source: Anova Health Institute

Box 4.7

PrEP for young men who have sex with men

None of the completed PrEP trials has included persons under the age of 18. Therefore, clinicians should consider carefully the lack of data on safety and effectiveness of PrEP taken by persons under 18 years of age, the possibility of bone or other toxicities among youth who are still growing, and the safety evidence available when TDF/FTC is used in treatment regimens for HIV positive youth. These factors should be weighed against the potential benefit of providing PrEP for a young man at substantial risk of HIV acquisition.

12 For more information, see http://i-base.info/htb/24904 and http://www.projectinform.org/pdf/pip_0314.pdf. See also Section 4.5. Note that the PARTNER study is not due to conclude until 2017.

C. HIV counselling and testing and PrEP

Some countries are developing national guidelines for PrEP, including for HIV testing before PrEP begins. The CDC guidelines (see Footnote 11 above) state that an HIV test is required to confirm that the client does not have HIV infection when he starts taking PrEP medications. The two-drug regimen of TDF/FTC is inadequate therapy for established HIV infection, and its use may cause resistance to either or both drugs. At a minimum, clinicians should document a negative antibody test result within the week before initiating (or reinitiating) PrEP medications. Oral rapid tests should not be used to screen for HIV infection when considering PrEP use because they can be less sensitive than blood tests. Clinicians should not accept patient-reported test results or documented anonymous test results.

Clinicians should suspect acute HIV infection in persons exposed recently (e.g. a condom broke during sex with an HIV positive partner, injection drug use with shared injection equipment). In addition, clinicians should solicit a history of nonspecific signs or symptoms of viral infection during the preceding month or on the day of evaluation in all PrEP candidates with a negative or indeterminate result on an HIV antibody test.

For client safety, HIV testing and counselling should be repeated at least every three months (i.e. before prescriptions are refilled or reissued). This requirement should be explained to the client during the discussion about whether PrEP is appropriate for him. Note that while the CDC recommends follow-up appointments every three months, countries may consider repeat testing every three to six months to be in alignment with national ART guidelines.

D. Clinical monitoring

Vaccination against HBV is recommended for all adolescents and adults, including men who have sex with men (see Section 4.2.9, Part C). The client should be screened for HBV infection before PrEP is prescribed, and if determined to be susceptible to HBV infection he should be offered vaccination.

It is extremely important to note that since both TDF and FTC are active against HBV, if patients with active HBV infection stop taking these medications, liver function must be closely monitored because reactivated HBV infection can result in hepatic damage. Renal function should be assessed at baseline and monitored at least every six months while patients are taking PrEP so that those in whom renal failure is developing do not continue to take it.

A suggested follow-up schedule is shown in Table 4.1. Clinicians may wish to see patients more frequently at the beginning of PrEP (e.g. one month after initiation) to assess and confirm HIV negative test status, assess for early side-effects, discuss any difficulties with medication adherence and answer questions.

Clinical monitoring for a person on PrEP poses no greater burden than that placed upon HIV positive patients on ART. Thus countries may consider scheduling maintenance appointments in alignment with their national guidelines for ART. For example, if countries require HIV positive patients on ART to be seen by their health-care providers every three to six months, the same requirement could be made for seeing patients on PrEP.

Table 4.1 Suggested schedule of follow-up visits for clients receiving PrEP

At least every three months to:
• Repeat HIV testing and assess for signs or symptoms of acute infection to document that patients are still HIV negative
• Provide a prescription or refill authorization of daily TDF/FTC for no more than 90 days (until the next HIV test)
• Assess side-effects, adherence and HIV acquisition risk behaviours
• Provide support for medication adherence and risk-reduction behaviours
• Respond to new questions and provide any new information about PrEP use.
At least every six months to:
• Monitor renal function by measuring estimated creatinine clearance rate (eCrCl) If other threats to renal safety are present (e.g. hypertension, diabetes), renal function may require more frequent monitoring or may need to include additional tests (e.g. urinalysis for proteinuria) A rise in serum creatinine is not a reason to withhold treatment if eCrCl remains ≥60 ml/min If eCrCl is declining steadily (but still ≥60 ml/min), consultation with a nephrologist or other evaluation of possible threats to renal health may be indicated. • Repeat STI testing recommended for adolescents and adults (i.e. syphilis, gonorrhoea, chlamydia).
At least every 12 months to:
• Evaluate the need to continue PrEP as a component of HIV prevention.

Patients may discontinue PrEP for several reasons, including personal choice, a changed life situation resulting in lowered risk of HIV acquisition, intolerable toxicities, chronic non-adherence to the prescribed dosing regimen despite efforts to improve daily pill-taking, or acquisition of HIV infection. Upon discontinuation for any reason, the following should be documented in the health record:

- HIV status at the time of discontinuation
- Reason for PrEP discontinuation
- Recent medication adherence and reported sexual risk behaviour

E. Non-clinical activities

Efforts to standardize the use of PrEP with men who have sex with men will require multiple strategies. Developing country guidelines and standard operating procedures are important first steps. Working with decision-makers to accept and finance PrEP are additional processes.

Procurement of antiretroviral medicines, such as those for PrEP, is usually done by the designated agencies or organizations providing the services, i.e. local health authorities, which will need to access data for supply chain-management, drug financing and authorization to provide the needed supplies.

Appropriate preparation for delivering PrEP also includes building community awareness and demand and training providers. Access to PrEP in many low- and middle-income countries is lagging behind high-income countries. Advocacy for access to PrEP and provider know-how to prescribe PrEP are crucial, and local and global advocacy groups should be encouraged to work for this.

Community awareness for PrEP

Community members should be informed about the risks, costs, requirements and benefits of PrEP and, if they become infected with HIV, about the availability of HIV treatment. Since PrEP is a relatively new intervention, informed community discussion and awareness-raising activities should be initiated by and with men who have sex with men.

As part of awareness-raising campaigns, men who have sex with men should be informed of their right to confidentiality and informed consent, and their right to access and obtain PrEP or to decline it if they so choose. Concerns held by community members should be addressed sensistively and through the dissemination of factual information.

4.2.8 Post-exposure prophylaxis (PEP)

2014 Key Populations Consolidated Guidelines

Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV. *(p.51)*

Post-exposure prophylaxis (PEP) is the administration of antiretroviral medications as soon as possible after having been exposed or potentially exposed to HIV in order to reduce the chance of HIV infection. It is the only way to reduce the risk of infection after exposure to HIV.

PEP eligibility criteria

PEP should be offered to individuals who have experienced a situation where there is potential for HIV transmission. Exposure to bodily fluids of an individual who is HIV positive or has an unknown HIV status would warrant PEP. PEP is indicated for sexual exposure where condoms were not used or the condom came off or broke, and this is the main reason men who have sex with men seek out PEP. Exposure could also occur through episodes of sexual violence, needle-sticks, skin abrasions, rashes or other situations where there is a break in the skin or mucous membranes (i.e. sexual exposure, splashes to the eyes, nose or oral cavity).

PEP is not indicated for individuals already infected with HIV, exposures that do not pose a risk of transmission or for chronic exposures. Receptive oral sex is considered low-risk due to the anti-HIV properties of saliva, although infection can occur, especially if the exposed individual has very poor oral hygiene or gum disease.

Treatment regimen

PEP should be available to all eligible individuals, including men who have sex with men, on a voluntary basis after possible HIV exposure. Currently, WHO recommends that PEP be offered and initiated as soon as possible, and ideally within 72 hours of exposure. The duration of therapy should be 28 days.

WHO recommends tenofovir combined with lamivudine or emtricitabine for PEP, preferably combined with a third agent (ritonavir-boosted lopinavir or atazanavir). This choice is based on alignment of drugs used for PEP with drugs used for treatment, and the tolerability of these drugs compared to other drugs commonly available in low- and middle-income settings.

HIV testing with informed consent and pre- and post-test counselling should be conducted, but assessment of the HIV status of the exposed individual should not be a barrier to initiating PEP. In emergency situations where HIV testing and counselling is not readily available but the potential HIV risk is high or if the exposed person refuses initial testing, PEP should be initiated and HTC conducted as soon as possible. Follow-up HIV testing should also take place three months following HIV exposure. There is concern about the potential risk of hepatic flares among people infected with hepatitis B virus once tenofovir and lamivudine/emtricitabine-based PEP is stopped. Assessment of HBV status should not be a precondition to starting PEP, but people with established HBV infection should be monitored after PEP is stopped if these drugs are not continued for the treatment of HBV. Screening for HCV should be offered in accordance with WHO guidelines, but again there should be no delay of PEP initiation if HCV screening is not available. Counselling focused on adherence, side-effects and risk reduction is important, as well as attention to psychosocial challenges including mental health and issues of social support. It is essential that guidelines for confidentiality be strictly followed. Since research on the use of antiretroviral medications is evolving rapidly, it is recommended that programme developers consult WHO for the most recent guidelines.

4.2.9 Sexually transmitted infection services

2014 Key Populations Consolidated Guidelines

Screening, diagnosis and treatment of STIs are crucial parts of a comprehensive response to HIV; this includes services for men who have sex with men. STI management should accord with existing WHO guidance and be adapted to the national context. Also, it should be confidential and free from coercion, and patients must give informed consent for treatment.

Periodic screening of men who have sex with men for asymptomatic STIs is recommended.

In the absence of laboratory tests, symptomatic people from key populations should be managed syndromically in line with national STI management guidelines. *(p.79)*

Provision of basic services for the prevention, screening and management of HIV and STIs is an essential component of a comprehensive package of services for men who have sex with men and should be a priority intervention. Since infection with some STIs can facilitate transmission of HIV, all men who have sex with men should have access to acceptable, free or affordable, effective and high-quality STI services. An STI services package consists of case management for both symptomatic and asymptomatic STIs. Comprehensive STI case management also includes the promotion and provision of condoms and lubricants, support for compliance with treatment, and risk-reduction counselling.

A. Designing services

Assess current services

When mapping communities of men who have sex with men before establishing an intervention (see Chapter 6, Section 6.2.7 Part A), data should be collected on the quality of existing STI services, current use of services, and their acceptability and accessibility. This information, when coupled with local STI prevalence data, may be used to determine the demand for STI services and develop a plan to improve existing services or establish new ones.

Define essential STI service package and other services

STI services for men who have sex with men should meet basic standards of quantity and quality. The national programme should lead the development of STI guidelines and operational standards and define the essential package of STI and other services in consultation with technical experts, implementers and community representatives. These guidelines and standards will be the basis for implementation, training, supervision and monitoring.

The basic STI service package includes:

- screening and treatment of asymptomatic STIs:
  - periodic serological testing for asymptomatic syphilis infection
  - periodic testing for asymptomatic urethral and rectal *N. gonorrhoeae* and *C. trachomatis* infections using NAAT (nucleic acid amplification testing)
  - periodic testing for HIV (see Section 4.2.6)
  - routine STI check-ups
  - voluntary HTC or provider-initiated testing and counselling (PITC)
- syndromic case management for patients with symptoms.

It is important that the STI service package be linked or integrated with HIV, sexual and reproductive health (SRH) and primary-care services, when appropriate and feasible.

Since men who have sex with men have a higher risk of STIs and their risk factors differ from those of the general population, STI management flowcharts specific to men who have sex with men should be developed. Examples of these guidelines and standards are *Promoting the health of men who have sex with men worldwide: a training curriculum for providers* developed by the Global Forum on MSM & HIV and Johns Hopkins University; the *Clinical guidelines for sexual health care of men who have sex with men* produced by the International Union against Sexually Transmitted Infection's Asia Pacific Branch, and the Desmond Tutu HIV Foundation's *Men who have sex with men: an introductory guide for health workers in Africa* (see Section 4.5).

STI screening

Symptomatic STI patients may be aware they are infected and are more likely to seek care. Regular screening for asymptomatic infections among men who have sex with men using laboratory tests is cost-effective given the high rates of STIs, and can reduce STI prevalence over time. It is therefore essential to invest in STI screening. Where laboratory diagnosis is available, laboratories should be staffed by qualified personnel with adequate training to perform technically demanding procedures, with quality assurance systems in place.

Absence of laboratory tests should not be a barrier to screening and treating men who have sex with men for STIs. A regular STI check-up is an opportunity to reinforce prevention and address other health needs. The check-up may consist of probing for symptoms of STIs and checking for signs of genital and ano-rectal infections, including anal and proctoscopic examinations.

Syndromic case management

Even in highly structured, resource-rich environments there are limitations both to etiological diagnosis of STIs (using laboratory tests to identify the causative agent) and clinical diagnosis (using clinical experience to identify the symptoms commonly associated with a specific STI). While etiological diagnosis is often the most desired outcome, it can be expensive, time-consuming and resource-intensive (i.e. laboratory tests, trained laboratory personnel etc) and may result in delayed treatment. With clinical diagnosis, STIs may be incorrectly identified, especially if the client has several infections.

In resource-poor settings where reliable STI testing is not feasible, WHO has recommended a syndromic approach (locally adapted) to manage symptomatic infections. Syndromic case management focuses on the patient's symptoms, is highly sensitive and addresses the possibility of mixed infections. Treatment occurs with the initial assessment, following a flowchart design to guide the health-care provider in making diagnostic and treatment decisions. Challenges commonly seen in resource-limited settings are minimized, as care is accessible.

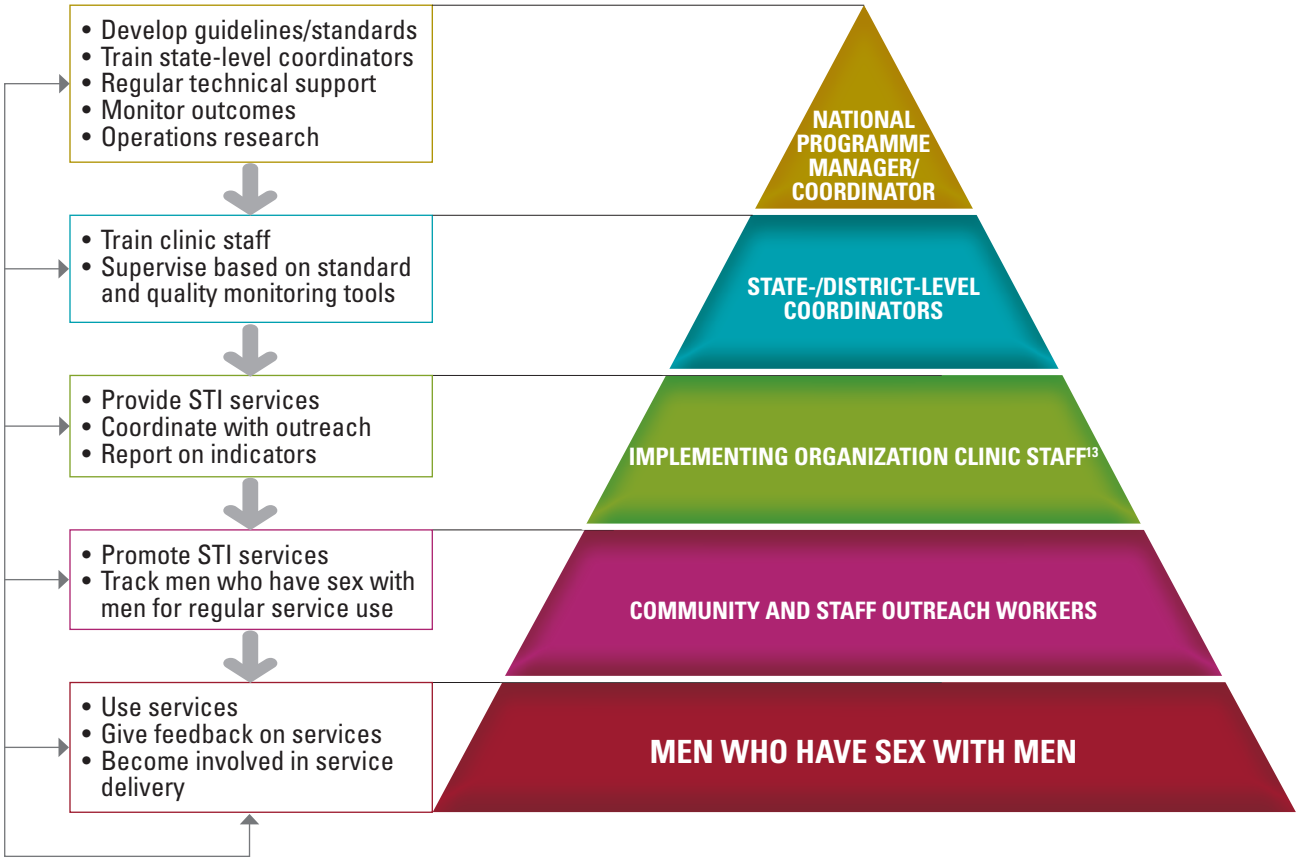
Asking about STIs should be standard practice during HTC sessions and during sexual history-taking. Speaking with a client about STIs and the symptoms associated with them can sometimes be difficult because the client may be embarrassed to speak openly about them. This barrier can often be overcome by explaining to the client that STIs are very common in men and that many are easily treatable.

B. Implementing and managing services

Organize services

A functioning management structure is important to implement and scale up STI and sexual-health services efficiently. It is important to specify roles and responsibilities at the different levels of the clinical services structure (see Figure 4.7). Communication and coordination mechanisms should be identified, and technical support and supervision at the different levels of care need to be clearly articulated.

Figure 4.7 Roles and responsibilities for STI services

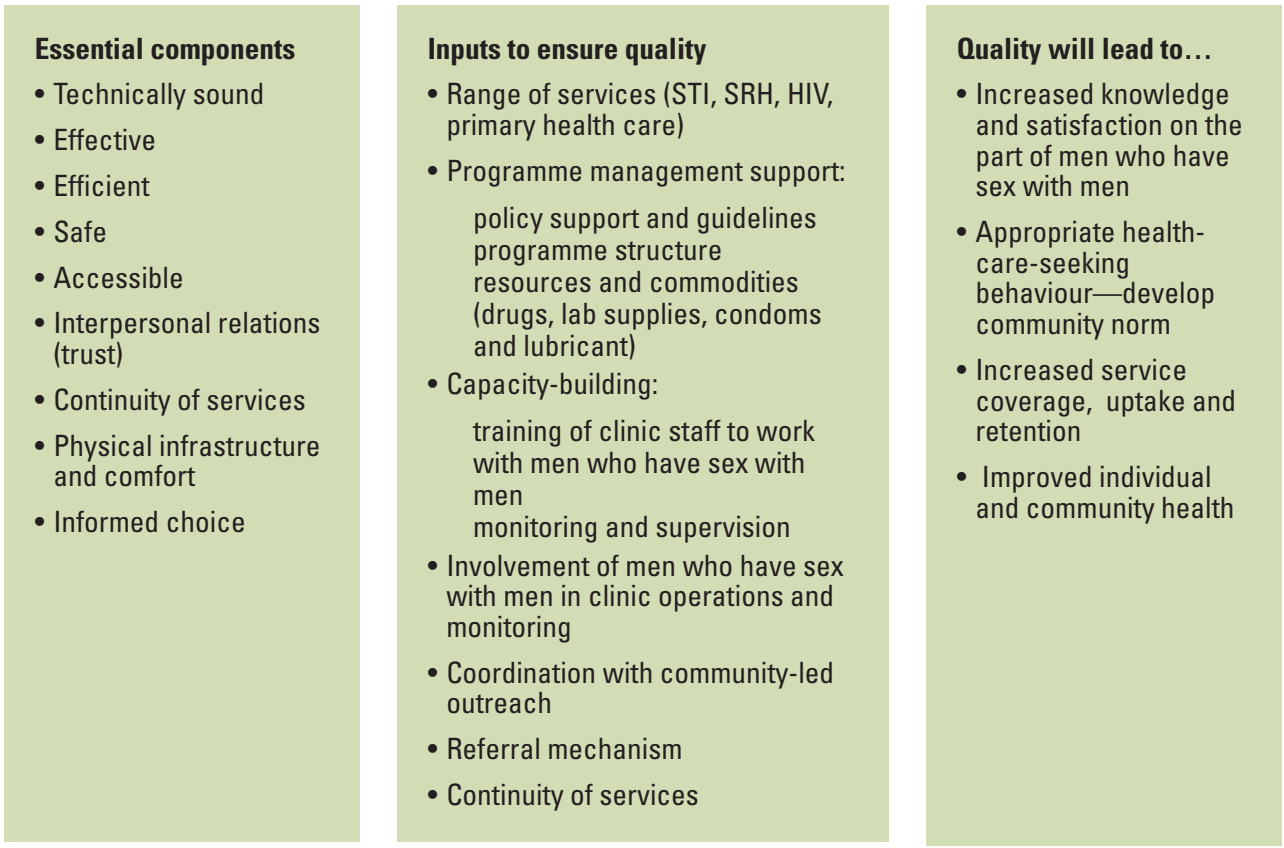


Provide an appropriate and high-quality STI service package

Providing high-quality services encourages STI patients to seek care regularly. Figure 4.8 shows the factors that ensure quality in STI services. For the treatment of STIs, please refer to national guidelines or the WHO *Guidelines for the management of sexually transmitted infections* (2003, to be updated in 2015) or the US Centers for Disease Control and Prevention *Sexually transmitted disease treatment guidelines, 2010* (see Section 4.5.)

13 An implementing organization is an organization delivering a prevention, care or treatment intervention to men who have sex with men. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

Figure 4.8 Ensuring high-quality STI services



Establish STI health care-seeking behaviour as a community norm

It is essential that men who have sex with men know the symptoms of STIs and be encouraged to seek care promptly if symptoms appear. Sexually active men who have sex with men without symptoms should seek regular STI screening because some STIs can remain asymptomatic. Linking STI services to outreach and community services helps achieve this.

Coordination with outreach led by men who have sex with men is essential to promote STI services and support clinic follow-up. At the same time, provision of STI services reinforces condom promotion and education by community outreach workers. Clinic staff should develop strong communication with community outreach workers. Improving communication and referrals increases the overall prevention effect.

Involve men who have sex with men and community outreach workers in clinic operations

STI services should promote meaningful participation of men who have sex with men. Men who have sex with men are capable of engaging at many levels of STI clinic operations, including management. Their involvement increases the sense of ownership and makes the clinic more acceptable and sustainable. Clinics should formalize involvement of men who have sex with men by specifying how they may be involved in developing, managing and monitoring services.

Professional development should be an integral part of community empowerment, allowing men who have sex with men to learn and be mentored to provide clinical services. Men who have sex with men involved in the clinic operations should be trained to undertake their tasks, should maintain confidentiality and professional boundaries with their patients, and should be remunerated for their work.

Link and integrate services

The majority of programmes providing health services to men who have sex with men focus on HIV and other STIs. However, men who have sex with men have the same needs for primary health care as anyone else. Men who have sex with men may also experience problems associated with mental health, alcohol and drug use.

Programmes should work to provide a full range of health and social services. These should be accessible on site or by referral, without fear of discrimination. Services may be added incrementally based on community priorities, availability, and the feasibility of providing services and alternative solutions. HIV, SRH, hepatitis B virus (HBV) immunization, TB and drug and alcohol dependency treatment are discussed in other sections of this chapter.

Box 4.8

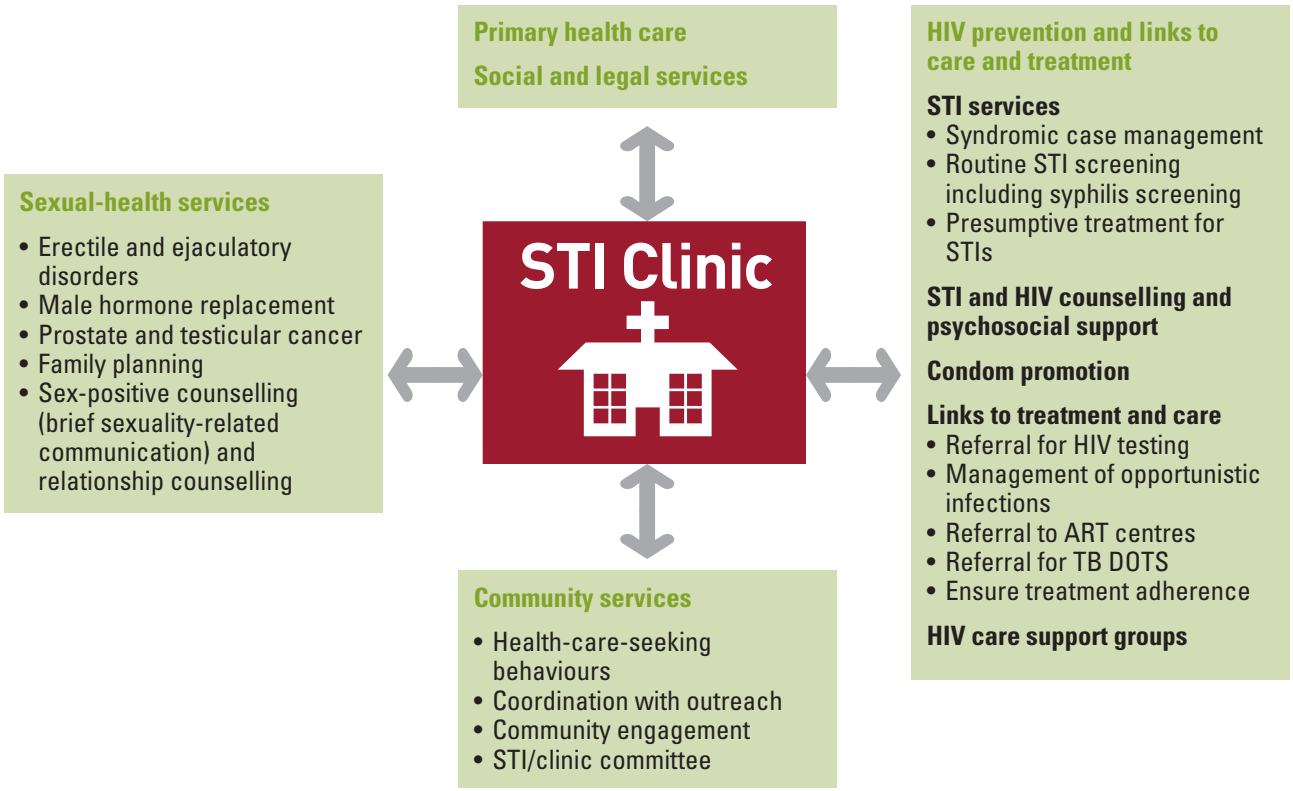
Case example: Creating an entry point to sexual-health services in Cambodia

Reproductive Health Association Cambodia (RHAC) implemented a programme to provide primary health care to men who have sex with men as an entry point for strengthened sexual and reproductive health and HIV testing services. One of the key activities was the provision of free hepatitis B vaccinations, during which men who have sex with men were also offered STI and HIV testing services.

Evaluation showed that free primary health care increased uptake of HBV vaccination among men who have sex with men, but was not by itself sufficient to increase the use of STI and HIV testing services. Other factors included the widespread information about the availability of services for men who have sex with men, provision of travel support to and from the clinics, a strong referral system, and having a supportive environment at the clinics, including counsellors trained to work with men who have sex with men.

Men who have sex with men whose HIV and other health issues cannot be met or managed appropriately by the programme's services should be referred. Any health request can be an entry point for other needed services, and referral networks should be established to address anticipated needs (see Figure 4.9). Clinics should compile a referral list of recommended providers, including names, addresses, telephone numbers and operating hours. Whenever necessary (e.g. due to perceived barriers to accessing services), accompanied referral should be considered (see Section 4.3.1, Part D).

Figure 4.9 STI referral network



Box 4.9

Case example: Providing sexual-health services to MSM with female partners in India

The Family Planning Association of India (FPAI) provides integrated sexual and reproductive health and HIV services to the general population through a network of 42 branches across the country. Many FPAI clinics have trained service-providers to be sensitive to the needs of men who have sex with men, including those with female partners. MSM with female partners often face real or perceived discrimination from within the community for being bisexual. Other community services for men who have sex with men often refer those with female partners to FPAI clinics for sexual-health services. Because the clinics maintain confidentiality and accessibility for all clients, they allow MSM with female partners to feel comfortable attending with their partners, or to discuss needs related to their sexual behaviour with men with the trained counsellors.

C. Viral hepatitis

2014 Key Populations Consolidated Guidelines

Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV. *(p.73)*

Catch-up hepatitis B immunization strategies should be instituted in settings where infant immunization has not reached full coverage. *(p.74)*

Hepatitis B virus (HBV) is transmitted by contact with the blood or other body fluids of an infected person. Sexual contact and injecting drug use can also transmit the virus. Risky sexual practices and sex work are associated with HBV infection in different regions of the world. Fortunately, a cheap, safe and effective vaccine against HBV is available.

WHO has published *Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection* (2015), *Guidelines for the screening, care and treatment of persons with hepatitis C infection* (2014) and *Guidance on prevention of viral hepatitis B and C among people who inject drugs* (2012).

HBV vaccination is recommended at birth in all countries. WHO recommends three doses of the vaccine for complete immunization and protection against potential HBV infection. Catch-up hepatitis B immunization strategies should be instituted in settings where adults have not had access to childhood vaccination, which is often the case among those older than 20 years in most settings, and among younger people in low- and middle-income countries. As more countries develop national infant immunization programmes with the administration of three doses of the HBV vaccine, vaccination specifically for high-risk groups will become less needed. Presently, however, it is recommended for at-risk groups including men who have sex with men.

It is important to note that MSM who are co-infected with HIV and HBV and who have severe chronic liver disease should be offered ART with a tenofovir (TDF) and lamivudine (3TC) (or emtricitabine [FTC])-based regimen irrespective of CD4 count or WHO clinical stage. The 2015 HBV Guidelines recommend tenofovir or other HBV active antivirals with a high barrier to resistance (not limivudine alone) for those with cirrhosis or high viral loads.

Like HBV, hepatitis C virus (HCV) is transmitted through contact with the blood or other body fluids of an infected person. Most HCV infections occur through the use of contaminated injection equipment among persons who inject drugs or in health-care settings. HCV can also be transmitted by sexual contact, especially anal sex among HIV positive men who have sex with men, although a small number of cases have also been reported among HIV negative men who have sex with men. There is no vaccine to prevent HCV infection, but for most people, chronic hepatitis can be cured with new oral treatment regimens. The current standard treatment for hepatitis C is combination antiviral therapy with pegylated interferon and ribavirin. The WHO 2014 heptatitis C guidelines recommend inteferon-free treatment regimens. New antiviral drugs, which are more effective, safer and better-tolerated, have been developed and are known as oral directly acting antiviral agent (DAA) therapies, but these are currently only available in in a limited number of countries. Service-providers are encouraged to refer to the most recent WHO guidance.

Infection with hepatitis A virus (HAV) commonly occurs when a person eats or drinks contaminated food or water. However, HAV is also found in the faeces of someone infected with the virus and can be sexually transmitted through activities such as oral–anal sex (rimming). HAV infection, unlike HBV and HCV, does not cause chronic liver disease and is rarely fatal, but it can cause debilitating symptoms and acute liver failure, which is associated with high mortality.

Attention to personal hygiene, such as careful handwashing and the washing of genital and anal areas before sex, can decrease risk of infection with HAV. The use of condoms or dental dams should be encouraged as they can also decrease transmission. There is no specific treatment for the virus once a person is infected. Treatment is aimed at maintaining comfort and adequate nutritional balance, including replacement of fluids that are lost from vomiting and diarrhoea. There is a vaccine for HAV, and a combination HAV and HBV vaccine is available and is recommended for men who have sex with men.

4.2.10 Other sexual-health services

2014 Key Populations Consolidated Guidelines

Members of key populations, including people living with HIV, should be able to experience full, pleasurable sex lives. *(p.81)*

A. Anal health care

Attention to anal health care among men is relatively recent, and well-defined guidelines for health-care practitioners are consequently lacking. Some general recommendations have been developed by the Pan American Health Organization (PAHO) and are included in its *Blueprint for the provision of comprehensive care to gay men and other men who have sex with men (MSM) in Latin America and the Caribbean* (see Section 4.5). The blueprint encourages men who have sex with men to have an anorectal examination as part of their sex-positive, holistic medical health care (see also Chapter 3, Box 3.1).[14] Health-care providers should be trained to provide and normalize the examination as part of a routine, comprehensive history and physical exam. Health-care providers should discuss:

- consistent and correct use of condoms and lubricants
- potential dangers of rectal douches or enemas (see below)
- use of foreign objects and other insertive practices (e.g. dildos, fisting etc)
- previous anorectal health problems
- use of drugs and other substances during anal sex.

The anorectal examination should focus on identifying:

- injuries or signs of trauma, including bleeding near the anus or to the anal mucosa
- sharp pain near the anus
- secretions in and around the anus or rectum
- haemorrhoids

14 For a webinar on anal pleasure and health, see http://www.msmgf.org/html/webinars/AnalPleasure/lib/playback.html

- anal fissures or fistulas
- anal warts
- ulcers around the anus or rectum
- foreign objects in the anus or rectum
- lesions suggestive of precancerous conditions or cancer of the anus or rectum
- intestinal injuries
- anorectal incontinence.

Following the anorectal examination and treatment of any identified diseases or conditions, it is important to counsel men who have sex with men on the importance of condom use and lubrication to reduce the chance of tearing and minimize the risk of transmitting diseases during anal sex. It is important to explain that since the anus does not produce lubrication it is at risk of being injured during "dry" anal sex. Emphasis should be placed on using condoms with compatible lubricant and stressing the role that condoms play in preventing the spread of HIV and STIs (and unintended pregnancy with female partners). See also Chapter 3, Section 3.2.3, and the WHO recommendations on brief sexuality-related communication (Section 4.5).

Box 4.10

Case example: Building skills for health-care providers in India

Avahan was a comprehensive HIV prevention programme which provided services to over 82,000 men who have sex with men and transgender people in six Indian states. Working with high-risk populations was a new experience for health-care providers, many of whom shared general misconceptions and negative views about men who have sex with men and transgender people. During field visits after an initial training on the Avahan *Clinic Operational Guidelines & Standards*, the STI capacity-building partner noted mutual embarrassment among clients and physicians when discussing personal sexual issues and risk behaviours. Health-care providers were unable to understand local slang used by men who have sex with men for their self-identities and risk behaviours, and this created a communication gap. Clinical examinations were rarely performed due to the reluctance of clients to undergo ano-genital examination and the limited experience of physicians, especially for proctoscopic examinations.

A training was developed to address sexuality issues; history-taking for behaviours specific to men who have sex with men and transgender people; oral, speculum and proctoscopic examinations; common ano-genital problems; and health education and counselling specific to these populations. An important aspect of the training was to demystify sexual behaviours and to promote a respectful attitude toward men who have sex with men and transgender people during clinic visits. A four-day training was conducted for 23 technical officers from the Avahan lead implementing agencies using participatory training techniques including case studies, role-plays, demonstration on pelvic models and hands-on clinical experience. Subsequently, the technical officers trained clinic staff serving men who have sex with men and transgender people across the programme and continued regular supportive supervision at the clinics. The staff gained the confidence of the communities, and rates of proctoscopic examination for clinic attendees reporting receptive anal sex increased from 18% to 79% in one year.

Human papillomavirus and anal cancer screenings

Human papillomavirus (HPV) has a significant impact among men, but there are no well-established guidelines pertaining to HPV and anal cancer screenings. Men who have sex with men are at a higher

risk than heterosexual men for conditions associated with HPV types 6, 11, 16 and 18. Anal, penile and oropharyngeal cancers have been associated with HPV. HIV positive individuals may be especially susceptible to HPV-associated outcomes. For example, genital warts are more common and more difficult to treat among HIV-infected individuals. Anal intraepithelial neoplasia and anal cancer are also common to HIV-infected individuals and can be identified through regular anal Pap smears.

Vaccinations for HPV may help decrease risk for genital warts and anal cancer. Some organizations have developed guidelines for anal cancer screening, but there are currently no universal formal recommendations for the use of anal Pap tests to screen for abnormal cells. As an example, the New York State Department of Health AIDS Institute recommends screening for HPV via:

1. visual inspection (clinicians should examine the ano-genital area to assess for visible HPV lesions at baseline and as part of the annual comprehensive physical examination)
2. anal cytology (clinicians should perform anal Pap tests at baseline and annually in men who have sex with men and in any patient with a history of anal warts)
3. HPV DNA testing (however, HPV DNA testing in HIV-infected patients is not recommended at this time).

Rectal douching and rectal fisting

Rectal douching (the use of enemas) and fisting (the penetration of the anus with the hand) among men who have sex with men are behaviours that have received little attention in research. Early research has found that enema use has been associated with several STIs in men who have sex with men and increases the risk for HIV infection, possibly by disrupting the rectal mucosa, which facilitates HIV entry. Fisting can lead to damage in the anus or the rectal lining, also facilitating HIV transmission. While more research on enema usage and rectal fisting is needed, especially to develop guidelines, health-care practitioners should assess for these practices. Men who have sex with men should be informed of these early findings and of the identified health risks associated with rectal douching and fisting.

B. Erectile dysfunction

Erectile dysfunction (ED)—the inability to attain or maintain an erection sufficient to have penetrative intercourse—is a medical disorder common primarily among men above 40 years of age, although it can occur at any age. It is not unique to men who have sex with men, but health providers who work with this population should be aware of it within the context of sexual health.

Normal sexual function, including the ability to experience an erection, depends on a combination of psychological, biological and social factors. Biological factors in ED can stem from cardiovascular disease, diabetes and hypertension, the use of certain medications, and cigarette, alcohol and drug use. Psychological and social factors may be intertwined and can include performance anxiety or the fear of failure during intercourse, mental-health conditions (e.g. depression, past traumatic experiences), relationship stressors, family problems and concerns about major life events (e.g. HIV status, loss of a job, starting a new relationship). Due to the numerous possible causes of ED, a thorough history must be taken along with a physical exam for a client with this condition. Treatment will depend on the cause of ED.

Medications that are used to treat ED have been found to be associated with high-risk sexual and drug-using behaviours among men who have sex with men. Infections with HIV and STIs have been

associated with the use of medications for ED, like Viagra. As well as assessing for ED among men who have sex with men, health-care providers should assess for the use of ED medications, whether for treatment or recreational purposes, as both kinds of use may facilitate high-risk sexual behaviours. Provision of services for ED can be an effective entry point for other services related to prevention of HIV and STIs. See also the WHO recommendations on brief sexuality-related communication (Section 4.5).

4.3 Care and treatment

4.3.1 Antiretroviral treatment and care

2014 Key Populations Consolidated Guidelines

Key populations living with HIV should have the same access to antiretroviral therapy (ART) and care and to the same ART management as other populations. *(p.61)*

Increased availability of and access to ART has significantly decreased HIV-related illness as well as deaths. Access in resource-limited settings may not be as comprehensive as needed, but ART services are now widely available in many countries. Providing ART to men who have sex with men is as feasible and effective as in the general population. Outreach services should link men who have sex with men to services for care and treatment that are sensitive and competent, to maximize the benefit and adherence to ART. Early and effective treatment has tremendous potential for preventing HIV transmission by reducing viral load and affecting community viral load (see Part E of this section).

In many settings, men who have sex with men fail to access ART due to multiple real and perceived barriers, which should be considered and addressed when providing ART services to men who have sex with men:

- Perceived and actual stigma and discrimination at health facilities against men who have sex with men impacts access, diagnosis, retention in care and adherence. This may be compounded in localities where criminalization and discrimination are politically sanctioned.
- Men in generalized epidemics have been noted to have poorer ART outcomes than women. A possible reason is that health facilities may be more welcoming to pregnant women.
- Syndemics associated with men who have sex with men should be considered. (A syndemic is the combination of two or more diseases with some level of biological interaction that exacerbates the negative health effects of any or all of the diseases.) For men who have sex with men, this may include a higher burden of STIs, smoking, alcohol and recreational drug use, combined with challenges due to migration, homelessness, sex work and mental illness.
- Adverse effects of medicines may impact well-being and function. For example, loose stools with some medications may impact the ability to engage in anal sex.

A. Essential definitions and prerequisites of ART services

The 2014 Key Populations Consolidated Guidelines outline recommendations on when to start ART. Providers should also refer to the WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* (2013). These guidelines are regularly updated to reflect changes in eligibility criteria, preferred ART regimens and monitoring approaches.

There are no clinical ART recommendations specific to men who have sex with men. However, because of stigma, discrimination and marginalization, they frequently present late for treatment.

- As a priority, ART should be initiated in all individuals with severe or advanced HIV clinical disease and individuals with CD4 count ≤350 cells/mm^3.
- ART should be initiated in all HIV positive individuals with CD4 count between 350 and ≤500 cells/mm3 regardless of WHO clinical stage.
- ART should be initiated in all HIV positive individuals, regardless of WHO clinical stage or CD4 cell count, in the following situations:

  co-infection of HIV and active TB disease

  co-infection of HIV and hepatitis B virus (HBV) with evidence of severe chronic liver disease

  the HIV positive individual is in a serodiscordant relationship.

The optimal time to initiate ART is still an open debate. There is increasing evidence from modelling and from several ongoing studies that earlier initation of ART (i.e. regardless of CD4 cell count, or even where the situations listed above do not pertain) is associated with additional benefits at population level, with impact on HIV incidence by reducing HIV transmission, and further reduction in morbidity and mortality, if HIV testing and ART coverage are very high at the population (see Section E below).

The guidelines also recommend:

- the use of simplified, less toxic and more convenient antiretroviral regimens for first- and second-line treatment, preferably as fixed-dose combinations
- the integration of ART in TB services, and in settings providing harm reduction services for MSM who use drugs, including opioid substitution therapy
- the decentralization of ART services and the provision of ART in peripheral or ancillary health facilities, initiated by nurses and with maintenance support from community health workers.

Other WHO normative documents also recommend:

- the "Three I's" for HIV/TB (intensified TB case-finding, isoniazid preventive therapy and TB infection control), as outlined in the *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders* (see Section 4.5).
- immunization against HBV (see Section 4.2.9 Part C)
- routine screening and management for mental-health disorders (particularly depression and psychosocial stress (see Section 4.3.3).

B. Specific considerations for men who have sex with men on ART

Like many people, men who have sex with men may have fears and concerns about ART. Knowledge of current community understanding of ART is imperative to address concerns, fears or misconceptions with accurate and appropriate information. Counselling should include why it is beneficial to initiate ART before feeling unwell or having symptoms. Adherence, maintaining a suppressed viral load to support good health and prevent treatment failure, as well as the benefit of ART in reducing risk of

HIV transmission, should be fully discussed. This may happen over several sessions. The potential benefits of treatment preventing transmission of HIV to sex partners should be specifically discussed, given the high risk of transmission during anal sex.

C. Provider training

Training for ART providers should follow national and international standards (see Section 4.5). For general guidelines on training of staff who will provide ART, see Section 4.3.1, Part C. For considerations of how to tailor ART service delivery to make it more accessible and acceptable to men who have sex with men, see Section 4.3.1.

D. Community care, support and case management

Additional but no less critical ancillary services to treatment include community pre-ART care, ART care and support, and case management. Care programmes provide a package of services that not only focus on the physical health of people living with HIV in the pre-ART and ART phases of care and on preventing new infections, but also address psychosocial challenges faced by HIV positive men who have sex with men. The package can include nutritional assessment and counselling, treatment literacy and adherence support and linkages to services.

Community support can take many forms. It can be delivered in-person, virtually on social networking Internet sites, and via phone or mobile text. Support can be provided one-on-one or in groups; the client's preference should dictate the approach when possible. Psychosocial community support may be especially important for men who have sex with men living in hostile environments and where family rejection and disconnect from community may be significant. Establishing opportunities for men who have sex with men, especially those who are HIV positive, to form interpersonal connections and gain social support has been shown to improve health and health-seeking behaviours. Online exchanges for HIV positive men who have sex with men also offer the protective cover of anonymity.

Community care, support and case management involve more than just providing preventive and treatment services. Establishing a trusting rapport and offering holistic and client-centred services are pivotal to engaging men who have sex with men. Efforts must be made to move beyond simply focusing on clinical needs and to treat the whole individual. The role of community outreach workers and community-led organizations in this process is critical (see Section 4.3.1, Part D).

Box 4.11

Case example: Outreach and services for MSM living with HIV in Nigeria

In Nigeria, The Initiative for Equal Rights (TIER) runs a programme to reduce the impact of HIV on men who have sex with men, their sexual partners and dependents by providing HIV prevention, care and support services. The programme trains providers from government health-care facilities and volunteers from community-based organizations in Lagos state to give services to men who have sex with men with sensitivity and respect.

Services include interventions for serodiscordant couples (primarily men married to female partners), counselling, prevention messages focusing on disclosure, promoting partner testing and correct and consistent use of condoms, case management, and basic home-based care and support for ART and treatment for TB and STIs.

More than 50 volunteers have been trained as commnity outreach workers, and over 5,000 MSM living with HIV have received HIV information and services, including ART and psychosocial support. Clients report better knowledge of HIV, improved risk perception and increased use of condoms and water-based lubricants.

E. Early initiation of ART for health and prevention benefits

There is mounting evidence to support the multiple health benefits of early initiation of ART among people living with HIV. As viral load is highly predictive of HIV transmission risk, viral suppression should be a goal not only to improve the health of people living with HIV, but also to decrease HIV incidence. ART decreases the risk of HIV transmission by suppressing viral load. Early initiation of ART for prevention is sometimes referred to as treatment as prevention (TasP). HIV positive men who have sex with men in sero-discordant relationships or who engage in sex work should be initiated on ART irrespective of CD4 cell count or clinical stage of infection.

In line with TasP, the strategy sometimes referred to as "test and treat" involves screening men who have sex with men for HIV and immediately initiating ART for those who are HIV positive, irrespective of CD4 cell count or clinical stage. This may be an effective strategy for improving health among HIV positive men who have sex with men and interrupting transmission of HIV, particularly in concentrated epidemic areas. Lowering community viral load should be a public-health goal. However, ensuring availability and unfettered access to treatment for all people living with HIV should remain a priority.

4.3.2 Tuberculosis

2014 Key Populations Consolidated Guidelines

Routine HIV testing should be offered to all people with presumptive and diagnosed TB. (p.69)
ART should be initiated in all individuals with HIV and active TB disease regardless WHO clinical stage or CD4 cell count. *(p.70)*

People living with HIV are 26-31 times more likely to develop TB than those who are HIV negative, and they are also at increased risk of dying from TB. A quarter of all HIV-related deaths in 2013 were due to TB. People who use drugs and people with a history of incarceration are also at increased risk of developing TB, regardless of HIV status. Although outbreaks of TB and multi-drug resistant TB (MDR-TB) have been reported among men who have sex with men and transgender sex workers, there is limited evidence to show that MSM living with HIV are at any more risk of developing TB than others living with HIV.

The 2012 WHO *Policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders* recommends a 12-point package of interventions known as the collaborative TB/HIV activities. The aim of the package is to establish and strengthen mechanisms for delivering integrated TB and HIV services; reduce the burden of TB among those living with HIV, which includes intensified case-finding, treatment of latent infection and infection control; and reduce the burden of HIV in TB patients. It recommends that all people living with HIV should be screened regularly for the following four symptoms: current cough, fever, weight loss and night sweats. If they do not report any one of the four symptoms, active TB may be reasonably excluded and, in resource-limited settings, they should be offered Isoniazid preventive therapy (IPT) as treatment for latent infection for at least six months. While studies have shown that people living with HIV who have a positive Mantoux tuberculin skin test (TST) benefit more from preventive therapy, TST is not a requirement for initiating treatment of latent infection, as it can create barriers to access.

In settings where resources allow, other shorter treatment regimens are also recommended. Those reporting one or more of the above-mentioned TB symptoms should be evaluated for TB and other conditions. If TB is suspected, WHO-approved molecular tests, such as Xpert MTB/RIF (a rapid automated test that also detects resistance to Rifampicin, one of the drugs used to treat TB), are recommended as the primary diagnostic test for TB in anyone living with HIV or at risk of drug-resistant TB.

Early ART significantly reduces the risk of mortality from HIV-associated TB. Given that TB is one of the most common AIDS-defining illnesses, WHO recommends that all TB patients are offered HTC as a priority if their HIV status is not already known. If an individual is found to be living with both TB and HIV, WHO recommends that they should be started on ART as soon as possible, irrespective of CD4 count.

Programmes or community outreach services for men who have sex with men are ideally placed to carry out TB screening and to support them throughout the cycle of care, from TB prevention through diagnosis and treatment. They also play a vital role in training men who have sex with men to recognize TB symptoms and understand TB transmission, as well as the importance of infection control and cough etiquette to reduce transmission. In addition, they can help them identify nearby health facilities for diagnosis and initiation of treatment of active or latent TB, as necessary.

4.3.3 Mental health

2014 Key Populations Consolidated Guidelines

Routine screening and management of mental health disorders (particularly depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimize health outcomes and improve adherence to ART. Management can range from co-counselling for HIV and depression to appropriate medical therapies. *(p.77)*

WHO defines mental health as a state of well-being in which the individual realizes his abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his community. Depression, stress from being a sexual minority and experiences with physical and emotional trauma may impact not only mental health but also sexual health.

Health-care providers commonly focus on the client's presenting complaint (i.e. the reason why the client is seeking health services), but without understanding the client in a holistic manner, important matters of health can be missed. Sexual health and HIV risk behaviours cannot be assessed alone, out of context, or in a silo fashion. When working with men who have sex with men, mental health must be considered along with physical and sexual health.

Mental health may be affected by numerous positive and negative factors, but this tool focuses on the experiences particular to men who have sex with men, i.e. sexual identity development, depression, minority stress and trauma, and their relationship to HIV sexual risk. Although there is no replacement

for a thorough clinical evaluation, the scales and questions described in the following sections may be used as tools to facilitate the dialogue between health-care providers and their clients.

While it is critical to address challenges to physical, mental and sexual health, health-care providers should remember to capitalize on the resilience that each individual possesses. Personal and individual-level factors such as sociodemographics (income, education, employment etc), personality traits and coping style, and interpersonal and community-level factors such as family support, friendships and religious and social affiliations, can contribute to an individual's ability not only to persevere but to successfully overcome challenges. Social support offered through the health-care system can complement personal resilience.

A. Sexual identity development

Sexual identity is an important aspect of an individual's overall identity and includes the manner in which they define themselves and their characteristic pattern of emotional, romantic or sexual attraction. The term sexual identity is commonly confused with gender identity. Gender identity is an individual's deeply felt internal experience of gender, which may or may not correspond with the sex assigned at birth.

Identity development is the process by which an individual develops an awareness and definition of their identity and, ideally, accepts and is comfortable with that identity.The process of sexual identity development includes an awareness of being attracted to males, females or both sexes. This development commonly occurs during adolescence, but like all people, men who have sex with men may become aware of their attraction to people of the same sex before, during or after adolescence. Because social norms almost universally privilege the representation and expression of opposite-sex attraction, some men who have sex with men may acknowledge their same-sex attraction later than their heterosexual counterparts. Some men may suppress a conscious recognition of their same-sex attraction, or, while acknowledging it to themselves, may conceal it from others or actively deny it in family or social contexts. Some men who have sex with men openly adopt a gay identity (a process known in some cultures as "coming out"), and they may do so at varying ages determined by factors including their own sexual identity development as well as cultural and community norms, family support and personal resilience. Some men who have sex with men, even while acknowledging their same-sex sexual behaviours, will not identify as gay, or may instead use a term specific to their particular culture.

Health-care providers should recognize that among men who have sex with men who dislose their same-sex attraction, the process of doing so may vary significantly. For some, it may be a positive experience, especially if they have a supportive family or social system. Others, however, may struggle with how, when and to whom to disclose their same-sex attraction. It is important to be aware that disclosing to different individuals, such as family versus friends or men versus women, may be easier or harder for some individuals. For married men who have sex with men, disclosure of same-sex sexual behaviour or identity can be particularly fraught. Issues of trust and acceptance may be of concern, as well as legal implications in settings where laws against same-sex sexual behaviour exist. The potential for rejection and violence as a consequence of disclosure is a cause for worry among most men who have sex with men. It is also important to consider that not only may psychological distress be associated with the disclosure process, but that not disclosing can also be stressful.

When providing services to men who have sex with men, health-care providers must refrain from assumptions about their sexual identity and take the time to get to know their clients, understand and accept how they choose to define themselves, and accept that they may not choose to disclose

their sexual identity. Health-care providers should also be aware that sexual identity is a fluid construct that may change and be redefined by the individual over time. By establishing a rapport with their clients, health-care providers will be able to have discussions and periodically revisit health issues that may be pertinent to sexual identity.

B. Depression and HIV sexual risk behaviours

Depression among sexual minorities is a significant mental-health problem. Research suggests that increased sexual risk behaviours may be associated with depression among men who have sex with men. Health-care providers should assess for depression among men who have sex with men in order to address both their mental and sexual-health needs. In addition to obtaining a history from the patient, depression screening tools can assist in making the diagnosis of depression. In primary-care settings, as well as in settings where resources may be limited, an instrument such as the Patient Health Questionnaire (PHQ-9) is an appropriate and validated screening and diagnostic tool for depression.[15] The PHQ-9 is a brief, nine-item self-report tool which incorporates diagnostic criteria and rates the frequency of symptoms, including thoughts of suicide. It is easily scored by the health-care provider. Based on the clinical interview and the findings from the PHQ-9, the health-care provider, working with the client, can develop a treatment plan.

C. Minority stress and HIV sexual risk behaviours

For men who have sex with men, experiences due to status as a sexual minority may be associated with mental and sexual-health problems. Minority stress can be caused by internalized homophobia, experiences of discrimination and expectations of rejection. It often compounds daily stressors, and stigmatized individuals must therefore develop mechanisms to adapt to it. While minority stress may result from acute experiences, it is more likely to be a chronic condition due to its relationship with established social and cultural norms that stigmatize and marginalize sexual minorities. Minority stress is a relatively new field of study, but it has been hypothesized that some men who have sex with men may respond to minority stress by excessive use of drugs or alcohol. This is associated with sexual risk behaviours, including condomless anal and/or vaginal sex. Thus it is critical for health-care providers to assess for stress and its association with mental and sexual health.

Assessing for minority stress can be done using several brief scales. The Revised Internalized Homophobia Scale (IHP-R) is a five-item measure used to assess internalized sexual stigma. A short series of questions/statements can also be used to examine experiences with discrimination and expectations of rejection. While these questions have been used with self-identified gay men, they can be adapted for use with all men who have sex with men:

1. Have you been assaulted because you are a man who has sex with men?
2. Have you been harassed or discriminated against professionally because you are a man who has sex with men?
3. Have you been harassed or discriminated against personally because you are a man who has sex with men?
4. Do you agree or disagree with the following statement: I believe the world is a dangerous place for men who have sex with men.
5. In the last 12 months, have you perceived a rise in homophobia?[16]

15 http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf

16 Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: results from a prospective study of bereaved gay men. Health Psychol. 2008 Jul;27(4):455-62. doi: 10.1037/0278-6133.27.4.455.

While not a substitute for a clinical assessment, the IHP-R and these questions to assess for experiences with discrimination and expectations of rejection can be used as tools to start a discussion with clients regarding minority stress.

D. Trauma and HIV sexual risk behaviours

Individuals who report experiencing trauma—whether through physical violence, sexual violence or psychological victimization—should be assessed for post-traumatic stress disorder. This is true whether the trauma occurred recently or in the past. Research indicates that men who have sex with men have experienced childhood sexual abuse at higher rates than heterosexual men, and that sexual trauma is associated with significantly higher incidence of HIV and STIs.

The Post-traumatic Stress Diagnostic Scale (PDS) is a brief but reliable self-report measure that has been used extensively in both clinical and research settings and in the emergency room setting. The scale assesses for severity and duration of symptoms and takes about 10-15 minutes to complete. (See Section 4.5, Further reading, Mental health item 11.)

Box 4.12

Case example: Holistic treatment of physical and psychosocial health needs in Uganda

A 30-year old Ugandan man went to a local clinic with the chief complaint of "right-sided pain" in his abdomen, after hearing that there was a "gay doctor" there. Previously he had undergone an extensive medical work-up with no definitive diagnosis. The client self-identified as gay but had not disclosed his sexuality to family, friends or members of the gay community. During his initial visit, he used an alias. The client was in a relationship which he described as abusive and "complicated". A physical exam was conducted and no definitive diagnosis was made.

In follow-up appointments, the doctor monitored the man's physical health and also discussed issues of mental health, including the challenges of being gay in Uganda. Over a period of three years the client ended his relationship and became active in the gay community. His report of physical symptoms decreased.

This case illustrates the importance of establishing supportive and therapeutic relationships with clients. While this client's chief complaint was abdominal pain, his history included information critical to his mental health. The health-care provider recognized the importance of holistic care, paying attention to physical, sexual and mental health. Establishing a rapport allowed for the development of trust and the exploration of health concerns. In primary-care settings, it may not be possible to address all health concerns immediately, and the client may not be willing to share information until trust is established. Thus it is important for the health-care provider to establish a safe environment, ask questions about sexual and mental health in a caring and sensitive manner and develop a plan to follow up on each health issue.

Source: Anova Health Institute

4.3.4 Drug and alcohol use

2014 Key Populations Consolidated Guidelines

All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice. (p.37)

Research suggests that men who have sex with men are more likely to use alcohol and drugs than other adults in the general population. "Drugs" refers here specifically to non-prescription drugs that are considered illegal in most countries. Drug use may be linked to HIV risk, especially through the sharing of injection equipment and unprotected sex with a serodiscordant partner while under the influence of these drugs.[17]

In the clinical setting, candid discussions between health-care providers and clients about the use of alcohol and drugs can be challenging, particularly because drug use and possession is not only highly stigmatized but also severely criminalized in nearly every country. If men who have sex with men encounter stigma when discussing their sexuality with health-care providers, it will be even more difficult for them to talk candidly about drug and alcohol use. This means that when conducting a conversation with a client about drug and alcohol use, just like conversations about sexual health, the provider must build rapport and confidence, use appropriate language and a nonjudgemental approach, and stress the confidentiality of the conversation.

Men who have sex with men may use alcohol and drugs for the same reasons as members of the general population. However, research suggests that higher than average use may be tied to experiences that are specific or unique to men who have sex with men, such as:

- To cope with anxiety, depression, isolation and loneliness that result from stigma, homophobia and social marginalization.
- Because alcohol and drugs may be common or appear normalized in some venues where men who have sex with men socialize.
- Alcohol and drugs help individuals relax, overcome social inhibitions, and increase confidence while seeking sexual partners.
- Alcohol and drugs can provide psychological enhancement of sexual experiences, the ability to engage in sex for extended periods of time, and lower sexual inhibitions.
- For men who have sex with men living with HIV, alcohol and drugs may help them cope with a diagnosis of HIV and escape from the fear of rejection due to their HIV positive status.

The limited data available infer the following patterns of drug use among men who have sex with men:

- Weekly or monthly use is more common than daily use, suggesting that a majority of men who have sex with men are not drug-dependent but use drugs only in specific situations (such as when they are experiencing stress, partying or having sex).

17 Section 4.3.4 is adapted from *Promoting the health of men who have sex with men worldwide: a training curriculum for providers.* The Global Forum on MSM & HIV and Johns Hopkins University; 2014.

- Patterns of drug use among men who have sex with men are not uniform within all communities of men who have sex with men. Some ethnic-minority groups, younger men and men living in urban areas may report higher rates of drug use.
- Men who have sex with men tend to use more than one drug during the same session or within a given time frame (known as polydrug use). For health-care providers, this has implications for taking a comprehensive drug use history in a clinical encounter and for delivering accurate health information and resources as necessary.
- Historically, prevalence of injection drug use, especially heroin, has been low mong men who have sex with men compared to non-injection drug use. However, high levels of injection drug use are reported in some settings.

It is important to recognize that, like other adults, many MSM who occasionally or regularly use alcohol or drugs may experience no negative impact on their social, professional or physical lives. A proportion of them may even report positive benefits from their use. It is also important to recognize that for others, drug and alcohol use might be problematic each time they use alcohol and drugs or only under specific circumstances, e.g. only when they use a particular drug or type of alcohol or only when they use an excessive amount. In these cases, they may report that their alcohol and drug use interferes—either at all times or under specific circumstances—with their personal health goals and/or with their goals for job, relationships or family.

Providers can effectively screen for drug and alcohol use with simple questions. For a list of resources, see Section 4.5.

The distinction between use and dependence is sometimes vague, as this varies greatly from individual to individual. Health-care providers must take into consideration whether or not clients are reporting their alcohol or drug use as problematic. It is ultimately the client's decision to stop alcohol or drug use, modify it or maintain it depending on their personal goals. The best method for assessing the way forward is:

1. Provide accurate information about the substances that the client consumes, and ensure that the client is aware of any potential detrimental effects, including risks of death (e.g. from drug overdose).
2. Identify what the client's goals are in relationship to drug use.
3. Engage in an open discussion about whether or not the client's current use aligns with where they want to be. The role of the health-care provider is to motivate the client to articulate their personal goals and come to a clear understanding of how their current drug and alcohol use relates to these goals.

If a client identifies a problem with drug or alcohol use, a useful technique for facilitating a conversation about the readiness to change is to ask questions about the client's perception of the importance of the issue and their confidence in making any kind of change. For those who do need assistance, health-care providers should refer to an appropriate drug counsellor or organization for a specialty evaluation and treatment.

The *WHO/UNODC/UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users—2012 revision* sets out key interventions with proven efficacy in reducing HIV transmission among people who inject drugs. Seven of these interventions are covered in other parts of this tool, and only the remaining two are exclusive to injecting

behaviour: opioid substitution therapy and needle and syringe programmes, as well as interventions for the management of opioid overdose. These two interventions specifically reduce transmission among people who inject drugs and should be prioritized in a comprehensive HIV prevention package for injection drug-using men who have sex with other men.

Behavioural treatments for dependence (particularly for stimulants) can reduce drug-related high-risk sexual behaviours. Interventions also exist to reduce sexual transmission behaviours in the context of ongoing stimulant use. For more information see the *Technical briefs on amphetamine-type stimulants (ATS)* published by the WHO Western Pacific Regional Office and the WHO *mHGAP intervention guide* (see Section 4.5).

For men who have sex with men who do not report problematic drug or alcohol use, providing health information related to use from credible sources in an honest and nonjudgemental manner may be adequate. If drug and alcohol use is within the context of sex, then engaging in a conversation about sexual health is also relevant, and access should be facilitated to HTC and testing for STIs.

4.4 Service delivery approaches

4.4.1 Clinical approaches

Different models exist for the provision of a comprehensive continuum of prevention, care and treatment services to men who have sex with men, depending on the context, number of potential clients and available resources. These involve non-governmental and community-led organizations, government and private-sector providers. In a large urban area with many men who have sex with men, such as a capital city, a dedicated clinic may be developed for men who have sex with men, either in government hospitals or clinics or in community settings, such as converting the drop-in centre of an organization with an established record of prevention outreach and condom and lubricant distribution and behaviour change work, so that it can also offer HTC, clinical examination rooms, lab and other necessary space and dedicated clinical providers. Where a dedicated clinic is not feasible, offering dedicated service times at an existing clinic for men who have sex with men may be an alternative.

In some contexts, hybrid models may be optimal. For example, a government hospital might partner with an organization serving men who have sex with men in order to formally link referrals for HTC and STIs to services by dedicated government staff, complemented onsite by support for HTC, follow-up and adherence provided by members of the community organization. A key principle across all these models is that "one-stop-shop" services are highly valued and reduce loss to follow-up among clients. Bundled services can include HTC, ART and treatment of HIV-related infections, distribution of condoms and condom-compatible lubricants, vaccinations, STI screening and treatment and viral hepatitis screening.

Table 4.2 illustrates different clinical approaches and a brief description of some potential advantages and disadvantages.

Table 4.2 Clinical service models

Type of clinic	Description	Advantages	Disadvantages
Dedicated NGO/ community-led clinic	• Full-time services in fixed location, often run by an NGO; ideal where there is a high concentration of men who have sex with men (over 500) • Dedicated staff required	• Technically efficient • Comprehensive services may be provided; mix of clinical and educational interventions is possible • Flexible to address needs of men who have sex with men • Possibility of linking to safe space (drop-in centre) • Involvement of men who have sex with men is possible	• May be costly if few men who have sex with men access the clinic • Possibility of stigma associated with clinic
Dedicated government-owned clinic	• Government clinics, including STI clinics, integrated HIV clinics, male clinics that include primary care	• Sustainable • Provision of technically efficient services if staff are well trained and facilities are available	• May not be acceptable and accessible to men who have sex with men • Links to community-led services, including the ability to track referrals, may not exist
Government or NGO/community-led clinic with decicated hours for men who have sex with men	• Existing STI, HIV or male clinic, with certain regular days/hours reserved each week exclusively for men who have sex with men	• Technically efficient • Comprehensive services • Sustainable	• Hours may not be convenient to all men who have sex with men • Acceptability of services may be compromised if clients feel stigmatized by attending on specific days/hours only
Outreach/mobile clinic (can be run by NGO or government)	• Satellite clinics (fixed location), mobile vans, health camps, often run by an NGO • Part-time clinics • Operate at fixed time in fixed locations • Ideal for reaching hard-to-reach men who have sex with men and for providing services to smaller numbers of men who have sex with men • Dedicated staff required	• May reach hard-to-reach men who have sex with men • Acceptable and accessible • Cost-effective if accessing hard-to-reach men who have sex with men	• Provision of comprehensive services for men who have sex with men may not be possible • Quality of services may be variable

Type of clinic	Description	Advantages	Disadvantages
Private-sector clinic	• Services provided by trained private providers identified by men who have sex with men	• Acceptable to men who have sex with men • May be cost-effective for a small number of men who have sex with men • Confidential • Sustainable	• Comprehensive services may not be provided (e.g. educational and counselling services) • Quality monitoring and reporting may not be possible
Hybrid partnership model of community-led organization working directly with government staff	• Government with community-led organization staff working onsite • Could be fixed-site or mobile • community-led organization with part-time clinic through government providers • Dedicated staff required	• Partially sustainable • Strong links between national programme and community-led organization possible • Opportunity for community-led organization members to gain valuable skills as providers • Wide range of services possible, including community care and follow-up to support retention can be optimized	• Government staff need to work (and be funded) outside of their comfort zone; similarly community members working in clinics may be less comfortable than in community settings • Confidentiality between clinic and community follow-up must be ensured

Each country and sub-national setting differs and will need to map out available resources and collaborate—always with community engagement—on the best strategies. These may be viewed differently by different subgroups of men who have sex with men. Some may not be comfortable going to a site that would identify them as a man who has sex with men. A more acceptable alternative may be male clinics, private clinics and gender-neutral spaces that are not identified or branded as "gay" but are linked to organizations that are respectful of men who have sex with men. On the other hand, some highly visible or feminine men who have sex with men may see community-led clinics run by their peers as their only safe option.

In countries with an enabling legal and social environment, facilities that openly provide services to gay and other men who have sex with men are possible. However, in more hostile environments, "male health" clinics that include expertise in the health of men who have sex with men may be a preferable option.

Clinical service delivery elements specific to men who have sex with men that may make access easier, more acceptable, effective, and support adherence and retention in care may include:

- Drug dispensing available in the same or nearby location
- Flexibility in prescriptions to cater for high mobility (i.e. 90-day prescriptions)
- Flexible services, including clinic hours (e.g. weekends, evenings), no-appointment-needed drop-in services, "emergency" drug pick-ups when running out of drugs, and patient-held records to enable them to access drugs at different sites.

- Addressing other vulnerabilities, e.g. injecting drug use, other substance use and violence (sexual, domestic)
- Linkage to appropriate community care and social services
- Ethnic minority and/or migrant men who have sex with men, including those without documentation, may experience significant barriers to accessing ART services. Flexibility of services to take this into account is recommended.
- In overtly hostile environments, men who have sex with men may have significant mental-health needs. Embedded mental-health expertise or the establishment of referral networks is advised. Where such resources are not readily available, health-care providers should receive training to address commonly encountered mental-health challenges (see Section 4.3.3).

A. Mobile service delivery

Clinical services, including STI services, HTC and point-of-care CD4 diagnostic services may be delivered on foot or by van at:

- men's day health events
- drop-in centres
- bars and clubs
- gathering and cruising areas
- sex-on-premise venues
- house parties
- community members' homes.

Box 4.13

Case example: Coordinating combination prevention services nationally and regionally in Central America

The Combination Prevention Project implemented by Population Services International and their network member PASMO, with funding from USAID, aims to increase access to a comprehensive package of HIV prevention interventions for key populations, including men who have sex with men, in Belize, El Salvador, Guatemala, Costa Rica, Nicaragua and Panama.

Services are provided through close coordination with a diverse set of partners. The programme's interventions respond to the PEPFAR Partnership Framework developed with the Council of Ministers of Health of Central America, and regular meetings with the ministries of health in each country ensure that interventions are aligned and coordinated with national AIDS programmes. Programme representatives participate in national multisectoral technical meetings to coordinate interventions and technical trainings related to HIV prevention. PASMO provides public and private clinics and laboratories with technical training on HIV and the combination prevention approach. For NGOs providing outreach and other interventions for men who have sex with men, the programme holds monthly meetings, conducts monitoring visits and provides training and technical assistance.

Organizations of men who have sex with men collaborate with the project team to map "hot zones" (areas with a high population of men who have sex with men) through existing databases and field visits, and participate in "sweeping the zones" activities in which all partners travel to hot zones to ensure that men who have sex with men have access to all the combination prevention interventions. The community organizations also validate tools and other materials developed by the programme. Outreach is conducted by trained community outreach workers and cyber educators—community members doing outreach through social media. More than 78,000 individuals have been reached since the start of the programme in October 2010, and the Global Fund in El Salvador has adopted this strategy and methodology at a national level.

B. Training clinic staff

All staff delivering clinical services should be trained and continuously updated in sensitivity towards men who have sex with men, with particular respect to ethical conduct. This includes:

- the duty to be respectful and nonjudgemental
- the specific needs of subpopulations of men who have sex with men
- the absolute requirement to maintain confidentiality about any information provided during the counselling session, including the patient's engagement in same-sex behaviour.

Provider training curricula are available through a collaboration between Johns Hopkins University and the Global Forum on MSM & HIV (see Section 4.5).

4.4.2 Community-led approaches

2014 Key Populations Consolidated Guidelines

Community-based approaches to service delivery can increase accessibility and acceptability for key populations. Outreach, mobile services, drop-in centres and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health facilities. These approaches allow for critical linkages and referrals between the community and health facilities, and they support decentralization. Community-based programmes can also refer to programmes that are led and delivered by members of the key population community. *(p.117)*

Community-led organizations can also play important roles in reaching key populations, engaging with them, linking them to services and providing ongoing care and support. *(p.116)*

Community-led organizations play a crucial role in delivering services that best meet the needs of key populations. *(p.129)*

Community-led approaches are an essential link between the community and HIV prevention, care and treatment services. They empower men who have sex with men to draw on their first-hand knowledge of vulnerability and risk to problem-solve with members of their community, strengthening access to services, and making HIV prevention, care and treatment viable. Trained community members can build rapport with other men who have sex with men, understand their needs as individuals, and on a regular basis provide them with or link them to appropriate high-quality services.

Community-led approaches to men who have sex with men involve building the capacity of a community-led organization to assess the needs of the community, design high-quality services based on identified needs (starting with the most essential) and roll out these services progressively as the capabilities of the organization grow. In most localities, the social-political context, HIV incidence and risk behaviours among men who have sex with men will shape how services are designed. In more tolerant settings (for example, some urban areas), community-led organizations may be able to be more visible about their work and hold public events and group outreach sessions. In much of the world, community-led organizations must operate very discreetly to provide outreach, HIV testing

and counselling and referrals to comprehensive care services. For more information on organizational capacity-building of community-led organizations, see Chapter 6.

Most community-led organizations initially build their outreach work around one-on-one and group education activities, with referrals to safe spaces, such as a drop-in-centres (where available), or to public or private health-care providers who are respectful of men who have sex with men. Since men who have sex with men have a diverse range of sexual behaviours, social networks and service preferences, not all may opt to seek information from a community outreach worker. Some may prefer to receive information through social media (e.g. Facebook or Grindr). Social network strategies may be able to reach men who have sex with men who are at very high risk of HIV and not otherwise linked with HIV information or services (see Section 4.4.2).

A. The role of community outreach workers

Community outreach workers typically perform a number of key functions.[18] They meet regularly (e.g. monthly) on a one-to-one basis with men who have sex with men in their assigned area. A ratio of one community outreach worker to approximately 50 men who have sex with men is feasible, depending on the density of the community. They assess the HIV prevention, care and treatment needs of men who have sex with men in their network or target zone and develop plans to address their needs through the programme network. This typically requires knowing how many condoms and lubricants each man requires based on his usual sexual activities and distributing the required number to cover the period until the next contact.

Other roles include:

- Promote and facilitate safe spaces (drop-in centres) within the community (see Section 4.4.4).
- Address online communities of men who have sex with men (i.e. online outreach), since some of these men may not seek out venues or other face-to-face encounters where they might physically meet with a community outreach worker.
- Provide information on sexual health and encourage men who have sex with men to visit clinics for STI check-ups, explain the services and accompany them to the clinic upon request. Advocate for access to services if they encounter difficulties.
- Directly provide voluntary HIV counselling and testing to their peers in community settings (home gatherings, safe spaces etc). Alternatively, support men who have sex with men to get voluntary HIV counselling and testing at other locations, and ensure that they are accompanied to referrals upon request.
- Screen men who have sex with men for STI and/or TB symptoms and refer them to previously identified "safe providers" for treatment.
- Share clinical provider score cards to encourage uptake of clinical care.
- Accompany HIV positive men who have sex with men to treatment centres upon request, and track and encourage their adherence to antiretroviral therapy.
- In programmes that provide services to people who use drugs, refer to counselling and medical services as needed.
- Help to manage crisis response systems responding to stigma, discrimination or violence. Give

18 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

information on additional support systems for men who have sex with men facing violence or threats.

- Take part in community committees and advisory groups (make recommendations to improve clinic–client relations, outreach, safe spaces) and community mobilization activities, and provide feedback from the field on ways to improve the programme.
- By monitoring the relative vulnerability of individual men who have sex with men, community outreach service workers also supply the first level of data collection for the programme.

Box 4.14

Community-led outreach and community empowerment

Community-led outreach can reach the largest proportion of the community, most regularly and with direct personal rapport. Community outreach workers' understanding and personal investment in the welfare of their community is as essential to the success of an intervention as the services they offer. Therefore they should be respected and engaged meaningfully. This has two important implications:

- The term "community" should never be understood or used to imply that community outreach workers are less qualified or less capable than non-community staff.
- Community outreach workers are not volunteers; they should be remunerated for their work at a rate comparable to that of other staff, and should have the opportunity to progress to permanent paid positions in the implementing organization.

Box 4.15

Case example: Approaches to conducting outreach to men who have sex with men in the Russian Federation

Organizations within the LaSky Network in the Russian Federation reach men who have sex with men through websites, social networks, clubs, saunas, informational hotlines and street outreach.

- Siberia-AIDS-Aid in Tomsk has an HIV prevention website for men who have sex with men which provides information about the project, HIV prevention, STIs, safe sex, sexual health, condom use etc. The website also hosts anonymous forums to answer questions about HIV, same-sex partnerships, sexual health and where to find health services respectful of men who have sex with men.
- Outreach workers use their own social networks to reach people as well as conducting outreach in clubs, saunas and bars, where they place informational posters, banners and flyers. These materials are attractive, colourful and use symbols recognizable to the population being reached. Outreach workers distribute condoms and informational materials to patrons of these establishments.
- Some organizations within the LaSky Network offer helplines (open daily from 10am until 10pm) through which community outreach workers or counsellors provide information about HIV, STIs, safe sex and sexual health, as well as referrals to appropriate respectful medical, psychological, social and legal services.
- LaSky Street Outreach provides face-to-face information on HIV and STIs, discussing the client's health-related needs and promoting services that may be useful for the client. These meetings take place with the voluntary participation of each individual, and confidentiality, security, acceptance and professionalism are of paramount importance. LaSky Street Outreach aims for the substantial and sustainable engagement of men who have sex with men in the project.
- Motivational Groups are meetings with 8-10 participants that focus on sexual health and HIV prevention. These 2-3 hour meetings include interactive exercises, informational discussions and role playing in order to motivate participants towards consistent condom use and safer sexual behaviour. The meetings function best with two facilitators who are knowledgeable about HIV, hepatitis B and C, testing and counselling, alcohol and drug use and behaviour change communication.

B. Steps in implementing community-led outreach

Several steps are required to establish community-led outreach in a community of men who have sex with men:

1. Map the community and design the outreach strategy with community representatives
2. Recruit and train community outreach workers
3. Implement and manage outreach
4. Foster leadership opportunities for community outreach workers

1. Map the community and design the outreach strategy with them

Reliable data collection and meaningful consultations with men who have sex with men and other key individuals and institutions will help ensure that the programme provides acceptable and accessible services to the greatest possible number of community members, and that it is seen as useful and is supported by the community.

Understanding where men who have sex with men are and how to reach them is essential. This starts with programmatic mapping and size estimation, a process that must involve men who have sex with men who know and live in locations where men who have sex with men gather. Once mapping focuses on specific locations within a coverage area, the continued participation of community members is needed to help assess the availability and quality of services and characteristics of the environment, as well as the relative risks and vulnerabilities of individual men who have sex with men. This process can also help identify additional men who have sex with men who could become community outreach workers.

It is important to take great care when identifying locations where men who have sex with men gather, especially in jurisdictions that criminalize same-sex sexual behaviour or within which violence is a concern. Mapping must be conducted in close partnership with communities of men who have sex with men and information gathered should be treated confidentially. Safeguarding data and the personal well-being of men who have sex with men at the community level must be a priority.

For detailed information on the steps involved in mapping and size estimation, including the need for security, see Chapter 6, Section 6.2.7, Part A.

Figure 4.10 Community service map

Source: Targeted outreach programme (TOP), Myanmar. Photo by Cameron Wolf

Box 4.16

Case example: Diversifying outreach channels in Cambodia

In Cambodia, FHI 360 launched M-Style to offer information and services to men who have sex with men. The USAID-funded programme was designed by organizations of men who have sex with men to include community-led education, events, a hotline, website and social media outreach through Facebook. In 2008, at the start of the initiative, the project was reaching just over 1,500 men who have sex with men with community-led education, free condoms and lubricant and referrals for health services. A year later, M-Style had provided more than 6,000 men who have sex with men a package of HIV prevention services. An evaluation of the programme found MStyle effective. It was highly recognized by men who have sex with men, the majority of whom received information and services from the programme, and when comparing those exposed to MStyle with those unexposed to it, the former had higher rates of knowledge and greater uptake of HIV services.

2. Recruit and train community outreach workers

The steps presented below represent an optimal process for recruiting and training community outreach workers. If a new intervention is being established, these steps may be implemented over time, as the programme reaches a greater number of community members. In practice, a programme might start with a small number of community outreach workers and a more informal organizational structure, but formalize as it reaches more men who have sex with men.

1. **Develop terms of reference** for community outreach workers that outline the necessary selection criteria (see Box 4.17) and roles and responsibilities. Include policies on remuneration, travel allowances, per diem etc.
2. **Develop guidelines for recruiting, retaining, assessing and promoting** community outreach workers. Where possible, the selection process should be well publicized in the community so that all those interested in being community outreach workers may be considered. Collaborate with other programmes in the state/country to ensure that, where possible, remuneration for community outreach workers is consistent and transparent across programmes.
3. **Develop a training curriculum.** Check whether an appropriate curriculum is available for the particular outreach setting. Ideally, the curriculum should be developed and standardized at the central/regional level, but it may need to be adapted to address local language and cultural issues (see the resources listed in Section 4.5). Check whether trainers are available.
4. **Adapt outreach tools for community outreach workers.** These may include daily and monthly tracking forms that assess each individual's risk and vulnerability factors as well as their access to services. Outreach tools should be pictorial for community outreach workers with low literacy.
5. **Develop a tiered training plan** to enhance community outreach workers' skills, confidence and leadership. This should incorporate regular training of new community outreach workers to ensure that an adequate number are always available. Training should also refresh and advance community outreach workers' skills and exposure to all components of the programme, e.g. making sure that they are able to explain clinic procedures to men who have sex with men.
6. **Develop a career progression plan** for community outreach workers to ensure they have the opportunity to take on greater leadership responsibility for programme activities, and to oversee outreach and other aspects of the programme, including roles that may have belonged to NGO staff. Link this to activities that enable community outreach workers to demonstrate leadership through outreach, safe-space activities, community committees etc.

Recruiting community outreach workers

In the initial stages of a programme, selecting community outreach workers may be an informal process: the implementing organization may invite men who have sex with men who have been involved in the initial mapping and planning stages to remain involved in the new programme as community outreach workers, and/or to identify other men who have sex with men with the potential to fulfil this role. In either case, the selection criteria listed in Box 4.17 should be considered. It is also important to observe the rapport between men who have sex with men involved in mapping and other members of their community.

Box 4.17

Suggested selection criteria for a community outreach worker

- Active in the community with time to do outreach
- Committed to the goals and objectives of the programme
- Knowledgeable about the local context and setting
- Accepted by the community
- Accountable to the community as well as to the programme
- Tolerant and respectful of all communities of men who have sex with men
- Able to maintain confidentiality
- Good listening, communication and interpersonal skills
- Self-confident and with potential for leadership
- Potential to be a strong role model for the behaviour he seeks to promote with others
- Willing to learn and experiment in the field
- Committed to being available to other men who have sex with men if they experience violence or an emergency
- Programmes that conduct outreach through social media may also choose outreach workers based on their profile as opinion leaders within social networks and other criteria such as age, class or local sexual and gender identities that will enable them to reach distinct subgroups for the programme.

Figure 4.11 Community outreach workers from SWING, Thailand

Photo by Cameron Wolf

As the programme matures, a more structured process for selecting new community outreach workers may be adopted:

1. A community advisory group and programme staff, including current community outreach workers, define the criteria for new community outreach workers, identify potential community outreach workers, contact them to see if they are willing to serve and conduct a basic interview with them. The candidates are ranked based on the criteria listed in Box 4.17.
2. The candidates are asked to take part in a social network mapping exercise, facilitated by outreach coordinators, to determine the size of their social networks of men who have sex with men.
3. Current community outreach workers consult with the potential community outreach worker's contacts to see whether the candidate would be acceptable to them as a community outreach worker.
4. Based on the interviews, social network mapping and consultations, the community advisory group selects the appropriate number of new community outreach workers.
5. The community advisory group discusses methods for community monitoring of the community outreach worker's performance. (This could be through a formal community committee or group: see Chapter 1, Section 1.2.3.) Community members should be able to contact the project if they have any issues related to the community outreach worker.

Recruitment should take into account the continuum of vulnerability to HIV among different sub-networks of men who have sex with men; some will be at greater risk than others. Research indicates that men who sell sex to other men,[19] and men who seek sex with men through the Internet may have high HIV prevalence compared to other networks of men who have sex with men. Community outreach workers from subgroups at higher risk should be recruited to do outreach to their peers.

Box 4.18

Case example: Targeting outreach to subgroups of male and transgender sex workers in Thailand

The work of the Service Worker in Group Foundation (SWING) targets male and transgender sex workers in Bangkok and Pattaya. Over the course of a decade the organization has targeted its outreach to specific subgroups that it has learned are particularly vulnerable to HIV and other health issues, including those who use drugs and non-Thai sex workers. Interventions are designed using mapping to identify bars and other locations where sex workers work. The maps are updated each year. Peer networks are used to identify those sex workers who use drugs as well as those who are non-Thai. Focus group discussions are used to gather information about the needs of the population and include them in designing interventions.

Through discussions with people who use drugs, SWING learned that there are two subgroups within the population: those who use drugs because they like to, and those who use drugs because their clients want them to. There is concern that the second group may be particularly vulnerable not only to drug dependence, but also to HIV and other STIs because when under the influence of drugs they may be less able to insist on clients using condoms.

SWING's interventions include HIV prevention, testing and counselling, and referrals, care and support for individuals living with HIV. SWING also provides non-formal education, English classes and legal aid. SWING believes that these comprehensive services help male and transgender sex workers improve their quality of life, and also helps keeps them engaged in SWING's network.

19 Some programmes with men who have sex with men also include targeted programmes for male sex workers. While those programmes are covered explicitly in *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* (WHO, UNFPA, UNAIDS, NSWP, World Bank; 2013), it should be understood that programmes described in this tool may also engage with male sex workers. Similarly, some programmes addressing men who have sex with men also offer services to transgender persons. A forthcoming tool on implementing programmes with transgender people will focus specifically on these strategies.

Training community outreach workers

Training should take place regularly and may be done at several levels:

1. basic training at the beginning of engagement in the programme
2. advanced training sessions at least quarterly to build knowledge and skills and to reinforce positive examples of outstanding outreach
3. informal mentoring by an outreach supervisor/manager to support community outreach workers (daily)
4. group discussions and mentoring with community outreach workers (weekly).

Training curricula should be interactive. The strength of community outreach workers in bringing their own experience and initiative to their work should be emphasized. This means that training may be most effective when facilitated by trainers who are themselves men who have sex with men. (Trainers should be remunerated.)

Basic training may include:

- interpersonal communication skills to build confidence and individual agency (the choice, control and power to act for oneself), including discussion of the need to be tactful and nonjudgemental, and to ensure confidentiality as a professional requirement
- condom gap analysis, condom negotiation, lubricants, and training on how many condoms outreach workers should take to meet their outreach needs (see Chapter 3, Section 3.2.1)
- social network mapping
- monitoring of programme reach
- making prevention and care referrals
- using micro-planning tools, record-keeping
- STI symptoms and disease processes, referrals and treatment of STIs, HIV and TB
- promotion of voluntary HTC
- identifying and discussing violence, providing psychosocial support
- community mobilization.

Advanced training may include:

- advanced communication and counselling skills
- leadership skills
- dealing with stigma, discrimination and harassment
- legal literacy, negotiating with police and calling upon the community for support
- violence screening and crisis intervention
- counselling for drug and alcohol use
- creating links to other services (e.g. sexual health, HIV and HTC, and other health services)
- helping people navigate systems for social benefits, e.g. health insurance, unemployment benefit
- care and support through community-led individual and group counselling, including for men who have sex with men living with HIV
- use of programme data to better target outreach services
- interacting with the media (to promote a positive image of the community).

Box 4.19

Case example: Referrals through social networks in Ghana

In a pilot study of peer social networks among men who have sex with men, conducted in 2013 in eight governmental health facilities in the regions of Greater Accra and Ashanti, Ghana, 25 men who have sex with men who had not been exposed to community outreach workers in the past 12 months were recruited as "seeds," through a network-based approach. Each seed was referred to HTC and asked to recruit three friends from their social networks of men who have sex with men, who were also referred to HTC. These friends became "peer recruiters" and were asked to recruit additional men who have sex with men from their social networks.

HTC counsellors conducted face-to-face interviews with seeds and with peer recruiters to collect information on demographics, social network size, HIV testing history and previous exposure to community outreach workers. In total, the seeds referred 166 peer recruiters for HTC services. Almost two-thirds of the peer recruiters reported that they had not been exposed to community outreach workers in the past year, a similar proportion said they had never been tested for HIV or had not been tested in the past year, and one-third were found to be HIV positive. Among the peer recruiters who were living with HIV, 91 percent accepted referral for HIV care, support or treatment services.

An analysis of the referral patterns showed that MSM living with HIV were significantly more likely to refer peers who were HIV positive than negative. Similarly, recruiters who had not been exposed to community outreach workers tended to refer men who have sex with men who also had not been exposed to the programme.

Source: Girault et al; 2015. See Section 4.5, Further reading.

3. Implement and manage outreach

Outreach happens at two levels: the community outreach worker manages his own outreach to men who have sex with men; and programme staff supervise and support the community outreach workers.

The community outreach worker uses a prevention and case management approach for each man who has sex with men, consisting of several steps that are re-assessed and repeated, as circumstances require.

1. Assess the range of needs of the individual, using a standardized tool (see "Micro-planning" below).
2. Develop a plan of action with the individual based on needs that can be addressed.
3. Provide commodities, information and counselling to address the beneficiary's needs.
4. Facilitate referrals to other services, as needed.
5. Follow up referrals with support and information, as needed.
6. Re-assess and evaluate the needs of the individual on a regular basis.

Micro-planning

Micro-planning gives community outreach workers the responsibility and authority to manage their own work. In this approach, community outreach workers use their knowledge of the community, and the information they record during their contacts with men who have sex with men, to prioritize and manage outreach.

In micro-planning, community outreach workers are trained to use tools to capture data on the vulnerability and risk of each individual they serve, and the services they deliver. Micro-planning tools are designed to be user-friendly, e.g. they are pictorial and can be used by people with low literacy skills. They may be adapted so that routine monitoring can be reported using a mobile phone, in addition to recording data on paper.

Community outreach workers record data at each encounter with the individual man who has sex with men, and aggregate them onto a weekly or monthly reporting form (unless the data have already been submitted electronically), with the assistance of a supervisor/manager if necessary. Some of the aggregated information may be reported by the programme according to regional or national reporting requirements, but its primary purpose is to enable community outreach workers to analyse their outreach efforts and plan their outreach according to the most urgent needs of the men who have sex with men they are serving (e.g. those with the highest risk or vulnerability, or those who have not been contacted for a significant period of time). The community outreach worker may do this planning in the context of weekly review sessions with the supervisor/manager.

Supervising and supporting outreach

An outreach supervisor/manager has the responsibility to train, motivate and monitor the work of 5-20 community outreach workers. The role may be filled by a community outreach worker who has progressed into this supervisory role or by an NGO staff member until community outreach workers are trained.

The outreach supervisor/manager observes community outreach workers in their day-to-day outreach work, reviews their data on components of the service package (number of one-to-one contacts, group contacts, referrals or accompanied visits, condoms distributed etc), and may input the data into a computerized management information system if there is no dedicated data entry officer. The supervisor/manager has weekly meetings with his group of community outreach workers, usually at the safe space (drop-in centre), to discuss high-priority individuals and any problems the community outreach workers may be encountering, and to provide informal training.

Remunerating community outreach workers

Community outreach workers should always be remunerated for their work. However, certain approaches may be problematic. For example, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services—rather than providing a fixed salary or stipend—may distort demand and lead to coercion. In addition to fixed remuneration, effective incentives and evaluation-based recognition can include phone credit, non-monetary gifts and leadership opportunities that are not linked directly to the number of men who have sex with men who are brought to the programme. Offering the chance to participate in national or international trainings and meetings, where possible, may also be an effective way of recognizing outstanding community outreach workers.

Table 4.3 shows the various activities for which community outreach workers may require remuneration.

Table 4.3 Remuneration of community outreach workers

Resource spent by community outreach worker	Remuneration	Rationale
Time on outreach (includes time for travel, meeting with men who have sex with men, reporting, planning further outreach)	Salary	Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.
Time on extra training	Stipend	Hours spent in training are lost work time, and programmes should recognize that community outreach workers may have other work and personal obligations that cannot be fulfilled when they are in training.
Travelling between venues, for referrals, training etc.	Bus, train, taxi charges, as required	It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers.
Mobile phone airtime	Mobile phone airtime (predetermined is usually best)	Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.
Mobile phone batteries	Chargers, access to power and safe charging	Community outreach workers need their phones for outreach, and phone battery chargers should be made available at agreed-upon charging locations.

4. Foster leadership opportunities for community outreach workers

Experienced community outreach workers improve the effectiveness of outreach and provide leadership in their community beyond programme services. It is important that programmes adopt an approach from the beginning that allows community outreach workers to grow as leaders. Programmes do this not only by showing respect and appreciation to community outreach workers, but by:

- providing support through training, mentoring, constructive feedback and remuneration
- offering opportunities for them to learn new skills and apply their experience in expanded ways through the programme and in their communities, so that they and other men who have sex with men are empowered
- develop individual promotion plans, whether it be from within the ommunity-led organization (higher salaried jobs within the organization) or outside entities that the community outreach workers may want to pursue.

Training and mentoring of community outreach workers should focus not only on outreach, but also on strengthening their leadership. Community outreach workers with leadership skills are more likely to use critical thinking and take the initiative to reach greater numbers of men who have sex with men. They may also support the programme in other important ways:

Advocacy: Confident community outreach workers may be able to advocate with the police. Community outreach workers may initially need support in this role from staff of the implementing organization who are not themselves men who have sex with men, but staff should be sensitive to the need to reinforce the community outreach worker as a leader for their community, only stepping in when needed.

Programme monitoring: With experience and support, community outreach workers can participate in monitoring the programme and improving its quality. This develops naturally from the approach taken with micro-planning, where community outreach workers assume responsibility for recording, analysing and acting on data about the men who have sex with men to whom they provide services.

Monitoring tools should not require literacy to be used, and community outreach workers who collect monitoring data should also be provided with tools to analyse them (as with micro-planning) and the authority to act on the analysis. They should also be supported in monitoring aspects of the intervention that the community considers important but which the implementing organization may not monitor for its own purposes, such as trends in the service quality of referral clinics.

Programme management and leadership: Community outreach workers can train and mentor other community outreach workers, and may assume other roles in a programme. As programmes mature, community outreach workers naturally seek advancement as leaders, and jobs once done by implementing organization staff may be done by men who have sex with men who began as community outreach workers. Outreach supervisors/managers may be former men who have sex with men who generally work as full-time staff with a salary commensurate with that of NGO staff in similar positions.

C. Peer navigation

In order to reduce loss along the HIV prevention, care and treatment continuum, trained peer navigators can act as important mentors and guides for their peers to access and adhere to a programme. Peer navigators are community outreach workers who are knowledgeable about existing local care and treatment resources for people who are HIV positive. They may be HIV positive themselves and have first-hand experience of seeking and accessing services. Peer navigators guide new HIV programme clients from HIV counselling and testing at community sites to clinics which provide diagnostic screening and HIV treatment services. This is critical not only in contexts where all who test positive are required to register with a government clinic or hospital for ART (most treatment sites are government-run), but also for supporting case management more broadly.

In this model, clients are supported by peer navigators, who are the adhesive that bonds together the many components and sectors (government, private, community) within the continuum. The key components include HIV/STI screening and treatment, sexual health, and clinical care and support, including ART. The peer navigators should be aware of mobile clinics and flexible clinic times or after-hours services where sensitized staff may attend to men who have sex with men. Peer navigators may accompany or refer men who have sex with men to providers, using formal referral systems. Support groups for people living with HIV (some specifically developed for HIV positive men who have sex with men) and other NGOs may provide supportive and care services like counselling, psychosocial and legal support. A strong peer navigation programme can strengthen these linkages and ensure that clients are supported along the continuum of testing, care and treatment.

Peer navigators are a central component of the implementation of key population programming, and are a sound, sustainable investment in key population communities and networks. Members of a peer network act as linking agents in decentralized HIV service delivery models, and should lead in the ongoing sensitization efforts. They can act as a key lead in stigma and discrimination work, monitoring and reporting, as well as becoming leaders and experts in referrals, prevention, care and support and treatment literacy. Linkages between peer networks build coalitions and share information. These peer navigators must be trained on safety and security measures in order to mitigate potential discrimination.

4.4.3 Using information and communication technology

Many men who have sex with men use information and communication technology (ICT) to navigate sexual, social and safe spaces through mobile phones, tablets, computers and other Internet-enabled and SMS-only devices. These methods of connecting can enable them to interact—anonymously if they wish—with community outreach workers and peer navigators, health-service providers and counsellors, and to access information and education materials and other links to the continuum of prevention, care, treatment and support.

ICT can provide a broader reach and be instrumental in scaling up HIV services for men who have sex with men (see Box 4.20). ICT interventions should link the virtual to the physical by being complementary to physical spaces and people, i.e. by providing linkages to HIV testing, treatment, care and support; referrals to STI services; suggested mental-health and other sensitive and competent health services; and alerts to condom and lubrication stock-outs and replenishments. For more detailed information, see Chapter 5.

Box 4.20

Case example: Saturating outreach using social media in Ghana

Online community outreach workers (called "community liaison officers") conducted social-media outreach activities with men who have sex with men who were identified through canvassing and recommendations of community-based organizations and social contacts. The purpose of the initiative was to reach those who had proven "unreachable" through traditional physical community outreach methods. The community liaison officers were provided with a smartphone, laptop computer and a five-day training on HIV information and services. They used websites and social media applications like Facebook, Badoo, WhatsApp and Gay Romeo to reach new networks of men who have sex with men. Those reached were counted through a unique identifier code system.

The programme reached more than 15,000 men who have sex with men through social media, and this led to contact with a further 13,000 men through physical outreach activities. The combined total of over 28,000 men who have sex with men represented 94% of the estimated total in the project area, with little overlap between those reached through virtual and physical outreach.

Source: Green et al; 2014. See Section 4.5, Further reading.

4.4.4 Safe spaces

From the outset of a programme, "safe spaces" should be established to bring community members together. These have traditionally been rooms rented by the programme and furnished simply that provide community members with a comfortable place to relax, rest, get information and interact with each other and with the programme. Safe spaces may also be located in the office of a community-led organization, an implementing organization, within a clinic, or in a community member's home. They may also be virtual (online) spaces (see Section 4.4.3), and many of the functions listed here can be fulfilled by online spaces. Apart from places to socialize, safe spaces may also serve as:

- a place where community members may discuss programmes with programme managers to improve services
- a venue for psychosocial services and support
- a place to provide information on events and activities relevant to the community (not just programme-related information)
- a place to strengthen community empowerment by discussing discrimination and stigma and planning a response
- a distribution point for condoms and lubricants
- a place for community outreach workers to review their work and plan outreach
- a place for community trainings (of community outreach workers, but also of other men who have sex with men, e.g. in response to incidents of violence).

There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord, and the closer links between community activities and programme services. Nevertheless, care should be taken to ensure that safe spaces remain a distinct community area. It is often important to separate an implementing organization's office from the safe space and ensure that community leaders have clear responsibility for managing activities at the safe space.

In some contexts, it may prove most practicable to establish a safe space within an organization that serves the wider lesbian, gay, bisexual and transgender (LGBT) community. In this case, the space may be a room that is generally used by the organization, but with dedicated hours for men who have sex with men, e.g. a few hours daily or on certain days of the week.

A. Establishing safe spaces

Setting up the space

1. **Community consultation:** The consultation provides guidance on where to locate the safe space, services to be provided, staffing and service hours. Services should be available when men who have sex with men most need them.
2. **Location:** The choice of location should take into consideration not only its accessibility to men who have sex with men but also its visibility to the public and the response from the wider (non-MSM) community. Care should be taken to ensure that the space is safe from intrusion by outsiders and the police.
3. **Lease agreements and landlords:** Maintaining a fixed location for the safe space is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.
4. **Infrastructure and safety:** The safe space should ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. The safe space should be equipped with basic equipment to handle fires and other emergencies.

5. **Designing the space:** The space should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses to sit on can make the room comfortable. Walls may be painted or decorated with art made by the community.
6. **In hostile environments:** In contexts where men who have sex with men are particularly discriminated against or criminalized, a dedicated space men may become the target of harassment from law-enforcement authorities or others, i.e. it may not in fact be safe. In these situations, the community and any implementing organization involved in the process should consider carefully how best to meet the needs of the community. One possibility is for an ally organization that does not serve only (or specifically) men who have sex with men to host the safe space.

Operating the space

- **Management:** The programme should provide resources for the space. To ensure that the community feels ownership, men who have sex with men should have the lead role in decisions about the space and its management.
- **Service promotion:** To ensure men who have sex with men are aware of the safe space and its services, it may be promoted through flyers, SMS messages and community networking. (In environments hostile to men who have sex with men, word of mouth may be the safest way to promote the space, rather than printed information or SMS.)
- **House rules:** These should be formulated by those using the space so that they understand what behaviour is acceptable, e.g. with regard to noise levels (this is also important so as not to disturb neighbours) as well as drug and alcohol use.
- **Relationships with neighbours:** The safe space managers, including the community, should make plans to manage relationships with neighbours and those in the wider community.
- **Scheduling:** If the programme needs to use the safe space for programme activities that involve a limited number of participants (e.g. outreach planning, training, or interpersonal and group communication activities), these should be scheduled during off-peak hours so that they do not infringe upon access for the broader community of men who have sex with men.
- **Programme use:** Growing implementing organizations may want to use the safe space for other programme activities or as offices; efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The safe space should remain open to members of the community to use informally, even if the programme is using it.
- **Sustainability:** Safe spaces can be made financially sustainable when managed by the community, for example, if the community rents out the space to the programme on a limited basis.

B. Other activities in the safe space

Safe spaces may offer a range of activities and services to suit the specific needs of the communities they are serving. Offering a wide range of services may increase community participation in the safe space and ultimately help make it more sustainable. Examples include:

- classes in literacy, jobs training, high school equivalency
- celebrations of festivals and holidays
- a simple meal or nutritious food to take away
- leisure and relaxation activities (games, meditation, yoga)
- walk-in general health exam
- sleeping areas

- phone-charging stations
- clothes-washing facilities
- computer and Internet access
- remaining open 24 hours a day.

Box 4.21

Case example: A community centre in the Russian Federation

The LGBT Community Centre of the Pulsar Project in Omsk is the oldest LGBT community centre in the Russian Federation. It is open three days a week. Information about the community centre is provided by community outreach workers, on the project's website and through social networks. The community centre's services include counselling services from a psychologist, legal services and services from a social worker; Internet access, newspapers and magazines; tea and coffee; and participation in group games, discussions, trainings and interactive workshops.

The group meeting schedule is listed on the project's website. Meetings cover a wide range of themes, including sexual health, empowerment of LGBT communities, activism and volunteering, human rights and same-sex partnerships. Formats include discussions, trainings, workshops, hobby groups and movie screenings. During the summer some meetings are conducted outdoors, including "Pulsar-camping" and a two-day LGBT festival. Many of the community centre's clients have become community outreach workers, counsellors or volunteers for the project.

4.5 Resources and further reading

Training materials for practitioners

1. Promoting the health of men who have sex with men worldwide: a training curriculum for providers. Global Forum on MSM & HIV and Johns Hopkins University; 2014.
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2. An introductory guide for health workers in africa working with MSM. Desmund Tutu Foundation. http://
http://www.desmondtutuhivfoundation.org.za/documents/MSM-Manual.pdf
3. From top to bottom: a sex-positive approach for men who have sex with men. A manual for healthcare providers.
http://www.anovahealth.co.za/images/uploads/TOP2BTM_manual_WEB2.pdf

Planning and assessment

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3. Breaking through barriers: Avahan's scale-up of HIV Prevention among high-risk MSM and transgenders in India. New Delhi: Bill & Melinda Gates Foundation; 2010.
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4. Blueprint for the provision of comprehensive care to gay men and other men who have sex with men (MSM) in Latin America and the Caribbean. Washington (DC): Pan American Health Organization; 2010.
http://new.paho.org/hq/dmdocuments/2010/Blueprint%20MSM%20Final%20ENGLISH.pdf

5. Fenway guide to lesbian, gay, bisexual, and transgender health. American College of Physicians; 2007. http://www.acponline.org/acp_press/fenway/

6. A guide to participatory planning and monitoring of HIV prevention programs with high-risk groups. Bangalore, India: Karnataka Health Promotion Trust and India Health Action Trust; 2011.

   a. Module 1: Introduction and getting started. http://www.khpt.org/reports%20pdf/Module_1%20Introduction%20and%20Getting%20Started_Final.pdf

   b. Module 2: Participatory planning tools for FSWs, MSM and transgenders. http://www.khpt.org/reports%20pdf/Module_2%20Participatory%20Planning%20Tools_Final.pdf

   c. Module 3: Participatory monitoring tools for FSWs, MSM and transgenders. http://www.khpt.org/reports%20pdf/Module_3%20Participatory%20Monitoring%20Tools_Final.pdf

   d. Module 4: Individual tracking tools for FSWs, MSM and transgenders. http://www.khpt.org/reports%20pdf/Module_4%20Individual%20Tracking%20Tools_Final.pdf

Participatory assessment methods

1. All together now. International HIV/AIDS Alliance http://www.participatorymethods.org/sites/participatorymethods.org/files/all%20together%20now_int%20HIVAIDS.pdf

2. Rapid Policy Assessment and Response (RPAR) Tool http://www.temple.edu/lawschool/phrhcs/rpar/index.html.

Advocacy

1. Measuring up—a guide for facilitators: HIV-related advocacy evaluation training for civil society organisations. Brighton, United Kingdom: International HIV/AIDS Alliance, International Council of AIDS Service Organizations; 2010. http://www.aidsalliance.org/resources/340-measuring-up-hivrelated-advocacy-evaluation-training-pack

2. Measuring up—a guide for learners: HIV-related advocacy evaluation training for civil society organisations. Brighton, United Kingdom: International HIV/AIDS Alliance, International Council of AIDS Service Organizations; 2010. http://www.aidsalliance.org/resources/340-measuring-up-hivrelated-advocacy-evaluation-training-pack

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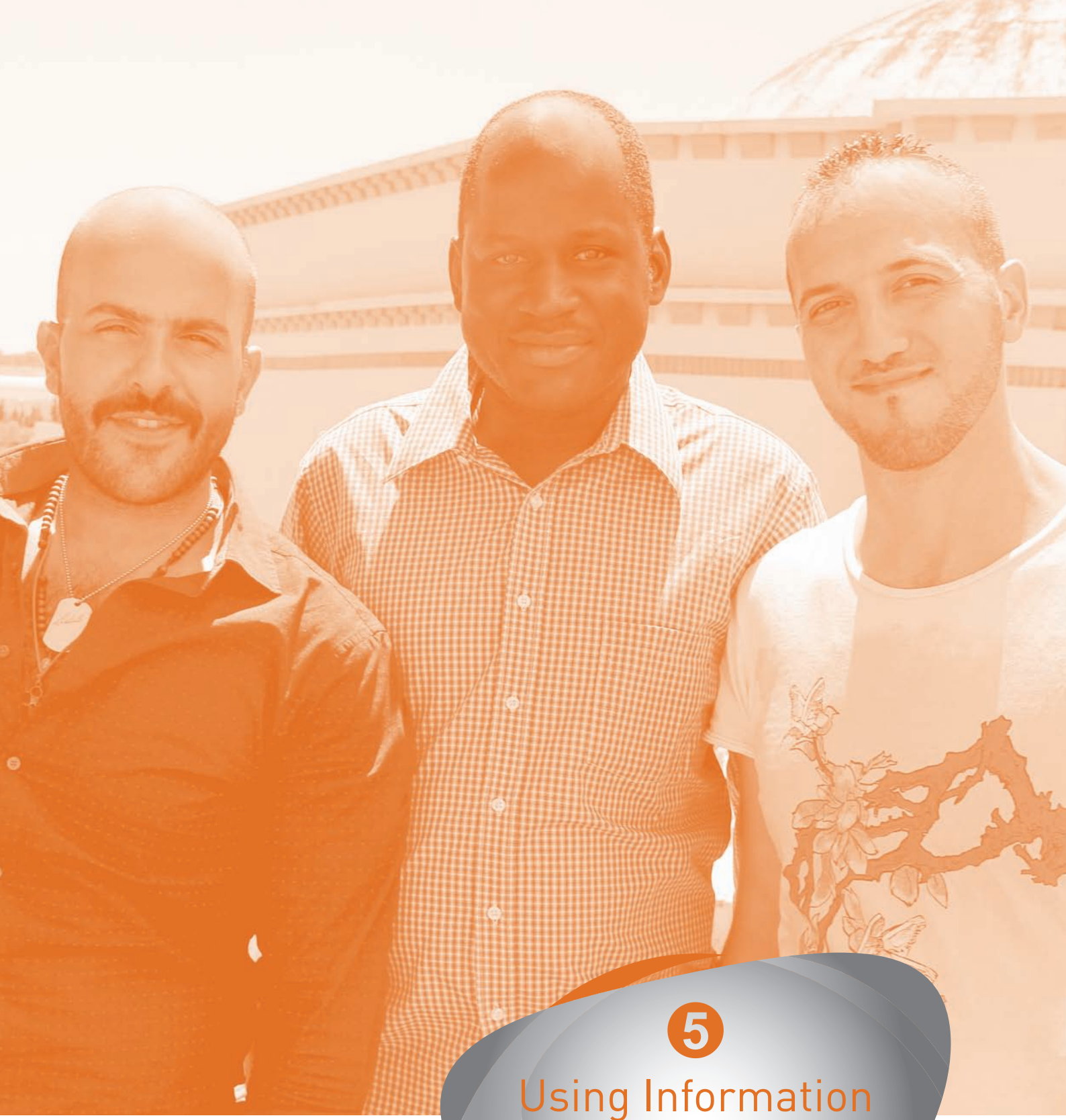


5 Using Information and Communication Technology

Contents

5.1 Introduction . . . 169
5.1.1 Background . . . 170

5.2. ICT programme planning and integration . . . 171
5.2.1 Is ICT the appropriate solution? . . . 171
5.2.2 Assessing the ICT landscape and identifying online leaders . . . 171
5.2.3 Designing a behavioural intervention for ICT . . . 172
5.2.4 Safety and ethical concerns . . . 174

5.3. ICT and programme implementation across the HIV continuum . . . 175
5.3.1 Increasing reach and promoting HIV prevention and testing . . . 175
5.3.2 Promotion of commodities and services . . . 177
5.3.3 Strengthening service quality . . . 178
5.3.4 Virtual supportive communities . . . 179

5.4 ICT for the enabling environment . . . 180

5.5 Engaging the private sector . . . 181

5.6 ICT and programme management . . . 181
5.6.1 Data collection . . . 181
5.6.2 Monitoring and evaluation . . . 181

5.7 Resources and further reading . . . 183

What's in this chapter?

This chapter explains:

- **what ICT is and why it is important to the HIV continuum** (Section 5.1)
- **things to consider when designing an ICT** intervention or integrating ICT into an existing intervention (Section 5.2)
- **how ICT can be used across the HIV continuum** (Section 5.3)
- **how ICT can be used to strengthen the enabling environment** (Section 5.4)
- **engaging the private sector** for ICT solutions (Section 5.5)
- **using ICT in programme management** (Section 5.6)

The chapter also provides a list of **resources and further reading** (Section 5.7).

2014 Key Populations Consolidated Guidelines[1]

[Recommended] strategies [...] to increase safer sexual behaviours and increase uptake of HIV testing and counselling among men who have sex with men [include] targeted Internet-based information. *(p.41)*

5.1 Introduction

This chapter outlines how information and communication technology (ICT) can be used across the HIV continuum of prevention, testing, treatment, care and retention, including programme planning, programme management and supporting an enabling environment. ICT refers to computers, mobile phones and other Internet-enabled communication devices. Examples of ICT platforms include social media, websites, chat rooms, applications (apps) for feature phones and smartphones (see Figure 5.1), text messaging and short message service (SMS). ICT is an umbrella term which can include other terms like eHealth (electronic health applications, i.e. electronic medical records) and mHealth (mobile health applications, i.e. mobile phone apps for health purposes).

Men who have sex with men may use ICT to access online ("virtual") safe spaces for social and sexual encounters, or to arrange such encounters in the "offline" (physical) world, often in private locations. Consequently, in many countries there has been a decline in the number and significance of public locations where men who have sex with men meet one another. The use of ICT is therefore increasingly important to reach the full range of men who have sex with men. ICT offers a variety of ways for service-providers to connect with men, including anonymously. These tools and methods can be instrumental in scaling up HIV services for men who have sex with men.

The increasing significance and reach of ICT make it applicable to all the areas covered by this tool—community empowerment[2], addressing violence, stigma and discrimination, condom and lubricant programming, services and service delivery, and programme management. It is therefore recommended that this chapter be read in conjunction with the others. The reader may also find it helpful, when reading the other chapters, to ask the question, "Is there a way that ICT could help deliver a programme more effectively in the context where I work?"

When programming with ICT, it is crucial to link online outreach (e.g. through social media and apps) to physical services (such as HIV testing and counselling). The safety, security and privacy of men who have sex with men must always be a key component of any ICT intervention. Engagement of the private sector should also be explored as a means of expanding reach and innovation.

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

2 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.

Figure 5.1 Feature phone and smartphone comparison

Feature phones (left) do not have third-party applications and have limited capabilities and Internet access compared to smartphones (right). Feature phones cost less and therefore maybe more common. However, in many countries the availability of smartphones is rapidly increasing, and planners should be ready to adapt ICT strategies to changing availabilities of smartphones. Smartphones have their own unique operating systems (i.e. iOS and Android). Not all apps are shared on all operating systems. When developing a product for a smartphone, a key question is "Which operating system?"

5.1.1 Background

ICT is making significant and accelerating advances globally. In 2014, about 3 billion people (around 40% of the world's population) were Internet users, and there were 6.9 billion mobile cellular subscriptions. One third of the world's population now have access to mobile Internet coverage, which naturally includes low- and middle-income countries.

ICT is changing the way men who have sex with men network with one another, find sexual partners and access health information. Examples include social media such as Facebook, Twitter and Instagram; messaging platforms such as WhatsApp and Viber (smartphone apps which allow the sharing of short messages or images using data); mobi sites (low-bandwidth web sites that can be accessed through feature phones); and geo-social networking apps such as Grindr, MISTER and Jack'd (also known colloquially as "hook-up" apps). The latter use the geo-location feature of mobile phones to display potential contacts based on their physical proximity. Grindr has become the most widely used dating app in Africa, more popular even than apps for heterosexual dating. The potential for anonymity offered by messaging platforms and networking apps can be of particular importance to men who have sex with men who fear stigma or persecution because of their sexual behaviour. Pornographic websites also offer a potential platform for programmes to reach men who have sex with men.

ICT is used by organizations of men who have sex with men for advocacy, community mobilization, advertising, fundraising, social marketing of condoms and lubricants, and to disseminate information on sexual health and living with HIV. Implementing organizations[3] are also using ICT tools to reach men who have sex with men, although experience with this so far is limited. While these new technologies have many advantages, they should not be seen as the only means necessary to provide information to men who have sex with men. ICT should complement rather than replace in-person outreach and other offline communications.

5.2. ICT programme planning and integration

Before implementing an ICT programme or integrating ICT into existing programming, it is crucial to engage with the community of men who have sex with men. Community-led organizations and other community leaders (both online and offline leaders—these individuals will not necessarily be the same people) should be included in the design, costing, implementation and evaluation of ICT interventions.

5.2.1 Is ICT the appropriate solution?

The following questions can guide the ICT programme planning and integration process:

- What is the issue or challenge you are trying to address?
- What are the root causes or drivers of the challenge?
- What is the goal of your effort? What benefits or results are you seeking?
- What potential solutions might address the issue? Can ICT improve or complement existing programmes, or do you need to start an entirely new ICT-based programme?
- Analyze and compare prospective solutions. Exactly how would ICT be applied? What seem to be the advantages and disadvantages, possible costs, and staffing, training and other human-resource needs? What are the prospective obstacles to making it happen?
- Considering the wide range of possible ICT methods and the above factors, which would be most beneficial and cost-effective for the intervention?

5.2.2 Assessing the ICT landscape and identifying online leaders

Community mobilization, both offline and online, is the crux of ICT planning and integration. Special consideration must be given to understanding the make-up and meaning of "community" when shifting from the physical to the virtual world. In some online social networks, men who have sex with men may know or interact with one another exclusively in this virtual space. There may be differences in levels of familiarity and influence between offline community outreach workers[4] and community leaders who have a greater presence online. Community members who already use ICT are essential in ICT intervention design and implementation, because they will be expert in using it for social and sexual networking. They will know about the most current and popular ICT methods and how to best capitalize on existing models.

3 An implementing organization is an organization delivering a prevention, care or treatment intervention to men who have sex with men. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

4 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

A rapid assessment can increase understanding of the ICT landscape and assist in the planning process for a new intervention, or in reconfiguring a programme to integrate ICT. Assessments of ICT should be refreshed as access and availability of technology and online behaviours change. Both online and offline methods can be used to collect the data, while maintaining ethical and safety considerations (see Section 5.2.4). Some sample categories of questions about ICT use for men who have sex with men include:

- devices used, ownership and degree of privacy
- access, availability and cost
- where, when and how frequently users meet sexual, romantic and social partners online
- extent of use of SMS, social media and location-based apps
- specific online sites or apps used; online community members followed or known; online "safe spaces" visited
- online opinion leaders or others who have a large online following.

5.2.3 Designing a behavioural intervention for ICT

After considering the best ICT approach for the programme in question, and mapping the ICT landscape for the community you are trying to reach, the specific programme can be designed in detail. The content and approach of each intervention will vary depending on the purpose of the intervention and the platform used to deliver it, e.g. a website, Facebook page or other social media app. The following are general components of the process that are applicable to many ICT platforms and interventions:[5]

1. Begin by referring to **established theories of behaviour change** as a basis for the intervention.
2. Consider how different ICT components can contribute collectively to the overall goal of the intervention (see Box 5.1).
3. **Tailor the message to the channel:** Each platform (e.g. Facebook, Twitter, Whatsapp) has its own unique way of displaying and conveying information, and its users will consume the content in different ways. Choose the theme, then the channel(s) and design the presentation of the message from there.
4. **Take a creative approach:** Having adopted a theory of behaviour change, be prepared to "think outside the box" as you apply it to ICT. You must entice people to click on your website or open your message.
5. **Know your story, know your voice.** Determine the voice for the intervention and be consistent. Every post should be composed with engagement in mind. Read aloud the content before posting. Does it sound conversational? Is the content written in a way that men who have sex with men will respond to? Does it address their needs and concerns?
6. **Be provocative:** Many ICT platforms, especially messaging and dating/hook-up apps, are informal. Most users are not shocked by content that uses colloquial language or is sexually explicit; this may be precisely what gets your message noticed. However, programme implementers should be mindful of any local laws regulating explicit and/or obscene content.

5 These components are sourced from a USAID mHealth Working Group report and USAID and FHI 360, Social media handbook for agricultural development practitioners. See Section 5.7 for links to these resources.

7. **Be authentic and realistic:** Shortcuts such as copying and pasting text from other sources and other automated ways of creating content may look and sound fake. Always consider whether material or approaches taken from another source should be adapted to the local context. Avoid lectures, and use language that acknowledges and supports the desire of men to have sex with other men.
8. **Keep the user's needs in mind:** User-driven content (i.e. content that as much as possible reflects the user's perspective, experiences and means of expressing himself) is likely to have the greatest appeal, encouraging the audience to communicate in their own language, slang and voice.
9. **Use pre-testing and iterative development:** Use the same audience to test each iteration of your content, to ensure that responses are comparable when using static platforms like SMS. Do not test the programme on staff or the principal beneficiaries of your organization (i.e. those who are already well connected with the services you are trying to promote). Never assume you know in advance what the results will be. Active platforms, like social media, can use iterative development, changing the content and messages depending on audience reaction.
10. **Continuously track and monitor results** and adjust the ICT intervention based on new information.

Box 5.1

Case example: Integrated communications strategy for HIV services in Thailand

Developed for the Adam's Love organization in Bangkok, this campaign centred on linking online and offline activities and messages to HIV services for gay men, men who have sex with men, and trans persons (GMT). This strategy resulted in 1,181 GMT recruited online and enrolled in Adam's Love's quarterly HIV testing programme.

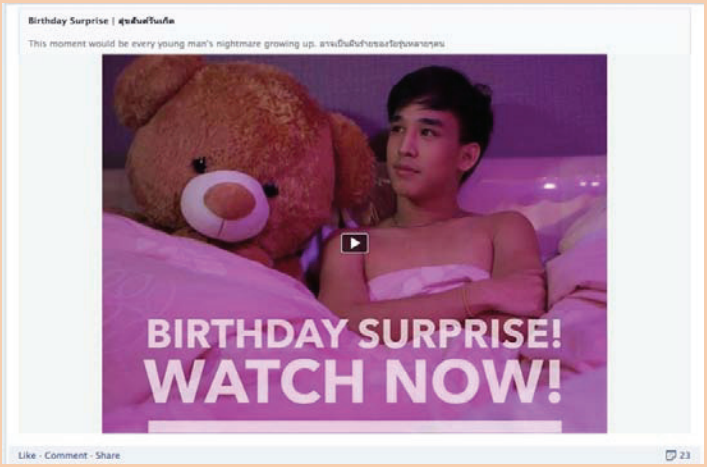
Source: Anand et al; 2015. See Section 5.7, Further reading. Image: Tarandeep Anand

Box 5.2

Case example: ICT for HIV testing in Southeast Asia

Organizations of men who have sex with men in Thailand joined to launch the TestBKK campaign (www.testbkk.org) addressing gay men and other men who have sex with men, to increase HIV testing awareness in Bangkok. The campaign included innovative, humorous short videos written and directed by men who have sex with men, which were viewed more than 400,000 times within 24 hours (see image below). Using the memorable slogan *Suck, F*#k, Test, Repeat,* TestBKK targeted online platforms through its website, Facebook, popular websites and mobile apps used by men who have sex with men, to disseminate key information and messages designed to encourage HIV testing and to increase awareness of HIV risks and the importance of protection.

Building on the lessons learned and recommendations from the evaluation of the pilot phase of TestBKK, the Asia Pacific Coalition on Male Sexual Health plans to work in partnership with CBOs to develop similar campaigns in Ho Chi Minh City, Jakarta and Manila, which have been selected due to the high prevalence of HIV among men who have sex with men.



An image from one of the TestBkk videos promoting HIV testing, posted on the TestBkk Facebook page.

Box 5.3

Case example: Community-driven content for local contexts in Latin America

Website content that is determined by communities of men who have sex with men and regularly updated by them can help foster an empowering environment. Below are examples of Facebook pages from organizations working with men who have sex with men in Latin America.

- **SOMOSGAY** is a solidarity association in Paraguay committed to implementing effective strategies against homophobia, improving HIV prevention, defending the rights of people affected by HIV and advancing human rights. (www.facebook.com/elcentrosomosgay)
- **Rio Sem Homofobia** is an organization of the Superintendence of Individual and Collective Rights of the State Department of Social Welfare and Human Rights of Rio de Janeiro, Brazil. Its mission is to disseminate information about rights and to combat homophobia. (www.facebook.com/RSHSuperDir)
- **Hombres y Mujeres Nuevos de Panamá** provides comprehensive preventive health services, education, counselling and advocacy for human and civil rights of the LGBT populations of Panama, including men who have sex with men. (www.facebook.com/AHMNP)

5.2.4 Safety and ethical concerns

Sensitivity around safety, security and privacy is required in ICT programming. Men who have sex with men may adopt multiple online identities for use with different sites, apps and even phone numbers to protect their privacy. Others may be less aware of the importance of protecting their identity, and may share information about themselves more freely. Regardless of these differing attitudes and practices, any organization using ICT to engage with men who have sex with men has a responsibility to protect the safety, security and privacy of these individuals as well as programme

staff. Organizations must always consider the loss of trust in the programme that might result if the identities (online or offline) of programme beneficiaries were not kept confidential—and, more importantly, the risk of online or offline harassment, discrimination or violence if their identities were obtained by the media or by law-enforcement authorities.

To mitigate this risk, safety and security protocols should be developed to protect online and offline identities (this includes considering whether records of online contacts should be retained and how they are to be secured). Examples of such protocols for programmes with men who have sex with men were not available to the authors of this tool. The best resource for developing effective and acceptable protocols are online and offline community members, programme managers and, when possible, technical experts in ICT security.

Programmes should also provide training and guidelines for staff who interact with programme beneficiaries online, both from the point of view of respecting professional boundaries, and in terms of protecting themselves from potential difficulties (see Box 5.4).

Box 5.4

Ethical and safety considerations in ICT for programme staff

- Staff should identify themselves immediately when talking with beneficiaries or clients.
- Staff should always remain professional; do not pursue personal, sexual or illegal activities when interacting with clients online. Do not misrepresent qualifications, e.g. community outreach workers should make it clear that they are providing HIV information and not medical advice.
- Never give out personal email addresses, screen names or other personal information. Staff should not accept social media requests to their personal profiles from outreach clients, e.g. Facebook friend requests.
- The implementing organization should develop safety protocols on how to handle abusive or bullying clients, where to refer them, and what procedures to take, e.g. blocking the abusers, or stopping the online engagement or activity.

5.3 ICT and programme implementation across the HIV continuum

ICT can enhance programming by complementing other approaches, with the aim of providing information and services to a larger number of men who have sex with men than ICT, community outreach or a drop-in centre alone could offer. Complementary and reinforcing forms of communication and services are always needed, given the diversity of men who have sex with men and their varying use of ICT. There must always be links between the virtual and the physical, i.e. any intervention using ICT must have a way to link users to services or resources.

5.3.1 Increasing reach and promoting HIV prevention and testing

ICT methods and strategies can complement existing face-to-face interactions and increase reach for prevention and mobilization as well as targeted behavioural interventions. Boxes 5.5 and 5.6 give examples of this, and show the importance of linking online interactions to referrals for HIV testing and counselling. As home-based HIV testing kits become more prolific, programme planners should strategize on how ICT interventions can complement this prevention commodity (Box 5.7).

Box 5.5

Case example: Using ICT to increase uptake of HIV counselling and testing in China

In a pilot programme in three Chinese provinces (Yunnan, Guangxi and Guangzhou), separate but complementary ICT approaches were used to promote HIV counselling and testing among men who have sex with men. One approach used dedicated, interactive websites that hosted online risk assessments and had options for making appointments online. A second used service promotion messaging that was crowd-sourced (i.e. information was solicited from a large group of people in an online community); the messages were disseminated via participants' microblog accounts and social media profiles. Finally, a digital video competition invited participants to share videos across their social media networks of themselves talking about testing and to encourage their friends to vote for their favourite video. Components of these approaches were integrated into physical community outreach programmes (i.e. community outreach workers promoted the online campaigns and resources; website visitors were able to make clinic appointments and receive directions to the clinic location online).

Source: Avery et al; 2014. See Section 5.7, Further reading.

Box 5.6

Case example: Linking the virtual and the physical to improve service access in Central America

The Pan-American Social Marketing Organization developed a combination prevention intervention for men who have sex with men in Central America that uses online community outreach workers who also serve as peer navigators. This innovative online "cyber-educator" intervention provides virtual one-on-one education and referrals for HIV counselling and testing. Once the client agrees to go for an HIV test, the community cyber-educator sends him a referral slip that can be printed and presented at the HIV testing site. With the client's permission, the cyber-educator can also support the client by going with him to the site.

Source: Rivas et al; 2014. See Section 5.7, Further reading.

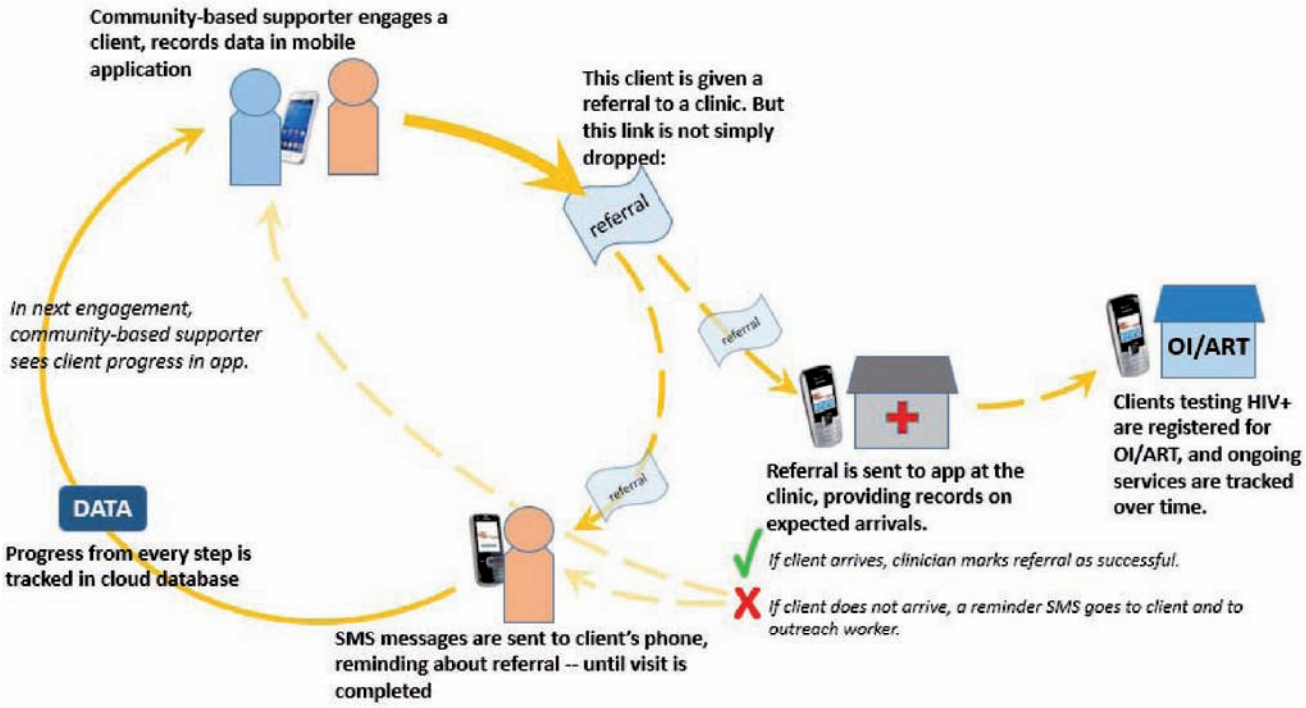
Box 5.7

Case example: Promoting testing via a hook-up app in England

The British NGO Terrence Higgins Trust (THT) placed paid advertising on Grindr for free HIV tests sent through the post, so that men who have sex with men could test themselves for HIV. Once the HIV test was completed, the users would send the test kit back in the post. Test results were communicated via text message if negative and over the phone if reactive, offering referrals to face-to-face services (three-quarters of those receiving positive results subsequently accessed care). The messaging on Grindr used language and descriptions that had been user-tested with men who have sex with men. A single advertising message on Grindr was highly cost-effective, generating more than 1,000 orders for postal HIV test kits.

Figure 5.2 shows how SMS messaging can be used to encourage clients to test regularly for HIV or to attend health and other social service appointments. For the sake of confidentiality and safety, the client's consent must always be obtained before any SMS messages are sent by the programme, since other people may have access to his phone.

Figure 5.2 Community-based monitoring through SMS



Comm Care (Dimagi) is an application for mobile data collection for HIV peer outreach and real-time tracking for clinic referrals.

Source: FHI 360

5.3.2 Promotion of commodities and services

Condom and lubricant promotion programmes can expand to online venues, particularly those where romantic and casual sexual contacts are made, including by those who sell sex online. Social media messaging should reinforce and complement condom and lubricant promotional messages in other mass media and inform individuals about condom and lubricant outlets (see Box 5.8, and also Chapter 3). Online condom and lubricant promotion programmes should also work within a broader sexual-health framework to promote access to other prevention services for HIV and sexually transmitted infections (STIs), such as testing and counselling.

Box 5.8

Case example: Getting the message: using social media to promote condoms and lubricants in Uganda

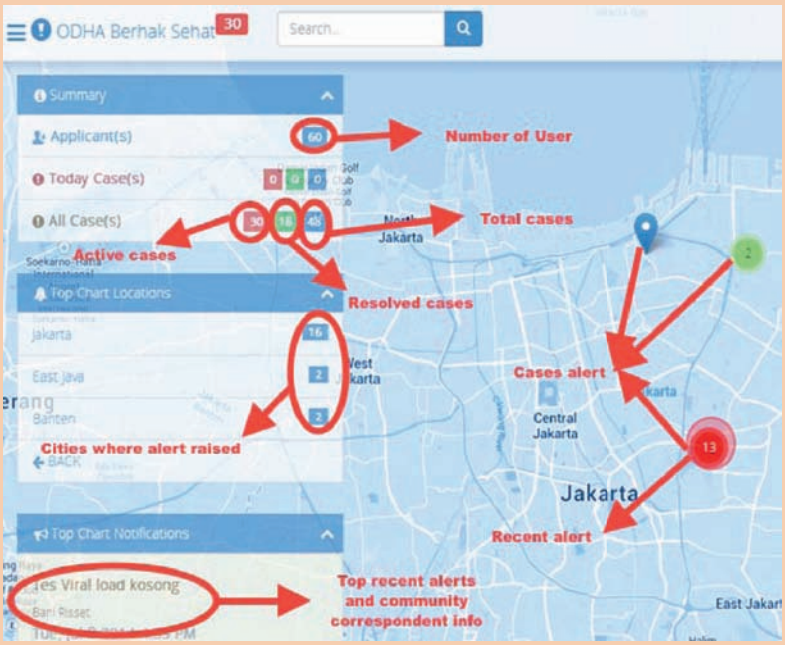
Using social media, apps and dating sites to promote condom and lubricant use has been a successful strategy for numerous local organizations of men who have sex with men. In Kampala, Uganda, Spectrum Uganda Initiatives uses websites such as Planet Romeo, Adam4Adam and the Grindr geo-networking app to post messages about their Safe Space meetings where men who have sex with men can drop in and receive free condoms and lubricants from trained community outreach workers.

ICT can also be used to monitor and report commodity stock-outs using SMS, Twitter, Facebook or other mass messaging applications. ICT allows a variety of people to report along the supply chain (i.e. men who have sex with men who obtain commodities reporting to community-led organizations, community-led organizations to the distributor, distributor to the supplier etc.). This method can be used to alert users of where to find stocks of condoms and lubricants and provide a means for the user to report any breakdowns in the supply chain (see Box 5.9).

Box 5.9

Case example: Community-based monitoring and reporting of stock-outs and access in Indonesia

The Indonesian AIDS Coalition (IAC) conducts community-based logistics monitoring for stocks of ARV, condoms and lubricant, needles and syringes, and methadone using iMonitor+ (Dure Technologies). iMonitor+ is a smartphone application that provides real-time data directly from grassroots communities and serves as a dynamic link between community members and project activities, empowering communities and driving public accountability (see screenshot). Ninety registered users have been enlisted to send in reports if they encounter difficulty accessing services. The reports are fielded by "community champions"—IAC staff who investigate situations and report to appropriate agencies. The system has been able to identify stock-outs at the clinic level which were not reflected in the national logistics monitoring system.



iMonitor+ screenshot from a smartphone demonstrating what the user sees when monitoring and reporting commodities, service access and quality of care.

5.3.3 Strengthening service quality

ICT interventions can be used to increase the quality of care for men who have sex with men by providing training and resources for health-care and social-service providers as well as for organizations of men who have sex with men. Additionally, ICT provides easy and anonymous avenues for men who have sex with men to provide feedback on the quality of services received. These interventions can address structural barriers to care for men who have sex with men (see Box 5.10).

Box 5.10

Case example: An online course for sensitizing health-care providers in Kenya

In Africa, health-care workers mostly have limited training on sensitivity to the experiences and health needs of men who have sex with men, especially with regard to anal health. In Kenya, a virtual–physical method of instruction was assessed using a free, online training about men who have sex with men (www.marps-africa.org) coupled with face-to-face group discussions. At the beginning of the training, 13% of the health-care workers participating had adequate knowledge about the health issues of men who have sex with men. By the end, that figure increased to 95%, and at three-month follow-up the retention of adequate knowledge was 49%, a 36% increase from baseline. There was also a significant reduction in reported homophobia immediately and three months following the training.

Source: van der Elst et al; 2013. See Section 5.7, Further reading.

5.3.4 Virtual supportive communities

Virtual safe spaces provide an opportunity for HIV positive men who have sex with men to gather, receive and give emotional support, and share information and resources in navigating their HIV diagnoses. A safe space can be used by men to share their thoughts, opinions and desires about sexuality and pleasurable and safe sexual experiences. Another example would be facilitating a support group on Skype.

Box 5.11

Case example: Surveying HIV positive men who have sex with men to inform the design of an online virtual community in Southeast Asia

B-Change Foundation in Manila, Philippines, conducted an online assessment among HIV positive men who have sex with men in Southeast Asia to inform the design of an online safe space. The 119 men surveyed prioritized four preferred functions of an online meeting space: 1) sharing experiences with other HIV positive men who have sex with men, 2) finding health services in their local areas, 3) asking questions about medication, and 4) learning how others deal with emotional issues.

Source: Hanckel et al; 2014. See Section 5.7, Further reading.

Box 5.12

Case example: Using games for behaviour change and social support in the USA

HealthMpowerment.org (HMP) is an online mobile phone intervention designed for HIV positive and negative young black men who have sex with men in the USA. It uses behaviour-change and gaming theories with the aim of reducing high-risk sexual behaviour and strengthening social support. Users participate through a series of games, forums and role-playing scenarios and by reporting on their own behaviours. They gain online standing by winning points and accolades. The app includes a social support system which allows users to discuss their concerns with other users, with HIV positive men who have sex with men giving advice to those who are newly diagnosed. During qualitative interviews with beneficiaries, participants described how components of HMP led to behaviour changes such as asking partners about their sexual histories, increased condom use, and testing for HIV and STIs.

Source: Muessig et al; 2014. See Section 5.7, Further reading.

5.4 ICT for the enabling environment

ICT can be an important tool in creating an enabling environment for HIV prevention and for the well-being of men who have sex with men more generally. As well as linking individuals who might not otherwise be able to connect with one another for the purposes of solidarity and support, ICT tools can help men who have sex with men communicate information about their needs and rights, and can collect and aggregate data that can be used in advocacy for funding or to confront structural barriers to rights and services. Implementers can create simple programs to reveal human-rights violations using open-source platforms like www.ushahidi.com. See also Box 5.13.

Box 5.13

Case example: An ICT-based discrimination reporting system in Ghana

A reporting system can form a critical part of a country's human-rights protection network. In Ghana, the combination of a supportive legal framework, an institutional home and engaged stakeholders created a favourable environment for developing such a system. The government and a consortium of partners, including organizations of men who have sex with men, developed a web- and SMS-based system for reporting incidents of discrimination. The reporting system allows relevant civil-society organizations to receive and follow up on case reports, and aggregate data on discrimination for analysis and advocacy. The system design and implementation included:

1. Key informant interviews and focus groups to understand the legal environment, define institutional actors, identify system requirements, and specify barriers to access.
2. The creation of a multisectoral oversight body, the Reporting System Committee, that included civil society and affected populations, to guide and monitor implementation.
3. An assessment of government capacity to manage HIV-related discrimination cases.
4. Government addressing policy and procedural gaps in the health-care system by creating a Health Rights Task Team to oversee case routing and develop a new privacy and confidentiality policy.
5. Sensitivity training of officers and front-desk staff who professionally manage cases of discrimination.
6. Updates to government technology infrastructure, including servers and web hosting.
7. Engagement and demand creation with men who have sex with men through the Reporting System Committee, peer-to-peer outreach, and government public education strategy.

Source: Futures Group Health Policy Project

5.5 Engaging the private sector

The private sector can play a key role in ICT HIV programme development for men who have sex with men. Private-sector actors include website and app owners and developers, chat room operators, video and web bloggers and mobile phone service-providers. All have the expertise and infrastructure that can be of potential use for ICT interventions with men who have sex with men.

There are several advantages to partnering with private-sectors providers for ICT. Pre-existing apps and online portals already have the structures and content, and the buy-in from users, to engage a wide and captive audience, resulting in a larger, sustained reach. Furthermore, the more interaction there is between the user and the site and the user and other users/community outreach workers, the more likely it is that men who have sex with men will stay engaged. By contrast, building a dedicated website to disseminate messages takes time and resources for a community-led organization or other civil-society organization; if it is not well planned, designed and implemented there is the risk that no one will use it.

When engaging with the private sector, it is important to be aware of the differences between the private, consumer-driven model and the beneficiary-centred model common to implementers. Strengths of the implementer model are sustained funding and high technical knowledge of HIV, with the drawback of inflexible funding mechanisms. Strengths of the private sector are technological expertise and the ability to change and respond quickly using data on demographics and behavioural trends of users; but the model may be limited by app store or government restrictions on content related to sex and sexuality. By acknowledging and anticipating these factors, public- and private-sector partners can mitigate and address issues before and as they arise. Incentives for private-sector collaboration could include shared branding on documentation and being exposed to new consumers through programmes and interventions.

5.6 ICT and programme management

5.6.1 Data collection

ICT is an important tool for data collection when planning and implementing a programme. For more information, see Chapter 6, Section 6.2.2.

5.6.2 Monitoring and evaluation

Monitoring and evaluating ICT programmes has its own unique benefits and challenges. In contrast to physical interactions, visits to a website or number of HIV-related chats in an online chat room may not be recognized by donor-reporting mechanisms. Yet these outputs are important to the programme, are easy to count and record (i.e. websites can be monitored by free applications like Google Analytics) and can demonstrate the reach of technology-based interventions for men who have sex with men. There can however be challenges in tracking the links from virtual interactions to physical sites. These can be mitigated through e-vouchers, unique identifier codes (see Chapter 4, Box 4.20), and the use of virtual-to-physical peer navigators (see Box 5.6 and Chapter 4, Section 4.4.2, Part C).

Attention should be given to evaluating the relationship between the uptake of technology-based services (e.g. the number of SMS messages sent) and the overall goals of a programme (e.g. an increase in HIV testing rates). Considering the anonymity of some online services and that some

users have multiple online identities, this kind of evaluation can be challenging and implementers are still working on finding ways to evaluate these links. (For more information on social media metrics, refer to *See, Say, Feel, Do: Social media metrics that matter* – see Section 5.7.)

Box 5.14

Smart metrics versus vanity metrics

Vanity metrics are the simple data that are easily collected, for example "likes" on Facebook, the number of followers, or re-tweets on Twitter. These metrics may not be helpful in evaluating the performance of an ICT intervention. Smart metrics take the simple data and turn them into ratios, for example the number of positive interactions (likes and shares) per post per 1,000 fans (any number of fans depending on the scale of the intervention).

Table 5.1 shows programme elements and corresponding sample indicators that can support M&E for ICT.

Table 5.1 Sample M&E indicators for ICT programmes

Programme elements	Sample indicators
Acceptability of the programme	• Percentage increase or decrease of users in the ICT programme • User-reported satisfaction
Quality and accessibility of ICT services	• Number of regular users • Demographic profile of users • Messages to target audience delivered in a timely manner
Capacity of target beneficiaries	• Increased use of related health services • Change in target health behaviour • Demonstrated understanding of health concepts addressed by ICT programme
Health behaviours	• Demand for health services related to ICT programme • Adherence to antiretroviral therapy
Programme sustainability, programme costs, and cost-effectiveness	• Average cost of ICT programme per beneficiary

Adapted from: https://www.k4health.org/toolkits/mhealth-planning-guide/evaluation

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6 Programme Management

Contents

6.1 Introduction . . . 189

PART I.

6.1.1 What are the challenges for programme management? . . . 190

6.1.2 Managing programmes with men who have sex with men . . . 190

6.2 Planning and implementing comprehensive sexual-health services for men who have sex with men . . . 193

6.2.1 Define programme and standards . . . 194

6.2.2 Establish a data system for programme design and routine management . . . 197

6.2.3 Plan the programme evaluation . . . 204

6.2.4 Define the management structure . . . 207

6.2.5 Progressively ensure full participation of men who have sex with men . . . 209

6.2.6 Prioritize . . . 209

6.2.7 Implement in a staged manner . . . 210

6.2.8 Establish a supportive supervision system . . . 219

6.3 Capacity-strengthening and programme learning . . . 221

6.4 Staff development . . . 222

PART II.

6.5 Strengthening the capacity of organizations of men who have sex with men . . . 222

6.5.1 Forming a registered organization . . . 223

6.5.2 Organizational capacity-building . . . 226

6.5.3 Governance . . . 226

6.5.4 Project management . . . 227

6.5.5 Technical support and capacity-strengthening . . . 228

6.5.6 Resource mobilization and financial management . . . 229

6.5.7 Networking . . . 230

PART III.

6.6 Programming in difficult or dangerous contexts . . . 231

6.7 Resources and further reading . . . 233

What's in this chapter?

This chapter explains:

- **how management systems support** effective HIV and STI prevention programmes with men who have sex with men (Section 6.1)
- **how to design, organize and implement a programme at scale,** including:
- establishing programme standards, data monitoring systems and an evaluation plan (Sections 6.2.1–6.2.3)
- setting up management structures (Section 6.2.4)
- ensuring the participation of men who have sex with men in programme implementation (Section 6.2.5)
- implementing the programme in stages (Sections 6.2.6–6.2.8)
- developing staff capacity (Sections 6.3–6.4).
- **how to strengthen the capacity** of organizations of men who have sex with men (Section 6.5)
- **how to operate programmes in difficult or dangerous contexts** (Section 6.6)

The chapter also provides a list of **resources and further reading** (Section 6.7).

6.1 Introduction

Comprehensive HIV and STI prevention and care interventions with communities of men who have sex with men are complex. Interventions must simultaneously address behavioural, bio-medical and structural issues, and they require regular contact with men who have sex with men, in varied settings depending on their social networks, and usually in environments that present significant social, cultural and legal barriers.

Given the often precarious legal, political and social status of men who have sex with men, it is imperative that interventions do not cause harm to the marginalized populations they aim to serve. This can best be ensured when programmes are built from the community[1] outwards, i.e. when men who have sex with men are involved from the start in interventions.

This chapter discusses three approaches to establishing and managing an HIV and STI prevention, care and treatment programme:

- A national or state/provincial programme serving multiple locations within a country and multiple sites within urban locations, with the goal of covering as large a proportion as possible of men who have sex with men with at least minimal services. Such a programme requires centralized management and, depending on the size of the country, additional layers of management to support local implementing organizations.[2]
- A programme implemented by organizations of men who have sex with men that involves strengthening the organization's capacity to provide services, receive funding and expand outreach.
- Programmes implemented in difficult and dangerous contexts where many of the traditional approaches to implementation are not possible.

These categories are not mutually exclusive. For example, organizations of men who have sex with men can provide services in the locations where the organizations are established, as part of a large-scale or even national programme. They can also implement and manage a programme with multiple sites themselves. And all types of implementing organizations—whether led by men who have sex with men or not—may have to work in difficult and dangerous contexts.

Part I of this chapter discusses management issues for a national or state/provincial programme serving multiple locations. Many of the data issues relevant to a multi-site programme are also relevant to programmes led by men who have sex with men. Part II discusses how to strengthen a programme led by an organization of men who have sex with men, where in addition to programme management there may be issues of organizational development. Part III addresses programming in difficult and dangerous contexts, where many of the programme management and organizational development activities described earlier in the chapter may not be possible.

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 An implementing organization is an organization delivering prevention, care or treatment interventions to men who have sex with men. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

PART I.

6.1.1 What are the challenges for programme management?

Many existing implementing organizations, especially large national and international nongovernmental organization (NGOs) that are successful at raising money, have little experience working with men who have sex with men. On the other hand, organizations of men who have sex with men may have limited organizational experience, capacity or access to funding to implement and scale up programmes themselves. Often they are contracted by larger NGOs to provide services locally. When this model is adopted, the NGO should invest in building and sustaining the organization of men who have sex with men so that programmes can be sustained by the communities themselves (see Sections 6.2.8 and 6.5). Another consideration is that contexts may vary within a country: in some areas of the country programming may be relatively straightforward, while in others the political or social context may make outreach to men who have sex with men difficult or even dangerous.

Given the wide spectrum of services needed by men who have sex with men, it is usually necessary to link with existing clinical and social services. This linkage often requires ongoing capacity-strengthening of providers so that they will deliver services to men who have sex with men in a non-stigmatizing and respectful way. Establishing clinical and social services outside the government or private sectors requires effort, expertise and funds to build infrastructure and processes. Finally, funding for programmes often comes from multiple sources, with different reporting requirements for government and other funders which can put a significant management and reporting burden on organizations.

Good management systems address these issues by:

- having a systematic approach to strengthening the capacity and leadership skills of community members
- defining roles and responsibilities, providing oversight, managing relationships with external partners and donors, doing advocacy and coordinating with other programmes
- planning and administering the activities of multiple interventions at local and national levels
- providing a support structure for operational activities, including data reporting systems, commodity procurement, quality monitoring and improvement, support and supervision, and training
- implementing financial procedures and controls
- using data to refine and redirect the programme, as needed
- developing strong data systems for reporting and to enhance programme monitoring and evaluation.

6.1.2 Managing programmes with men who have sex with men

This chapter is not a comprehensive strategic planning or management guide. Resources for essential aspects of strategic planning and programme management that are not unique to programmes for men who have sex with men are listed in Section 6.7. The chapter focuses on management approaches and systems that address the unique needs of programmes for men who have sex with men and that have been used in successful scaled programmes. These unique aspects include:

Approaches to achieving coverage: High coverage of populations of men who have sex with men is essential to achieve impact at a population level, and coverage should be monitored at all levels—municipal, district, state and central—also taking into account individuals who move between states, provinces or countries, and both visible and invisible populations of men who have sex with men.

Planning for and calculating coverage requires an estimate of the total population of men who have sex with men (the denominator). Estimating a programmatically relevant denominator is difficult due to the diverse identities of men who have sex with men and because traditional meeting-places have in some places been supplanted by mobile technology (see Chapter 5). For a country-wide view, the national AIDS control programme or a central management agency obtains or coordinates this coverage information, in partnership with all implementing organizations (see Section 6.2.7, Part A). Programmes that achieve high coverage of men who have sex with men and wide geographic scope ("scaled programmes") require close partnerships between government, NGOs, community-based organizations (CBOs), community-led organizations and, critically, community members themselves.

Addressing complexities in identity: When planning to scale up services for men who have sex with men, it is essential to avoid the assumption that they form a single, homogeneous community, or that a single organization led by men who have sex with men can represent all the various subgroups. Men who have sex with men have a range of diverse identities and forms of sexual and social associations. For example, the term "men who have sex with men" can include gay- or bisexual-identified men, transgender men who have sex with men, men who identify as completely heterosexual and men who identify through indigenous identities outside the largely Western concepts of hetero- or homosexuality. Other subgroups of men who have sex with men include gay-identified young men, married men and male sex workers.[3] It is important to bear in mind that since not every man who has sex with men has an identity associated with his sexual attraction or behaviour, many may remain non-self-identified, which poses an additional challenge to outreach.

These differences are important and must be considered to ensure that those with the greatest prevention needs—i.e. those at highest risk of acquiring HIV or STIs—are addressed first, especially in resource-constrained settings. Sexual risks as well as risk reduction options and access to them vary between and within these subgroups, e.g. risks associated with unprotected receptive anal intercourse are higher than those associated with insertive anal intercourse. Condom use is more often controlled by the insertive partner, particularly if gender or power dynamics impede the negotiation of condom use by the receptive partner. Pre-exposure prophylaxis (PrEP) (see Chapter 4, Section 4.2.7) may not be readily available to all men who have sex with men.

Programming requires recognizing and understanding the diversity and identifying the needs of the specific subgroups of men who have sex with men. Where it is appropriate and possible, community outreach workers[4] should be recruited from each of these subgroups (see also Chapter 4, Section 4.4.2, Part B). HIV positive men are sometimes discriminated against by other men who have sex with men, and programmes should be sensitive to this.

Stigma and legal sanction: Since sex between men is illegal, stigmatized and suppressed in many countries, social networks of men who have sex with men are frequently "underground" or hidden, making it hard to reach these communities. Fear of stigmatization can make it challenging to get men who have sex with men to openly discuss their sexual orientation, behaviours or practices. To provide services effectively, providers must be sensitive, respectful and nonjudgemental. (See Section 6.2.7, Part A and Section 6.3, and Chapter 1, Section 1.2.3.)

3 Male sex workers are discussed in greater detail in World Health Organization, Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva: WHO; 2013. http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/

4 In this tool, "community outreach worker" is used to mean a man who has sex with men who conducts outreach to other men who have sex with men, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers or outreach workers who are not community members.

Box 6.1

Case example: Issues of sexual identity and outreach needs in India

The Bill & Melinda Gates Foundation's Avahan programme was an HIV prevention intervention addressing key populations in six Indian states, including men who have sex with men. In India, male-to-male sexual behaviour takes place in diverse contexts that are not generally associated with a gay sexual orientation as it is understood in the West. Men who self-identify as gay are a small minority of all Indian men who have sex with men, who tend instead to identify themselves with one of several distinct groups. *Kothis* are men who practice mainly receptive anal and oral sex with men. Some assume the gender identity of a woman and may cross-dress, while others practice bisexual behaviour and may marry women. Some *kothis* engage in sex work. The regular partners of *kothis* are known as panthis and are generally the insertive partners in anal sex. "Double deckers" are both insertive and receptive partners in anal and oral sex with other men. Some men who do not identify as *kothis*, "double deckers" or gay engage in sex with other men for money, often for reasons of temporary economic need. Male sex workers may also have female partners.

Given that men who have sex with men are mostly a hidden population in India, Avahan's intervention focused primarily on the more visible men found in high-risk locations ("hotspots"). These included *kothis*, *hijras* (transgender women), double deckers and male sex workers—groups that tend to have a large number of sex partners and who regularly practise receptive anal sex or sell sex and were thus at highest risk of acquiring HIV.

Mobility and migration: Men who have sex with men are often highly mobile, moving within a city, country or across state or national borders because of stigma and discrimination, or to seek opportunities for education or work. Interventions should be flexible to meet the varying demand for outreach and commodities that accompanies shifts in local population, and to serve men who have sex with men who may not speak the local language.

Leadership by men who have sex with men: An overarching goal of the programme should be to build the capacity of men who have sex with men to take on a leadership role. There should be meaningful positions for men who have sex with men in the design, implementation, management, monitoring and evaluation of the programme at all levels, to make it more effective and sustainable. Men who have sex with men are best able to locate and communicate with their peers and to identify problems and issues in the community, and they should be assigned management positions with real decision-making authority and not simply hired as outreach workers or consultants (see Section 6.2.5, Chapter 1, Section 1.2.2 and Chapter 4, Section 4.4.2, Part B).

Addressing structural constraints: To be as effective as possible, HIV interventions should not only focus on individual behaviour change but also address the broader factors that contribute to the vulnerability of men who have sex with men, such as criminalization and other legal issues, stigma, discrimination, violence and harassment, as well as poverty, housing instability and food insecurity, and limited access to health, education, social insurance and financial services. Young men who have sex with men are especially vulnerable to HIV because of potential power imbalances in relationships and frequent alienation and lack of support from family and friends, in addition to more general stigma and discrimination, including homophobic bullying at school. Interventions at various levels to address some of these structural constraints are highlighted in Chapters 1, 2 and 5.

Strict confidentiality and protection of data: Designing and managing a programme with men who have sex with men requires information on locations where they gather and the size of the community as well as risk characteristics. Programmes should have sound methodologies to assess coverage and avoid double counting, particularly where there are multiple implementing organizations (see Section 6.2.7). However, data that identify locations or individuals, as well as unique identifiers or phone numbers if used, must be handled with strict confidentiality and protected from access

by individuals, groups or organizations that might cause harm to men who have sex with men. It is recommended that organizations have a written code of conduct that sets out clear practices to ensure security, safety and privacy of data about programme beneficiaries and implementers. This would include information related to mapping, staff hiring and training, and on-the-ground implementation, including the collection and maintenance of programme data.

It is also essential to protect communities of men who have sex with men who receive HIV care, treatment and support services, or those that participate in research and data collection. They should not be put at risk of discrimination, arrest or prosecution. Staff training focusing on the importance of maintaining confidentiality and the consequences of disclosing an individual's sexual orientation or HIV status or otherwise violating confidentiality can play an important role in preventing discrimination and potential arrest.

Incorporate new advances and recent technology: Internet-based information and communication technologies (ICT) and mobile telephony have made significant advances in recent years. ICT is changing the way men who have sex with men find friends or sexual partners, access health information and locate entertainment. Implementing organizations are using ICT platforms to reach men who have sex with men, although experience is limited, particularly on a large scale, and there is limited understanding of how to monitor and evaluate them. Chapter 5 explores some of the potential uses, as well as the limitations, of ICT for programming. It is important to note that many ICT platforms can be monitored by law-enforcement agencies. Ensuring security of beneficiary data is paramount (see Chapter 5, Section 5.2.4).

Flexibility and continuous programme learning: The context in which men who have sex with men live is changing rapidly because of legal and social developments as well as the adoption of new technologies. Given this evolving context and the relative inexperience of many organizations in programming for men who have sex with men, it is important to develop systems to quickly adjust the programme where necessary, and to disseminate lessons and innovations across it. As noted above, men who have sex with men are best placed to inform programme design and be aware of changes in their community.

6.2 Planning and implementing comprehensive sexual-health services for men who have sex with men

Designing an HIV and comprehensive sexual-health service for men who have sex with men requires some basic knowledge of how and where they can be accessed and some understanding of the behaviours that need to be addressed. Gathering this information is best done by working with the communities. Information is usually available from key informants in the country, and from studies that have been performed in the country or in neighbouring countries with a similar culture and context. As part of setting up and implementing a programme, mechanisms should be established to capture this information (see section 6.2.7, Part A), which can in turn inform necessary programme and implementation adjustments.

Creating a scaled programme with public health impact requires collaboration among partners at different levels:

- **The central level:** if the programme is countrywide, this could be the national AIDS control programme, ministry of health, or a central institution, along with key stakeholders, donors and technical assistance agencies; if the programme is sub-national, it could be a regional or state government or organization.
- **An intermediate level:** this could be an NGO or large CBO, community-led organization or other partner at the level of a state, district or municipality.

- **The local level:** implementing organizations, such as an NGO or community-led organization.

The elements of a scaled programme are outlined in Table 6.1 and described in detail below. In each case, the highest-level agency or institution takes the lead in planning each element, in collaboration with the agencies or organizations at the other levels. Although this section of the chapter is written primarily from the viewpoint of central-level planning, there are multiple roles and responsibilities for each level of the programme in management, supervision and monitoring, as shown in Figure 6.3 (Section 6.2.4) and Figure 6.6 (Section 6.2.8). Many of the elements described for a scaled programme are relevant to a programme of any size.

Table 6.1 Elements of a scaled HIV/STI programme with men who have sex with men

Designing a scaled programme for men who have sex with men
• Define programme and standards (Section 6.2.1)
• Establish a data system for programme design and management (Section 6.2.2)
• Plan the programme evaluation (Section 6.2.3)
Organizing a scaled programme for men who have sex with men
• Define the management structure (Section 6.2.4)
Implementing a scaled programme for men who have sex with men
• Progressively ensure full participation of men who have sex with men (Section 6.2.5)
• Prioritize (Section 6.2.6)
• Implement in a staged manner (Section 6.2.7)
• Establish a supportive supervision system for quality monitoring, quality improvement and mentoring (Section 6.2.8)

Designing a scaled programme for men who have sex with men

6.2.1 Define programme and standards

It is very important to clearly articulate and understand the programme logic model, the specific interventions and the expected standards of implementation. Being able to articulate and understand them will:

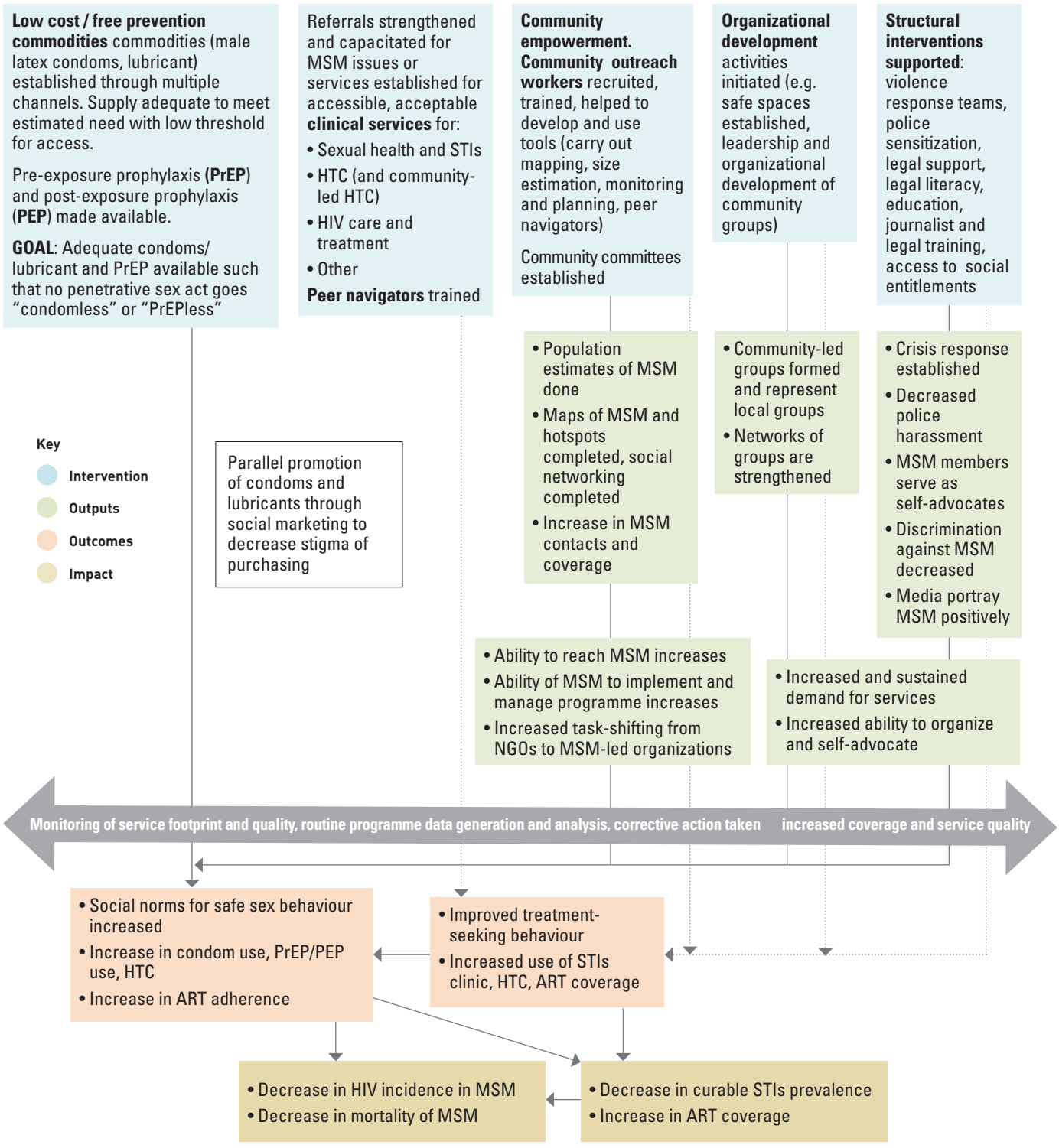
- give clarity across the programme on the intervention elements and programme packages
- establish a basis for the design of the monitoring system (e.g. defining the process, input, output, outcome and impact indicators) that all NGOs and community-led organizations report into
- make it possible to assess programme quality.

A logic model illustrates the programme's interventions as well as how these are expected to lead to the desired impact. It helps identify the technical skills and human resources required, as well as commodities and supplies, training and—depending on the size of the intervention—the budget. These elements are periodically adjusted based on new data and improved as lessons and local innovations are shown to be successful.

Many countries have strategic plans and implementation guides in which a logic model is implicit. However, defining an explicit logic model helps clarify monitoring and evaluation. Figure 6.1 is a programme logic model for a multi-component intervention with men who have sex with men. The sequencing of expected changes is important to the programme evaluation design discussed in Section 6.2.3.

Figure 6.1 Programme logic model for a multi-component programme with men who have sex with men

Target services: Based on mapping and size estimation in each district, implement multi-component intervention package for men who have sex with men, focusing first on highest density, highest risk, greatest prevalence



Source: Avahan India AIDS Initiative

This logic model does not articulate the standards expected during implementation. Technical and management standards for each aspect of the intervention are defined by the programme, ideally in collaboration with implementing organizations and the community, and consistent with the community's values and preferences. These standards may change over time as more information becomes available and implementation experience increases. For example:

- **Technical**

  How is the community going to be reached? Through community outreach workers, ICT or a combination of both?

  What is the target ratio of community outreach workers to community members?

  Are services designed to address the needs of the various subpopulations , e.g. through varied days/hours of operation; mobile or fixed clinics; point-of-care testing; access to antiretroviral therapy (ART)?

  How often is a community outreach worker expected to meet men who have sex with men?

  What is the content of outreach sessions?

  What prevention and sexual-health services are provided?

  How often is voluntary HIV testing offered?

  What drugs will be used to treat STIs?

  How many condoms and lubricant packages should be distributed?

  What are the standards for training referral physicians in the sexual-health issues of men who have sex with men and appropriate techniques for giving physical exams?

- **Management**

  Supervision frequency by programme level and technical area, including frequency of meetings between community outreach workers and their supervisor/manager

  Definitions of reporting indicators

  Frequency of reporting monitoring data

  Definition and frequency of quality monitoring for all components of the intervention.

Clinical service standards are defined by each country as part of its national guidelines or, if not available, by the World Health Organization (WHO) regional or global guidelines. STI management guidelines often need to be developed or modified for populations of men who have sex with men, given the higher prevalence of STIs among men who have sex with men in most countries, and to address diagnosis and management issues of rectal STIs, which are often not covered in national guidelines. PrEP guidelines may need to be defined base on international recommendations.

Standards for outreach, organizational development and structural interventions should be developed or adapted to the specific setting (see Part II of this chapter). The approach and the content of outreach are also context-specific. For example, programmes will want to assess the behavioural triggers needed to drive a behavioural change, and the most important characteristics of the subgroup that must be considered when developing new materials or a new approach.

6.2.2 Establish a data system for programme design and management

A routine data collection system is critical for assessing programme reach and fidelity to design. A good monitoring system aggregates and consolidates information from frontline workers so that dashboard indicators[5] may be monitored by the various levels of managers, and it gives managers the ability to look at detailed reports from lower levels. Central (national) management should be able to see data from the level of states/provinces and districts, while state/province managers and implementing organizations should be able to see data reports from frontline workers. This allows managers to identify areas or implementing sites whose performance differs significantly from the others (for example, low condom and lubricant distribution, or low coverage of the estimated population of men who have sex with men) and that may need additional management attention to improve.

A well-designed monitoring system:

- enhances the transparency, accountability and acceptability of the programme.
- captures the interactions of men who have sex with men with community outreach workers or clinical services (e.g. formal contact with a community outreach worker, attended a clinic, was referred for a service etc.) with minimal error, by limiting the transfer and cross-posting of data.
- aggregates data upwards but retains a structure to allow examination of data at the lowest implementing level. Aggregation of data requires that recording and reporting systems be consistent across all service-providers and funders. Ideally, standards will be developed by the national HIV control programme, but if there is no central guidance it is best if different service-providers, NGOs and funders harmonize their data collection approach. WHO has published guidance on practical indicators to monitor coverage, utilization and quality.[6]
- develops reporting indicators from data that are routinely collected and that are useful for programme and management decisions at the level where they are collected. Frontline workers are less likely to gather data that are not useful at the level of collection, and such data will often not be of high quality. Note that at each level of implementation and management, additional data may be collected that are not reported upwards at all, but are used directly to improve services.
- has clear indicator definitions and ongoing control of data quality.
- is anonymized with respect to individuals and specific geographic locations to protect programme beneficiaries and is handled with appropriate protection in storage.

Health programmes are increasingly using electronic health records and electronic medical records, data collection by mobile phone, and web-based monitoring. While these approaches are often more accurate than paper-based systems, implementers must ensure that the identity of individuals will be protected should the data fall into the hands of law-enforcement authorities. A further consideration is that there are as yet few precedents for how programmes can develop indicators to incorporate contacts and interactions made through ICT platforms.

Eight principal data sources are needed to design, monitor and manage programmes for men who have sex with men (Table 6.2). They can be used to create indicators to measure the availability, coverage, quality and costs of specific services, to track service utilization and monitor some outcomes, as well as to help assess the extent of an enabling environment for HIV and STI prevention.

5 Dashboard indicators are the most important programme monitoring indicators, aggregated to a national level. They provide an overview of how well the programme is functioning (rather like the gauges on the dashboard of a car inform the driver how well the engine is running).

6 Tool for setting and monitoring targets for HIV prevention, diagnosis, treatment and care for key populations. Geneva: WHO; 2015.

These data sources are based on experience from successful scaled programmes and are discussed on the following four pages. Table 6.3, which follows this section, is an example of a programme indicator table that may be used at higher levels in management to monitor progress towards the goal of scale-up.

Table 6.2 Main sources of data for design, monitoring and management of HIV and comprehensive sexual-health programmes with men who have sex with men

A. Special data-collection exercises
B. Programme data collected outside routine direct contact with men who have sex with men
C. Programme data from routine direct contact with men who have sex with men
D. Administrative data related to services including drugs, consumables and referrals
E. Qualitative assessments
F. Quality monitoring
G. Expenditure data
H. Other outside data

A. Special data-collection exercises

Even if pre-existing empirical estimates of the size of the population of men who have sex with men are available, it is always preferable to conduct independent population size estimates based on primary data if one is unsure of the methods used for the previous estimates, or if they are old. This approach ensures that data is truly local and up to date. The multiplier method and capture-recapture method have been used extensively to estimate sizes of populations at risk for HIV.

The participation of communities of men who have sex with men in population size estimations is critical. Active involvement of community members in mapping can help build their self-esteem, empowerment and identification with the programme.

Given the high levels of stigma faced by men who have sex with men, their multiple self-identities and the varying visibility of different subpopulations, size estimates may significantly underestimate some populations. Estimates should therefore be updated periodically, and remapping may be done if social, political or economic forces lead to significant changes in the population of men who have sex with men. Estimates will become more accurate as the programme gains experience and the trust of communities.

Population size estimates are important for budget and programme planning and for deciding how many services to place, and where. Size estimates are also important for estimating levels of coverage, using data on men who have sex with men's contact with fixed-site or outreach services. Size estimates should be site-based, rather than country- or province-based, as they help implementing organizations develop localized intervention plans. Mathematical size estimate exercises may be used to validate these programme estimates.

Mapping is necessary for deciding the necessary quantity, intensity and location of services. The process is described in detail in Section 6.2.7, Part A. Mapping should include the collection of additional data to inform programme design and implementation, e.g. on current risk behaviours, the variety of subpopulations of men who have sex with men, the location of clinical service-providers by type of service (STI management, HIV treatment, mental-health services, HIV testing etc).

Spot polling-booth surveys are used to assess reported condom and lubricant use, needle sharing or access to HIV services for monitoring progress. Polling-booth surveys offer participants anonymity and thus attempt to overcome reporting bias. ICT survey methods may be an additional approach to gain more unbiased responses.

B. Programme data collected outside routine direct contact with men who have sex with men

Data on infrastructure and programme personnel are important to monitor service provision and human resources over the predetermined geographic area. Data collected upon enrolment in the programme set a baseline for understanding individual and collective programme needs.

Monitoring of infrastructure should include services that are specifically designed to serve men who have sex with men (including safe spaces or drop-in centres—see Chapter 4, Section 4.4.4), as well as services provided to the general population which are also used by men who have sex with men. Infrastructure monitoring should be by intervention type (e.g. behaviour change, condom provision, HIV testing and counselling, ART provision, sexual-health services and support services for people who experience violence). Monitoring should include not only the availability of services but also whether they are respectful of men who have sex with men, in order to ensure that they have accessible, acceptable services covering the full range of needs.

Monitoring of personnel includes the number of people hired, trained and retrained by the programme, including their positions, the quality of training, and the availability of clinical service-providers acceptable to the community, by service type. For groups providing services, monitoring the planned and unplanned turnover of community outreach workers is necessary to plan trainings for new recruits as well as progressive capacity-building activities.

Data from enrolment of men who have sex with men as they become affiliated with the programme: Upon enrolment in the programme, the individual community member is assigned a unique identification code, symbol or avatar (which must maintain his anonymity). Useful data to collect at enrolment include:

- demographic variables: age, race/ethnicity, marital status etc
- variables that capture "baseline" behaviour: reported condom use at last insertive and receptive anal sex; number of sexual partners in the last year/six months; use of water-based lubricants during sex; whether voluntarily tested for HIV in the last year, etc.

These data are useful to estimate the expected condom and lubricant needs of men who have sex with men and gauge levels of risk behaviour in the subpopulations in order to prioritize services. The data may be triangulated with other data for programme evaluation.

C. Programme data from routine direct contact between men who have sex with men and programme services

Data on routine contacts by men who have sex with men with the programme are key to monitoring coverage. This includes contacts with outreach workers, cyber-educators (see Chapter 5, Section 5.3.1), educational and self-risk assessment sites on the Internet, outreach services and clinical services. Ideally, this information (e.g. number of new and repeat contacts, number of condoms distributed, number of referrals etc.) should be collected at the point of contact and aggregated upward to the implementing organization, district, state and central levels, with minimal transcription to minimize errors. Electronic and cell-phone-based technology, if available, may be optimal in this respect by avoiding the need for transcription. If community outreach workers are not fully literate, they may also use specially designed pictorial paper-based tools to record data. In this case, the role of the community outreach worker's supervisor or manager is to capture this information anonymously in a format that can be made electronic.

As noted above, the increasing use of phone and web-based contact and education has not been accompanied by recommendations about how to use such data in programme monitoring and indicators.

Data on programme participants' occasional services or needs. In addition to data associated with routine outreach activities, some data the programme may want to monitor are generated more irregularly, such as data on incidents of violence or access to entitlements. Because these events are not routine and usually require an additional form to be submitted, they are more difficult to track. It is recommended that sites submit reports routinely even if there are no events to report, in order to understand whether low numbers reflect reality or represent a failure to report the information.

Mechanism to address mobility and migration. The mobility of many men who have sex with men—both within countries and across borders—makes it difficult to monitor the total number receiving services, because as they move into areas serviced by a different team or implementing organization they may be counted as new to the programme. One way to address this is to ask men who have sex with men who appear new to the programme whether they have received services before and from where; another is to provide an anonymous, non-stigmatizing ID card that indicates that the individual has received services from the programme. Another option is an ID with a barcode used exclusively by the programme. An implementing unit might record new contacts, new-to-area contacts and previous contacts as a way to track the number of discrete individuals served while capturing the degree of mobility. This will also help understand what services community members access as they move from one location to the other. In countries that implement universal ID cards with unique identifying codes, use of the ID by the programme may also be an option, but it is important to ensure that no information identifying the holder as a man who has sex with men is stored on the card or otherwise accessible to government authorities who might also handle the card. In general, the expense associated with installing electronic data collection devices at all service points and establishing and maintaining a centralized database makes the use of scannable IDs unfeasible for most programmes.

Biometric markers, such as electronically recorded fingerprints, have sometimes been proposed as a way to identify programme participants. However, even where the cost of electronic tracking is not an issue, the use of biometric data is considered an infringement of the rights of men who have sex with men, because of the potential for the abuse of the identifying data by law-enforcement authorities or other groups. Therefore the use of biometric data in programmes with men who have sex with men should be considered only with caution and depending on the context.

D. Administrative data related to services, including drugs, consumables and referrals

Drugs and consumable supplies are managed with appropriate stock management policies and procedures. The importance of these administrative data is to ensure consistent, uninterrupted supply of drugs, consumables and commodities; monitor consumption or distribution as a marker of coverage (e.g. condoms distributed compared to the estimated gap); and corroborate clinic reporting (e.g. STI drugs and syndromes reported).

Referral outcomes (i.e. whether an individual referred to a service attended the service, not the clinical outcome) should be assessed through an established communication channel with the referral service. (Clinical outcomes, such as the result of an HIV test or undetectable viral load, are important outcomes to monitor, but collecting this type of data is not the responsibility of interventions for men who have sex with men, but rather of the clinical-service provider.)

E. Qualitative assessments

Regular qualitative assessments of the needs of the population with community members is important for the initial planning of interventions and, when done regularly, can determine whether communication is being understood, whether stigma and discrimination persist, and whether there are unaddressed needs that could be met by the programme. They may also be used to further investigate and understand answers on quantitative surveys. (See Section 6.7.)

F. Quality monitoring

The standard-setting process outlined in Section 6.2.1 is the foundation of quality monitoring, as services are assessed against specified standards (quality assurance). Assessments may be done externally through quality audits, by using participatory approaches, or anonymously on the Internet by using anonymous rating programs like Yelp. Taking action to solve any identified deficiencies (quality improvement) is an important step to maximize service quality. All laboratory services should be monitored with standard laboratory quality monitoring procedures. These may include use of internal quality controls, external quality assurance through retesting a percentage of samples, and assessment panels from a central quality assurance laboratory.

G. Expenditure data

These data are important to monitor the project's financial status and ensure that payments to implementing organizations are punctual, so that the programme keeps running. In addition, if coded in a standardized manner across all of the implementing organizations, the data may enable the programme to estimate the cost per beneficiary for each of the implementing organizations and to reveal any that may need additional management scrutiny.

H. Other outside data

Data from other sources outside the programme, such as government surveillance, academic research, or surveys done by other institutions, may be useful to inform progress or highlight necessary adjustments in the programme.

Before defining and setting an indicator for a programme (even if it comes from an international agency such as UNAIDS or PEPFAR), the programming organization should be sure that the action required by the indicator will contribute to the national response, and in particular to the national set of indicators, and that it is consistent with the needs of service users. As noted earlier, uniform

data systems (indicators, definitions, frequency, forms) enable consistent aggregation and analysis of data to ensure coverage with comprehensive, high-quality services. Table 6.3 presents illustrative indicators; additional ones may be appropriate for each intervention area. For a comprehensive list of practical national indicators, see the WHO *Tool for setting and monitoring targets for HIV prevention, diagnosis, treatment and care for key populations* (2015). Guidance for service-level monitoring can be found in the UNAIDS *Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people* (2012).

Table 6.3 Illustrative programme monitoring indicators for multi-component intervention with men who have sex with men

Component	Indicator	Data Sources
Establishing and maintaining programme infrastructure		
Presence of services in geographic area that are either focused on or respectful of men who have sex with men	Number of sites providing comprehensive condom and lubricant programming by location Number of sites providing behavioural interventions for sexual risk reduction by location Number of safe spaces (drop-in centres)/community centres established/open by location Number of sites providing HIV testing and counselling by location Number of sites providing PEP by location Number of sites providing antiretroviral therapy by location Number of sites providing hepatitis B vaccination by location Number of sites providing PrEP by location Number of sites providing sexual and reproductive health services by location Number of sites providing defined package of health-sector interventions by location	Programme data/reports Planning documents based on mapping men who have sex with men and service sites Site assessment reports
Project staff hired and trained	Number of district/county directors/coordinators	Programme reports Planning documents
	Number of outreach supervisors/managers (target is enough to ensure oversight of outreach teams and weekly meeting)	Programme reports Population size estimates
	Number of technical staff at district/county level (target is enough to visit all project sites at least monthly for supportive supervision/data review). Illustrative technical areas: monitoring for management, clinical services (sexual health, voluntary HIV testing and counselling [HTC], ART), structural interventions/advocacy, outreach, management/financial, ITC	Programme reports Planning documents
	Number of finance and administration staff	Programme reports Planning documents
	Number of community outreach workers and ratio of community outreach workers to men who have sex with men	Programme reports Population size estimates

Component	Indicator	Data Sources
Project staff turnover	Number of community outreach workers who discontinued working in the last month	Programme reports
Project staff training	Number of community outreach workers trained during the last month	Programme reports
	Number of outreach supervisors/managers trained during the last month	Programme reports
	Number of technical staff trained during the last month	Programme reports
Sensitization of non-project service-providers	Number of government and private providers sensitized to working with men who have sex with men	Programme reports (need based on initial mapping of service-providers, assessment and ongoing feedback from community)
Behavioural interventions		
Intensity of engagement with men who have sex with men	Percentage of individual men who have sex with men reached monthly with prevention package (as defined by the programme; see Section 6.2.1) (Calculated by dividing total number of individual men who have sex with men contacted by community outreach workers in a month by the total number of men who have sex with men targeted)	Micro-planning tools Periodic denominator estimates
Condoms and lubricants (see also indicators in Chapter 3, Table 3.3)		
Adequacy of condom and lubricant distribution and supply	Ratio of condoms and lubricant distributed to estimated monthly requirements	Micro-planning tools Condom stock registers Enrolment questions on average number of partners Other condom gap assessments
	Number of organizations reporting any condom stock-outs for free distribution in the last month	Organizations' condom stock registers
	Number of organizations reporting lubricant stock-outs for free distribution in last month	Organizations' stock registers
Behaviour Change	Percentage of men who have sex with men reporting condom and lubricant use during last receptive anal sex act with primary/steady partner	Enrolment questions (quasi-baseline) Routine question in clinic encounter Small programme polling-booth survey/web-based surveys
	Percentage of men who have sex with men reporting condom and lubricant use during last receptive anal sex act with casual/non-steady partner	(Same as above)
	Percentage of men who have sex with men reporting condom and lubricant use during last insertive anal sex act with primary/steady partner	(Same as above)
	Percentage of men who have sex with men reporting condom and lubricant use during last insertive anal sex act with casual/non-steady partner	(Same as above)

Component	Indicator	Data Sources
PrEP		
Coverage of PrEP	Number of men who have sex with men prescribed oral PrEP during the specified reporting period	Programme reports
Clinical services		
Sexual-health services	Percentage of men who have sex with men accessing STI services monthly	Clinic forms Periodic denominator estimates
HIV testing and counselling	Percentage of men who have sex with men referred to voluntary HTC services monthly	Referral forms Periodic denominator estimates
HIV care and treatment	Percentage of men who have sex with men newly diagnosed with HIV successfully referred to care services monthly	Programme forms (depending on the relationship with the clinic and need for anonymity, a programme may set up a feedback mechanism with the clinical services. Otherwise, this indicator requires the programme to gather the data itself.)
	Percentage of men who have sex with men eligible for ART who are started on ART monthly	Programme forms
	Percentage of men who have sex with men started on ART who remain in care and are adherent (keep all appointments and take ART consistently to regimens at one year)	Clinic forms (only if able to determine without putting individual at risk)
Structural interventions/Community mobilization		
Rights violations	Number of reported incidents of violence against individual men who have sex with men	Violence report forms
	Percentage of reports of violence responded to within [designated time period] by crisis response system	Crisis response forms
Enabling environment	Number of sensitization trainings for law-enforcement officers on men who have sex with men	Programme forms
	Number of locations with legal support services for men who have sex with men	Programme forms
Stigma	Number of reported incidents of stigma in clinical services	Stigma report forms / YELP-like postings
Community mobilization	Percentage of community group members who are men who have sex with men but not community outreach workers	Report forms

6.2.3 Plan the programme evaluation

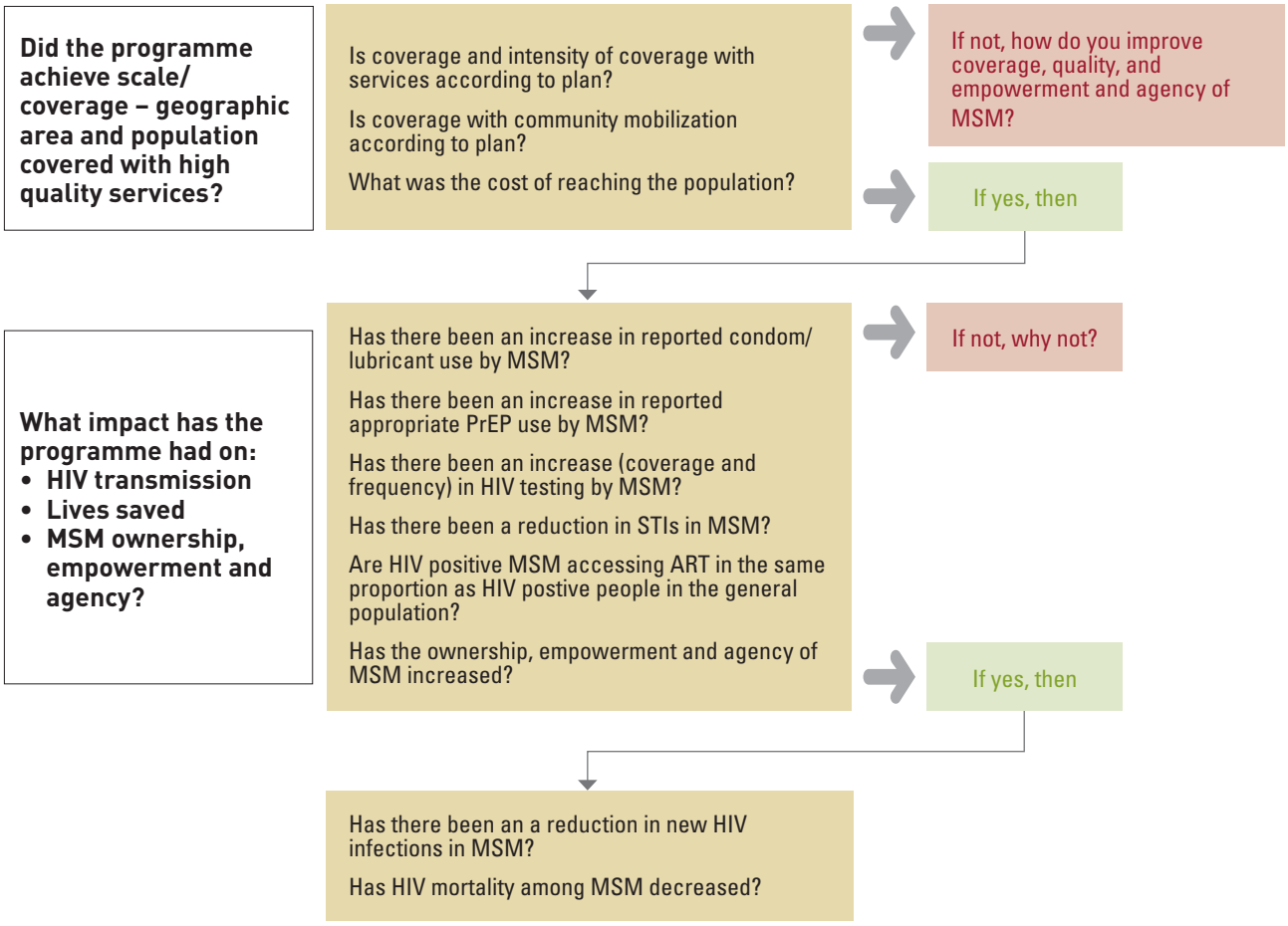
An evaluation plan at both the national and state/provincial level should assess the programme's fidelity to its original design (i.e. was it implemented to the intended scale and coverage, and with the elements defined in the programme logic model?) as well as to its intended impact. The evaluation should be designed with community involvement and in a way that enables the community to act on the results.

Five dimensions of quality of health interventions have been defined in the RE-AIM framework:

1. **Reach:** proportion of the target population that participated in the intervention (referred to in this tool as coverage)
2. **Efficacy:** success rate if implemented as designed (measured through the evaluation efforts described below)
3. **Adoption:** proportion of settings adopting the interventions
4. **Implementation:** extent to which the intervention is implemented as intended (referred to in this tool as fidelity to the design; see Section 6.2.7)
5. **Maintenance:** extent to which a programme is sustained over time (referred to in this tool as sustainability).

An illustrative high-level evaluation framework is depicted in Figure 6.2. See Section 6.7 for a reference to the RE-AIM framework and a list of guidance documents for designing evaluation programmes for men who have sex with men. See also the WHO 2015 target-setting tool for quality indicators.

Figure 6.2 Evaluation framework for a multi-component HIV and STI programme with men who have sex with men



Some key issues to consider when designing the evaluation are:

- **Clarity on evaluation goal:** Clarity is required on what is being measured and for whom, and how much "certainty" is required in the inference that the programme contributed to outcome and impact results. These levels of certainty have been defined as adequacy, plausibility and probability:

  Adequacy evaluations assess how well the interventions met the programme logic model and whether the expected change occurred. For example, over time the HIV incidence in men who have sex decreased concurrent with the programme.

  Plausibility evaluations collect data to increase the level of confidence that changes observed were due to the programme, usually by choosing a control group. In the case of programmes with men who have sex with men, this is likely to be an historical control group obtained with baseline data collection. Other types of plausibility evaluations are to include a control group for which an intervention is withheld and outcomes/impact are compared to the intervention group. In HIV prevention and treatment, this kind of evaluation generally cannot be done because it is unethical to withhold known interventions from a control group. A plausibility evaluation is possible when comparing two different approaches to interventions. Programmes considering such evaluations should consider consulting an evaluation expert.

  Probability evaluations prove that the intervention was responsible for changes. These involve randomization and are not necessary or feasible for most programme evaluations because of complexity of design, the ethics of withholding services, and because successful combination prevention and treatment interventions are a result of activities from multiple interventions and donors. A programme seeking to do a probability evaluation is advised to consult an evaluation expert.

Most evaluations fall somewhere between adequacy and plausibility. It should be noted that good monitoring data are essential to all types of evaluations. They demonstrate that the programme was implemented as planned, help to validate the programme logic pathways and are an early measure for managers and funders that the programme is on track with respect to implementation.

Since data analysis and dissemination are nearly always under-budgeted, it is best practice to define and budget for monitoring and evaluation activities at the start of the programme. It is recommended that 5–10% of the total project budget be allocated to monitoring and evaluation.

- **Data triangulation:** True baseline surveys (i.e. before interventions are started) in communities of men who have sex with men are difficult. Programmes need to build experience and trust with the various communities of men who have sex with men before they can access the population, ask intimate questions or take biologic specimens. Building trust usually entails providing services, and baseline behaviour related to condom and lubricant use may change quickly in areas where these commodities have not previously been provided. It is therefore important to try and collect additional information on "baseline" condom and lubricant use, high-risk sexual behaviour, and service access and use through enrolment questionnaires, or to use programme monitoring data to triangulate with survey data (see Section 6.2.2).
- **Validation of programme data:** Surveys used for evaluation should also be used to validate the other programme data, where possible. In particular, surveys may be used to:

  estimate programme coverage (condom and lubricant distribution, HTC use, ART use, etc)

  validate routine monitoring data

  do size estimates using more mathematically based approaches

assess the level of reported violence

assess the level of individual and community agency.[7]

- **Dissemination plan:** Dissemination plans should involve activities at all levels—from central to local levels—including to the men who have sex with men themselves. Dissemination creates ownership of the results to help improve programmes.

Organizing a scaled programme for men who have sex with men

6.2.4 Define the management structure

A clear structure for implementation is essential for smooth programme management, along with well-defined roles and responsibilities at each level of implementation, both within the programme and outside (government, media, medical services etc). In the most successful organizations there is a plan to regularly and clearly communicate the goals of the institution and contribute to each person's understanding of their role in achieving these goals. Regular feedback about the achievements or challenges in achieving the goals are important for the entire institution.
At the national/central level, the government or central management agency:

- sets programming standards
- monitors dashboard indicators from all implementing organizations in the country
- ensures that programmes are implemented in prioritized areas to reach sub-populations of men who have sex with men
- has a centralized view of the monitoring data
- ensures a country-wide evaluation plan.

If government or a designated central management agency is not setting standards or requiring centralized indicator reporting, implementing organizations should work together to standardize a minimum package and centralize indicator collection in consultation with the government.

Figure 6.3 illustrates a management structure of a national programme, showing the oversight and reporting relationships with the programme as well as the external relationships managed at the various levels. Key management roles are:

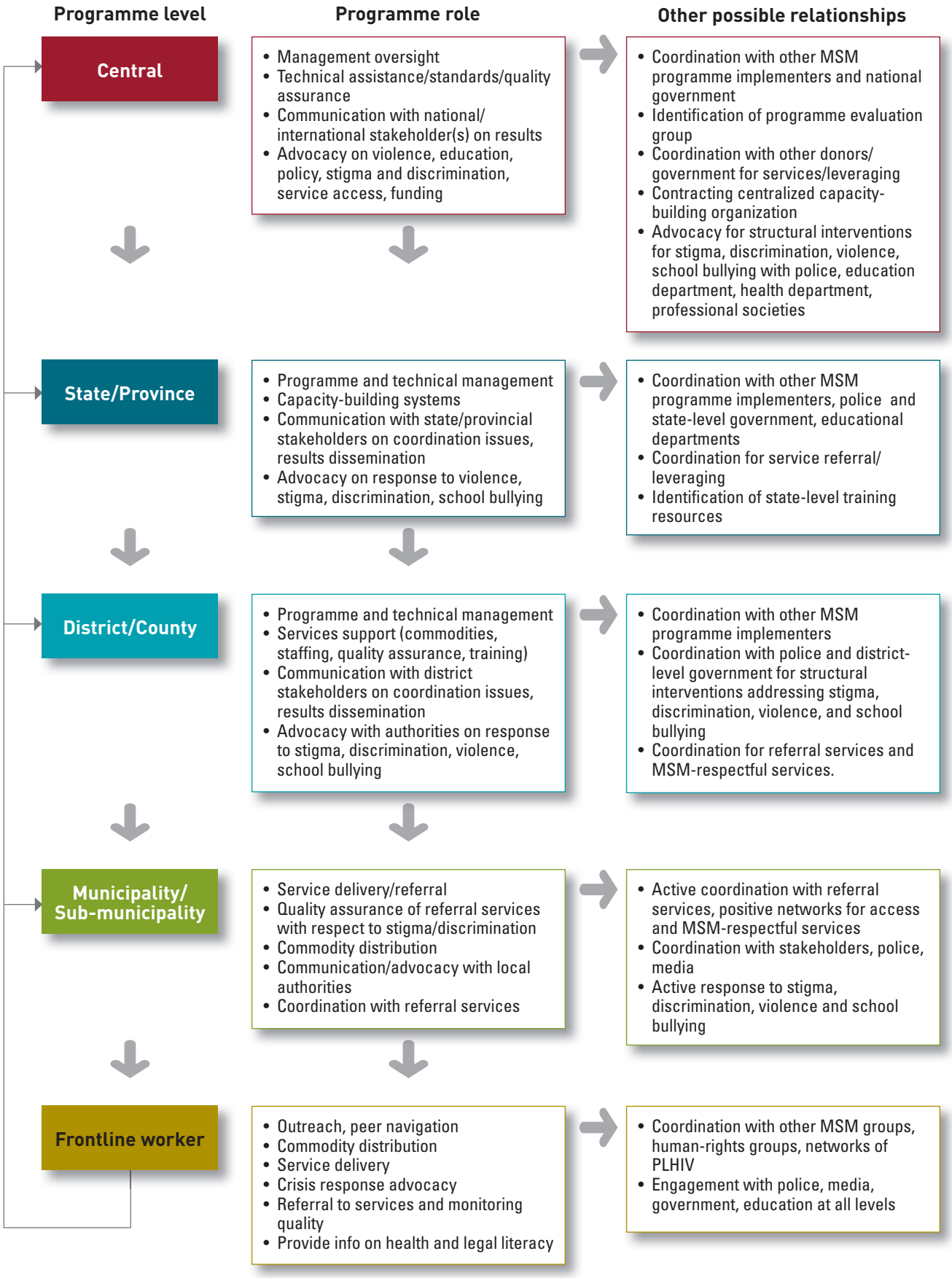
- **setting milestones** coupled with field oversight for both quality and progress; regular review of progress against targets to adjust strategies and tactics; and use of programme experience and data to make mid-course corrections.
- **establishing an organizational culture** that aims to:

  empower men who have sex with men to manage the programme

  empower staff at all levels to use local monitoring data to improve the programme.

7 Agency in this context (and in other parts of this chapter where the word clearly does not mean "organization") refers to the choice, control and power that a man who has sex with men has to act for himself.

Figure 6.3 Illustrative management structure for a national HIV prevention and care programme with men who have sex with men



Implementing a scaled programme for men who have sex with men

6.2.5 Progressively ensure full participation of men who have sex with men

Programmes should be designed to transition from doing programmes *for* men who have sex *with* men to doing them with men who have sex with men, and ultimately to programmes done *by* men who have sex with men. To accomplish this:

- Leadership by management at all levels should maintain a focus on the community empowerment component of the intervention just as much as the more technical components. This prioritization should be repeatedly articulated and given ongoing support.
- Capacity-strengthening and mentoring of men who have sex with men are necessary to provide them the tools, support and skills to deliver services themselves, which potentially increases the sustainability of the programmes (see Section 6.3 and Section 6.5, as well as Chapter 1, Section 1.2.4 and Chapter 4, Section 4.4.2).
- Investment should be made in working with and sustaining organizations led by men who have sex with men, as opposed to simply hiring leaders as consultants. When programmes build community organizations, they have a stronger infrastructure to work on issues beyond HIV programming, e.g. structural barriers such as laws against same-sex behaviour. While directly hiring community leaders as a means to reach their network may appear an efficient way to reach men who have sex with men, it is not as sustainable as investing in an organization which can sustain programming through diverse funding streams and eventually local and national support.
- Human resource policies that define terms of reference for positions held by men who have sex with men and clear advancement criteria are essential (see also Chapter 4, Section 4.4.2, Part B).
- Management should explicitly address staff expectations and the processes of transferring responsibility from NGO staff to men who have sex with men (see Chapter 1, Section 1.2.2 and Section 1.2.4).

6.2.6 Prioritize

Financial resources are usually insufficient to cover all men who have sex with men in the entire country with the same comprehensive package of services; as a result, programmes must make choices about both the range and the manner in which interventions are delivered, and their locations. This may be accomplished by varying the way in which technical components are delivered and by prioritizing those areas where the largest number of men who have sex with men and those at highest risk may be reached. Budget planning needs to take into account the sub-populations of men who have sex with men. Hidden subpopulations such as bisexual men or clients of male sex workers are harder to reach and therefore may be expensive to contact via traditional person-to-person outreach. New online recruitment and geosocial networking apps may accomplish this at lower cost, although less is known as yet about the efficacy of these approaches (see Chapter 5, Section 5.3.1). The following are considerations for prioritization:

Where to establish services

Locations with the largest number of men who have sex with men in a geographic area: This allows a few implementing organizations with the attendant management costs to reach a large proportion of men who have sex with men. Larger numbers of men who have sex with men are usually found in urban areas because of the higher population density.

Locations with men who have sex with men at higher risk of exposure to HIV, or higher prevalence of HIV with low or no access to ART services: Higher risk is associated with factors such as the number of partners, type of sex practised and the agency of men who have

sex with men. Young men who have sex with men or those becoming sexually active for the first time may be at higher risk because of stigma, or because they have less experience in negotiating condom use and avoiding or mitigating potentially violent situations. MSM who also inject drugs are at higher risk of infection.

What services to provide: At a minimum, these should include:

HIV testing and counselling on a regular basis. It is critical to know one's HIV status for both prevention and care. Slogans such as "Reach, test, treat, retain" illustrate the central role of HIV testing in any comprehensive programme.

Risk reduction commodities including adequate availability of condoms and lubricant, and needles and syringes for those men who also inject drugs, where programmes are designed to provide harm reduction services. These are essential for men who have sex with men to protect themselves. In many settings, supplies are completely inadequate to the need. See Chapter 3 and Chapter 4, Section 4.2.5 for full details. In settings where PrEP and PEP are available, they should also be provided.

Community empowerment activities to increase service coverage and effectiveness and the agency of men who have sex with men. As Chapter 1, Section 1.2.9 explains, community mobilization activities are increasingly being shown to be cost-effective and should be considered part of an essential package and not just "nice to have".

Referrals to accessible and acceptable clinical services for sexual health, STIs, ART, tuberculosis (TB) screening and treatment, hepatitis B vaccine and management, and opioid substitution therapy (see Chapter 4 for more details). High-quality referral services are sometimes more difficult to establish than project-owned services. One-stop services are preferred and the establishment of referral services should aim for this goal. Training and sensitization is often needed for providers of referral services to ensure that they are non-discriminatory, non-stigmatizing and confidential; while men who have sex with men, who may have experienced abuse or discrimination from service-providers on earlier occasions, will need to be encouraged to attend and reassured that they will be well cared for. Sometimes is it necessary to work with administrative bodies to change clinic hours to make them more accessible to men who have sex with men, e.g. outside normal business hours. Training of staff is also often required to familiarize them with clinical techniques and protocols specific to men who have sex with men. Some programmes use voucher schemes to increase access to clinical services from private providers. In the long run, however, effective referrals to respectful, accessible services may be more sustainable than programme-run clinical services if the level of use by the community is high and peer navigators are available (see Chapter 4, Section 4.4.2, Part C).

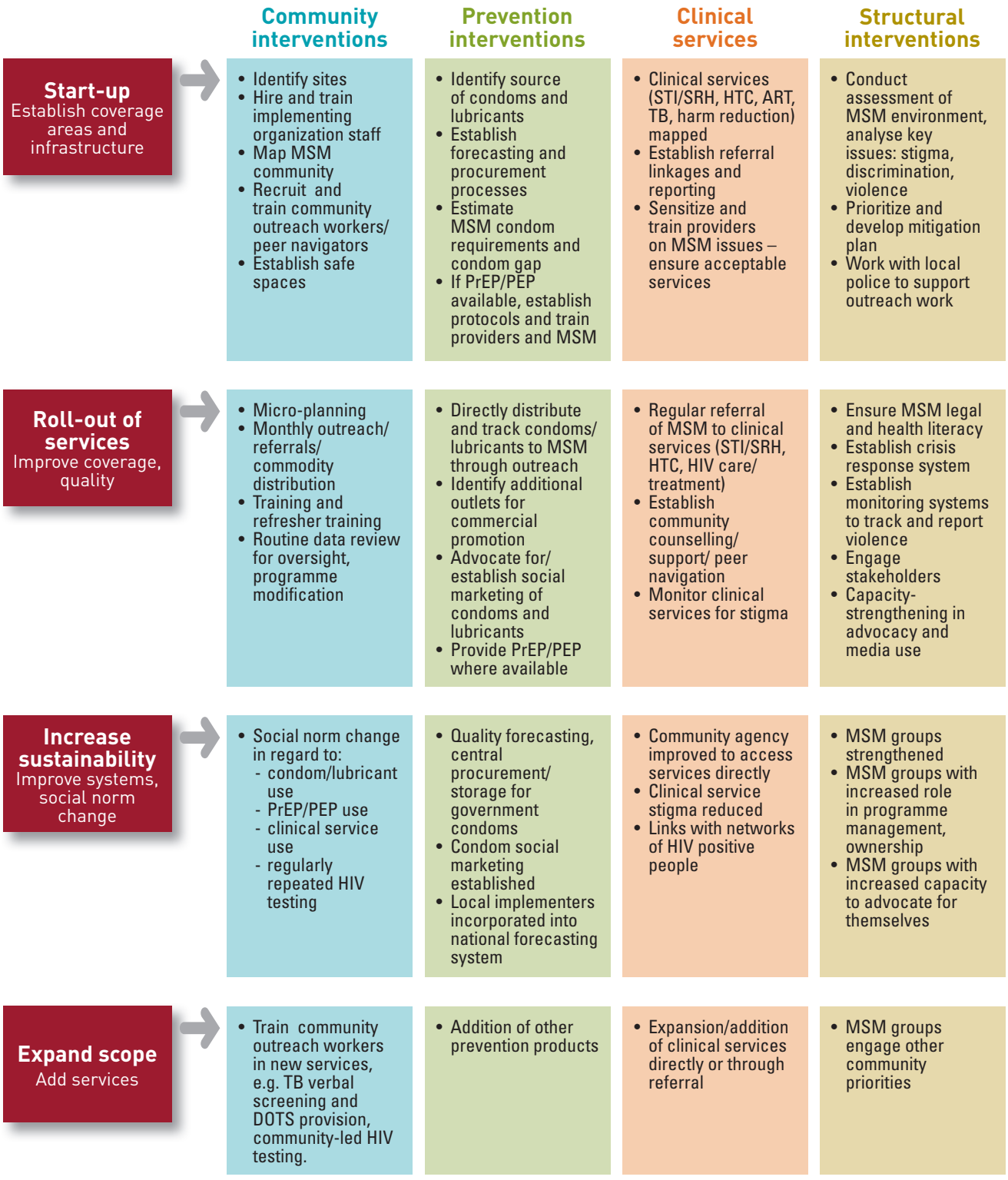
Addressing key structural barriers such as violence, and police interference in service delivery. Measures will be determined by the local context but span input into current laws and policies, legal support for men who have sex with men, support services for men who have sex with men who experience violence, and sensitization of law-enforcement officers. For younger men who have sex with men, interventions to prevent bullying in schools are important in order to reduce the risk of homophobic violence and harassment. Where it is not possible to address homophobia directly, general policies against bullying can still have a protective effect. (See Chapter 2 for more details on structural interventions.)

6.2.7 Implement in a staged manner

Implementing and executing the programme in clearly defined stages helps achieve wide geographic coverage. First, the programme is rolled out nearly simultaneously across the target geographic areas

(as opposed to a pilot-and-replicate approach) by establishing a physical infrastructure (offices, safe spaces, clinical service sites) in these areas. This is followed by a focus on implementing services and constant quality improvement. Finally, as the interventions mature, the focus of implementation shifts to making interventions and services more sustainable. Additional services may be layered on over time. Figure 6.4 summarizes the staged implementation of a programme.

Figure 6.4 Stages of implementing a multi-component programme with men who have sex with men



A. From start-up to establishing infrastructure across the target geographic area

Mapping and size estimates

Mapping provides reliable information about the size of the community of men who have sex with men in a given geographic area, its sub-groups and risk behaviours, available clinical services where men who have sex with men are located, and knowledge of needs and preferences. This information forms the basis for locating services, directing them at subgroups of men who have sex with men, setting performance targets, obtaining funding, allocating programme resources and assessing coverage.

Mapping makes it possible to identify NGOs and CBOs acceptable by the community for implementing core outreach interventions, clinical referrals, and—if decided by the programme and within the legal and financial scope—some components of clinical services.

At the implementation level, programmers can use mapping and size estimates to:

- estimate the size of the community in a given area to determine personnel needs
- define locations of men who have sex with men for locating interventions (see Figure 6.5)
- identify which clinical services are needed and where
- obtain information on risk behaviours, risk perceptions and barriers to inform the initial intervention design.

It is important to note that in many countries the use of smartphone apps and other ICT platforms by men who have sex with men to plan social and sexual encounters is changing the way men who have sex with men meet one another, and the extent to which they gather in customary locations such as "cruising" areas. The overall number of men who have sex with men may not change, but they may be less visible in such places. Where community members indicate that there is significant use of ICT for this purpose, mapping and size estimation should take this into account. In these cases, the more traditional approaches described below should be supplemented by information supplied by men who have sex with men on the extent and impact of ICT upon their social and sexual networks.

Mapping and size estimation is a multi-stage process, focusing on progressively more local levels to refine information and make it more accurate. High-level mapping by itself may not define the subset of men who have sex with men that the programme needs to reach. An overall estimate of the number of men who have sex with men in a given city will include some who are already accessing services and do not require additional ones, and some who are not at high risk of HIV and STIs. It is necessary to define sub-populations and their risk behaviours in order to understand needs and prioritize service delivery.

First stage: "Where in the country are significant numbers of men who have sex with men?" To determine where services should be established, a central-level planner must first understand where men who have sex with men are most concentrated. Information on locations of large numbers of men who have sex with men may be obtained by interviewing key informants in urban areas, such as health-care providers and men who have sex with men who are already known to the programme. Social networking sites or geospatial app information, if available, may also be used to get information. An approximate number of men who have sex with men should be obtained for each identified area in order to focus interventions initially on the locations with the largest number.

Second stage: "How many men who have sex with men are found in this municipality/ area, and where? What is their risk and vulnerability, and what are their service needs and preferences?" Once the general geographic area is known, more detailed mapping and size estimation is usually done. This exercise can be an adaptation of the PLACE method (Priorities for Local AIDS Control Efforts—see Section 6.7) or a participatory site assessment, depending on the level of involvement of men who have sex with men in the mapping and size estimation process. Again, use of the Internet, social networking sites or geospatial apps may supplement or replace many of these traditional approaches.

Participatory site assessments can be conducted with trained community members, researchers and local community organizations. These help establish initial population size estimates and map subgroups (e.g. gay-identified, non-gay-identified, younger men, people who use drugs, sex workers etc) in order to identify those at high risk of HIV, as well as hotspots/cruising sites where community members gather, and existing services for men who have sex with men. By ensuring the involvement of community members, the participatory mapping process can help increase their self-esteem, empowerment and identification with the programme and ensure that programmes are implemented with maximum safety in mind.

Locations identified by multiple informants or described as having large numbers of men who have sex with men are investigated further to ascertain whether these are men at high risk of HIV and other STIs. Detailed information is sought from men who have sex with men on the number of men who gather, specific times and places, and any additional locations nearby where other men who have sex with men may be found.

Depending on the relationship with the broader community of men who have sex with men in the identified areas, findings may be validated by presenting and discussing them with the community. Maps may be prepared showing local landmarks and locations where men who have sex gather, either on paper or using electronic equipment such as global positioning systems (GPS) or geographic information systems (GIS).

The programme uses this information in close consultation with the community to decide where service points such as safe spaces (drop-in centres) and programme-supported clinics should be located. Other clinics may be listed and mapped to establish referral relationships to preferred providers. The programme design is further refined and informed by men who have sex with men who describe the locations, hours, habits and other information that will determine when, where and how services are set up.

Third stage: "How can the men who have sex with men at highest risk be reached?" In this stage, social network maps are typically used to identify precisely who may be reached by individual community outreach workers. This approach can be supplemented by peer driven intervention (PDI). Pioneered in the USA for persons who inject drugs, PDI is a chain referral outreach methodology that has been expanded and adapted for use in populations including men who have sex with men, homeless youth and sex workers. It has been used successfully in Ghana to identify higher risk men who have sex with men who were at higher risk than those already receiving services. Information from the wider community further informs local planning, while including men who have sex with men's values and preferences. (See Section 6.7 for more information.)

Box 6.2

Using maps responsibly

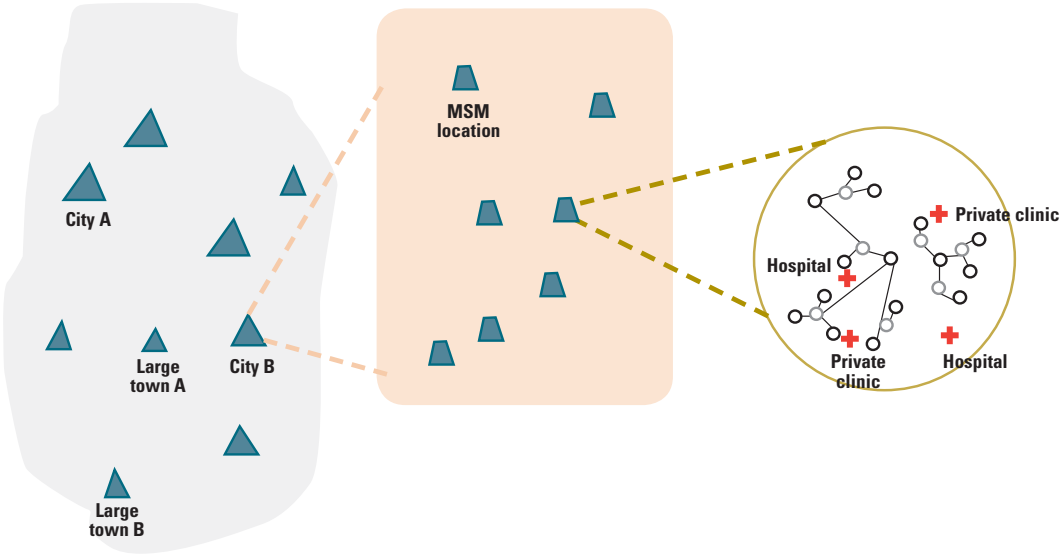
Ethical principles for mapping must be used to ensure safety and security. Mapping should only be done when the confidentiality of participants and programme sites can be respected. Programmes should balance the need for data and the need to do no harm in potentially hostile environments. (This may be a less significant issue in places where sex between men is not criminalized.)

Special care should be taken with mapped data. Maps or other data representations containing information about the location of men who have sex with men may carry special risk if they are obtained by law-enforcement authorities or other groups such as the media that who might use them to locate sites or otherwise cause harm to men who have sex with men. These maps should be considered confidential and stored securely at a central location. Programme planners and implementing organizations should seek community advice about the best ways to conduct mapping, present the data, and secure or obscure data and records.

If implementing organizations are worried that maps may be obtained by others outside the programme, they should avoid using labels or titles on the map, or use general language (e.g. "participants" or "members") that is not associated directly with men who have sex with men from the map. If maps are published for an audience outside the programme, e.g. as an example in an article about the programme, names that identify precise locations should be obscured, and, where possible, point data should be aggregated into larger areas, so that the maps cannot be used to identify specific locations of men who have sex with men.

It should be remembered that maps have symbolic power. Viewers who have not been directly involved in their creation may take them as exact representations of reality, but all maps are selective in what they represent, and those created as part of a mapping exercise are inevitably more approximate than professionally published maps. Data may be unintentionally exaggerated or underrepresented; colours or symbols may unintentionally convey approval or disapproval of a place or group of people. Those involved in mapping exercises should therefore be thoughtful about factors such as colour choice, wording, data classification groupings, symbols, and the content to be included and/or excluded.

Figure 6.5 Stages in determining where to establish services for men who have sex with men



Stage 1:
Identify significant MSM locations in the country

Stage 2:
Identify location and number of MSM in municipality and hotspots.

Identify location and type of public and private services near hotspots

Stage 3:
Micro-planning: identify social networks linking individuals.

Assess risks and vulnerabilities, and current access to medical care (public services, private insurance and preferred providers)

Source: Adapted from Karnataka Health Promotion Trust (KHPT). A systematic approach to the design and scale-up of targeted interventions for HIV prevention among urban sex workers. Bangalore, India: KHPT; 2012.

Allocating responsibilities among implementing organizations

In assigning implementing organizations, it is important to designate distinct catchment areas for coverage responsibility. As far as possible, overlaps in geographic areas among organizations should be avoided, but this should be balanced against the size and subgroups of the communities of men who have sex with men assigned to each implementing organization. If the target population is too small, it will make the intervention too costly per individual man reached; if it is too large, it may exceed the organization's management capabilities.

Hiring and training staff

A multi-component HIV intervention for men who have sex with men requires team members with a variety of skills. The composition of a team depends on the services provided, how the services are delivered, the size of the community of men who have sex with men, and the geographic area being covered. Table 6.4 gives an example of an implementation team at a municipality/sub-municipality level.

Identifying and strengthening government or private-sector services

Many or all clinical services may not be provided by the implementing organization but will be offered by public- or private-sector services. The role of the implementing organization will be to identify or develop non-stigmatizing, respectful service-providers for referrals, with the goal of one-stop service provision. Some men who have sex with men will already have identified appropriate service-providers, so interviewing the community is one way to finds providers. The implementing organization can also provide training to key providers and monitor issues of stigma and discrimination through feedback from the community. In some countries health care is available through job-related private insurance, and many men who have sex with men may receive health services in this way. Education of providers in these systems may take place on a one-on-one basis if the provider is open to this, or it may be done through continuing education programmes and professional bodies. Implementing organizations can contribute to these mechanisms.

Box 6.3

Case example: Strengthening government services for community members in China

China Family Planning Association (CFPA) promotes sexual health among men who have sex with men in three cities of Gansu Province, with a focus on creating a more supportive environment and improving their sexual-health practices and behaviour. In consultation with the community and with local government health departments, 11 hospitals were chosen for a programme to strengthen non-discriminatory sexual-health services for men who have sex with men with men. Thirty health-service providers received sensitization training from CFPA and community representatives.

Before the training, a high proportion of staff surveyed expressed the opinion that men who have sex with men had psychological problems or were immoral. Following the training, service-providers' attitudes improved, and 95% said they would respect their patients' privacy and help them. A referral system was established with these hospitals and clinics to provide voluntary HCT, STI treatment and other services to men who have sex with men. Service cards were printed and distributed to promote the referral services among community members.

Table 6.4 Illustrative composition of an implementation team for an implementing organization at the municipal/sub-municipal level for ~1,000 men who have sex with men

Position (number of staff)	General responsibility	Comments
Coordination and administrative personnel		
Programme coordinator (1)	Responsible for the overall implementation of the project.	
Data officer (1)	Aggregate the data, generate the reports and monitor data quality.	
Accountant (1)	Maintain accounts and pay local expenses of the programme.	A larger organization may also need a finance manager.
Medical and technical personnel		
Physician (1)	Provide clinical services offered by the programme.	If clinical services to the community are entirely referral-based, this position is not necessary. If any diagnostic tests are performed on-site or in the community, a quality assurance process should be established to ensure appropriate storage of the kits, proper training, and quality monitoring.
Nurse (1)	Provide/support clinical services offered by the programme.	If clinical services are entirely referral-based, this position is not necessary.
Counsellor (1)	Counsel on HIV treatment and HIV prevention options. Identify and manage mental-health issues, such as depression and anxiety. Provide additional support for behaviour-change processes. Support community counsellors if community-led HTC is offered.	Even if clinical services are not offered by the programme, a counsellor may provide additional counselling to men who have sex with men on issues related to referral clinical services.
Clinic support staff (1)	Greet patients, maintain reception area.	
Information and communication technology expert (1)	Manage the use of web-based messaging platforms and social media for outreach.	Necessary if ICT is an important communications channel for the community.
Outreach personnel		
Outreach supervisors/ managers (~5)	Supervise community outreach workers on a weekly basis. Ensure that outreach information on men who have sex with men is recorded and incorporated into routine monitoring systems.	

Position (number of staff)	General responsibility	Comments
Community outreach workers (~20) and peer navigators	Provide routine outreach to men who have sex with men, provision of commodities, referrals, follow-up and structural interventions. Support behaviour-change process. Support men who have sex with men in responding to stigma, discrimination and violence. Adherence support. Initial counselling, if community-led HTC is offered.	Assumption is that one community outreach worker works 5 days a week, 4 hours per day and can meet 2 or 3 men who have sex with men in a day. Will need time for routine meetings with outreach supervisors/ managers and monthly implementing organization meeting. Number may be adjusted if men who have sex with men are in close proximity or are dispersed, if there are additional responsibilities such as community-led HTC, or if much of the outreach is ICT-based.
Office support staff (1)	Support routine office processes.	

Table 6.5 lists budget considerations for a single implementing organization site.

Table 6.5 Cost considerations for local implementing organization operations

A. Personnel	**D. Direct Costs**
Salary	Venue rental for events
Health insurance/social benefits	**E. Contracts**
Training/professional development	Auditing services
Social liability costs*	Financial management
B. Infrastructure/equipment	Evaluation expert
Rent	**F. Clinical Services**
Utilities	Lab tests and associated equipment and supplies
Insurance	Drugs for diseases managed
Furniture	Hazardous waste containers
Computers	Secure and appropriate storage for drugs and diagnostics
Safe	Medical supplies (gloves, alcohols swabs, bandaids, swabs)
Internet fee/hotline costs	Hepatitis B vaccination for clinical providers
Vehicles	Quality assurance/quality control contract for laboratory
Fuel	Liability insurance
Projectors	Refrigerator
C. Supplies	Registration fees/licence fees
Paper/printing	Training for infection control
Outreach supplies	Secure storage for clinic records
Condoms/lubricants	
Refreshments for committee meetings	

*Includes funds for legal retainers, emergency fund for lawyers, bail, safe houses, repair of vandalism. The more criminalized and stigmatized men who have sex with men are in a given country, the larger this line item should be.

The implementing team is likely to include both community members and non-community members. Staff who are not men who have sex with men should be sensitive to the context of identity, discrimination, violence and other problems faced by men who have sex with men. They should also be able to discuss such topics as sex and service delivery needs in a nonjudgemental manner. Given the overarching goal of progression and community empowerment for men who have sex with men, staff should be prepared to learn from the men who have sex with men as well as serve as mentors to the process. Chapter 4, Box 4.17 describes the characteristics of successful community outreach workers. Although staff are hired for a specific role in the programme and will have a job description, they need to be flexible to adapt to new situations on the ground and incorporate new approaches.

Capacity-building of human resources is an important aspect of any programme but is particularly important in programmes with men who have sex with men, where the intent is to progressively increase their involvement in decision-making and ownership of the programme. This involves increasing the number of men who have sex with men in staff management positions as well as field staff. A discussion of strengthening organizational capacity can be found in Section 6.5.

B. From rolling out services to improving coverage and quality

During this stage of implementation the focus is on ensuring coverage of the community with services (outreach, education, prevention drugs and commodities, referral to appropriate services etc) and improving quality. This roll-out stage is a continuous process in which management at all levels reviews progress against targets and adjusts strategies and tactics, as necessary. Mid-course corrections are made where necessary, based on new data, new approaches or environmental or structural changes that affect programming. The intensity and quality of coverage increase as staff become more skilled in their positions. It is during this phase that flexibility and continuous programme learning are extremely valuable. A large programme should establish mechanisms for cross-learning. A strong monitoring system with regular reviews is essential to the successful roll-out of services. It also signals to funders and the government whether programming is being implemented successfully, with fidelity to programme design and coverage goals.

C. Aiming toward systems improvement, social norm change and increased sustainability

The overall aim of the programme is: (1) to provide services and products to reduce risk of transmission and decrease mortality, (2) to promote an enabling environment to reduce vulnerability and increase access to and use of services, and (3) to empower men who have sex with men to participate and progressively build their capacity to implement the programme. This latter aim will make the programme more effective and potentially more sustainable. The ideal characteristics of such a programme include the following:

- Men who have sex with men lead in implementing outreach, distributing condoms and lubricant and facilitating effective clinical referrals. As skills and interest develop in the community they should fill management positions in the implementing organization.
- Men who have sex with men have enough individual and collective agency to address problems themselves with the police, the health system, the government and other men who have sex with men.
- Men who have sex with men have positions at local, district and national level on planning bodies for service delivery and violence response.
- Social norm change among men who have sex with men makes use of prevention commodities (condoms and lubricants, PrEP) routine.

- Men who have sex with men are able to access comprehensive sexual-health and HIV care and treatment services without stigma and discrimination, at the same frequency as the general population.
- Prevention commodity supplies are adequate, through both social marketing and strengthened country procurement and distribution mechanisms, and programmes for men who have sex with men are part of a commodity tracking system (see Chapter 3).

Programme implementation in this stage is a matter of strengthening systems, addressing structural barriers and empowering communities while simultaneously providing and measuring services. Some of the earlier intensive programme activities may be reduced as social norms regarding safer sex and clinical service use change and respectful services are increased.

D. From expanding scope to adding services

Once the infrastructure, community engagement and coverage with core services have been established and the programme is functioning well, additional services needed or requested by the community can be added.

6.2.8 Establish a supportive supervision system

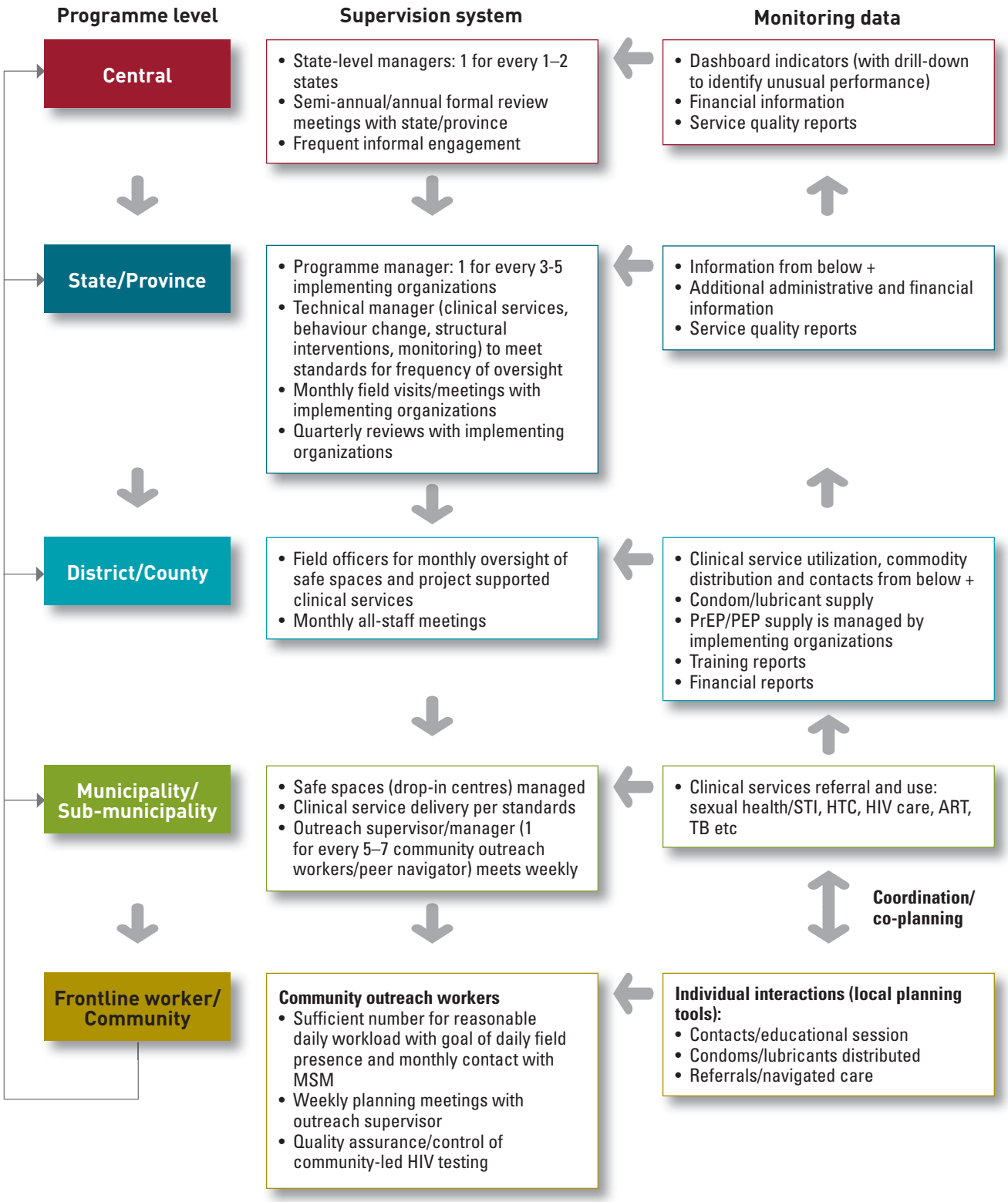
Regularly scheduled supervision meetings help create a "data use culture" that enables corrective action and continuous improvement at all levels, as well as independent problem-solving. Periodic meetings should be scheduled to review data at every level, from community outreach workers and the staff of implementing organizations to the state/provincial level and central management. Visits by supervision staff to the field also provide qualitative information on implementation to help interpret data and find solutions.

As an example, a supervision and programme review system used by a large project in India is depicted in Figure 6.6, along with the level of data that was used as part of the review. Community committee meetings and regular supervision meetings between community outreach workers and their supervisors/managers are two ways in which qualitative as well as quantitative data about the programme may be gathered. This is an important part of the community empowerment process described in Chapter 1.

Further functions of supportive supervision (e.g. mentoring) include:

- motivating and training staff in outreach, counselling and clinical issues
- monitoring quality of programme-supported clinics
- sharing and explaining guidelines
- monitoring and evaluating staff performance
- managing day-to-day challenges
- facilitating organizational support.

Figure 6.6 Supervision and monitoring system for a national HIV prevention and care programme with men who have sex with men



6.3 Capacity-strengthening and programme learning

In many settings, NGOs have limited experience implementing interventions with men who have sex with men, and organizations of men who have sex with men that provide services are small. The capacity-strengthening system needs to address the varying needs of implementing organizations to achieve comprehensive, high-quality programming for men who have sex with men. Staff capacity may be strengthened through regular classroom training, field exposure, supervision/mentoring and interactive problem-solving sessions. Ideally, training materials should be adapted or developed centrally to maintain quality of training and consistency with the minimum standards specified by the programme, and should be based on an assessment of the capacity-building needs. Pre- and post-assessments are useful to monitor the quality of the trainings.

Although MSM staff and non-MSM staff may differ in their types and levels of experience, wherever possible training should take place jointly so that all participants can learn from one another and bridge the gaps in their knowledge and skills in a collaborative manner.

Staff who are not men who have sex with men: Training goals should be developed with input from the community and can include:

- acquainting the staff with the specifics of the project (e.g. intervention, reporting forms, quality monitoring)
- explaining national guidelines and standards for HIV prevention, care and treatment
- building technical skills in new areas being provided by the implementing organization (e.g. examining for anal and oral STIs, counselling issues relevant to men who have sex with men such as violence, alcohol and drug use, self-esteem, mental health, community HIV testing, etc)
- sensitizing staff to issues faced by communities of men who have sex with men, e.g. criminalization, violence, stigma, discrimination, low self-esteem. For some staff members, this may also require changes in attitude toward men who have sex with men (e.g. sexuality, morality, etc)
- sensitizing staff to the overall goal of transferring skills and responsibilities to the community of men who have sex with men.

Staff who are men who have sex with men: The programme goal is to increasingly involve men who have sex with men in the management of the programme and to strengthen capacities to enable them to address some of the environmental and structural constraints that inhibit preventive behaviour. Training objectives are to strengthen the capacity of the men who have sex with men to do outreach, increasingly manage all aspects of outreach and to move into other staff positions in the programme, including management. This can be phased as basic and advanced training. More details can be found in Chapter 4, Section 4.4.2 Part B.

Some approaches to capture programme lessons include:

- routine visits for programme managers to learn about local innovations and transfer lessons to other sites
- regularly scheduled programme reviews with several implementing organizations together; these may also be used for cross-sharing
- cross-site meetings of technical officers to share approaches
- cross-site meetings of community outreach workers/peer navigators to share approaches
- formal revision of programme approaches, minimum standards, standard operating procedures and reporting forms
- consultation with men who have sex with men.

6.4 Staff development

Several good practices have been articulated to ensure that staffing is optimal and that staff are motivated and satisfied by their work. These include:

- clear job descriptions and roles and responsibilities for all positions in the programme, including those occupied by community members
- clear reporting lines showing to whom each person is accountable
- team-building and a culture of mentoring
- clear criteria for performance reviews, with regular performance evaluation and feedback
- creating a culture where all staff members understand the whole programme and contribute to management practices to achieve excellence
- clear policies on leave, travel reimbursement, and remuneration for work, including equitable policies for men who have sex with men. Ideally, these should be uniform across a country.
- opportunities for training for different positions in the organization, such as outreach supervisor, clinic assistant, nursing, counselling, social work, office manager, technical officer, programme director.

PART II.

6.5 Strengthening the capacity of organizations of men who have sex with men

Organizational capacity-building is a comprehensive approach to strengthening an organization's ability to plan, manage and finance itself so that it can implement its own vision and strategy. At the same time, capacity-building helps the organization deliver on indicators and targets of government, donors and technical assistance agencies, where these are a source of funding. Whether organizations of men who have sex with men are already established or come into being as a result of HIV prevention programming, it is important for them to understand the goals and needs of donors, while developing the ability to shape those goals where necessary to ensure that they do not conflict with the organization's own vision.[8]

Like other organizations, organizations of men who have sex with men face varying challenges to becoming stronger and more sustainable, and they benefit from varied approaches. An established organization may have a mature understanding of its community's needs and be better able to lead the process of capacity-building itself, while a recently formed organization may need more guidance. But certain principles apply to capacity-building in general. Support should be:

- **Comprehensive:** Acknowledging all the capacity-building needs of an organization allows for a more systematic approach and the opportunity to address all the essential needs.
- **Contextualized and customized:** The support should address the specific cultural, political and social settings of the organization being strengthened.
- **Locally owned:** Groups supporting capacity-building may understand the processes and can help the organization of men who have sex with men identify needs. But unless that organization makes its own decisions, capacity-building efforts will not be as successful.

8 The development community has a long history of capacity-building. Early efforts generally aimed to help organizations manage the funds from a specific donor, or implement donor-supported technical programmes. Today, the approach to organizational capacity-building is to strengthen the organization as a whole, but capacity-building in the context of project implementation is generally more effective than organizational capacity-building in isolation, as it allows for practical application of the theoretical learning. Although the term capacity-building is used here, "capacity development", "organizational development" or a number of other terms would serve equally well.

- **Readiness-based:** The type, level and amount of capacity-building should be based on the organization's ability to absorb and use the support being given.
- **Inward/outward-oriented:** While it is essential for an organization to ensure the health of its staff and internal structures, it is also important to remember that any organization is part of a larger community and needs to understand opportunities for partnership and the potential benefits from external links.
- **Sustainability-based:** Capacity-building should strengthen an organization's ability to maintain a resource base so that it may continue to function well.
- **Learning-focused:** An organization that does not continue to learn about its functions, beneficiaries, community, technical areas, etc will become stagnant and cease to be relevant.

Box 6.4

The role of community empowerment in capacity-building

The role of capacity-building is to institutionalize support for men who have sex with men and to further empower these groups to lead their own responses. This is important in two respects:

- Creating an organizational structure provides consistency over time and establishes processes so that key people are replaced if they leave, ensuring that community empowerment continues.
- Organizations led by men who have sex with men are less beholden to external forces and will, therefore, be more empowered.

Note that not all groups of men who have sex with men will (or necessarily should) become independent organizations. It is up to each community of men who have sex with men to define its own way forward. This may entail the development of a CBO or NGO, but some organizations may find it easier and more appropriate to continue to work through other organizations. This may be the case in contexts where men who have sex with men face severe social or legal repression.

6.5.1 Forming a registered organization

Chapter 1, Section 1.2.3 describes some of the ways organizations of men who have sex with men may be formed. Such organizations are likely at first to be informal groups that then create structures and processes in order to carry out a community-led agenda more effectively.

Organizations of men who have sex with men can be established in various ways. Two primary ones are:

- developed from within an established or existing organization
- independently formed.

The advantage of the first is that the partner organization may be able to support the process through funding, the provision of space, assistance with activities and advocacy to remove any barriers. This support is often necessary and welcome and should include connecting the local group to existing national and regional networks of men who have sex with men. This approach may also be useful in contexts where the legal or social environment makes it impossible to form a freestanding group for men who have sex with men.

Regardless of which approach is chosen, if an organization of men who have sex with men is to have true accountability and credibility, ownership must rest with the community, and its form and function

should be based on the needs and priorities identified by its members, which may include priorities other than those focused on HIV. It is crucial for the partner to understand that the organization needs to be given the freedom to navigate its own organizational trajectory.

In some cases, groups of men who have sex with men hire consultants to lead them through the process of forming an organization, or receive support from one or two NGO employees. Others work with large international NGOs that can offer technical assistance and funding. An organization experienced in project management, financial management, monitoring and reporting, communication and fundraising can help build the capacity of men who have sex with men by providing training and opportunities to practise skills. Alternatively, they may do it themselves with the help of a partner NGO's lawyer or with support from national or regional networks of men who have sex with men or AIDS service organizations (see Box 6.5).

It is important that the organization have a clear understanding of its expectations with respect to size, geographic reach, types of activities etc. Mission and vision statements and a strategy statement or strategic plan help an organization to define these elements.

Box 6.5

Global and regional networks of men who have sex with men

Most countries have NGO coordinating bodies that offer advice or guidance through the process of forming a formal organization. Regional or global organizations of men who have sex with men can also provide advice and support on overcoming the barriers that men who have sex with men may face in registering their own organizations. Networks of AIDS service organizations include:

- The Global Forum on MSM & HIV (MSMGF) — www.msmgf.org
- Asia Pacific Council of AIDS Service Organizations (APCASO) — www.apcaso.org
- African Council of AIDS Service Organizations (AfriCASO) — www.africaso.net
- Asociación para la Salud Integral y Ciudadanía en Latinoamérica y el Caribe (ASICAL) — www.portalsida.org/Organisation_Details.aspx?orgid=1451
- Asia Pacific Coalition on Male Health (APCOM) — www.apcom.org
- African Men for Sexual Health and Rights (AMSHeR) — www.amsher.org
- East African Sexual Health and Rights Initiative (UHAI) — www.uhai-eashri.org
- Caribbean Vulnerable Communities Coalition (CVC) — www.cvccoalition.org
- Eurasian Coalition on Male Health (ECOM) — www.msmeurasia.org
- M-Coalition – www.m-coalition.org
- International Lesbian, Gay, Bisexual, Transgender and Intersex Association for Latin America and the Caribbean (ILGA-LAC) — www.ilga-lac.org/en/international-lesbian-gay-bisexual-trans-and-intersex-association-for-latin-america-and-the-caribbean/

A growing number of donors offer support for organizational development and capacity-strengthening activities, including:

- Global Fund to Fight AIDS, Tuberculosis and Malaria — www.theglobalfund.org
- Funders Concerned about AIDS — www.fcaaids.org
- Robert Carr Fund for Civil Society Networks — www.robertcarrfund.org

Numerous capacity assessment tools, organizational tools and resourcing guides are available (see Section 6.7).

Depending on the organization's type, size and goals, as well as the country in which it is forming, it may decide to become a legally registered entity. The process to do this varies from country to country. The necessary registration materials must be obtained from the relevant government office. Precise requirements for documentation are set out by the government. Examples of the types of documentation required are:

- one of the following: memorandum of association, by-laws, constitution, charter etc
- report of annual activities
- financial reports/audit reports
- organizational resources
- organizational chart/staffing plan (and human resources manual, if available)
- board of directors and rules and regulations governing the board (board endorsement of registration is also needed)
- letters of support from key partners.

Some of these documents may not be available for organizations just starting up and may need to be developed. If the organization finds the requirements too complex or difficult to meet, it may be possible to register as a member of a network. This may be an appropriate intermediate step for a nascent organization on its way to registration, giving it the protection and support of the network as it grows and develops the materials needed for individual registration.

Establishing and strengthening community organizations is a complex and long-term investment. Funders should be clear and realistic about what they can commit to this process, so as not to create expectations that cannot be fulfilled. Establishing organizations of men who have sex with men may not be feasible in every context. In some countries, regulatory frameworks will not permit the registration of such groups, and even if they do, the establishment of these groups may leave the members open to abuse, violence or legal proceedings.

Community groups of men who have sex with men should also be realistic about the decision to establish or formalize a group. Will it be the most effective way of achieving the goals their communities wish to achieve? Will donors support them with sufficient resources and for a sufficient amount of time? Is there enough support within communities of men who have sex with men for creating such a group or movement? What other options are available?

In the initial stages of establishing a group or organization it may be useful to "house" the group within an existing structure—for instance, an NGO or CBO that has demonstrated its understanding and acceptance of men who have sex with men and its willingness to offer support. Where this "incubation" process is used, men who have sex with men and transgender people should of course be in a position to define how the emerging organization will be governed, and when (if at all) it should move to an autonomous status.

A further aspect of developing an organization is creating a visual identity or brand. This should be done with the participation of all group members. A brand is useful in more or less structured settings, even when the group decides to exist informally (i.e. not as a legal entity). To create a sense of belonging among the individuals who make up the group and to reflect its values and personality, all activities and communications should make use of the brand. In environments that are hostile to men who have sex with men, a brand can draw unwanted attention to the group, but if designed carefully it can be a discreet but effective way of communicating with the group and attracting new members.

6.5.2 Organizational capacity-building

Capacity-building for organizations of men who have sex with men presents specific challenges. To deal with missing skills, some organizations outsource certain functions, such as financial management, to businesses that provide this service. One way to mitigate the loss of staff is to have more people involved in organizational activities, so that there is a larger institutional memory. This is especially important to facilitate smooth transitions.

Organizations can also build their capacities in specific areas. A best practice is for an organization to undergo a capacity assessment. There are many tools for this, including self-assessment tools, although a good assessment by an outside facilitator can bring out issues that an organization might not identify itself. The assessment provides the organization with a capacity-building plan to address the identified areas for improvement. Chapter 1, Section 1.2.4 describes issues of leadership and financial management, while Chapter 6, Sections 6.2.2. and 6.2.3 describe data monitoring and programme evaluation. Other areas that are also generally explored in an assessment and that are the most important for organizations to build capacity are discussed below.

6.5.3 Governance

Good governance means the responsible management of an organization's strategic vision and resources. Transparency, accountability, effective management and rule of law are essential components of good governance and of an organization's ability to meet its mandate. Organizational assessments help organizations ensure the following, which are considered best practices in governance:

- clear vision and mission that is reflected in the organization's strategic planning
- organizational structure that aligns with mission
- strong and active governing body (board) that helps guide and advocate
- participatory selection process for governing body and leadership
- defined processes for decision-making that engage and inform the membership
- community involvement in committees to oversee programmes
- processes in place to manage change and seek new opportunities.

It is important for an organization to have a clear vision. There are often many internal and external pressures on an organization to address issues that may not be within its real area of concern, and the vision allows it to stay focused on what it has identified as its core mission.

A board gives strategic direction, provides support in legal affairs, accounting etc and protects the organization. In the case of organizations of men who have sex with men, a board may include members with the connections and influence to advocate to reduce stigma and help with fundraising. The size of a board is less important than its members' demonstrated commitment to the organization's cause and their desire to establish and grow the organization. It is also not necessary for the membership to be comprised exclusively of community members.

Organizations of men who have sex with men are often started by a small number of dynamic individuals. However, to be sustainable, these organizations must ensure strong leadership and

organizational management and invest in developing future leaders. This requires resources for leadership training and capacity-building as well as connections with national, sub-regional, regional and global networks of men who have sex with men to exchange knowledge, experience and support.

Box 6.6

Case example: The Multi-Country South Asia (MSA) programme

The Multi-Country South Asia (MSA) programme of the Global Fund to Fight AIDS, Tuberculosis and Malaria is building the capacity of CBOs and staff to deliver high-quality and coordinated HIV-related services and advocacy for men who have sex with men and transgender persons in South Asia, through trainings, peer mentoring, ongoing technical support and supervision. As a result, approximately 61 CBOs delivering services to men who have sex with men and transgender people will strengthen their organizational governance and programme and financial management.

Additionally, two HIV prevention grantees in Afghanistan and Pakistan will build capacity through community-led outreach services, HIV testing, STI testing and treatment and referral to national treatment centres. As part of the project, the Asia Pacific Network of People Living with HIV/AIDS (APN+) will develop a regional "Treatment as Prevention" training package to strengthen CBOs' capacity to understand human-rights issues and their own role in supporting national treatment and testing programmes, and to integrate these concepts in their community outreach programmes.

These activities will be monitored using two indicators:

- **Human-resources capacity for HIV service delivery:** Number of community workers currently working with implementing organizations who received training on HIV-related service delivery for men who have sex with men and transgender people according to national guidelines (where these exist) or international standards.
- **Organizational capacity:** Number of implementing organizations (with minimum capacity) that deliver HIV-related services to men who have sex with men and transgender people. The minimum capacity will be defined through a short assessment and will include both functional capacities (financial, programmatic, governance, monitoring and evaluation) and HIV service-delivery capacity.

6.5.4 Project management

An organization's agenda is accomplished through concrete activities, often developed as programmes and projects. An organization is on the right track if it:

- develops and follows realistic workplans and budgets that are in line with its vision and mission
- defines technical interventions that are in line with local and international best practices
- ensures that its programmes and projects are responsive to the needs of its members.

Well-managed, technically sound projects and programmes not only ensure that organizational objectives are achieved, but also instil confidence in donors and key stakeholders about the competence of the organization.

Box 6.7

Case example: Opportunities and challenges for organizational development in the Russian Federation

menZDRAV Foundation builds the capacity of NGOs and community-led organizations to develop, implement, monitor and evaluate programmes that provide direct services to men who have sex with men living with HIV in six districts of the Russian Federation. menZDRAV also strengthens partnerships between governmental and nongovernmental organizations by advocating for the inclusion of needs of men who have sex with men living with HIV, and for national public-health strategies in response to the HIV epidemic.

Within two years, five new community-led organizations were registered. These organizations received mini-grants to provide direct services to men who have sex with men living with HIV. About 1,500 men who have sex with men living with HIV (80% of them under 25 years old) gained access to ART or STI treatment, received free regular voluntary medical check-ups, and received support and skills training in living positively with HIV.

menZDRAV coordinated training for 20 doctors, social workers and psychologists working in state AIDS centres in six regions in the specific needs of men who have sex with men and the prevention of homophobia, stigma and discrimination.

Among the challenges faced by the programme, stigma, harassment and criminalization have adversely impacted community mobilization. Groups of men who have sex with men suffer from community fragmentation, self-stigmatization and the absence of leaders. Community-led organizations have not been included as equal partners in the HIV response and recent legislation has had the effect of making men who have sex with men less willing to organize, which has made capacity-strengthening of the community more difficult. In addition, the programme cannot officially provide services to those men under 18 years of age.

6.5.5 Technical support and capacity-strengthening

Technical support should aim to strengthen the capacity of organizations to operate effectively and in the interests of their communities.

Technical support takes a range of forms, including:

- training
- mentoring and supervision
- feedback
- exchanges with community organizations
- manuals and tools.

Technical support should address not only organizational development issues, but also technical or programmatic issues.

Organizational development issues include:

- governance, transparency and accountability to the constituent community
- management, supervision and recruitment of staff and volunteers
- partnerships and coordination with other organizations and services
- financial management systems
- monitoring and adapting to change.

Technical or programmatic issues include:

- participatory assessments and other forms of community engagement
- service-related skills (e.g. for outreach, counselling, clinical service support, community-led HIV testing, depending on the organization's role)
- advocacy.

As with financial support, technical support should be planned and predictable. Because there are so many technical issues, and also because education and professional experience in new organizations is often limited, it is easy for a new organization to become overwhelmed by all the tools and training provided. To ensure support is realistic, it should focus on the specific activities that an organization is undertaking so that "learning by doing" is prioritized.[9]

Box 6.8

Case example: Capacity-strengthening of CBOs in India

With support from the Global Fund, India HIV/AIDS Alliance and six consortium partners implement the Pehchan programme (2010–2015) in 18 states of India. The programme strengthens the capacity of 200 CBOs to provide HIV prevention programming to more than 450,000 men who have sex with men, transgender people and *hijras* (referred to collectively as MTH communities). Pehchan is a rare example of a community systems strengthening programme at national scale working in collaboration with the government to support improved HIV prevention efforts with marginalized and vulnerable sexual minorities.

Using a rights-based approach, Pehchan develops CBOs to serve as implementing partners with the National AIDS Control Programme, fosters community-friendly services within the health system, and engages in advocacy to improve the lives and well-being of MTH populations in India. The programme provides organizational development, technical and capacity-building support to CBOs working with MTH communities. These organizations complement the government's HIV prevention strategy for MTH by providing additional services beyond basic HIV prevention which are necessary to support an enabling environment for healthy behaviours. These include mental-health counselling, family support, relationship counselling, crisis management, legal aid, sexual and reproductive health linkages for female partners, and support to MTH people living with HIV.[10]

6.5.6 Resource mobilization and financial management

Funding is vital to the effective functioning of community-led organizations. An important principle is to ensure stable, predictable funding, as rapid increases or decreases make it very hard for organizations to plan and can lead to service interruptions, which can damage the confidence of men who have sex with men in the organization and in its ability to support them.Organizations should always be engaged in resource mobilization to fund efforts on a long-term basis. It is important that the organization be strategic and look beyond the short term, especially if it is currently benefitting from a grant that will end after several years. While there is no guarantee that an organization will be able to raise money, there are best practices that may help it do so. Important issues to consider with respect to resource mobilization include:

9 For more information and resources on technical support, see the webpage of the Global Fund to Fight AIDS, Tuberculosis and Malaria at http://www.theglobalfund.org/en/fundingmodel/technicalcooperation/.

10 The Pehchan Training Curriculum is available at http://www.allianceindia.org/ourwork/pehchan-training-curriculum-msm-transgender-hijra-community-systems-strengthening-curriculum-guide-pdf-1-1-mb/

- Is the organization performing well with current funding and is this performance documented?
- Is the resource mobilization strategy in line with the organization's vision and mission?
- Can resources be raised from members of the organization, i.e. through a small monthly or annual membership fee? This increases a sense of ownership, but the sum should not be so high as to exclude men who have sex with men from joining.
- Are there government schemes that may be able to fund specific activities or programmes?
- Is there a possibility of public–private partnership with the national AIDS control programme?
- Could the organization start a social enterprise—a for-profit arm to fund service delivery? Social enterprises make money by selling goods and services but reinvest their profits into their own business or the local community. If social enterprises already exist in the region or country, they may be able to offer mentoring support.
- Using global networking, could the organization find a sponsor organization or individuals to fund service delivery; could it engage in philanthropic crowd sourcing?

Many donors focus a lot of attention on financial management. While it is reasonable to expect any grantee organization to manage and account for funding received, due consideration should be given to the special circumstances of emergent groups that represent stigmatized populations. Although group members may be strong leaders, they may have limited levels of formal education or professional experience. At the same time they may find it difficult to express their unease with policies and procedures, particularly if they feel that doing so will jeopardize funding. Organizations receiving funding should be asked to report in ways that are appropriate to their capacities, and funders should accept the risks in supporting new groups.

Financial management is another key component of organizational sustainability. It can be developed in a number of ways depending on the capacity of the organization, its resources and the complexity of its finances. An organization may manage its finances in-house or may outsource the work to another local organization. As an organization grows, important components of a strong financial management system will include:

- well-documented financial systems and financial controls
- finances that are clearly documented and audit-ready
- financial reporting procedures that are known and understood by members
- an adequate number of qualified financial staff, depending upon the complexity and size of the organization.

6.5.7 Networking

Developing a strong, successful organization of men who have sex with men is as much about relationships as it is about systems. Networking involves donors, communities, government at both national and local levels, service-providers and NGO networks. Some of the functions of networking are ensuring human rights, securing comprehensive services for beneficiaries and developing relationships with donors (see Box 6.9 and also Chapter 1, Section 1.2.8).

Two areas of networking that are especially important for organizations of men who have sex with men are engagement with the state, e.g. politicians, police, health and social entitlement programmes; and engagement with non-state organizations and institutions.

Engagement with the state

This is particularly important to enable programmes for men who have sex with men to advocate for access to health services, freedom from discrimination and harassment, protection from and redress for violence, and securing rights and entitlements as citizens. A partner organization working with the organization of men who have sex with men on capacity-building may have the connections to place members of community-led groups on committees that oversee health programmes, or provide access to politicians and other officials. Capacity-building may help men who have sex with men unfamiliar with the structure of formal meetings, or the protocol for dealing with officials, learn how to participate and engage effectively.

Engagement with non-state organizations and institutions

This includes:

- other CBOs/NGOs or community-led organizations of men who have sex with men
- religious and other community groups
- media
- youth organizations
- other CBOs/NGOs working on related areas (social entitlements, rights, violence, health etc).

Capacity-building helps organizations of men who have sex with men analyze the significance of socially powerful groups or institutions, such as religious groups and the media, and learn how to engage and influence them. Examples include changing a church's focus from condemning homosexuality to respect for people with HIV, or encouraging newspapers to report positively and accurately about men who have sex with men and their efforts to reduce HIV infection.

PART III.

6.6 Programming in difficult or dangerous contexts

When programming in difficult, hostile or dangerous contexts, implementers should try and supply services to as many people as possible without putting clients or providers at risk. Implementers must consider the political and legal context of the site as part of deciding how best to initiate outreach or services to men who have sex with men. Issues to consider include:

- Anticipate that any records linking an individual man to a programme can be used by authorities to target men who have sex with men. These include records with real names, addresses, biometric information, project maps, identification numbers used for other purposes (medical records, university ID, driver's license etc), phone numbers and Facebook pages. Depending on the degree of danger, programmes should either ensure protection of the information or forgo collecting it at all. In such situations, the safest way to disseminate information about the programme and HIV, STIs and sexual health may be via word of mouth and referral to websites that are globally available or managed by the programme.
- De-stigmatize the programme by, for example, incorporating programming into a broader HIV programme for the general population or by partnering with a women's health organization to make the programme appear gender-balanced.

- Identify sympathetic providers who would be willing to provide services, provide necessary training for them, and refer via word of mouth.
- Distribute condoms and lubricants to all individuals using an HIV clinic or service centre or women's health clinics, to avoid stigmatizing lubricants.
- Men who have sex with men may be unable to disclose their sexual behaviours at public health services for HTC or ART. In this case, necessary information and counselling may need to be provided through separate outreach or at a venue managed by the programme.
- Link with global and regional human-rights and MSM groups (see Section 6.5.1).
- Retain a sympathetic lawyer for possible legal issues. Ensure adequate budgets for bail and legal fees.

Many of the recommended activities described earlier in this chapter regarding monitoring, coverage and record-keeping may have to be greatly curtailed because of safety concerns. It may still be possible to estimate programme coverage through surveys. However, funders should understand these monitoring constraints, and changes in the legal or social environment that affect the programme's ability to do its work should be communicated promptly to them.

In contexts where there is social or legal hostility towards men who have sex with men, homophobia can exist within service organizations as well as outside them, and can affect the willingness of men who have sex with men to receive services. Box 6.9 provides an example of steps taken to create a welcoming environment within a service-providing organization as well as in the wider society.

Box 6.9

Case example: Fostering organizational and social change for better sexual-health services in Venezuela

Same-sex sexual relations are not criminalized in Venezuela, and workplace discrimination on the basis of sexual orientation is illegal. However, a prevalent culture of machismo and strong traditional views make homophobia a widespread problem, including among providers of sexual-health services. The Asociación Civil de Planificación Familiar (PLAFAM) tackled these challenges in three ways: increasing the skills and sensitivity of its own staff; engaging with skilled and supportive local partners; and doing public outreach.

PLAFAM assessed the attitudes of its staff, management and governing board through a baseline survey. Experts provided technical assistance and training on sexual diversity and sexual rights, with a focus on implementing non-discriminatory policies. Institutional guidelines were developed to help guarantee an inclusive approach to sexuality in all programmes, policies and practices. The project improved the quality of care provided by the clinics, where service-providers now ensure a non-discriminatory and confidential environment for members of sexual minorities, and care that is responsive to their specific needs. PLAFAM found that the significant amount of time and ongoing effort it invested helped create lasting and positive organizational change.

Partnerships with local organizations working with sexual minorities were established, and their knowledge and expertise shaped PLAFAM's own programmes. Referral systems between the partner organizations created a network providing a wide range of non-discriminatory sexual-health services. Pooling resources and sharing tools helped prevent duplication of activities and made the programmes more efficient and effective. The civil-society organizations have also worked together to advocate for sexual rights.

PLAFAM conducted its own outreach with the public to raise awareness of existing laws and sexual rights as human rights. Drama and discussions were used with young people, with messages challenging traditional gender roles and stereotypes and promoting respect for sexual diversity.

6.7 Resources and further reading

Strategic planning and programme management

1. Planning guide for the health sector response to HIV/AIDS. Geneva: World Health Organization; 2011. http://whqlibdoc.who.int/publications/2011/9789241502535_eng.pdf
2. Planning and managing for HIV/AIDS results: a handbook. Washington (DC): Global AIDS Monitoring and Evaluation Team, World Bank Global HIV/AIDS Programme; 2007. http://documents.worldbank.org/curated/en/2007/09/9095764/planning-managing-hivaids-results-handbook
3. Guide to the strategic planning process for a national response to HIV/AIDS. Geneva: United Nations Joint Programme on HIV/AIDS; 1998. http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro_en.pdf
4. Practical guidance for scaling up health service innovations. Geneva: World Health Organization and ExpandNet; 2009. http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf
5. Nine steps for developing a scaling-up strategy. Geneva: World Health Organization and ExpandNet; 2010. http://whqlibdoc.who.int/publications/2010/9789241500319_eng.pdf
6. A commodity management planning guide for the scale-up of HIV counseling and testing services. Arlington (VA): Management Sciences for Health; 2008. http://www.msh.org/sites/msh.org/files/HIV-Testing-Commodity-Guide-VCT_final.pdf
7. Management and Organizational Sustainability Tool (MOST): a guide for users and facilitators, second edition. Cambridge (MA): Management Sciences for Health; 2004. http://www.msh.org/resources/management-and-organizational-sustainability-tool-most
8. Combination approaches: enhancing the reach & effectiveness of MSM-targeted combination HIV prevention interventions. HIV Prevention Knowledge Base, AIDSTAR-One. http://www.aidstar-one.com/focus_areas/prevention/pkb/combination_approaches/msm_reach
9. Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. World Health Organization, United Nations Joint Programme on HIV/AIDS, German Federal Ministry for Economic Cooperation and Development, The Global Forum on MSM & HIV, United Nations Development Programme; 2011. http://whqlibdoc.who.int/publications/2011/9789241501750_eng.pdf
10. Breaking through barriers: Avahan's scale-up of HIV interventions among high-risk MSM and transgenders in India. New Delhi: Bill & Melinda Gates Foundation; 2009. https://docs.gatesfoundation.org/Documents/breaking-thru-barriers.pdf
11. Technical guidance on combination HIV prevention: as part of PEPFAR's overall prevention strategy, this guidance document addresses prevention programmes for Men Who Have Sex with Men. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR); 2011. http://www.pepfar.gov/documents/organization/164010.pdf
12. Services for gay men and other men who have sex with men: guidance note. United Nations Joint Programme on HIV/AIDS; 2014. http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_servicesforMSM_en.pdf
13. The essential NGO guide to managing your USAID award. FHI360 and Management Systems International; 2010. http://www.fhi360.org/sites/default/files/media/documents/EssentialGuide.pdf

Defining programme logic model, implementation components and standards

1. Guidelines on estimating the size of populations most at risk to HIV. Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance; 2010. http://www.who.int/hiv/pub/surveillance/estimating_populations_HIV_risk/en/
2. It all starts here: estimating the size of populations of men who have sex with men and transgender people. Asia Pacific Coalition on Male Sexual Health; 2010 (Policy Brief No. 3). http://www.apcom.org/it-all-starts-here-estimating-size-populations-men-who-have-sex-men-and-transgender-people

3. PLACE—Priorities for Local AIDS Control Efforts: a manual for implementing the PLACE method. Chapel Hill (NC): MEASURE Evaluation; 2005.
http://www.cpc.unc.edu/measure/publications/ms-05-13

4. Using logic models to bring together planning, evaluation, and action: logic model development guide. Battle Creek (MI): W.K. Kellogg Foundation; 2004.
http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx

5. Proposals that work: a systematic guide to planning HIV projects. London: International Planned Parenthood Federation; 2006.
http://www.ippf.org/sites/default/files/hiv_proposals_that_work.pdf

6. HIV and young men who have sex with men: a technical brief (draft). Interagency Working Group on Key Populations; 2015.
http://www.who.int/hiv/pub/guidelines/briefs_msm_2014.pdf

7. Clinical guidelines for sexual health care of men who have sex with men. IUSTI Asia Pacific Branch; 2006.
http://www.iusti.org/sti-information/pdf/iusti_ap_msm_nov_2006.pdf

8. Clinic operational guidelines & standards: comprehensive STI services for sex workers in Avahan-supported clinics in India. New Delhi: Family Health international [no date].
https://www.indiahiv.org/Documents/Avahan%20COGS.pdf

9. Engaging with men who have sex with men in the clinical setting: a primer for physicians, nurses and other health care providers. The Global Forum on MSM and HIV; 2011.
http://www.msmgf.org/files/msmgf/Publications/MSMGF_Healthcare_Primer.pdf

10. Lessons from the front lines: effective community-led responses to HIV and AIDS among MSM and transgender populations. The Foundation for AIDS Research and The Global Forum on MSM and HIV (no date).
http://www.amfar.org/uploadedFiles/_amfarorg/Around_the_World/Lessons-Front-Lines.pdf

11. Peer Driven Interventions. Paper available at:
https://www.chip.uconn.edu/chipweb/pdfs/PDI%20Summary.pdf

Qualitative data assessment

1. Participatory Ethnographic Evaluation and Research (PEER).
http://www.rutgers.international/our-products/tools/explore

2. Explore toolkit for involving young people as researchers in sexual and reproductive health programmes. Utrecht, Netherlands: Rutgers WPF and International Planned Parenthood Federation; 2013.
http://www.rutgerswpf.org/our-products/tools/explore

Monitoring and evaluation

1. Tool for setting and monitoring targets for HIV prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization, 2015.
http://www.who.int/hiv/pub/toolkits/kpp-monitoring-tools/en/

2. Operational guidelines for monitoring and evaluation of HIV programmes for sex workers, men who have sex with men, and transgender people. Volume 1: national and sub-national levels. Chapel Hill (NC): MEASURE Evaluation; 2013.
http://www.cpc.unc.edu/measure/publications/ms-11-49a

3. National AIDS programmes: a guide to monitoring and evaluation. Geneva: Joint United Nations Programme on HIV/AIDS; 2000.
www.who.int/hiv/pub/me/pubnap/en/

4. A guide to monitoring and evaluation of capacity-building interventions in the health sector in developing countries. Chapel Hill (NC): Carolina Population Center, University of North Carolina at Chapel Hill; 2003 (MEASURE Evaluation Manual Series, No.7).
http://www.aidstar-two.org/Tools-Database.cfm?action=detail&id=86&language_id=

5. Monitoring and evaluation systems strengthening tool. Developed by the Global Fund, PEPFAR, USAID, and others. Published through the USAID Measure Evaluation Project, 2007.
http://www.cpc.unc.edu/measure/publications/ms-07-18

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http://www.amfar.org/uploadedFiles/_amfar.org/In_The_Community/Publications/MSMguidance2011.pdf

Supervision system

1. Making supervision supportive and sustainable: new approaches to old problems. Washington, DC: Maximizing Access and Quality Initiative; 2002.
http://www.k4health.org/sites/default/files/maqpaperonsupervision.pdf
2. Supportive supervision to improve integrated primary health care. Cambridge (MA): Management Sciences for Health; 2006.
http://www.popline.org/node/193349

Other

1. Fundraising toolkit: a resource for hiv-related community-based projects serving gay, bisexual and other men who have sex with men (MSM) and transgender individuals in low- and middle-income countries. The Foundation for AIDS Research; 2012.
http://www.amfar.org/uploadedfiles/_amfarorg/around_the_world/msmtoolkit.pdf
2. Lessons from the Front Lines: Political Impact and System Change. The Foundation for AIDS Research and The Global Forum on MSM & HIV; 2012.
http://www.amfar.org/uploadedFiles/_amfarorg/In_The_Community/LessonsFrontlines2012.pdf
3. Keys to youth-friendly services: celebrating diversity. London: International Planned Parenthood Federation' 2011.
http://www.ippf.org/resource/Celebrating-diversity

Organizational capacity-building

1. Managers who lead: a handbook for improving health services. Cambridge (MA): Management Sciences for Health; 2005.
http://www.msh.org/sites/msh.org/files/mwl-2008-edition.pdf
2. Health systems in action: an eHandbook for leaders and managers. Cambridge (MA): Management Sciences for Health; 2010.
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3. Systematic organizational capacity building: tackling planning and implementation challenges. Cambridge (MA): Management Sciences for Health; 2011.
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4. Organizational capacity building framework: a foundation for stronger, more sustainable HIV/AIDS programs, organizations & networks. Cambridge (MA): Management Sciences for Health; 2011.
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Further reading

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3. Key Populations Action Plan 2014-2017. Geneva: The Global Fund to fight AIDS, Tuberculosis and Malaria; 2014.
4. Kirby T, Thormber-Dunwell M. Phone apps could promote sexual health in MSM. Lancet 2014; 384(9952):1415.
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