



# Summary of a Regional Consultation on Health Promotion and the Provision of Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean

July 14-16, 2009 • Panama City, Panama



**Pan American Health Organization**



Regional Office of the World Health Organization



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## Document Description

This document summarizes discussion and the most relevant recommendations emerging from an expert “Regional Consultation on Health Promotion and the Provision of Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean.”

The Regional Consultation was held July 14-16, 2009, in Panama City, Panama, and was organized by the Pan American Health Organization (PAHO), in collaboration with the United Nations Development Program (UNDP); the United Nations Educational, Scientific, and Cultural Organization (UNESCO); the United Nations Population Fund (UNFPA); the United Nations Children’s Emergency Fund (UNICEF); the Joint United Nations Program on HIV/AIDS (UNAIDS); the World Association of Sexology (WAS); and the International Association of Physicians in AIDS Care (IAPAC). The Regional Consultation was made possible through the financial support of GTZ (*Gesellschaft fuer Technische Zusammenarbeit*).

More than 50 experts from North America, Latin America, and the Caribbean participated in the consultation and contributed knowledge and expertise producing a set of tools that will guide planning and implementation of health promotion and health care activities for MSM in the Region.

## Background

Early in 2008, the Joint United Nations Program on HIV/AIDS (UNAIDS) and the Group of Horizontal Technical Cooperation (GCTH) – a group of national AIDS program directors from 21 countries in the Latin America and Caribbean (LAC) Region – held a consultation meeting in Brazil to identify general lines of action for a regional strategic plan intended to improve overall quality of life and health for lesbian, transgender, bisexual, gay, and other MSM communities. During that meeting, participants agreed that a core line of action had to be focused on the provision of accessible, high quality health care services.

In November 2008, a separate group of experts in the provision of clinical care met in Acapulco, Mexico, and proposed general lines of action to address the health care needs of MSM communities in Latin America. Recommendations from both these meetings gave shape to a “Regional Consultation on Health Promotion and the Provision of Care to Men Who Have Sex with Men (MSM) in Latin America and the Caribbean,” which was held July 14-16, 2009, in Panama City, Panama. These same recommendations underpinned preparation of the working documents utilized at the Regional Consultation, which was the first large meeting on this topic held in The Americas, and follows similar consultations in Europe (Slovenia, May 2008) and Asia (Hong Kong, February 2009).

More than 50 experts from various specialties, disciplines, and fields of health promotion and health care from throughout North America, Latin America, and the Caribbean responded positively to the invitation to attend the Regional Consultation in Panama City. Prior to the meeting they received working documents that were in draft form. Also prior to the meeting, many of these experts provided valuable insights and suggestions. At the meeting, this group of experts, along with technical officers from United Nations agencies and other relevant stakeholders worked intensively to review and revise the working documents that would serve as the blueprint to develop the main outcome of the meeting: a set of tools and instruments to guide the planning and implementation of health promotion and health care activities for MSM communities in the LAC Region.

Following are some important caveats:

- 1) The tools discussed were intended to be designed for and implemented primarily in health care settings. However, caution was urged during the meeting that those activities should not be disconnected from other strategies and social services and outreach programs, but rather an integral part of them; and
- 2) The Regional Consultation focused mainly on gay and bisexual men as the points of reference for MSM communities. Participants agreed that further consultations should focus on other populations whose needs were not adequately addressed at the meeting, such as the more particular health care needs of transgendered individuals and communities. These other meetings would need to include broader representation of stakeholders from these communities (e.g., transgendered communities) to ascertain appropriateness and relevance of recommendations, and to develop more specific tools and instruments for these communities.

## Rationale for a Regional Plan to Improve Health Promotion and Health Care for MSM Communities

The HIV pandemic has helped place neglect of care and support for MSM communities in stark relief. Despite evidence that the HIV epidemic in the Western Hemisphere is mainly concentrated in certain populations, such as MSM, commercial sex workers, and injecting and non-injecting drug users, few countries have taken proactive measures to address this situation and to establish and promote appropriate health care services to tend to the needs of these specific groups.

Available data show that MSM are disproportionately affected by sexually transmitted infections (STIs), particularly HIV, with rates of infection that are five to 10 times higher than the general population in most of the large cities in the LAC Region. However, programs directed to MSM receive less than 1% of total HIV spending in Latin America and the Caribbean, although these men represent 25% of the 1.7 million people living with HIV/AIDS.

*It is a public health imperative to develop a supportive environment in which all people are treated with dignity and respect, and where health care services are geared to the various realities confronted by MSM.*

Other frequent and related health issues that disproportionately affect MSM communities include mental health problems, drug and alcohol abuse, chronic stress, anxiety, and depression as a result of hostility, bullying, and other forms of ignorance, stigma, and discrimination. Indeed, the triad of ignorance, stigma, and discrimination has played a significant

role not only in affecting the health of MSM in Latin America and the Caribbean, but in restricting access to health services. In addition to overt forms of exclusion from health services – which varies from country to country in the LAC Region – existing services are often delivered by personnel with no or insufficient expertise in the unique health needs of MSM, which for purposes of this document includes homosexual and bisexual men, as well as men who do not self-identify as gay but who have sex with other men.

It is a public health imperative to develop a supportive environment in which all people are treated with dignity and respect, and where health care services are geared to the various realities confronted by MSM. While these challenges come into very clear focus through the lens of the HIV pandemic, a similar pattern of exclusion and discrimination shapes the experience of MSM irrespective of HIV. These barriers make it imperative that a broad approach to appropriate “health care” be taken in addressing the needs of MSM communities, and not uniquely focused on HIV prevention, care, and treatment.

As a fundamental principle, it must be agreed that all individuals play a valuable role in a healthy society, regardless of perceived or actual sexual orientation or gender identity. Unfortunately, sexual prejudice and repression have impeded and curtailed the human rights

1. The Institute of Medicine defines quality of care as, “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” The system components of health care quality are safety, effectiveness, patient centeredness, and timeliness. US Department of Health and Human Services, Agency for Healthcare Research and Quality. *National Healthcare Quality Report 2005*. Rockville, MD: Agency for Healthcare Research and Quality, 2006.

and recognition of sexual minorities throughout the LAC Region, including access to universal and non-discriminatory health care.

Therefore, developing supportive health care environments where all individuals are treated respectfully and provided high quality services<sup>1</sup> must not be considered an option, but rather a requirement of health systems. In order to fully address the health needs of the diverse MSM population, health systems and services will require reforms that distribute resources adequately and equitably, and that implement systemic policies that appropriately address the needs of MSM communities. The sum of these efforts must be to eliminate discrimination against MSM in access to and promotion of appropriate health services and, thereby, to help reduce ignorance, stigma, and discrimination in broader societal terms, beyond the health system.

Public policies are typically grounded in assumptions that reflect the perceptions, attitudes, and values of society at large. These social constructs and the manner in which they result in decisions about how, where, and for whom social resources are allocated and/or to whom we make available public services, have a tendency to outcast certain vulnerable groups. At the same time, however, these resources and services can become rallying “symbols” allowing vulnerable groups that are excluded to develop resilience and advocate their respective causes and needs.

Health authorities, providers, and all other relevant stakeholders should be aware of the social constructs that underlie health policy designs and health services decisions, as well as their own attitudes and behaviors that may accentuate disparities, augment vulnerabilities, and violate human rights. Development of this “critical consciousness” among health planners and health care providers is an essential step toward reversing prejudicial and exclusionary public health practices and in building more equitable health systems.

Accordingly, the provision of inclusive and effective health services to MSM communities in Latin America and the Caribbean will require not only a more equitable distribution of resources to appropriate services, but also a conscious shift in attitudes and practices among health system planners and health care providers as leaders of change.

## Access to Comprehensive Care by MSM

Discussions about this underserved population require a clear, conceptual understanding of MSM as a distinct and vulnerable group requiring attention and services that appropriately reflect their distinct needs (or “target population”).

Schneider and Ingram<sup>2</sup> define a “target group” as one that is or will be the subject of a particular policy, intervention, program, or project. Often, these target populations are socially constructed, and this construction is based on values, symbols, or images that one group has about another. This definition of a “target group” is thus instrumental in identifying the “policy problem” and the “policy agenda,” and in framing interventions and solutions. This is so because these symbols or images remain “enshrined” in public policy. Public policy communicates which individuals or groups deserve what type of benefits and information, and therefore what kind of participation is desirable and appropriate.

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2. Schneider A, Ingram H. Social construction of target populations: implications for politics and policy. *The American Political Science Review*. 1993;87(2): 334-347.

Furthermore, the definition of “MSM” as a “target population” takes on the practical problem of defining “MSM” as a construct that refers to a diverse population of individuals whose main common trait are the gender and the sexual attractions and desires of their sexual partners, and perhaps nothing else. In other words, it does not account intrinsically for the broad differences of identity (e.g., race, class, age, language, and other factors) that are also important in shaping individual experiences and behaviors. Developing customized recommendations and proposing standardized interventions is very difficult, if not impossible, and there is a consistent tension between the notion of MSM as a common group, and between significant diversity among MSM.

Moreover, given that sexual activities between people of the same sex are still socially frowned upon in the LAC Region (even though there has been a trend toward decriminalizing homosexuality, particularly in Latin America), it is likely that same-sex sexual activity will remain hidden, often occurring in a clandestine manner and not being disclosed at all to health care providers. This reality contributes to the spread of stereotypes and absurd oversimplifications, jeopardizing the collection of health data that could contribute to further understanding the complexities of MSM populations.

Within the MSM population there is one particular group, gay men, who in general terms acknowledge a sexual orientation toward other men and recognize their attractions and desires – provided a relatively safe social environment – and take public pride in their identity and relationships. However, other MSM, including those who have sex with both men and women, do not share these attitudes. This type of openness and public disclosure does not occur regularly among men who are married to women but who are sexually active with males, or among men who only have sex with men but do not acknowledge doing so, and/or among men who are socially isolated (e.g., in prisons) and without access to sexual partners of the opposite sex, and therefore have sex with other men.

To deal with this practical difficulty of “hidden identity,” it would be useful to describe the target population as “gay men and other men who have sex with men,” following the consensus reached by the International Lesbian and Gay Association (ILGA) on the use of the term “MSM.” The motion was accepted by participants in the Panama City meeting since this description provides both a group identity and an encompassing definition that are necessary to develop diverse and complementary strategies to expand access to comprehensive health care. Extramural interventions and outreach by health care services may serve to increase their utilization by gay men. On the other hand, other MSM may need targeting through the expansion of coverage strategies, provision of safe spaces, and other strategies.

## **Determinants of Health of Gay Men and other MSM: Design and Performance of Health Systems**

Like that of any other human population, the health of MSM is associated with and affected by a wide range of factors that can be roughly grouped as:

- Biological: heredity, nutritional status, physical condition, existing diseases, sequels of previous conditions;
- Non-biological: education, income, race/racism, sexual identity/heterosexism, language, social support networks, conditions conducive to self-protection and self-care;

- Health care system design: policy and delivery characteristics that affect costs, expenditure, and utilization patterns; and
- Health care system performance: processes, inputs, outcomes, efficiency, and equity.

The MSM population shares many of the determinants of health of the male population at large (e.g., gender codes associated to health care-seeking behaviors). Nevertheless, some specific factors are more relevant to the health of MSM, such as homo-negative public policies; social values strongly rooted in a patriarchal, heterosexist tradition; discrimination, bullying, and harassment in public spaces; alienation and exclusion from social groups of reference; and homophobia, both external and internalized.

In addition, other behavioral factors play a critical role in the attainment and maintenance of the health of gay men and other MSM – physical activity, use of alcohol and tobacco, dietary and sleep habits, and susceptibility to infectious diseases, among others.

The design and performance of health systems play a critical role in the attainment and maintenance of the health of gay men and other MSM. Health care systems in the LAC Region have some specific features that may enhance or obfuscate health-seeking behaviors and utilization of health care services by gay men and other MSM. Among others, the following are not uncommon:

- Generally designed to provide curative/repairative responses with limited emphasis on health promotion and illness prevention;
- Tend to privilege the provision of care at specialized levels;
- Give limited attention to sexual health, which is usually reduced to reproductive outcomes;
- Pay inadequate attention to the health care needs of all adult men, even within reproductive health programs and services;
- Their priorities may be affected by values, interests, and beliefs of decision-makers;
- Their functional linkages with other sectors (e.g., education, justice, welfare, labor) are not always clearly defined;
- Have no, few, or very narrow provisions for dealing with the health impact of discrimination, bullying, and other stigmatizing and discriminatory practices;
- Have inadequate capacity to deal with non-heterosexual sexualities;
- Have serious limitations to provide services for under age youth (e.g., counseling, testing); and
- Have no, few, or very narrow provisions to facilitate access to men in the labor force who have working schedules usually incompatible with health care service delivery schedules.

*...the specific and concrete actions to ensure expanded access to inclusive and quality attention should be undertaken in ways that effectively address perceived and actual barriers to receiving health care services and treatment, and resources to improve health in general.*

Some of these features may represent barriers that prevent men in general, and homosexual men in particular from accessing routine services that are essential for HIV prevention, care, and treatment, and for the overall care of their health and well-being. Consequently, the specific and concrete actions to ensure expanded access to inclusive and quality attention should be undertaken in ways that effectively address perceived and actual barriers to receiving health care services and treatment, and resources to improve health in general.

## Strategic Actions to Achieve Inclusive and Quality MSM-Focused Services

The establishment of clinics devoted exclusively to the needs of MSM would seem a concrete solution to deal with limitations resulting from the design and performance of the general health system (i.e., one that either prevents MSM from being served or poses barriers to MSM in utilizing existing services). While this solution may be useful in some situations, it may prove of very limited reach and effectiveness, and is perhaps only feasible in sites where stigma, discrimination, and fear of intimidation and violence may not represent a serious barrier for potential users. A more practical, and in turn effective, approach may be to expand coverage for young and adult men at large, and in the context of comprehensive male health care services. These services could incorporate strategic orientations, actions, and interventions that are essential for MSM. This requires careful service design to ensure that:

- Providers are aware that the user of the service may require some specific attention because of his sexual activities, orientation, and/or identity;
- Providers are familiar with a set of core algorithms for the management of the most common health (including mental) care concerns and needs of MSM;
- Users of male health care services perceive and recognize these spaces as safe, supportive, and inclusive;
- User needs are met through comprehensive approaches that include educational interventions, laboratory examinations, and referral to other appropriate services; and
- Services are open to the diversity that exists within the male population.

Young men should also be taken into consideration and, in those places in which comprehensive, youth-friendly health care services exist, the set of core algorithms for the management of common health care needs of young MSM (YMSM) must be in place. These algorithms should be an essential part of routine youth health service delivery and applied whenever health service providers identify the need to do so or when users of these services explicitly request them.

In some places, the entry point for the provision of comprehensive care to MSM could be family health, family planning, or other sexual and reproductive health care services. Even if the use of this approach might make it more difficult to identify individuals who engage in same-sex sexual activities, the fact that an important number of MSM also have sex with women demands that the proposed set of strategic actions have a “spill-over” benefit for the female population.

Perhaps the most relevant element that deters the provision of inclusive and high quality services to gay men and other MSM is the constellation of negative attitudes and behaviors, usually stemming from ignorance, fundamentalism, and patriarchal heterosexism that demean and disqualify people who engage in non-heterosexual activities. These negative attitudes and behaviors are commonly defined as “homophobia.” Homophobic expressions oscillate from disapproving gestures and demeaning slurs to overt discrimination, and some times even violence. Health care providers are not exempt from the influence of pervading homophobia and this may:

- Reduce coverage to MSM populations because providers refuse to tend to the concerns and needs of MSM;
- Impede voluntary access by members of the gay community and MSM population at large since they will feel and be unable to be recognized in an open, inclusive, friendly,

and safe setting; and

- Further impede utilization, because MSM do not want to be re-victimized by facing further stigmatization and discrimination.

Accordingly, high quality health services for MSM must be inclusive, non-judgmental, and free from stigma, discrimination, and homophobia. This inclusivity can only be attained through strategies designed to sensitize and educate providers and all other staff members to be accepting, respectful of diversity, sympathetic, and supportive of gay men, other MSM/YMSM, and indeed to the full sexual diversity continuum. These critical strategies are based on comprehensive training on human sexuality, familiarity, and interaction with members of sexually diverse communities, and an understanding of the emotional, health, and social cost of inaction against homophobia. Many organizations that have achieved inclusive environments such as these have entrenched these practices and values in:

- Service provider agreements;
- Staff codes of conduct;
- Organizational policies and vision statements; and
- Ongoing professional development and group learning.

While these practices may not always be practical or possible, and will vary from setting to setting according to laws, regulations, and other local realities, organization-wide practices such as these can help to ensure that inclusivity is entrenched in organization culture and not limited to individual preferences or attitude.

## Blueprint for the Provision of Comprehensive Care to Gay Men and Other MSM in Latin America and the Caribbean

One of the tools discussed and adapted during this Regional Consultation was a “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” (hereafter referred to as the “Blueprint”) that describes the sequence of events that should ideally occur when a gay man or other MSM visits a health care setting requesting guidance or attention for a specific concern or need. The participants selected a group of health issues that are of particular relevance for the “target population” and established algorithms to guide the actions of providers and other staff members in health care settings.

The Blueprint includes the following sections:

- The first encounter, which relates to the arrival to the health care setting and the necessary actions to ascertain information and data on the sexual behaviors of the male users, to guide subsequent actions;
- The first clinical evaluation, focused on guidance in conducting a comprehensive clinical history and physical examination, to better define health care concerns and needs; and
- Clinical management algorithms that provide specific guidance with respect to HIV risk and infection; STIs; anal-rectal health; substance use, abuse, and dependence; mental health issues; sexual concerns; and consequences of sexual violence.

Importantly, the relevance and peculiarities of all these topics for YMSM was carefully reviewed by an ad-hoc working group, and a number of their recommendations are noted throughout this summary of the Regional Consultation.

In terms of specific recommendations, the participants raised some concrete points related to the various sections of the Blueprint that were analyzed and incorporated, as appropriate.

*While bearing in mind best practices, the way forward in most settings will be to deliver services that are more comprehensive, and in inclusive environments.*

#### THE FIRST ENCOUNTER

In places where services are offered to MSM, there has been a tendency to focus almost exclusively on the care and treatment of HIV/AIDS and other STIs, and to offer these services separate from coordinated primary health care. While bearing in mind best prac-

tices, the way forward in most settings will be to deliver services that are more comprehensive, and in inclusive environments. For example, these environments may include primary health care clinics with services for men, comprehensive care services for youth, and family or community health centers (e.g., *dispensarios comunitarios*). Specialized clinics for MSM may be an option in places where men attending may not feel threatened by stigma and discrimination.

Regardless of the setting, the place where the first encounter takes place and the atmosphere surrounding this event are crucial for all the subsequent events in the provision of comprehensive care. Mindful of the importance of this first encounter interaction, key recommendations highlighted by the participants included the following:

- MSM community endorsement is essential to conduct effective outreach, thus augmenting service utilization;
- Clear and visible indications that services are friendly to MSM (e.g., signs, patient bill of rights on display) contribute to building trust and user confidence;
- Patient-staff discussions in the waiting room must be treated as confidential (e.g., appropriate distance between sign-in counter and seating area);
- Welcoming of companions as a form of encouragement/support, advocacy, and/or safety must be allowed and supported (e.g., female companions in distinctly homophobic environments);
- Staff selection should include an assessment of attitudes appropriate to interacting with the “target population”; and
- Hours of availability should match needs of MSM – after-hours services may be offered even when centers are not staffed (e.g., consistent availability of reference and safer sex educational materials).

#### THE FIRST CLINICAL EVALUATION

The participants stressed that in reviewing patient history, health staff should be encouraged to frankly and openly discuss a patient’s sexual orientation or sexual behavior(s) while being at the same time tactful and respectful. Correspondingly, during the first clinical evaluation, health staff should encourage all MSM to have twice-annual HIV testing and an annual anal-rectal examination.

## CLINICAL MANAGEMENT ALGORITHMS

### HIV Risk and Infection

Participants cited contemporary research which clearly indicates that HIV infection still disproportionately affects gay men and other MSM. HIV prevalence may be much higher among MSM than the general population. Yet, treatment is available to less than one-fifth of HIV-infected MSM. Therefore, efforts to promote and facilitate early diagnosis of HIV infection and timely initiation of antiretroviral therapy among MSM are crucial. Moreover, reduction-of-risk activities must be a critical component of the “package of core interventions for HIV care,” particularly among MSM/YMSM. This includes:

- Providing accurate, concise, non-judgmental, and direct information to ensure full understanding of the notion of risk of exposure to HIV and the value of testing and timely initiation of treatment;
- Posing direct questions during the process of HIV risk assessment that are presented in a respectful manner, and which focus on sexual practices that may increase such risk (unprotected anal intercourse, fisting [a sexual activity that involves inserting a hand into the rectum], sharing sex toys);
- When suggesting provider-initiated HIV testing, clearly stating that the offer is being made because a potential risk of exposure to HIV has been ascertained, not because the individual is gay or bisexual or has had sex with men; and
- Providing support for the voluntary disclosure of HIV testing results with others, particularly sexual partners.

Antiretroviral therapy recommendations are in alignment with international standards, with the proposed algorithm taking into consideration the specific needs and challenges faced by gay men and other MSM.

### Sexually Transmitted Infections

Since the Blueprint document is not meant to supplant existing algorithms on STI care for countries in Latin America and the Caribbean, only the most neglected and relevant STIs are discussed in the Blueprint. For example, special emphasis has been placed on the extra-genital location of manifestations of infection (e.g., oropharyngeal, anal, rectal). Participants stressed the asymptomatic nature of certain STIs as a factor that should serve to encourage at least one STI examination per year among sexually active men who have had unprotected sexual activities.

### Anal-Rectal Health

Anal examination should be part of the overall physical examination routine. Sexual practices that are found among MSM populations such as fisting, rimming (anal-oral contact), and douching should be openly discussed and the risk for lesions or infections assessed. Concise and well-supported information should be provided in a non-judgmental manner. Pre-cancerous lesions and tumoral growths must be identified and treated.

There may be considerable challenges with health care workers who are not familiar with the associated sexual activities that may result in adverse anal health outcomes. Such lack of familiarity may compromise the practitioner’s ability to sensitively and respectfully undertake such an exam.

Practitioners should be trained to conduct anal examination and sensitized to the fact that for some MSM the anal area is considered a sexual organ. Therefore, specific conditions and infections can be associated with sexual activity outside of conditions associated with intestinal evacuation.

Participants noted that any discussion about sexual health in MSM should be cautious about treating the body as a collection of sexually related “orifices and pipes.” Practitioners should be encouraged to see the patient holistically and not to reduce men only to their sexual functions and activities.

#### **Substance Use, Abuse, and Dependence**

This section of the Blueprint includes a carefully written recognition of the increased risk of substance use, abuse, or dependence among certain segments of the MSM population, and how alcohol and other drugs may increase vulnerability to HIV and other STIs. The section also explores how alcohol and drug use may be the expression of underlying conditions such as anxiety or depression that need to be recognized and addressed. The associated algorithm discusses interactions between antiretroviral drugs and recreational drugs.

#### **Sexual Concerns**

The MSM population, much like the male population in general, presents concerns and expresses complaints about their sexual performance and satisfaction. These concerns and complaints, in addition to the suffering and pain they cause, may also be the root for other conditions such as anxiety and fear that perpetuate dysfunctional patterns of sexual response. Sexual dysfunction may also be the first recognizable manifestation of some other health condition (e.g., diabetes, cardiovascular disease) or the side effects of some medications.

Drugs used to enhance sexual performance may have unwanted effects that must be prevented. Amyl nitrates (“poppers”) taken through direct inhalation for recreational purposes and/or for improving sexual experience (reducing discomfort during receptive anal sex) can cause severe cardiovascular symptoms if taken with medications for enhancing erection.

Participants noted that health care practitioners, in general terms, have little experience in dealing with and addressing sexual complaints and concerns. This lack of experience is particularly evident when practitioners have to deal with complaints related to non-heterosexual activities.

#### **Consequences of Sexual Violence**

Protocols already exist for women who fall victim to sexual violence. In the Blueprint, these existing protocols have been adapted for the purposes of MSM who are victims of sexual violence, particularly as it relates to the provision of antiretroviral post-exposure prophylaxis (PEP), as well as emotional and social support.

## **Young Men Who Have Sex with Men**

Participants recommended that health communication tools and even staff selection needs to account for age-related differences in decision-making, health-seeking behaviors, adherence to treatments, trust in providers, and disclosure of private information. Cultural aspects of youth, such as use of language, should be taken into consideration when training providers to tend to the specific needs of the YMSM population.

Youth should also be recognized as a quickly evolving segment of the population whose characteristics cannot be easily described since many of them undergo several transformations in sexual behavior and/or identity throughout their adolescent and teenage years.

The Blueprint recognizes that not all YMSM have sex with other YMSM. For example, there is a high degree of cross-generational sex in Latin America and the Caribbean. The document also acknowledges the factors that increase the vulnerability of YMSM to certain situations (especially suicide and depression) and proposes strategies to address those factors (including homophobic bullying). While most clinical management algorithms do not differ in their content whether they are directed to YMSM or adult MSM, participants noted a clear need to adjust approaches when meeting the needs of young men.

*Youth should also be recognized as a quickly evolving segment of the population whose characteristics cannot be easily described since many of them undergo several transformations in sexual behavior and/or identity throughout their adolescent and teenage years.*

## Implementation of the Recommendations

In addition to contributions made for the development and revision of the technical documents, participants at the Regional Consultation made a series of concrete proposals to ensure the prompt and effective implementation of the recommendations they made in Panama City. These proposed actions are as follows:

- The highlights of the Regional Consultation will be widely disseminated (e.g., this “Summary of a Regional Consultation on Health Promotion and the Provision of Care to Men Who Have Sex with Men (MSM) in Latin America”) and presented at regional events and via virtual/Internet-based discussions.
- A Committee will be established to review and finalize the various sections of the Blueprint. The Pan American Health Organization (PAHO) is charged with finalizing the Blueprint. English, Portuguese, and Spanish versions should be made available.
- Prior to finalization, the draft Blueprint will be shared with heads of national AIDS programs via the Horizontal Technical Cooperation Group (GCTH) and other stakeholders to make any necessary adjustments that would enhance the relevance and appropriateness of the document.
- A feasibility study will be conducted in two to three countries to examine the opportunities and barriers to implement the Blueprint’s recommendations in primary health care settings and sexual and reproductive health care services.
- PAHO member countries will receive direct technical cooperation for the adoption/adaptation of the Blueprint’s recommendations, and will set goals of coverage for gay men and other MSM.
- A set of similar documents will be prepared for transgendered populations, and a Regional Consultation scheduled for 2010.
- A virtual space for exchange of reference and working materials for MSM is to be created and administered by PAHO. This virtual space will serve as a forum for the exchange of technical information, a clearinghouse for relevant MSM health documents, and a virtual journal on Male Sexual Health.

## Participants in the Regional Consultation

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