

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

Based on Recommendations from a Group of Experts Convened for 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" held July 14-16, 2009, in Panama City, Panama



Pan American Health Organization



Regional Office of the World Health Organization



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

Based on Recommendations from a Group of Experts Convened for 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” held July 14-16, 2009, in Panama City, Panama



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*

PAHO HQ Library Catalog-in-Publication

Pan American Health Organization

“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, D.C.: OPS, © 2010

ISBN: 978-92-75-13088-9

I. Title

1. HOMOSEXUALITY, MALE
2. SEXUAL BEHAVIOR
3. SEXUALLY TRANSMITTED INFECTION – prevention & control
4. HIV INFECTION
5. HEALTH PROMOTION
6. LATIN AMERICA – ethnology
7. HEALTH KNOWLEDGE, ATTITUDES, PRACTICE
8. HEALTH VULNERABILITY
9. CARIBBEAN REGION

NLM WA300

The Pan American Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

Applications and inquiries should be addressed to the HIV/AIDS Unit, Pan American Health Organization, Washington, DC, USA, which will be glad to provide the latest information on any changes made to the text, plans for new editions, and reprints and translations already available.

© Pan American Health Organization, 2010

Publications of the Pan American Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. All rights are reserved. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the Pan American Health Organization concerning the status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the Pan American Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The Pan American Health Organization is an international public health agency with 100 years of experience working to improve health and living standards of the people of the Americas. It enjoys international recognition as part of the United Nations system, serving as the Regional Office for the Americas of the World Health Organization, and as the health organization of the Inter-American System. Further information: <http://www.paho.org>

Document Description

This document reflects 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); World Association for Sexual Health (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 Regional Consultation and contributed knowledge and expertise producing a set of tools – including this “Blueprint for the Provision of Comprehensive Care to Gay Men and Other Men Who Have Sex with Men (MSM) in Latin American and the Caribbean” – that will guide planning and implementation of MSM-oriented health promotion and health care activities in the region.

Background

Early in 2008, the Joint United Nations Program on HIV/AIDS (UNAIDS) and the Group for 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 men who have sex with men (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 Pan American Health Organization (PAHO)-hosted “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 an 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, these experts, along with technical officers from United Nations (UN) agencies and other relevant stakeholders, worked intensively to review and revise the working documents that would serve as a foundation 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 two 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 consultation meeting that those activities should not be disconnected from other strategies, social services, and outreach programs, but rather an integral part of them; and
- 2) The Regional Consultation focused mainly on gay and other MSM 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 transgender individuals and communities. These other consultation meetings would need to include a broader representation of stakeholders from these communities (e.g., transgender communities) to ascertain appropriateness and relevance of recommendations, and to develop more specific tools and instruments for these communities.

Abbreviations

AIDS – acquired immune deficiency syndrome
ART – antiretroviral therapy
BID – twice daily
CBC – complete blood count
CBO – community-based organization
CSB – compulsive sexual behavior
ED – erectile dysfunction
ELISA – enzyme-linked immunosorbent assay
GCTH - Group of Horizontal Technical Cooperation
HAV – hepatitis A virus
HBV – hepatitis B virus
HCV – hepatitis C virus
HIV – human immunodeficiency virus
HPV – human papilloma virus
HSV – herpes simplex virus
IDU – injection drug user
IM – intramuscular
LAC – Latin America and the Caribbean
LGV – lymphogranuloma venereum
MAC – Mycobacterium avium complex
MSM – men who have sex with men
NGO – nongovernmental organization
NRTI – nucleoside reverse transcriptase inhibitor
OI – opportunistic infection
PAHO – Pan American Health Organization
PCP – *Pneumocystis pneumonia*
PCR – polymerase chain reaction
PEP – post-exposure prophylaxis
PI – protease inhibitor
PO – by mouth
PPD – purified protein derivative
PTSD – post-traumatic stress disorder
SSRI – selective serotonin reuptake inhibitor
STI – sexually transmitted infection
SUAD – substance use, abuse, and dependence
TB – tuberculosis
UNAIDS – Joint United Nations Program on HIV/AIDS
WHO – World Health Organization
YMSM – young men who have sex with men

Table of Contents

Introduction	1
Conditions Affecting MSM in the LAC Region	2
MSM Health Determinants	8
MSM Health Challenges	9
MSM Self-Care and Health-Seeking Behaviors	10
Planning MSM-Inclusive Health Care Settings	11
MSM Service Delivery Approaches	16
Management Algorithms	
First Clinical Evaluation	18
HIV Risk and Infection	21
Sexually Transmitted Infections	24
Anorectal Health	26
Substance Use and Associated Problems	28
Sexual Concerns	31
Emotional and Mental Health.....	34
Consequences of Violence	35
MSM Health Promotion Activities.....	38
Health Outreach for MSM	39
Considerations for Working with YMSM	41
Conclusion.....	43
Bibliography.....	46
Annexes: Management Algorithms	
Annex 1: First Clinical Evaluation	49
Annex 2: HIV Risk and Infection	50
Annex 3: Anorectal Health	51
Annex 4: Substance Use	52
Annex 5: Sexual Concerns	53
Annex 6: Emotional and Mental Health	54
Annex 7: Consequences of Violence.....	55
Annex 8: Community-Clinic Interaction	56

Introduction

The World Health Organization (WHO) has recognized the importance of strong primary health care services for ensuring the health of communities and nations. In addition to equitable geographic distribution, health services must also be available to a variety of multifaceted communities within towns, cities, regions, and countries throughout the world.

In part due to ignorance, stigma, and homophobia, health services, including primary health care, typically have not been adequately responsive to the health needs of gay men and other men who have sex with men (MSM) in the Latin America and the Caribbean (LAC) Region. The formal health sector, including Ministries of Health and Social Security Administrations, often lack personnel with expertise in the diverse health needs of gay men and other MSM populations. Conversely, health centers designed to serve diverse MSM often lack resources to provide the full array of needed services and may benefit from strengthening their core health services.

The WHO has also recognized the importance of sexual health services as an important component of health services available to a community. Gay men and other MSM have distinct sexual health needs, many of which are overlooked in the formal health setting. Given the increasingly high rates of sexually transmitted infections (STIs), including HIV infection, within these communities, high quality primary health care and sexual health services are critically important in mitigating the effect of HIV and other infectious diseases. In particular, specialized outreach and targeted health promotion initiatives may be needed to address rapidly increasing STI and HIV rates among young men who have sex with men (YMSM).

This “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 “Blueprint”) has been created as a guide for clinicians and health administrators in LAC Region countries, in both the formal health sector as well as within specialized MSM health clinics. It is intended to strengthen the ability of health care providers to address the distinct health needs of gay men and other MSM within the context of health promotion and health care delivery.

The operational definition of MSM used in this document includes any man whose sexual practices include, or have included oral or anal sex with another man, regardless of whether the individual self-identifies as gay, bisexual, transgender, transsexual, “travesty,” heterosexual, or any other local denomination that describes his sexual behavior.

This Blueprint provides a framework for the provision of health services to MSM in the LAC Region context, and applies to health facilities that specialize in the care of MSM as well as those that serve mixed populations that may include MSM. It applies to the care of self-identified gay or bisexual men and other MSM who may refer to themselves in other terms. And, the document also provides specific references to the unique needs of YMSM who, in addition to the stressors of being a sexual minority, face additional challenges due to their age.

In addition to the psychosocial burdens of being an MSM in the LAC Region, STIs are a major reason for entry into the health system. Certain behaviors among MSM (e.g., anal intercourse, particularly without barrier protection) place individuals and their communities at higher risk for STIs, including HIV infection. Health systems, clinicians, and care protocols will thus need to be structured to engage MSM in a safe and welcoming environment, with an understanding of the diversity that exists within these communities and geographic locations.

Conditions Affecting MSM in the LAC Region

Following the devastating impact of AIDS in the 1980s and 1990s, particularly within the gay community, it seems inconceivable that a similar scenario could be repeated today. However, stigma, heterosexism, denial, and discrimination against MSM continue to fuel this global health crisis, mirroring much of what occurred at the dawn of the AIDS era. These negative determinants of health fuel not only a deep HIV crisis, but numerous other health crises among MSM, including high rates of other STIs; high rates of anxiety, depression, and other mental health problems; high rates of substance and alcohol abuse; and a number of other concomitant health concerns.

These health concerns among MSM have a profound impact on the health and well being of MSM throughout Latin America and the Caribbean. The HIV pandemic, for instance, places these health concerns in very stark relief. Throughout the LAC Region, MSM are 33% more likely than the general population to become HIV infected.

Despite evidence that the HIV epidemic continues to grow among MSM populations, few countries in the LAC Region have taken proactive measures to reverse this crisis, or to establish appropriate health care services for vulnerable/high-risk groups. For HIV, programs aimed at MSM comprise less than 1% of total HIV spending in the LAC Region, despite the fact that one quarter of known HIV-positive people in the region are MSM. This fact reflects a general trend, since few

resources throughout the region in general are dedicated to care and support for MSM communities, HIV/AIDS being the latest, and perhaps most poignant example of unmet need.

Through a commitment by national stakeholders to action at the levels of civil society, health care services, and public policy, the human right to health for MSM and other sexual minority groups can be made a reality throughout Latin America and the Caribbean.

The key to understanding this neglect and barriers to care and support for MSM in general, is the context of social exclusion and marginalization for MSM in which HIV and other health concerns are situated. Despite nearly

three decades of advocacy on the part of gay communities around the world for appropriate legal rights and health care services, including HIV prevention and care, in most parts of the world MSM still have little or no access to either HIV services or other MSM-oriented general health services (e.g., general sexual health services, substance abuse programs, mental health services).

On an encouraging note, several evidence-based interventions have proven effective in combating the spread of HIV among MSM in various settings and countries around the world despite tremendous social and other barriers. Grassroots movements have formed, to varying degrees, in all regions of the world, including the LAC Region. In addition, the Global Forum on MSM and HIV, an international collaboration between groups of men and individuals in several countries, was recently formed to coordinate and focus these advocacy efforts.

Action to improve the health of MSM communities and the availability of appropriate health care are human rights imperatives. These human rights – to health, safety, and well-being – have been achieved to varying degrees in different parts of the world. They are both possible and practicable. Through a commitment by national stakeholders to action at the levels of civil soci-

ety, health care services, and public policy, the human right to health for MSM and other sexual minority groups can be made a reality throughout Latin America and the Caribbean.

SOCIOCULTURAL CONTEXT OF HEALTH CARE FOR MSM

In addition to the crisis of HIV/AIDS, MSM communities face high rates of mental illness, including anxiety and depression, alcohol and substance abuse, and a range of other health concerns. Risk factors for many of these health concerns may be linked to the psychosocial impact of social exclusion, and a general lack of access to appropriate health care services.

In many countries throughout the LAC Region, identification as an MSM carries a high risk of not only social exclusion, but physical violence. In Brazil, for example, every two or three days a person dies by violence related to their sexuality, according to the *Grupo Gay da Bahia* (GGB), the oldest gay rights association in Brazil. In Mexico, this figure is about two individuals per week. Such violence is common elsewhere in the region as well, including in El Salvador, Honduras, Jamaica, Trinidad and Tobago, and numerous other LAC region countries. Brazil and Mexico are the only two countries in the region that have a registry which officially tracks this kind of violence, the lack of which makes it difficult to fully account for accurate levels of hate crimes committed based upon sexual orientation through the LAC Region.

Since sex and other forms of intimate contact between men carry such heavy social consequences, these sexual activities often occur secretly. These activities may include sex in clandestine settings, anonymous partners, and concurrent heterosexual relationships, which may be viewed as more acceptable and are used to mask sex with other men.

Stigma pertaining to MSM and the difficulty of opening up dialogue regarding sexual health for MSM in general has hampered efforts to promote safer sex, and to establish communities of trust. Hostile environments, including the targeting of MSM communities, have had a detrimental impact upon self-esteem and have driven sexual behavior “underground.” Again, this complicates efforts to contact members from MSM communities, to carry out education efforts, and to involve MSM in routine health care.

For these and other reasons, it is critical for countries and local authorities to re-configure their health systems with an aim to embrace this marginalized community, and provide appropriate services and support, adapted to the realities and needs that MSM face. An important starting point is in contact with civil society organizations that have emerged, despite great odds and sacrifice, to address the needs of MSM communities in different parts of the LAC Region.

BETTER UNDERSTANDING HEALTH AND HEALTH CARE FOR MSM

Although the health and health care needs of MSM in Latin America and the Caribbean are deeply influenced by cultural, social, political, and economic realities in each country, and at a more localized level (e.g., urban versus rural), there is, nonetheless, an important global body of knowledge that may be accessed as a gateway to better understand the health concerns of MSM, as well as measures to improve health care for MSM. As several leading US physicians have noted, for example, from their experience at Fenway Health (a Boston-based community health center which has pioneered MSM health care and health promotion service delivery in the United States):

Even though most major health care issues for MSM are similar to the routine health recommendations for all men, independent of sexual orientation or sexual behavior, there are

unique issues to consider, including screening for and immunizing against hepatitis A and B virus (HAV and HBV, respectively); routine screening for STIs; routine screening for certain cancers (i.e., anal human papillomavirus [HPV]-related neoplasia); assessing drug, alcohol, and tobacco use; screening for psychological health and mental health disorders, domestic violence, hate crimes, and posttraumatic stress; and helping patients deal with stigma associated with being a sexual minority as well as the social and psychological issues of coming out.

The critical, distinguishing factor in appreciating these health concerns is the general context of stigma and marginalization in which the daily lives of MSM unfold, as individuals and in communities. A few examples of common health concerns, outside of HIV/AIDS are as follows:

- **Mental health concerns:** Due to the multiple sources of negative social reinforcement faced by MSM, high rates of episodic and chronic mental illness are common. These vary from anxieties related to a daily life lived in secret; long-term depression and anxiety related to social isolation; post-traumatic stress related to physical or emotional violence, or loss of family; and many other effects on mental well-being. When combined with other forms of illness, such as HIV infection, these mental health problems can become further and further entrenched.
- **Substance abuse:** The reported frequency of drug use and alcohol abuse among MSM is higher than the general population. In addition to the direct health effects of drug use and alcohol abuse, including addiction, there is high secondary risk for STIs and other conditions that may affect MSM. Drug use and alcohol abuse are associated with increased rates of high-risk sexual behavior, as well as sharing of infected injecting equipment.
- **HPV/cancers:** There are about 200 different types of HPV, of which about 70 are associated with anogenital malignancies. Of these malignancies, a subgroup is often associated with the formation of squamous intraepithelial lesions and carcinomas, and therefore has been categorized as high risk. Several reports have shown that MSM, and particularly HIV-positive MSM, have a higher incidence of precursor lesions and anal cancer.
- **STIs:** Sexually transmitted infections remain a major health problem for gay men and other MSM. In addition to a higher prevalence of many common STIs, depending on one's sexual behavior, there may also be increased risk of infection outside the genital tract, including diseases of the rectum and pharynx. Most STIs place an individual at increased risk for acquisition of other STIs, including HIV infection. The identification and treatment of STIs in MSM is thus extremely important both for the individual's health and the general health of the community.

THE SPREAD OF HIV/AIDS AMONG MSM

The inability to halt the global spread of HIV among MSM is a shared failure of service agencies, populations, and health systems worldwide. Recent data indicate that HIV prevalence among MSM around the world is higher than in the general adult population and the incidence is growing, accounting for at least 5-10% of total infections globally. These high rates of HIV infection among MSM, in low-, middle- and high-income countries are commonly coupled with high rates of other STIs, mental illness, substance abuse, and other health-related problems.

The likelihood of infection among MSM (pooled odds ratio) has been found to be higher in the LAC Region than in any other region of the world. Indeed, a recent study of HIV/AIDS in Latin

America concluded that the epidemic in the region is still highly concentrated among MSM. Throughout Latin America and the Caribbean, there were an estimated 140,000 new HIV infections in 2007, according to the Joint United Nations Program on HIV/AIDS (UNAIDS), bringing the total number of people living with HIV/AIDS in the LAC Region to 1.7 million. Of these, 63,000 people have died of HIV-related causes. Overall prevalence rates are 1.1% and 0.5% for the Caribbean and Latin America, respectively.

Men who have sex with men account for at least 25% of known HIV infections within the LAC Region, a disproportionate percentage considering the global average of 5-10%. Other highly vulnerable groups in the region include commercial sex workers, and to a lesser extent, injecting drug users (IDUs), of which MSM represent considerable proportions, which points to the multiple risks affecting diverse subsets of MSM (e.g., commercial sex workers, IDUs).

BARRIERS TO APPROPRIATE MSM CARE, TREATMENT, AND SUPPORT

The state of care, treatment, and support for MSM communities varies throughout the LAC Region. A wide variety of factors affect access and delivery, including the relative wealth of a country, the level of political leadership, the development of civil society activism and, certainly not least, the overall development of national and local health systems.

There is also significant nuance to levels of care and support based on a wide range of physical and sociodemographic factors both between and within countries, including geographical size (e.g., in smaller districts or islands, challenges regarding confidentiality may hamper efforts), and the influence of more “cosmopolitan values” in certain settings (some urban versus rural settings, for example).

The likelihood of infection among MSM (pooled odds ratio) has been found to be higher in the LAC Region than in any other region of the world. Indeed, a recent study of HIV/AIDS in Latin America concluded that the epidemic in the region is still highly concentrated among MSM.

While it is impossible to fully list and describe the wide variety of barriers to care for MSM groups, it is critical to appreciate that these barriers are part of a dynamic and varied tapestry. At their root, all barriers to care and support share in common the context of social exclusion, stigma, and “othering” that is the daily reality of MSM communities.

What a non-MSM individual may see as a “nice, modern health clinic,” for instance, a member of the MSM community may see as a potentially unsafe space with imminent threat from judgment, exposure, exploitation, or even physical violence. The psychosocial impact of daily exclusion must be the gateway to understanding barriers that affect delivery of and access to care and support for MSM communities.

A marker for success in enhancing HIV care for MSM communities is through a country or region’s progress in re-orienting health service delivery and prevention efforts, so that more of these services are consciously constructed from the MSM client perspective. The delivery of appropriate prevention, care, treatment, and support services must be mindful that influencing factors are often deeply rooted in individuals from MSM communities. Some very practical examples of health services that are not appropriately informed by these client perspectives may

include, but are not limited to:

- Prevention programs which only use images and messages that pertain to heterosexual activity, or, at the same time, prevention program messages and images intended for MSM communities that are not properly informed by the local realities of the MSM community (e.g., use of graphic sexual imagery when MSM may, nevertheless, be more socially conservative);
- Health centers or other services which have images, welcome messages, and other signs and symbols that reinforce heterosexual identities exclusively;
- Health services which require or only permit the identification of “family” and/or “next of kin” as individuals in the nuclear family or heterosexual relationship;
- The use of health information forms which require information that may not be pertinent to MSM communities (e.g., marital status), and therefore reinforce the “othering” of MSM individuals; and
- Clinical services which focus exclusively on sexual behavior risk factors, and provide little or no opportunity for counseling and psychological assessment and care.

At the level of policy and broader decision making, the lack of sufficient budgets and funding targeted to address the HIV epidemic in MSM, and language itself is often a key barrier to change. At the same time, noticeable changes in the language used by decision makers – to reflect greater inclusion, less “othering” of MSM – is often a sign of progress, and a gateway to affecting accompanying change at the level of actual policy and resource allocation.

The use of language, through oral and written communication within the health system, and more broadly among decision makers, must be appreciated as a key barrier to effective prevention, care, and treatment programs. Overcoming this barrier applies not only to HIV, but to overall health care and support services which can potentially affect the lives of MSM. Furthermore, it must be appreciated as a key area for advocacy – just as important as the delivery of actual services and support. Consider the example below, for instance.

The following is a recent statement from the Ministry of Health of a country in the LAC Region, followed by a proposed revision of the statement. What are the key differences between the two?

Men who have sex with men do not readily reveal sexual orientation due to stigma and discrimination. This reduces the ability of this group to access prevention and treatment interventions.

COMPARED TO:

Men who have sex with men face daily stigma and discrimination and, therefore, encounter significant barriers in accessing prevention and treatment programs, particularly where there is a risk of having their identity exposed/revealed.

In the first statement, the tone of language and the weight of action and responsibility are shifted onto the shoulders of MSM. In this way, the reality of stigma and discrimination are neutralized, and the barrier to effective programming is made out to be the ability of MSM to access programs. In the second, revised statement (though it also may be imperfect), there is an effort to shift the onus of responsibility off of MSM exclusively, and onto society more broadly (a shared weight and responsibility). In this way, the “othering” of MSM and lived experiences are acknowledged and validated, but not reinforced. The reinforcement of “othering” and the shift of responsibility onto

the individual already heavily burdened by exclusion will inevitably prove a stumbling block not only to prevention, care, treatment, and support but to change at the level of public policy. As such, language may be seen as both a barrier and an opportunity/gateway to change.

OVERCOMING BARRIERS TO MSM CARE, TREATMENT, AND SUPPORT SERVICES

Despite the many barriers to the provision of appropriate care, treatment, and support to MSM in the LAC Region, there are important actions that can be taken at the civil society, health care system, and public policy levels to move important health and human rights concerns forward. This Blueprint focuses primarily on actions at the level of direct health care provision. Nevertheless, it is important for such recommendations, algorithms, and other guidance to be placed in the context of broader social change, and linked to civil society and public policy efforts.

- **Civil society actions:** Within civil society, relevant stakeholders can support progress by helping empower those who are most likely to advocate and benefit from enhanced care – MSM communities themselves. The most effective ways to achieve this is through support (moral and financial) for MSM-oriented civil society organizations. These organizations are best equipped and situated to offer MSM groups safe spaces, access to health information, education and prevention services, and to carry forward advocacy with other stakeholder groups. Successful sexual health and rights movements around the world have been rooted in strong civil society, nongovernmental organization (NGO) group activism. This is not limited to the wealthier countries of the global north. Examples already exist in many low- and middle-income countries, such as Brazil and Mexico, in which MSM and other sexual minority groups have exerted pressure on their governments to protect the rights of HIV-positive people, and to expand appropriate services and supports since the early years of their countries' HIV epidemics. Throughout Latin America and the Caribbean, in fact, whether large and open, or smaller and discreet, civil society groups have emerged to advance the push for human rights and effective care and treatment for MSM and other sexual minority groups.
- **Health care system actions:** Across the spectrum of healthcare services, both public and private, a number of service-oriented and systemic interventions can achieve important results in expanding access to appropriate prevention and treatment services for MSM. Often these represent little new cost to the health care system, and involve increasing awareness among clinicians, health promoters, and other health providers of the barriers and unique health concerns faced by diverse MSM populations. At a rudimentary level, for instance, clinicians should learn how to listen to MSM patients more openly and without judgment, becoming better educated about current recommendations for the care of gay men and other MSM. This Blueprint provides substantial recommendations and algorithms for care and support of gay men and other MSM, and should be viewed as guidance by all practitioners providing services to MSM populations in the LAC Region.

Beyond the delivery of more appropriate services for MSM, it is also critical for the broader health system to shift toward a primary health care orientation, integrating approaches rooted in health equity and a consideration of the social determinants of health. By expanding access to robust, first-tier health services – including re-allocation of resources to this level of care – health systems have a much greater chance not only in routinizing illness prevention and health promotion programming, but doing so in ways that best suit the diverse needs of various populations that face barriers in accessing appropriate health care services. Examples such as the community health centers movement of both the

United States and Canada and the family health team movement of Brazil, demonstrate how primary health care services can be effectively adapted to deliver welcoming and appropriate services to MSM and other communities through a health equity perspective. Indeed, a re-orientation toward primary health care, as a gateway for enhanced service to MSM communities, is both in keeping with the WHO's recent guidance for health system reform, and one of the most effective ways to encourage health equity.

- **Public policy actions:** Governments, at all levels, can play a unique role in supporting human rights by addressing the rights of MSM and other sexual minorities in public policy, and by committing to more equitable health care funding that supports appropriate and safe services for MSM communities. Across government, this means decriminalizing sexual contact between men (where such law exists), as well as reviewing other legislation that may contribute to stigma and discrimination: in labor, housing, social service, and other policy areas. Key to action in these areas is the fact that equity in access to employment, housing, and other day-to-day life resources has a direct impact upon the health of MSM, as they do for other segments of the population.

MSM Health Determinants

As in any other human population, the health of gay men and other 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, equity.

Gay men and other MSM share many of the determinants of health of the male population at large (e.g., gender codes associated to health care-seeking behaviors). However, some specific factors are more relevant to the health of MSM, such as lack of targeted funding, 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, tobacco, and drugs; dietary and sleep habits; and susceptibility to infectious diseases, among others).

The design and performance of health systems plays a critical role in the attainment by and maintenance of health of gay men and other MSM. In terms of seeking health and accessing the health system, a variety of individual perceptions, of oneself and the surrounding community, will affect each man's approach to risk-taking, self-care, and health-seeking behaviors. Men differ in their sexual self-

identification, their attraction to men and/or women, the degree to which they are comfortable in disclosing their identity and preferences, and in the particular behaviors in which they engage.

Some men identify themselves as homosexual, and may use the term “gay” to describe themselves to the community at large. These individuals may be comfortable entering the health system through a clinic that is specifically dedicated to the health needs of MSM. Gay men may include individuals who participate in a wide spectrum of sexual relationships, including monogamous, same-sex couples; single men who engage in multiple sexual encounters; and individuals who participate in a heterosexual relationship, but engage in discreet same-sex sexual encounters.

Some men may also self-identify as bisexual. They might include men who are attracted to women and men, but only engage in intercourse with other men, as well as those who are sexually active with both. Likewise, self-identified heterosexual men may engage in sex with other men, whether or not they acknowledge an attraction. There are also differences among some MSM in terms of gender self-identification, including a preference for dressing as a woman, taking supplemental hormones to modify their bodies and/or deciding to undergo surgical interventions, such as breast augmentation or sex reassignment surgery. These facets of gender identity, in turn, also affect sexual attitudes/preferences, and decisions related to accessing routine health services.

In terms of seeking health and accessing the health system, a variety of individual perceptions, of oneself and the surrounding community, will affect each man’s approach to risk-taking, self-care, and health-seeking behaviors.

Each of these factors can have an impact on the overall health of gay men and other MSM. Since sex between men is often viewed as unacceptable by many societies, sexual activity very often occurs secretly. This may include sex in clandestine settings, it may include anonymous partners, and it may involve concurrent heterosexual relationships, which are viewed as more socially acceptable and provide a safe haven from discrimination and/or violence. In addition to risks for STIs, there can be grave emotional consequences for men whose sexual identity must be kept secret through most of their lives. The effect of having a stigmatized identity is often called “minority stress,” which may be a compounding factor in health-compromising behaviors.

Regardless of how someone may self-identify their sexual orientation, health care providers should be cautioned about making assumptions about sexual behaviors, and must be open to asking questions about a range of sexual activities in order to determine levels of risk for STIs, including HIV infection.

MSM Health Challenges

Although gay men and other MSM encounter many of the same health issues as the rest of the population, there are a number of health-related concerns that are particular to their experiences. Health centers and clinics that care for MSM must be prepared to address these concerns in a safe, supportive, and therapeutic environment. Distinct from non-MSM populations, MSM may experience STIs that manifest through anal, rectal, oropharyngeal, and/or genital symptoms, and may result from local trauma as well as pathogenic organisms.

Sexually transmitted infections may be highly symptomatic before a man is willing to present for care, given the shame or fear that may be associated with disclosing his sexual orientation or the presence of sexually oriented symptoms. It is not uncommon for MSM to present with longstanding STIs, such as warts or latent syphilis, because they may have avoided clinicians for long periods of time or may have chosen not to disclose their sexual orientation in prior encounters with the health system.

Psychological symptoms, including depression, anxiety, and suicidal ideation are more common among the MSM population. Clinicians need to be aware of hidden emotional or psychological distress that may be at the root of a health visit, and must be sensitive to the underlying context of discrimination and exclusion in which gay men and other MSM experience the world on a day-to-day basis. At a systemic level, health centers and providers need to be prepared to address the psychological needs of their clients.

Men who have sex with men, particularly older men, may also present with chronic medical conditions, either as established diagnoses, as new symptoms that require evaluation, or as confounding complications of STIs or psychological distress which brought them to the health center. Whether the chronic condition was the reason for the visit, the clinician will need to be prepared to address all aspects of the patient's health. It is important that clinicians and the health system be prepared for a high level of complexity in addressing the health and needs of some MSM patients, and thus clinical visits should be as flexible as possible in terms of scheduling, time allotment, and adaptation to diagnoses that may be made during screening.

MSM Self-Care and Health-Seeking Behaviors

There is likely to be a wide range of health-seeking behaviors among MSM in any given community. Clients are likely to include the “worried well,” who present for an evaluation of even minor symptoms or concerns, as well as those who avoid the health system unless gravely ill. Some of these behaviors may be cultural, but others may relate to a man's comfort level with engaging in care. Men who are comfortable with their sexuality and who have good relationships with their clinicians may be more likely to seek care in a setting that serves MSM, while those who have emotional conflicts and fears about their sexual identity, sexual encounters, and/or the presence of STIs, may avoid care.

The age of the individual may also influence his ability and willingness to access the health system. Young men who have sex with men, for example, are less likely to see preventive health practices as a priority, and are often acutely fearful of disclosing their sexual identity or the fact that they are “questioning” their sexual orientation. Clinicians and health centers serving YMSM, including young men who may appear to be or openly express that they question their sexual identity, must be prepared to address the complex needs of these individuals. Clinicians should strive to build a trusting and non-judgmental relationship, as this can have a profound impact in encouraging future contact with the health system as well as in mitigating potentially harmful behaviors related to emotional and psychological distress.

Similarly, there will be a range of self-care behaviors among MSM clients in general. Again, some of this might be cultural, but some differences may relate to self-esteem, level of health education, and/or an individual's age, race, or language group. New clients should be encouraged to

take more responsibility for their own health, but it is important that this not be done in an accusatory or judgmental manner. Health seeking should also be stressed independent of the steps taken to address the presenting condition (i.e., that it is about more than simply addressing the presenting condition, if there is one).

In the context of the health visit, or during follow-up care, MSM should be encouraged to address issues such as nutrition, vaccinations, personal safety, STI prevention, screening for chronic conditions, and leading an emotionally balanced life. If available, health education programs in the health center can be crafted to address self-care from the unique perspectives of gay men or other MSM, including information about how to develop healthy coping mechanisms for dealing with minority stressors such as homophobia and heterosexism. An important secondary goal of most visits will be to encourage each individual to take more responsibility for his own health and to use the health center staff as advisors or consultants.

In the context of the health visit, or during follow-up care, MSM should be encouraged to address issues such as nutrition, vaccinations, personal safety, STI prevention, screening for chronic conditions, and leading an emotionally balanced life.

Planning MSM-Inclusive Health Care Settings

A number of factors contribute to disparities in the levels and quality of services delivered to gay men and other MSM within the health care sector across the LAC Region. These factors include implicit and explicit homophobia within the health professions, a lack of MSM-friendly and relevant spaces within health systems and the general context of homophobia in society at-large. These factors help explain why gay men and other MSM across the region are more highly sensitive to the experience of their first encounter with the health care setting, particularly around issues such as safe environments and standards of confidentiality. This issue is especially true for YMSM who struggle with widespread stigma associated with their emerging sexual identity.

The client's decision about whether to disclose information critical for care may hinge on a range of external clues/signs which he interprets at the health center. His observations may include whether service signage, photographs, and other visual elements are welcoming and MSM inclusive or hetero-centric; whether protocol for the collection of personal information allows discretion or whether they require disclosure of sensitive personal information; and other factors. Ultimately, these factors can make the difference between a patient being open and forthcoming with a clinician, enabling the delivery of services that are comprehensive and relevant versus the delivery of services that are guided by incomplete information facilitated by a patient withholding relevant information.

Other considerations revolve around the understanding that gay men and other MSM will inherently encounter health needs different from those of men who exclusively have sex with women. Without addressing knowledge gaps among health professionals and reorienting health settings to be inclusive of MSM, barriers will persist in providing appropriate, high quality care to MSM and YMSM.

It is critical for providers and health system planners to understand that providing access to MSM inclusive services, alone, will not ensure utilization. Existing service providers across the LAC Region must work to curb the expression of societal attitudes that are detrimental to MSM health, and must facilitate ongoing training of staff to serve the health needs of sexual minorities, ensuring high standards of quality, respect, and dignity.

Involving MSM in the planning and delivery of health services can be an important part of planning and implementing MSM inclusive service delivery. Input given by organized communities of gay men and other MSM also can be indispensable when making decisions about clinic signage, hours of operation, and scopes of service (e.g., in some cultural settings, a clinic that provides a wider range of men’s health services, such as management of sexual dysfunction,

may be more effective in attracting a greater number of MSM). These efforts also send an important message to MSM that health providers value the opinions of diverse groups, that gay men and MSM are more than just the “subjects” of care, and that the provider is committed to the health of the catchment area at large.

It is critical for providers and health system planners to understand that providing access to MSM inclusive services, alone, will not ensure utilization. Existing service providers across the LAC Region must work to curb the expression of societal attitudes that are detrimental to MSM health.

In places where directed services are offered to gay men and/or other MSM, there has been a tendency to focus almost exclusively on HIV clinical management, or the management of other STIs, and to offer these services in isolation from broader primary health care. While bearing in mind best practices, the way forward in most settings will be to deliver more comprehensive services in integrated environments. An example of what can be done to foster more MSM-friendly facilities is the case of Mexico, where a new strategy involves certification of HIV care services as “Homophobia Free Facilities.”

Below are key areas that require attention when reorienting the health setting to offer comprehensive services for gay men and other MSM:

ENVIRONMENT

The environment in the clinic should allow MSM clients to feel safe, accepted, and valued. The waiting areas should be comfortable, with sufficient seating for expected clients. Ideally there should be sufficient space so that some individuals can sit alone, while others might wish to converse in small groups. Conversations with front desk staff should be conducted out of earshot of other waiting clients.

Artwork, logos, and brochures should be designed so that MSM recognize that services have been designed with their needs in mind. While it may not be appropriate in many contexts to openly display images of same-sex/MSM couples, an inclusive environment may be fostered by not displaying images of couples, especially if those images convey the image only of heterosexual relationships. Special consideration should also be given to ensure that all life stages are represented in visuals and printed information (e.g., YMSM may not see themselves reflected in materials that are oriented toward older MSM).

A confidentiality statement, a non-discrimination statement, and/or a patient’s “bill of rights” should be placed in a visible location. Depending on the setting, it may be useful to state clearly that discrimination against persons of any sexual orientation, as well as other factors such as race, age, and language, is strictly prohibited.

Part of protecting a patient’s right to privacy could be to delegate health service provision to MSM-experienced or more thoroughly trained health professionals (e.g., restricting the area from medical students when or where possible and appropriate). Separating the entrance point/door from the exit point/door may also be useful in preventing uncomfortable sightings between patients, potentially encouraging those with a greater need for privacy to access services.

EXAMINATION ROOMS

Each room should be equipped with at minimum an examination table and two chairs, to allow an extended conversation, if necessary, and a complete physical examination. There must be appropriate equipment available, including a sphygmomanometer, otoscope/ophthalmoscope, stethoscope, examination gloves, lubricating jelly, and additional lighting sources, as necessary. All examination rooms must have doors that close completely and should have barriers to prevent sound transmission to other parts of the clinic.

Outwardly displaying images or objects in the examination room that indicate MSM-friendliness may encourage greater disclosure of information critical for care, but this is highly dependent upon social context, geographical location, and other factors. Most important, however, is to maintain a balance between images and objects specific to heterosexual and MSM patients. In some places that cater primarily to non-gay-identifying MSM, it may make more sense to maintain sexual orientation neutrality when deciding what images and objects to display.

CLEANLINESS

Just as any other health facility, the clinic must be cleaned daily, including an antiseptic wipe-down of all surfaces and equipment. All trash must be disposed of daily and syringes and other sharps must be disposed of in appropriate containers. Adequate facilities must be available for staff and clients to have access to toilets and sinks, with adequate water supply, soap, and paper towels. Sinks must be available for staff to wash hands between patients.

HOURS AND AVAILABILITY

The hours of operation should match the needs of the clients, with provisions made for their safety and the safety and availability of staff. Hours should be consistent and clearly designated on the building, on after-hours messages, and in promotional literature. A policy must be developed for the provision of after-hours care, especially if the clinic staff is unavailable to provide care after hours. Special consideration should be given to ensuring that operating hours are sensitive to the needs of YMSM, in that they do not conflict with school hours.

SCHEDULING SYSTEM

A consistent system must be used to schedule clients’ clinic visits and to ensure that sufficient time is allocated for each client. This system should include a degree of flexibility in adjusting the duration of consultation times to allow for complexities that may arise during the consult. Staff should be trained not to make assumptions about a client’s health needs and to be mindful of the many hurdles MSM have often overcome before presenting for care. Occasionally, ensuring equity of care will mean prioritizing MSM during triage. Whether a paper system or an electronic system is used, training staff on its appropriate use will be important in reaching this goal.

TELEPHONE SYSTEM

Whether a single telephone or an extensive telephone system is used, staff must be trained on the policies of telephone use. Consistent hours of availability should be designated, with clear-cut instructions on an answering machine regarding after-hours policies, including the management of after-hours urgencies. A telephone log should be employed to document all telephone messages for staff.

STAFF SELECTION

Among the criteria for the selection of staff members, including clinicians, front desk and support staff, security personnel, and other contractors, is that they must be willing to work closely with gay men and other MSM. Overt and covert stigma will be problem enough from the outside world. Encountering stigma within the clinic can be particularly destructive, especially as it can discourage MSM from presenting or returning for care.

Tools such as informal interviewing and survey instruments can be used as methods of identifying discriminatory beliefs. In a setting that is newly introducing MSM-specific services, staff members who are uncomfortable working with gay men or other MSM should be advised their responsibility is to either adjust to new policies and requirements or to seek employment elsewhere, which could potentially include transfer to a division that does not bear responsibility for MSM-specific service delivery.

As part of the staff member selection process, applicants should be made aware that the health care setting is not to be used as a venue for the pursuit or promotion of ideologies (e.g., religious proselytizing). This prohibition should be articulated clearly, in written staff policy, as grounds for disciplinary action or potential termination of employment.

A clinic or health center should aim to recruit staff members who are reflective of the community it serves. This may include actively hiring MSM and/or self-identified gay men or transgen-

Outreach as a First Encounter

In some countries, the health care setting may not be the ideal location for the “first encounter” with all members of the population. Outreach may represent the first encounter - an effort to perform an initial screening in safe places and spaces.

Some examples of this type of first encounter include:

- Involving women or men as companions for MSM to reach clinical settings in order to dispel any potential fear that by attending a clinic the individual may be “outed” as MSM.
- Providing incentives to encourage MSM to attend (e.g., free lubricant and/or condoms, especially in places where they are difficult to find; free wireless Internet).

- Opening social environments (e.g., bars, cafés, saunas) on alternate hours for the provision of health screening and services in a place where MSM may already feel comfortable.
- Exploring new technologies such as emerging social media that may be especially popular among youth (e.g., social and sexual networking websites and mobile phones) as an adjunct to testing.

There are many conditions for which basic screenings and treatment could take place effectively and efficiently in the community setting and could help reduce burdens on the existing primary care setting.

For more on this topic, refer to page 39 of this Blueprint, in the section entitled, “Health Outreach for MSM.”

dered individuals in direct service delivery or to serve in the reception area. More than just indicating a non-discriminatory and welcoming environment, doing so improves the quality of care and service delivery by capitalizing on the staff's uniquely relevant knowledge and skills.

TRAINING

Since not all new staff members arrive with a good sense of the issues faced by gay men and other MSM, a training curriculum should be developed to help these new staff members better serve their clients. Respect and sensitivity on the part of clinic management and experienced staff members will be critical to setting the right tone in the clinic. Periodic staff meetings might be scheduled to discuss complex cases, both clinical and social, during which MSM-specific issues can be raised and discussed.

Although cross training is important in small clinical programs, having clear-cut roles among staff is helpful for clients to know what to expect during each phase of their visit. Staff members who report discomfort when receiving MSM clients should be trained on how and when to refer clients to alternative MSM-friendly providers or health care locations.

YOUTH AND THE HEALTH CARE SETTING

Much like their older peers, YMSM report having many of the same expectations of health care settings. They too require settings that provide privacy and deliver services respectfully and with confidentiality. There is also an expectation that facilities will demonstrate cleanliness and that their health care providers are well trained and honest with them about their sexual health.

There are some unique challenges for younger MSM. One of the key considerations for providers is the fact that MSM-relevant health care for YMSM takes place in the context of the particular emotional, physical, and psychological development of adolescence and teenage years. Providers who work with YMSM require significant training to ensure they are able to communicate with YMSM about issues related to sexual identity and behavior, and to situate these issues within the context of this developmental/life stage. If providers are not equipped to facilitate such communication, this presents a barrier that prevents YMSM from receiving prevention education and/or health care services appropriate to their true needs.

Another particular concern is the issue of the legal age of consent for sexual activities as set out by respective countries. Young men who have sex with men are often concerned that if their consensual sexual activity is determined by local laws to be illegal, either by virtue of a specific practice (e.g., same-sex activities) or the age at which that practice occurred, health care providers may be obligated to report them to local justice or social service officials.

In some instances, sexual activity may be described as the result of sexual violence, or the provider may suspect that a degree of sexual violence is involved (e.g., rape, coercion, or other forms of pressure). In such cases, there may be very challenging and blurred lines regarding a clinician's obligations of client confidentiality versus other legal obligations. These issues and considerations are discussed in further detail beginning on page 35 of this Blueprint, in the section entitled, "Consequences of Violence."

Young men who have sex with men may also have concerns about their own ability to legally consent to care based on their age, and whether health care providers are even willing to offer sexual health services in such circumstances. Health care settings and practitioners should estab-

lish protocol for circumstances related to issues of legal age of consent. Given more limited financial abilities, YMSM may also feel prevented from accessing health care services for fear that they will be unable to afford either the medical examinations, or the subsequent treatment provided.

For both the issue of age of consent and costs related to medical care and treatment, health care settings need to ensure that information about these issues is readily available in order that these potential barriers for YMSM seeking care are eliminated or reduced. Health settings should seek out youth-friendly spaces within their communities where they can promote their services as being accessible, along with any special conditions that may need to be met to comply with local laws.

MSM Service Delivery Approaches

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

- **Safety.** The facility where health services are provided must be safe, clean, inviting, and be appropriately designed and equipped to care for patients. It must be located in a place that is easily reached by the target population, whether urban, semi-urban or rural. Ideally, it should be on or near public transportation lines and have adequate parking. Access to the facility must be well lit, well maintained, and clients should not be required to wait in, or pass through isolated or unsafe areas to reach the clinic. The entry to the facility should be secure and allow for a locked door, a security guard, and/or a double-door entry, as appropriate. Given the stigma associated with MSM in some LAC Region countries, uninvited individuals should not be allowed to freely enter the building or the clinic. Security personnel must be trained to be sensitive to the needs and concerns of MSM. Staff should be trained to protect the safety of clients and fellow staff. Ideally, clinic staff should have identification badges that they wear during clinic hours, but depending on the location of the clinic/center, requirements should not be made that may compromise the safety of staff. If possible, a security system might be obtained that limits the entry to sensitive areas to appropriate staff only.
- **Permits and licenses.** Given the stigma that might be leveled against a clinic that treats gay men and other MSM, each program must assure that all laws are adhered to and all permits for the operation of a health facility have been obtained and updated. This might include permits from the building owners in accordance with city, state, and federal mandates. Sufficient insurance must be purchased to protect the clinic, the staff, and/or the Board of Directors.
- **Confidentiality.** An environment that respects the confidentiality of each client is critical for a facility that cares for MSM. Confidentiality must be emphasized at all levels, including leadership, staff, contractors, and anyone else associated with the clinic. A confidentiality policy statement must be developed and each staff member must sign a confidentiality agreement, which is kept on file. Anyone with potential access to client information and/or files must also sign an agreement as well. Individuals will agree to hold confidential a client's presence at the clinic, verbal communication, and the contents of medical records, including laboratory results, studies, and other communication.
- **Medical records.** A medical records system must be in place to ensure that client medical information is safely and securely organized and stored. Records must be kept away

from client and visitor traffic and be available only to those staff involved in the care of the clients and client scheduling/intake. Records should not be accessible to unauthorized individuals either during clinic hours or after hours.

- **Payment for services.** Many clinics are grant funded, some are fully funded by the government and there is no fee charged, while others have some form of fee-for-service payment. Whether services are free, covered by insurance, offered on a sliding fee scale, or require a co-payment, the payment policy should be transparent and consistent. Detailed records of financial transactions must be kept, money should be handled by a limited number of staff, and clients should feel comfortable that their funds are being handled carefully. A client who perceives that his funds are being handled in a cavalier fashion may feel as if that same attitude may be directed toward his health services. Specific consideration should be given to how fee structures may be preventing YMSM from accessing care and treatment services, and whether or not special fee scales can be established that would result in greater service uptake by YMSM.
- **Infection control.** Clients and staff at a health center may be at risk for infections that are transmitted in the health care setting. Every health care facility must take special precautions to protect everyone from exposure to pathogens while working in, or receiving services at the facility. The main types of exposures likely to be encountered in the health center include those organisms transmitted through the air (tuberculosis [TB] and influenza) and those transmitted via hand-hand contact or via contaminated surfaces. Each health facility must develop an infection control policy, which is reviewed annually. Provisions should be made to ensure that clients and staff can wash their hands after using the bathroom and between contacts with each client. Staff and clients should be trained on how to manage acute or chronic respiratory symptoms in the health center, including considerations for a preliminary phone call prior to the visit, a separate entrance, a designated room, and the use of masks for patients with cough syndromes. Staff should be instructed to avoid reporting to work when acutely ill, and a work culture must be developed that does not discourage or punish absence due to illness.
- **Linkages to other resources.** A clinic providing services to MSM may be required to refer clients for additional services that are not available through the clinic. Health outcomes and client satisfaction are likely to be improved if relationships have already been developed with key providers of other services. Clinic leadership should plan to invest time creating these relationships and work to ensure that MSM clients are treated respectfully and professionally. Programs that do not meet the needs of referred clients can be dropped in favor of programs that are receptive to MSM clientele. Other resources might include: emergency care, medical and surgical specialists, addictions specialists, mental health and counseling specialists, shelters and food aid, advocacy organizations for MSM, and the law enforcement community. Certainly any relationships that can be created between clinic management and political, civic, and spiritual leaders would likely be helpful in reducing stigma and in improving services in general for MSM.
- **Promotion.** The health facility may wish to promote itself and its services in the community in order to reach MSM in need of services. Promotion efforts might need to strike a balance between reaching the target audience and avoiding inflaming the broader community, and increasing stigma in the environs of the clinic. Word of mouth promotion by members of linked or affiliated organizations is often the most effective and confidential means of attracting new clients.

Management Algorithms

FIRST CLINICAL EVALUATION

Below are described the various components and requirements for conducting a high-quality, effective first clinical evaluation:

Scheduling

Clients must be able to make an appointment in person, by phone, or other methods; they must be able to physically reach the clinic; and they must be received and evaluated at the appointed time.

Arrival and sign-in

Clients are received by a staff member without a prolonged wait. Necessary paperwork can be completed in privacy and staff members are available to confidentially answer questions. Conversations about sensitive information are avoided at the check-in “window” or in the waiting room itself. Clients are usually attuned to stigma and rejection in the health setting, thus a warm reception on the part of security and clerical staff can be very reassuring even before the client sees the clinician. Materials on display in the waiting room can also set the tone for what the client might expect from the staff.

Many MSM need to return to work or to social activities, but especially YMSM, have many pressures on their time and are less likely to be patient and wait for a prolonged period of time. Consideration should be given to the establishment of a process that would see them move quickly from the arrival process to the intake process, perhaps even as a priority over older patients.

Intake

The initial conversation for a new client can occur with any one of a number of professionals, depending on the clinic setting and model of care. In some cases, it may be with a counselor or social worker, in others a nurse, while in others the client may see a physician initially. In any case, the first conversation will set the tone for all other interactions, which means it is extremely important. Clients will be attuned to the comfort level on the part of the provider, including body language, use of terminology, and the level of perceived interest in their health. Clinicians who are respectful, genuine, and comfortable with the client are likely to break down some of the initial barriers and thus have a more fruitful interaction.

Regardless of the clinician, the initial intake will need to address the reason(s) for the visit, begin to identify any potential subtexts or hidden agendas, and the need for any urgent or emergent care. In the absence of medical or mental health emergencies, the pace of the rest of the visit (or visits) can be dictated by the comfort of the client and the available time. In many cases, the initial evaluation may actually require more than a single visit, so the development of a rapport between the clinician and the client should not be sacrificed in order to complete all categories of the history and physical examination. All conversations should occur in a private setting with verbal assurance that others cannot overhear conversations.

Young men who have sex with men report two consistent frustrations with the patient intake process; particularly, these frustrations pertain to practitioners making certain assumptions about YMSM sexual behaviors. First, YMSM may have greater resistance to assumptions that their sexual practices place them at a greater risk than their heterosexual peers. Second, YMSM report resistance to practitioners who immediately equate YMSM with the presence of HIV

infection. While YMSM may well be at greater risk for acquiring HIV, practitioners should be cautioned about initiating their interaction with a patient in a way that HIV becomes the singular or primary focus. Young men who have sex with men are frequently more concerned about issues related to their sexual orientation, and associated mental health issues related to successful social inclusion and integration, rather than specific concerns about HIV infection.

Medical history

A detailed medical history should be obtained and documented. The history should include: current complaints and symptoms, chronic conditions and medications, past history, surgery and prior medications, and drug allergies. Obtain family history, travel history, as well as smoking, tobacco, and drug use history through standardized screening questionnaires. Prior vaccinations should be documented.

Mental health screening

A detailed psychiatric history should be elicited, including psychiatric diagnoses, hospitalizations, and medications. Sensitive questions should be asked, respectfully, about the client's current mood and state of mind, as well as concerns he may have about his own emotional state. A short, one-page screening tool might be employed to elicit evidence of depression or affective disorder.

Gay men and other MSM experience mental health concerns, from depression to suicidal ideation, at rates far greater than their heterosexual peers. For YMSM who are seeking to understand their sexual orientation, they may be more vulnerable to engaging in at-risk behavior as a means of gaining acceptance and validation from their sexual partners. Special efforts should be made to determine where a YMSM is in terms of developing his sexual identity and the degree to which he has accepted and incorporated this identity into his daily life. In addition to obtaining information about mental health status, practitioners should also determine whether a YMSM is using (or contemplating) drugs or alcohol as a means of coping with his mental health issues or in struggles to come to terms with his sexuality.

Young men who have sex with men also have unique challenges as a result of harassment and violence, experienced in the school setting and familial pressures or abuse they may be experiencing at home. Practitioners are encouraged to ask youth about their experiences in both the home setting and school setting (favorite subject, sporting events, etc.) as a means of gauging mental health status.

Sexual history

Although many gay men and other MSM are willing to discuss all aspects of their sexuality, others may need some time to establish a rapport with their clinicians before disclosing many details of their sexual history. While the details of the sexual history remain important, most are not critical to collect in the first visit, if the review of these details is uncomfortable for the client. Ultimately, the clinician should understand the sexual preferences of the client, types of sexual activity, and history of STIs. It is important to document prior testing for STIs, including HIV infection.

Young men who have sex with men may be less open to discussing sexuality as they have had less time to clearly define, or develop comfort with their own identities. They are often more likely to be isolated from positive MSM role models and communities and subsequently have a diminished sense of self-esteem related to their sexual orientation; as such, YMSM may experience deeper feelings of denial or repression of their sexuality. Nevertheless, and perhaps main-

ly due to a history of institutional homophobia and discrimination during repressive regimes, there are some Latin American countries where YMSM are more likely to disclose and feel comfortable about their sexual orientation than older MSM. Practitioners should reinforce the fact that homosexual behaviors are normal and acceptable forms of sexual expression. This reinforcement from a socially accepted role-model figure may help YMSM patients who have difficulty acknowledging their emotions, thoughts, behaviors, or associated risks.

For YMSM who are comfortable defining themselves as such, practitioners are cautioned from assuming that the sexual activity of YMSM is exclusive to other males. Studies report that some YMSM may engage in sex with women and are more likely than their heterosexual peers to engage in unprotected vaginal intercourse resulting in an unintended pregnancy.

Violence screening

Men who have sex with men are at risk for physical and emotional injury from violence. Non-judgmental screening for prior or ongoing violence is critical. School-based harassment and violence toward sexual minorities is common and therefore YMSM may be at greater risk for injuries from such violence. Issues of violence and sexual violence are discussed in further detail on page 35 of this Blueprint in the section entitled, “Consequences of Violence.”

Physical examination

A physical examination is a necessary component of the complete evaluation. A private, comfortable setting in an examination room, with proper equipment allows a fully unclothed examination, with draping as needed. The examination should include vital signs, including temperature, pulse rate, and blood pressure. A baseline weight should be obtained. Head and neck examination should include a careful examination of the mouth, teeth and gums, throat, neck (including lymph nodes), and scalp.

The examination should cover the lungs and heart, the abdomen, including enlargement of the liver and spleen, the lymph nodes (axillary and inguinal) and the extremities. The skin should be inspected for rash. The genitals should be inspected for signs of STIs. Particular attention should be paid to the glands, with retraction of the foreskin, the shaft, the pubis, the testicles, and the perineum. Anorectal examinations are encouraged for all MSM. The anus should be inspected and a digital rectal exam performed to palpate the prostate gland and to feel for masses in the anal canal and distal rectum. Prostate examinations for all MSM over the age of 50 are encouraged.

Special attention should be paid to YMSM who experience a higher degree of physical and sexual violence. Any physical signs of violence may be an opportunity to ensure the patient receives more fulsome services to help address such concerns. Consideration should be given to signs of anal tearing or bruising, including the presence of anal fissures, as an indication of forced penetration.

Presumptive diagnosis

At the conclusion of the examination, the client should be given the opportunity to dress and subsequently to meet with the clinician in a quiet setting to discuss the evaluation, the presumptive diagnosis, additional concerns on the part of the clinician, and recommendations for a diagnostic and treatment plan. The client must be given the opportunity to ask questions, and the client and clinician should jointly agree on next steps.

Laboratory testing

Following are laboratory testing recommendations for gay men and other MSM:

- *Symptom or syndrome directed testing:* Laboratory, radiographic and/or other studies should be ordered according to the diagnoses under consideration. Barriers to further testing may include limitations in finances, transportation, or perceived stigma associated with seeking services in other settings. A plan should be developed to include those studies that can be feasibly performed.
- *Screening tests:* Based on the diseases under consideration and based upon risk behaviors elicited in the history, some screening tests should be ordered for MSM. These may include screening for certain STIs, such as HIV infection and syphilis, HBV and hepatitis C virus (HCV), and, if available, screening tests (urine or direct swab) for Chlamydia and gonorrhea. Men who have sex with men should be offered all available vaccines (e.g., HAV and HBV), particularly in settings where screening is not available. The client should be briefed on all studies under consideration, with a short description of the rationale for recommended tests. The client should have the opportunity to opt out of any of the recommended tests.

Urgent treatment

After presenting the rationale for empiric or definitive treatment for conditions discovered in the initial evaluation, the client should be given the opportunity to consent to the indicated therapy. The potential risks, benefits, and alternatives should be briefly presented to the client prior to administration. Once given, the medication, dose, and route of administration should be documented in the patient's record.

Planning for the follow-up visit

Before discharging the client, the clinician should briefly discuss plans for follow-up. A follow-up appointment should be set to review laboratory and other diagnostic studies and/or to review a response to therapy. Indications for more urgent therapy should be offered to the client and he should be briefed on the policies for after-hours emergencies. Follow-up planning may include referrals to other professionals within the clinic or to outside specialists. These may include professionals in mental health, substance abuse, social work, and nutrition. Whenever possible, the client should be escorted through the clinic by the clinician or another staff member, introducing him to other staff members as indicated, and creating a comfortable environment for the client.

Refer to Annex 1 – Management Algorithm: First Clinical Evaluation.

HIV RISK AND INFECTION**Risk assessment and offering an HIV test**

Sexual activity is a healthy component of a person's life. Providers should adopt, promote, and exemplify a non-judgmental, empathetic interaction with clients. This entails consideration for both verbal and non-verbal expression.

Any sexually active individual should be considered for baseline screening for HIV infection. Given the higher risk of HIV transmission among MSM, routine testing is recommended at least twice per year. More frequent testing is recommended for individuals who engage in high risk behaviors. High risk behaviors might include sexual intercourse without a condom with partners who are

non-primary, serodiscordant, transactional, drug-users, or unknown, whether male or female.

HIV testing and counseling may be offered by a range of professionals, from community health workers to physicians. Training procedures to become certified to test for HIV may vary across countries. Furthermore, practitioners should refer to existing pre-test counseling guidelines specific to their respective countries.

Individuals who are presumed to be HIV negative should be offered an HIV test when presenting with symptoms related to an opportunistic infection (OI). When individuals are found to be HIV positive, the provider is encouraged to follow an STI management algorithm (refer to page 24 of this Blueprint, in the section entitled, “Sexually Transmitted Infections”). The use of checklists is recommended to ensure consistent quality of the risk assessment. Upon completion of a risk assessment, providers should offer clients an HIV test. Clients, however, may opt out of taking the test.

Necessary information prior to testing

Prior to administering an HIV test, providers should explain:

- the rationale for testing, the type of test to be used, and the meaning of a positive/negative result;
- that if managed with antiretroviral therapy (ART) and quality clinical care, HIV infection may be controlled as a chronic condition;
- that the test result is confidential and that disclosure of a positive result is needed to enroll in treatment;
- that clients are encouraged to ask questions regarding the test process; and
- that clients may opt out of testing without repercussion to other care services.

Testing

Screening should be conducted with an enzyme-linked immunosorbent assay (ELISA) or rapid test. Confirmation of a positive result should be performed with a Western blot or with an additional rapid test if a Western blot is unavailable. Results should be communicated as soon as possible as there is growing evidence that a significant percentage of people tested for HIV do not come back for the results.

Post-test counseling

Counseling is critical post-test regardless of the test’s results. Following are recommendations for provider post-test follow up:

- *Negative test:* Explain the result and provide risk reduction counseling. If recently at high risk and/or acute HIV suspected, consider virologic testing and encourage STI examination. If acute HIV infection is suspected, patients should be provided additional counseling, screened for CD4 count and viral load, and encouraged to return for testing within six weeks of a negative result. As relevant by country, advise patient of availability of post-exposure prophylaxis (PEP) and how it can be obtained, should an at-risk event occur later – regardless of the conditions that led to possible exposure (i.e., limiting access to PEP only for victims of sexual violence is not sufficient).
- *Positive test:* Explain the result; provide support and access to counseling. Provide access to HIV-experienced medical and mental health care. Report cases as required by national reg-

ulations, but be sure to advise patient of the reporting requirement and how his information will be managed, stressing issues of non-disclosure and confidentiality. Men who have sex with men should be encouraged to provide information about their sexual partners so that testing of contacts is undertaken. Understanding the nature of the individuals partnering in a respectful way will be important to obtaining a thorough list of possible contacts.

In addition, all individuals should be provided with free condoms and lubricant.

Entry into HIV care

Patients should be made aware of the treatment options available to them (and the right to opt out of treatment), and patients should be made aware of their rights as persons living with HIV (the right to employment, education, housing, health care, etc.). Patients should also be provided with (or referred onto) an orientation about the country's care system for persons living with HIV – how it will work, who provides it, how it can be accessed, etc.

Urgent referrals to HIV care are required in the setting of acute illness, suspected acute retroviral illness, and when there is evidence of marked immune suppression. Markers of immune suppression can include thrush, weight loss, known OIs, and neurologic abnormalities. Chronic diarrhea lasting more than a month should be included in the list of markers of immune suppression.

Prevention messaging should be repeated at this juncture (including information about multiple infection), and individuals should be encouraged to reconsider their list of contacts to ensure that all possible contacts have been notified to be tested. Positive prevention, and preventing further spread of HIV, should be reinforced. Furthermore, it is vital to provide extensive initial counseling and education for individuals about HIV infection, with ample opportunity for the client to have questions answered and to be empowered to begin a lifelong pattern of self-education.

Following are recommendations related to the initial assessment of the HIV-infected individual:

- Insist on telling him from the outset that HIV is not a deadly disease, if ART is started in a timely manner
- Provide emotional support in a welcoming environment
- Ensure intake with minimal delay, in a convenient location
- Triage for indications of medical or psychosocial urgencies
- Take an initial history and conduct a physical examination
- Perform baseline laboratory testing including: CBC, chemistry, urinalysis, CD4 count, RPR, HBsAg, HBsAb, HBcAb, HCV Ab, HAAb, Toxoplasma IgG Ab, PPD (if available, include G6pd and a quantitative HIV-1 RNA PCR)
- Perform additional STI screening as per STI protocols
- Orient the patient on navigating the health system, health center staff, and additional support services available
- Orient the patient on networks of people living with HIV/AIDS
- Provide information on the importance of informing sexual partners or encouraging them to get tested

As per national treatment guidelines, HIV-positive MSM should be offered OI prophylaxis, including prophylaxis for TB, *Pneumocystis pneumonia* (PCP), and *Mycobacterium avium* complex (MAC), based on CD4 count, prior disease(s), or clinical syndrome. These patients should also be

screened for other common OIs and diseases (e.g., lymphomas, Hodgkin's disease, sarcomas). In addition, patients should be offered all available vaccines, including HAV and HBV vaccines.

Patients should be evaluated to determine their readiness for ART, their ability to remain treatment adherent, and their willingness to commence treatment – with an aim to support the patient through behavioral and clinical interventions proven to enhance long-term treatment adherence. Adherence considerations should be made in the course of developing a treatment regimen with due consideration and planning for how treatment could affect personal security/confidentiality. Once these considerations are made, and in line with national treatment guidelines, early ART should be offered in cases where OIs are present, HIV/TB coinfection, or where acute retroviral illness is present.

Refer to Annex 2 – Management Algorithm: HIV Risk and Infection.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections remain an important health problem for gay men and other MSM. In addition to a higher prevalence of many STIs in the MSM community, depending on sexual behaviors, an MSM, may be at risk for infections outside the genital tract, such as pharyngeal and rectal disease. Many STIs place an individual at increased risk for acquiring additional STIs, including HIV infection. Identification and treatment of STIs in gay men and other MSM is important both for the health of the individual as well as the overall health of the community.

Anyone who presents with an STI should be screened for other STIs, including HIV infection. Sexual contacts of individuals with an STI should be referred for screening and treatment. Sexually transmitted infections are often suspected when an individual presents with one of a small number of STI syndromes. These may include:

- Urethritis: Pain on urination and/or urethral discharge
- Genital ulceration: Ulcers or vesicles
- Proctitis: Painful defecation, rectal urgency, or a rectal discharge
- Pharyngitis
- Prostatitis
- Scrotal swelling
- Swollen inguinal lymph nodes (buboes)
- Wart-like skin lesions

Syphilis

Syphilis is a systemic disease, caused by the spirochete, *Treponema pallidum*. The disease has been divided into two stages, early and late, based on clinical symptoms and/or duration of presumed infection. Early syphilis includes primary and secondary syphilis and early latent disease. Late syphilis includes late latent (greater than 2 years) and tertiary stages of disease.

Primary syphilis

- Presence of a painless genital or extra-genital ulcer
- May be diagnosed by dark-field examination of ulcer scraping
- RPR or VDRL may be negative at this stage

Secondary syphilis

- Systemic disease that may include fever, rash, adenopathy, and mucous membrane lesions
- Rash often involves palms and soles
- Non-treponemal tests, such as RPR and VDRL are usually very reactive
- Positive RPR or VDRL need confirmation with treponemal tests (FTA)

Latent syphilis

- Asymptomatic individual with serologic evidence of syphilis
- Early latent is infection of less than 2 years
- Late latent is infection of greater than 2 years

Tertiary syphilis

- Neurosyphilis can include meningovascular, dementia, or gumma
- Tertiary syphilis can involve the heart, the skin, and many other organs
- The treatment of syphilis is usually penicillin. Alternate therapies for penicillin-allergic individuals include doxycycline, tetracycline, and erythromycin.

Gonorrhea

Gonorrhea can present in MSM as a urethritis, proctitis, or pharyngitis. It can be abrupt in onset, is highly contagious and, if not treated, may cause long-term symptoms such as scarring and tissue destruction. The diagnosis is usually made by clinical presentation, by demonstration of intracellular gram-negative diplococci in the secretions, or by culture. Early gonorrhea may cause local extension to the epididymis, or disseminated disease, characterized by fever, arthritis and teno-synovitis, and a pustular skin eruption. The bacteria can sometimes be seen in the pustular secretions.

It is important to note that in some men gonorrhea may be asymptomatic, meaning they do not experience subjective discomfort such as dysuria and urethral discharge. This means that while they are infected, sexual activity is continued. Thus any effort to control gonorrhea must recognize the presence of this potentially important reservoir for the continuing spread of this disease.

Treatment for this infection usually includes either oral cefixime or intramuscular ceftriaxone or spectinomycin. Due to the emergence of resistance, ciprofloxacin should usually not be relied upon to treat gonorrhea.

Chlamydia

Chlamydia often presents with symptoms similar to gonorrhea (urethritis, proctitis, and pharyngitis), although usually milder, with pruritis and irritation rather than frank pain. Chlamydia can also lead to epididymitis, and long term scarring of the urethra and rectum. Diagnosis is usually made by clinical presentation or culture rapid test of material from the urethra or rectum. Chlamydial infections are usually treated with doxycycline or azithromycin.

Herpes simplex

Herpes simplex virus (HSV) usually presents as a crop of painful vesicles and/or ulcerations on the lip (most often HSV-1) or anogenital area (most often HSV-2). It can be characterized by an initial outbreak, that may include systemic symptoms, including adenopathy, fever and local neuropathy, but the lesions almost always resolve. Many individuals experience recurrences of the lesions, although they are usually milder. Lesions associated with a recurrence may last 3-10

days. Although herpes simplex cannot be cured, lesions will resolve more quickly when treated with acyclovir, or a related drug. The recurrence rate for local outbreaks and the incidence of viral shedding can be reduced with daily dosing with these drugs.

Lymphogranuloma venereum

Lymphogranuloma venereum (LGV) is an STI caused by a sub-type of *Chlamydia trachomatis*, which usually results in swollen inguinal and/or femoral adenopathy. Sometimes a genital ulceration is present though it has usually disappeared by the time an individual seeks medical attention. Lymphogranuloma venereum can be associated with proctitis in MSM. Untreated LGV can lead to rectal scarring, fistula formation, and predispose to bacterial infections. Diagnostic testing is often difficult and, when suspected, individuals are usually treated empirically with doxycycline or erythromycin.

Chancroid

Chancroid is a genital ulcer disease caused by *Hemophilus ducreii*. It is usually associated with a painful genital or peri-anal ulceration and accompanying inguinal adenopathy. Since diagnosis is often difficult, chancroid is often treated empirically in the setting of genital ulcer disease without evidence of syphilis or HSV. Treatment may include azithromycin, ceftriaxone, ciprofloxacin, or erythromycin.

Human papilloma virus

Human papilloma virus subtypes have shown to be the cause of venereal warts. These warts can be found anywhere on the genitals, the anus and surrounding skin, and can also be located within the anal canal. Other subtypes of HPV are associated with an increased risk of anal dysplasia and anal cancer. Human papilloma virus-related venereal warts are referred to as condyloma acuminata and must be differentiated from other causes of urogenital papules, such as molluscum contagiosum and secondary syphilitic lesions, called condyloma lata. Condyloma acuminata is usually treated with local measures including cryotherapy, local irritant treatment, or locally immunomodulatory agents.

Syndromic management

The most recent WHO algorithms should guide the management of common STI syndromes. Refer to “Guidelines for the Management of Sexually Transmitted Infections” (WHO, 2003).

ANORECTAL HEALTH

All MSM who access health services should be encouraged to undergo an anorectal examination. The anorectal examination should not be the focus of an MSM’s clinical examination; rather, it should be one of the several procedures to be carried out in a comprehensive, holistic, and sex-positive medical routine. Health care workers should be educated and familiarized with sexual activities that may result in adverse anorectal health outcomes. Practitioners should be trained and sensitized to the fact that the anorectal area is considered a sexual organ for some MSM, as not all MSM engage in receptive anal sex. Therefore, specific infections and conditions can be associated with sexual activity outside of conditions associated with biological function.

While it should be presented as a routine procedure, a client’s decision to opt out should be respected. Because of the nature of the anorectal examination, it is important to recognize that the patient may wish to postpone the procedure for reasons relating to hygiene or wanting to

become more informed. Furthermore, there may be a great deal of resistance among MSM to undergo an anorectal examination – more will be required to encourage MSM to make such examinations part of their overall healthcare.

Structural pressures within the health system may limit a physician’s ability to take the necessary time to perform anorectal health counseling. With appropriate training, community members and other health care providers can undertake the responsibility for this work. Therefore, greater peer and health care worker education on the benefits of undergoing an anorectal examination as part of a comprehensive health assessment is encouraged. The development of printed educational materials specific to MSM on anorectal health and the procedures of an anorectal examination should be created. Health care providers may also adopt practices to help overcome some of the shame that may be associated with an anorectal examination, and encourage greater adoption of this examination. Health care providers, for example, should employ the flank position to decrease patient physical and emotional discomfort.

In the context of an anorectal examination, the health provider should ask the patient about:

- Consistent condom use
- Use of rectal douches or enemas (over-the-counter or homemade)
- Consistent use of water-based lubricant in anal sex
- Use of foreign objects and other insertive practices (e.g., dildos, fisting)
- Previous anorectal health problems
- Use of drugs and other substances during anal sex

The anorectal examination should focus on identifying:

- Injuries near the anus or to the anal mucosa
- Sharp pain near the anus
- Secretions in and around the anus or rectum
- Hemorrhoidal diseases or symptoms
- Hemorrhoidal thrombosis
- Anal fissures or fistulas
- Foreign objects in the anus or rectum
- Cancer of the anus or rectum
- Complications from sexual practices involving trauma to the anus or rectum (e.g., post-penetration bleeding)
- Intestinal injuries
- Ulcers around the anus or rectum
- Anorectal incontinence

Following the anorectal examination and treatment of any identified diseases or conditions, MSM should be counseled on the importance of lubrication, cleanliness, and condom use to reduce the chance of tearing and minimize the risk of transmitting disease during anal sex. They should be advised that because the anus does not produce lubrication, and anal skin and tissue is likely to tear when it is dry, lubrication is important prior to penetration. Lubricant should be water-based or “condom or latex friendly,” not oil-based because such lubricants destroy latex condoms, and lubricants that contain nonoxonyl-9 spermicide should be avoided.

There are other issues a health care provider should address, including: the importance of washing the anal region before and after anal sex, which reduces the amount of bacteria that could be spread from partner to partner, but which may also remove some of the natural protection the body has to infection; the role that condoms play in preventing the spread of STIs when worn prior to any contact; and a warning regarding the overuse of enemas, which can destroy the normal, healthy balance of bacteria in the lower intestine.

Refer to Annex 3 – Anorectal Health.

SUBSTANCE USE AND ASSOCIATED PROBLEMS

Men who have sex with men may use an array of substances across their life-course. Substances may include tobacco, alcohol, prescription medications, or illicit drugs. Similar to other adults and adolescents, MSM may present with symptoms or complications suggesting substance use. Substance use is related to availability, price, access, and marketing, as well as norms and policies regarding their use in a particular society. In addition, at a personal level, substance use can be a response to societal and environmental stressors such as stigma experienced by MSM, as well as a coping strategy for psychological distress, including depression, anxiety, and other mental illness symptoms. Men who have sex with men may also use substances as sexual enhancers/facilitators during sex. An individual's use of substances prior to or during sexual intercourse may increase his risks of acquiring HIV or STIs by diminishing his inhibitions as well as his ability to negotiate the use of condoms successfully. Among HIV-positive individuals, alcohol and drug use may also interfere with HIV treatment adherence and/or weaken the efficacy of antiretroviral therapy. Alcohol use is also linked to intimate and interpersonal violence, among heterosexual men and women, as well as MSM.

Screening and recognition

Given the high prevalence of substance use (particularly alcohol and tobacco) among MSM, and the fact that many clients without dependence can benefit from a brief intervention to reduce their substance use, health care providers must screen all clients regardless of whether they show any signs suggesting a substance use disorder and should provide a supportive, care-based, non-judgmental environment where they may ask questions regarding such use. Screening questions regarding substance use should be embedded into the medical interview.

An initial screening must include questions regarding the last 12 months and more recent use of tobacco, alcohol, and prescription medications, as well as the use of “street drugs,” covering quantity and frequency as well as injecting drug use. Screening tools have been developed and validated by the WHO and they are able to identify different levels of risk regarding alcohol and substance use (e.g., Alcohol Use Disorders Identification Test [AUDIT]; Alcohol, Smoking, Substance Involvement Screening Test [ASSIST]).

Depending on questionnaire scores, a brief intervention, brief treatment, or referral to treatment can be done. They aim at assessing the motivation for change, discuss ways of reducing substance use, developing a plan, and providing non-judgmental advice to the client. When problems with specific drugs are detected, appropriate information must be provided to the client, through direct discussion, or written leaflets. Clients with signs of dependence (and high scores in the screening instrument) can be referred to specialized services where they exist and accept MSM.

Toxicity and withdrawal

During the initial assessment of the client, the clinician must be attuned to signs of drug or alcohol intoxication or withdrawal. Signs might include excessive sedation, agitation, confusion, or delirium. Those individuals who are acutely intoxicated, who have overdosed, or who are in acute withdrawal, must receive urgent and immediate medical attention. Post-crisis treatment should be sensitive to MSM.

Examination

Similar to the clinical history screening, the physical examination should include an assessment of psychological and emotional circumstances that may lead individuals to use drugs, whether legal or illegal, when clinicians are trained and prepared to do so. During the physical examination, the clinician should also be vigilant for signs of some of the complications of drug use, including subtle mental status changes, changes in nasal tissue (mucosa) or bone and cartilage (septum) suggestive of intranasal drug use, skin abscesses or superficial inflammation (thrombophlebitis), suggesting infected injection sites. Yellow stains in the skin (jaundice) may suggest hepatitis (drug induced or not). Heart murmurs may also suggest inflammation of the inside lining of the heart (endocarditis). Individuals who misuse drugs may be at higher risk of contracting STIs, especially if they engage in heightened sexual activity in exchange for drugs. Health care providers should encourage the screening for HIV/STIs among MSM who report a prior history of injecting substances or having sex in combination with substance use.

Drug testing

Blood and urine tests may be used to detect substances that were not apparent in the original history and examination. However, these tests may not be available to health services in all countries and their costs may be prohibitive in clinical practice. These tests should be used only if they will lead to improved clinical care and are not necessary for managing substance use disorders.

Human rights and legal issues

Although tobacco and alcohol use are usually legal for adults, use of other drugs may be illegal in most countries in the LAC Region. The penalties for use will also vary, and in many instances being caught in possession or using an illegal substance can place MSM in contact with the law enforcement, justice, and penal systems, where being MSM can carry heavy consequences, including deep discrimination and physical violence. Health care providers should guarantee the human rights of all clients and treat them with dignity and respect, irrespective of the reasons or situations where substance use has occurred. Confidentiality of medical records is critical. The clinician's care and support is often one of the only safe spaces in which an individual can receive critical information about the impact of substance use, but can also begin to steps necessary to address that use and some of the underlying causes for use.

Clinicians and staff must do their utmost to protect the confidentiality, as well as the physical and emotional safety of their clients. Men who have sex with men should be guaranteed clinical care and, whenever possible, provided substitutive/replacement therapies and/or harm reduction strategies. This is an especially significant issue for YMSM who may be engaged in substance use and doing so illegally.

Dependence treatment

While most clients will benefit from a brief intervention where screening warrants, provided by a trained professional without specialization in substance abuse issues, when a diagnosis of sub-

stance dependence is established, the involvement of trained and specialized health care professionals may be required. Referrals should be made after discussion with the individual and with his prior consent. The clinician should be able to provide full and accurate information about local treatment centers. A detailed discussion and consent process will maximize buy-in from clients and protect their confidentiality.

Drug treatment services should be selected based upon the skills of the clinicians and staff at these centers, their ability to provide a stigma-free and non-homophobic environment, and their willingness to be sensitive to the needs of the MSM population. In many areas of the LAC Region, there may be very few dependence treatment centers and there may be none that are sensitive to the needs of gay men and other MSM. Attempting drug dependence treatment at a religiously affiliated center, for example, may prove hostile to MSM, and may do more harm than good.

Methadone and buprenorphine are effective treatments for opioid dependence, and should be available where opiates are misused. In many LAC Region countries, dependence on stimulants such as cocaine and amphetamines cannot be treated with replacement therapies, as there are no medications which could be used as substitute therapies. Nicotine replacement therapy is an effective option, along with behavioral interventions. For alcohol, there is no effective replacement therapy. Some medications used for alcohol dependence treatment are available, but their efficacy and effectiveness are limited.

There is no easy solution for a gay man or other MSM in need of substance dependence treatment in an area without a specialized or mental health center that is sensitive to the needs of the MSM population. In situations where MSM-sensitive treatments are unavailable, it is the responsibility of the health sector and/or health-related professions to provide training and technical assistance workshops to build capacity in dealing with MSM clients and others with substance use disorders. Furthermore, each MSM should be free to decide whether to seek treatment at an available center, to attempt treatment with someone who is sensitive to MSM issues but with limited competencies in drug dependence treatment, or to forego treatment. Self help groups formed among MSM only may be available in some countries and may support recovery.

Behavior modification and harm reduction

Behavior modification, provided through brief interventions and brief treatment for harmful substance use, is effective and can benefit a large number of clients who do not meet criteria for substance dependence.

Another group of clients may not be motivated or ready to change their substance use or seek treatment, even when they meet criteria for substance dependence. However, particularly when injecting drug use or other unsafe patterns of substance use exist, accessing services such as needle exchange programs, low threshold outreach services, are not only effective but can facilitate later acceptance of treatment. Therefore, links with such services are recommended, although it is recognized that some harm reduction services are still illegal in many countries.

Treatment and recovery from substance dependence is similar to other chronic medical conditions, requiring long-term follow up, includes periods of relapse, and with successes measured over a period of years. Health care providers serving MSM should be aware of the challenges faced by their clients and understand the chronic nature of dependence. Health services with a substantial population of patients with substance use issues should have some staff knowledge-

able about substance use-related care. Group and individual therapy, and supportive care during relapses may be provided in collaboration with more formal drug treatment centers.

Individuals may face a number of obstacles to healthier behaviors during their substance use life. These obstacles may include behavioral triggers in clients' environments such as limited social support, availability of substances in social venues, and/or invitations to use substances from members of their social networks. Furthermore, clients may need to overcome biomedical triggers such as drug withdrawal. Health care providers should embrace a harm reduction approach, providing judgment-free interactions with MSM and strategies to overcome these triggers.

Finally, health care providers should be aware that changes in substance use practices may lead to repercussions in other domains within individuals' lives, including dealing with and overcoming social stigma. Strategies to overcome such "new stigma" need to be provided, to empower MSM to maintain healthier lifestyles.

Refer to Annex 4 – Management Algorithm: Substance Use.

SEXUAL CONCERNS

There are many sexual concerns among gay men and other MSM that can be addressed in health care settings. Health centers offering services to MSM populations must create a compassionate, non-threatening, and nonjudgmental environment, both through interpersonal contact (e.g., in the examination or counseling room with the provider, or on the phone) and through visual displays and environment (e.g., in marketing displays, brochures, main entrance). Providers can make a positive and even life-altering impact on MSM patients by educating themselves about the distinct needs of MSM patients, and then being sensitive to these issues.

Sexual identity/orientation/coming out

Clarification and self-acceptance of a gay, bisexual, or transgender identity often evolves gradually over a period of many years. Sexual orientation/identity is complex and multidimensional. There is no one single process for coming out to oneself, and coming out to others is a complex, dynamic, and lifelong challenge. While sexual behavior exists along a continuum, and can therefore be described and discussed more concretely, sexual identity is more nuanced and may change depending on the individual, group or network with which the individual MSM is interacting. One may therefore present a diverse range of "identities," depending on whether one is interacting with peers, employers, family, health care providers, and others. Other determinants of health will also affect this presentation of identity, including socioeconomic status, race, ethnicity, culture, and other factors. It is important for health care providers to be sensitive to this phenomenon, but to not make assumptions about how and when the individual chooses to self-identify.

Gay men and other MSM will often internalize societal prejudice and stigma relating to sexual behaviors and identity; this can lead to shame, isolation, loneliness, and/or confusion. Social support can reduce these feelings and promote the formation of a more positive identity.

There is a wide spectrum of coping behaviors for MSM as they both come out and come to terms with their non-heterosexual identity. Coping behaviors may include appearing more stereotypically heterosexual, becoming sexually and romantically involved with same sex partners, avoiding/sublimating sexuality (pursuit of non sexuality-related activities that will validate self-worth,

such as greater academic achievement), and engaging in unhealthy behaviors (drug/alcohol use, compulsive sexual behavior) as a means of distraction from what the individual deems as unacceptable feelings. Clinicians in health centers caring for MSM populations can assess a client's stage of self-awareness and contribute most effectively to this process by doing the following:

- Remain open to flexible, non-binary models of gender and sexuality with all patients; not everyone initially shares their sexual orientation and/or gender identity. Young men who have sex with men are more likely than their older peers to be struggling with internalized negative feelings about their orientation and isolation socially as their sexual identity is still in development.
- Avoid assumptions based on conventional stereotypes of how MSM look and behave.
- Understand the coming out process and consider where in that process a person might be, what factors might be affecting his sense of self, and how that might be affecting his life choices.
- Develop awareness of how age, race, ethnicity, culture, class, economic standing, and religion can affect a patient's circumstances and perspective of their gender and sexuality and the process of coming out.
- Become aware of and sensitive to the bigotry and stigmatization that MSM and their families experience in daily life and the stress it places on them.
- Listen to how patients describe themselves; then, mirror their language and use non-biased language to describe and discuss sexual issues. Variations in sexual orientation/identity are naturally occurring and are entitled to full human rights protection. Forms of "reparative therapy" are unethical and, therefore, MSM should not be encouraged to change their sexual orientation, but rather to express their orientation in a safe and responsible manner.
- Communicate that sexual behaviors such as homosexuality are positive expressions of gender and sexuality.
- Assess a patient's level of self-esteem and how it might be related to internalized homophobia.
- Assess a patient's connection to or isolation from community resources and the open MSM community.
- Remain positive and affirming when talking to patients about their sexuality. Young men who have sex with men are likely unaware of the fact their community of MSM have historically been a very resilient population. In spite of efforts to suppress and/or elimination the expression of homosexuality, MSM continue to survive and many thrive. Young men who have sex with men need to understand that many of the challenges they face can be mitigated over time and that they can easily go on to flourish socially.
- Include specific non-binary questions about sexuality on intake forms and in history taking, examinations, and discussions.
- Affirm the patient's true sense of self and/or his desire to find his true self-identity.
- Have referrals to MSM affirmative support groups, community organizations, specialized professional mental health and health providers; information on relevant MSM community organizations and resources; reading materials on relevant health issues and supportive resources; resources for friends and family members of MSM.

Sexual performance and dysfunction

Gay men and other MSM face many of the same issues regarding sexual dysfunction that heterosexual men face, but also have some unique challenges that an informed clinician can address. A secure and positive clinician-client relationship will allow for evaluation of both the emotional and physical aspects of the client's sexual health.

Erectile dysfunction

This is a common complaint among men, irrespective of sexual orientation. It can be caused by psychogenic issues (most rapid onset ED is associated with these), medications, medical diseases (most gradual onset ED is associated with these), or a combination of the above. Loss of spontaneous erections (such as those experienced in the morning when waking) often points to an organic cause. Completely reviewing a patient's prescription, recreational and over-the-counter drug use, in addition to his alcohol use, can help pinpoint an easily reversible pharmacologic cause of ED.

Physical examination should focus on endocrine (testicular, thyroid), vascular (peripheral pulses), and neurologic (pituitary: visual fields, chest; brain: cremasteric reflex) systems. Laboratory examination should include thyroid function testing, glucose tolerance testing, lipid testing, prolactin testing, and testosterone level tests. Referral to a urologist is recommended in the event that no obvious cause is identified. Treatment includes phosphodiesterase (PDE)-5 inhibitors such as sildenafil, prostaglandin injections, vacuum devices, and/or penile implants. Because condom use can worsen ED, patients with this condition are more likely to engage in unprotected sex. Lastly, since the use of amyl nitrate ("poppers") and cocaine can be higher in the MSM population, patients on PDE-5 inhibitors should be cautioned about the lethal effects of taking these drugs concomitantly.

Ejaculatory complaints

Premature ejaculation can be treated with behavioral exercises to train the patient to better delay ejaculation or with medications such as selective serotonin reuptake inhibitors (SSRIs). Retrograde and retarded ejaculation, conversely, are often associated with SSRI use and can be improved by decreasing the dose of this medication or discontinuing its use.

Anal complaints

Hemorrhoids and fissures will commonly interfere with anal receptive sex and can be treated with topical therapies, stool softeners, sitz baths, and surgical consultation. Relaxation techniques and anal dilators may be indicated for patients having trouble physically tolerating anal sex.

Compulsive sexual behavior

Men who have sex with men are at risk for compulsive sexual behavior (CSB) involving sexual urges, sexually arousing fantasies, and sexual behaviors that are recurrent, intense, and a distressful interference in one's daily functioning. Individuals with CSB often perceive their sexual behavior to be excessive, but are unable to control it; they act out impulsively and/or are plagued by intrusive, obsessive thoughts and driven behaviors. This craving may interfere with the development of social, occupational, interpersonal and intimate relationship functioning. Compulsive sexual behavior does not need to involve another person, (e.g., compulsion with pornography), nor does it require that the individual experience an orgasm. With respect to MSM, compulsive sexual behaviors with a high risk of HIV transmission are especially important to address. Treatment of CSB often requires a referral to a qualified specialist.

Unique vulnerabilities

The threat of legal, familial, and social repercussions can leave MSM vulnerable to sexual coercion and exploitation, particularly when coupled with other factors such as poverty, racism, and homelessness. As well, MSM seeking validation from, or intimacy with, other men may be more inclined to engage in behaviors that put them at risk for HIV infection and other adverse sexu-

al health outcomes. These issues are even more exacerbated for YMSM who are even more vulnerable than their older peers.

For YMSM who are comfortable defining themselves as such, practitioners are cautioned from assuming that the sexual activity of YMSM is exclusive to other males. Young men who have sex with men may experiment sexually with women as a means of confirming their attraction to other men, or in an effort to suppress their attraction to other men. Whatever the motivation, studies report that YMSM are more likely than their heterosexual peers to engage in an episode of unprotected vaginal intercourse that results in an unintended pregnancy. Efforts should be made to explain the contraceptive benefits of condom use to YMSM in addition to information provided about STI/HIV prevention.

Refer to Annex 5 – Management Algorithm: Sexual Concerns.

EMOTIONAL AND MENTAL HEALTH

Homosexuality is not a mental or social disorder. However, it is widely frowned upon and judged as a disorder. The resulting social and cultural circumstances in which MSM live often lead to stigma and discrimination, low self-esteem, loneliness, exclusion, and social isolation across the life-course. As a result, gay men and other MSM may be at heightened risk of developing and manifesting symptoms of mental illness; however, these symptoms may decrease if MSM have greater access to supportive social networks and/or involvement in community groups.

Health services focusing on MSM health should offer behavioral health screening, diagnostic, and therapeutic services that are both accessible and efficient. Depression, anxiety, sleep disturbances, bullying/harassment, adjustment disorder, bipolar disorder, and post-traumatic stress disorder (PTSD) are common behavioral health problems affecting MSM populations, especially those living with HIV/AIDS. Among HIV-positive MSM, the presence of mental illness symptoms or disorders may exacerbate HIV-related stress, and decrease access to quality care, as well as reduced adherence to treatment.

Screening and diagnosis

Emotional and behavioral health problems occur at high enough rates in both the general and MSM populations to warrant screening as part of general primary care. Because MSM patients, and especially HIV-positive patients have a higher risk of developing psychiatric illness, screenings should be repeated annually, or sooner if major life changes (such as the death of a partner, diagnosis of HIV, or other chronic illness) occur. Screening for emotional distress, sexual problems, and social isolation should be ascertained, since they are risk factors that may lead to mental health symptoms.

A detailed and sensitive clinical interview may identify mental illness symptoms or risk contexts. In some cases, where there is an absence of trained personnel to carry out these clinical interviews, health care providers may use simple screening tools that have been developed in several languages, and have been culturally validated to detect symptoms of depression, anxiety, PTSD, and bipolar disorder among Latino MSM. Although these tools may not be completely valid throughout the LAC Region, in many settings they will be highly useful or may be locally adapted.

Patients with positive screens should be referred in a timely manner for appropriate treatment, as outlined below. In many cases, especially when disease severity is mild or detection of disease

is early, treatment can be initiated and even maintained by primary care providers. Patients who visit with their primary care provider(s) may be too ashamed to explicitly state their behavioral health issues and concerns. In these instances, effective clinician-patient communication is vital. Providers working with gay men and other MSM should be supportive and empathic, and they should focus on establishing trust and encouraging candor with these patients in order to allow for proper diagnosis and referral to behavioral health care providers.

Treatment

With gay men and other MSM, it is especially important for treatment plans to focus on helping patients achieve a positive identity, to improve self-esteem and to build a support system. Especially with severely mentally ill and/or HIV-positive MSM, a multidisciplinary approach to behavioral health care, consisting of a primary care provider, medical social worker, therapist, and psycho-pharmacologist, is often needed. In settings where referral to behavioral health services can be challenging because of limited resources or heightened stigma, utilizing relevant (e.g., MSM-specific) community-based organizations (CBOs), social networks, and support groups can be beneficial. When appropriate, health care providers may also provide referrals to traditional and alternative medicine services. Providing behavioral health treatment in the same venue that patients receive their medical care can help to combat this stigma.

Refer to Annex 6 – Management Algorithm: Emotional and Mental Health.

CONSEQUENCES OF VIOLENCE

Because of stigma, prejudice, and in certain countries, laws, gay men and other MSM are more prone to be or become victims of violence than the general population. This is often more pervasive when/where multiple forms of social exclusion combine to increase the likelihood of violence. Factors that can increase the incidence of violence against MSM can include discrimination based on race or ethnicity; exclusion based on class, poverty or homelessness; and/or other social factors. Therefore, health care providers should become sensitive to issues of diversity within MSM populations based on these various factors, and be aware of how an individual's "social location" can be a factor in his experience of exclusion or violence. Health centers that offer services to MSM will often need to evaluate and treat men who have been victims of violence, including sexual assault. This violence or sexual assault may be recent, past, or recurring.

Screening

Violence and sexual assault may be suspected when an individual presents for treatment after an alleged assault, or when clues or statements are elicited in the history or physical examination that suggest recent, past, or ongoing violence. In addition to this direct or indirect evidence, MSM should be screened for a history of domestic or non-domestic violence. Health care providers should remain open-minded, and recognize that the origin of violence and/or sexual assault may be in the family setting, with sexual partner(s), in the school or employment setting, or elsewhere.

Sometimes, and often due to stigma and a heightened sense of needing to remain quiet about one's sexual identity, a history of violence and/or sexual assault may be ascertained which includes multiple settings and/or perpetrators. It is critical for health providers to not arrive at quick and complete diagnoses about the existence/experience/forms of violence and sexual abuse, while at the same time being careful to not pressure clients into disclosure or discussion of highly sensitive incidents or situations. In many cases, complex histories or instances of vio-

lence/abuse may only be revealed over time, and once a strong rapport is developed between the client and his care provider(s).

In cases of past or ongoing violence and/or sexual assault, it is critical for clinicians to discuss available options for counseling, legal support, and other forms of support. Health care providers should guarantee the human rights of all clients and treat them with dignity and respect, and provide empathy to clients to ensure candid disclosure of how, why, when, and where a violent incident occurred. Given the limited legislation against hate crimes or same-sex assault across several LAC Region countries, the clinician's care and support is often one of the only safe spaces in which an individual can discuss violent episodes, and may be an important resource to secure their safety. The subsections below address issues related to screening, treatment, and support of MSM in the context of a recent or emergent case of violence or sexual assault.

Triage

All clients should be immediately evaluated for evidence of emergent injuries, either physical or psychiatric. If present, the client must be safely taken to a setting that can immediately address these injuries; this process should be discussed and negotiated with the client to address concerns related to confidentiality and safety. If the client is to remain at the facility for evaluation and treatment he, and any accompanying family or close friends, must be assured that they will be safe while in the clinic, that their confidentiality will be safeguarded, and that their emotional and physical health needs will be addressed.

It is important for clinicians and other health center staff to be aware that while a client may feel comfortable with the services and environment of one particular health center, he may often be highly anxious or fearful of other locations, particularly if they are unknown. Support and reassurances are particularly important in such instances, and staff should be trained to identify resistance or a tendency to diminish the significance of an urgent injury as a potential sign of anxiety or fear.

Initial evaluation

History-taking and physical examination must be conducted in an environment that is comfortable for the victim, and one that respects the distress that he may feel. Although the evaluation may need to include difficult questions and a careful examination of the body, efforts should be made to avoid further distress to the victim. If the victim wishes to be accompanied, a family member, partner, or friend may be allowed to quietly be present during the evaluation. The key factor is to support the client in being an active participant in deciding the details of the examination, and what will make him feel most comfortable.

History

The history should include details about the assault and the assailant(s). The client should be assured that these details are required only as a means of assisting in the clinical diagnosis of impact and health risk, and will not be used to pursue or take action against the assailant(s), except where the client himself wishes to pursue action against the assailant(s). This is critical in order to reassure the client that he will not be exposing others, and to reduce fear of the repercussions this may have. At the same time, the clinician should be aware of any legal requirements that he/she may have to report instances of violence and/or sexual assault and must be open and honest with the client about any such requirements.

Particular attention should be paid to areas of sexual assault, including oral, genital, and rectal contact. The prior medical history should be reviewed, including medications and allergies. The presence of any concurrent infections, such as HIV or hepatitis, should be documented, as should prior or existing STIs. Prior or recent consensual sexual activity should be documented, if legal action is anticipated.

Examination

In a private, comfortable environment, the patient should be undressed and examined completely. The collection of samples for forensic evidence will depend on whether the clinician is empowered or authorized to do so and should be performed according to local protocol. Skin should be inspected carefully for bruising, abrasions, and lacerations. The mouth, genitalia, and anal areas should all be inspected for evidence of trauma.

Laboratory testing

In the absence of major trauma and internal organ injury, laboratory testing may be mostly directed toward excluding a pre-existing STI. If elected, samples may be taken from the throat, genitalia, and rectum for gonorrhea and Chlamydia, and blood samples for an RPR, HIV ELISA or rapid test, HBV and HCV antibody levels, and HSV serology.

Empiric therapy

Victims of recent sexual assault are often treated empirically for certain STIs. Therapy might include: ceftriaxone 125 mg IM for gonorrhea; azithromycin 1 gram PO or doxycycline 100 mg PO BID x 7 days for Chlamydia; and metronidazole 2 grams PO for trichomoniasis. For those individuals who are not immune to HBV, the three-part vaccine should be initiated, with the first vaccine given within the first 72 hours.

HIV post-exposure prophylaxis

If the sexual assault occurred less than 72 hours prior to the evaluation, PEP should be explained and offered to the victim consistent with existing PEP protocols. Ideally, drugs should be offered within the first 4 hours of the event, or as soon as possible afterwards within the 72 hour window of effectiveness. The drugs available in the community or the country's formulary may dictate the choice of drugs. Individuals on PEP must be monitored closely during the course of PEP therapy and follow-up testing is recommended.

Legal considerations

A medical or psychological evaluation of a victim of violence or sexual assault may be considered part of a body of evidence for a legal case, which may be filed well after the case. Accurate and complete records of the evaluation must be kept. In addition, the clinician and the clinic staff must be aware of local and national laws governing the evaluation of victims of rape or violence. Some countries have specific protocol dealing with a post-rape evaluation; however, they often only pertain to female victims. If forensic evidence is to be gathered, clinic protocol must include issues pertaining to the laboratory kits used, the laboratories chosen, the chain of custody, and reporting to the police.

Refer to Annex 7 – Management Algorithm: Consequences of Violence.

MSM Health Promotion Activities

In addition to addressing the health concerns that brought a man to the clinic, health centers that serve gay men and other MSM need to incorporate health promotion efforts into their routine practices. Factual information must be available to clients in a language that is understandable and credible. Information may be provided through written pamphlets, handouts, or newsletters, or it may be communicated verbally during or after a medical visit and during group activities sponsored by the facility. Particularly if clients become long-term patients at the

health facility, a more longitudinal approach to health promotion can be developed, and will likely include all of these elements.

While youth generally have poor preventive health skills, YMSM are even less likely to concern themselves with health promotion information since they tend to be more focused on the challenges of coming to terms with their sexual orientation and identity.

Health promotion efforts should be provided in the context of its delivery to a sexual minority population that is exposed to unique stressors within society. Helping gay men and other MSM to understand the effects of homophobia and heterosexism on their health can be an important tool in getting MSM to

seek out healthier coping mechanisms, and in building networks of peer educators in the community. Young men who have sex with men are also well-served by receiving health promotion information within this same context since it may well prevent the establishment of unhealthy coping mechanisms before dependencies set in, and prevent other harmful/risky behaviors.

In addition to clinicians, staff at the health center should include individuals with excellent communication skills, who relate well to MSM clients and engage men comfortably during their visits. Even brief communications about health-related issues, when presented by a trusted health professional, can make a difference in some health behaviors. Staff may sponsor regular support groups that appeal to some of the clients, and elements of support group discussions can include training on health promotion.

Topics for health promotion activities should include prevention of STIs, including HIV, and especially condom use. Some sessions and materials might focus on the dangers of tobacco, illicit drugs, and excessive alcohol use. Vaccinations and regular health check-ups should be encouraged. Others group sessions and health promotion efforts could address relationships and negotiation skills, nutrition, exercise and other issues related to the pursuit of health and prevention of illness. Men who have sex with men in some LAC Region countries may benefit from understanding some of the legal aspects of being a gay man or other MSM in the region and how they might protect themselves with and from the law enforcement community.

Health center clients should also be encouraged to communicate health promotion activities within the greater MSM community in their region and to advocate within other health facilities for a similar focus on health promotion among gay men and other MSM.

While youth generally have poor preventive health skills, YMSM are even less likely to concern themselves with health promotion information since they tend to be more focused on the chal-

lenges of coming to terms with their sexual orientation and identity. Health center staffs need to ensure that communications with YMSM are respectful and that traditional communication challenges between youth and adults do not impede the provision of care. Youth do not want to be made to feel like they are being talked down to by adults; they want adults to listen non-judgmentally to their concerns, and they do not want their issues dismissed or diminished.

Health Outreach for MSM

There are a number of reasons to consider health outreach activities before clinic-based health consultations, including that they help link clinical care to the population in the community.

The advantages of community-based health care outreach include:

- Lower cost and more effective triage of services
- The use of physician services for more serious health conditions: a significant amount of testing and counseling can be done by counselors and do not require a nurse or physician
- The high prevalence of silent (asymptomatic) disease in STIs and HIV infection and the need to raise STI and HIV awareness
- Conducting screening in the community and retaining the clinic for confirmation and treatment of detected cases; and the possibility of empirical field treatment, with complicated cases referred to the clinic
- Expanding the geographical catchment and clientele of the clinic
- Taking services and counseling in mobile/street clinics to the locations of risk behavior and community foci
- Utilizing community animators/advocates (translating medical terminology into community terminology and vice versa) to assist in interaction with clinical personnel; and utilizing peer outreach or volunteers to walk or introduce community members to the clinic and to serve as an interface between clinics and community
- Integrating existing civil society institutions, including NGOs and CBOs, schools, and other educational institutions into the health care system
- Reducing class and socioeconomic disparities where disadvantaged individuals may see clinics as sites only for care of the privileged or care for life-threatening conditions
- Providing outreach health services expands provision of psychosocial, nutritional and other needs that may reciprocally impact the full range of the determinants of health

Ideally, health encounters with MSM may be conceptualized as a continuum or a series of stages, commencing with needs assessment and an assessment of health gaps in the population of concern. The first stage of health encounters may commence with a needs assessment, community setting assessment, or examination of epidemiological data, where available. The second stage of the health encounter involves community outreach education regarding risk behaviors and the availability of testing and treatment, referral, and sources of support for conditions of concern. The third stage may involve taking basic services such as counseling, testing, and screening to the community in the form of mobile units, street clinics, and temporary clinical services at particular times in community locations (e.g., bars, bathhouses, brothels, house parties, youth groups for HIV/STI testing).

Community health outreach can provide the clinic with a screened population who then will attend the clinic for confirmation, additional diagnostic testing, and treatment of complex cases. It can also provide an opportunity to develop evidence-informed innovation and best practices in MSM disease prevention, intervention and program evaluation.

There is a need to ensure adequate ethical and quality assurance of community outreach testing and screening, including clear referral mechanisms and linkages between services and organizations. Appropriate selection and training of outreach workers, and standards and responsible professional behavior in community settings, should occur regardless of whether the workers volunteer or are remunerated.

In the longer term, facilitating appropriate health care and clinic attendance needs to be based on effective school-based outreach, which includes education on health care with particular regard to ethnicity, race, gender, sexual diversity, and human rights.

Where communities are stigmatized and are “underground,” outreach has particular advantages. Health outreach workers can go to specific locales (e.g., cruising areas, parties) and integrate prevention and care (e.g., handing out condoms and facilitating counseling and testing at the same time). They can facilitate the reduction of social barriers to services; as well as educate a hidden population about locations of street clinics or

mobile clinics, availability of appropriate vaccinations, community resources, and disease signs and symptoms that could reveal the presence of silent disease. The use of mapping approaches to risk in community locales is particularly helpful in determining outreach in mobile and street clinic locations.

Outreach is important in bridging the gap between the community and clinic-based health services. Where populations may feel alienated from health and medical care, peer educators may be of considerable importance in providing word of mouth information on clinic confidentiality or anonymity of testing, and the importance of health care for clinically silent disease. Further, peer educators and outreach workers may walk clients to clinics and assist in their registration and introduction to clinical staff. This may also include acting as an advocate to the client by explaining or translating medical information into community terms.

Where there is high use of the Internet and other communication technologies (e.g., cell phones) by MSM, the Internet and cell phones can be adapted for outreach messages by providing health information, clinic details, on-line appointments, and links to health and prevention information sites. In cases of disease outbreaks (e.g., syphilis, LGV), these technologies have also proved useful in the provision of information on symptoms and risk behaviors to gay men and other MSM. Provision of print-out coupons for treatment and free condoms/lubricant may also facilitate recruitment of MSM into clinics. Electronic technologies offer particular opportunities for innovation in reaching stigmatized populations such as MSM, since the information can be accessed in a context of anonymity.

There are models of community outreach in which networks are accessed to provide training to community members, who subsequently recruit other contacts. Such proactive approaches may

facilitate community development and provide an opportunity to receive ongoing feedback on health issues of concern to the community. Such approaches are useful for vulnerable groups such as commercial sex workers or transgender individuals, and migrant and other mobile populations.

Such approaches require that outreach workers/clinicians receive training so that they are aware of strategies to find men using, for example, public sex venues to meet partners. Community endorsement for these outreach activities will be important to legitimize these efforts. These efforts then become focused on the venue rather than on how men identify themselves sexually. In the longer term, facilitating appropriate health care and clinic attendance needs to be based on effective school-based outreach, which includes education on health care with particular regard to ethnicity, race, gender, sexual diversity, and human rights, as emphasized in the 2008 “Mexico City Declaration on Sex Education in Latin America and the Caribbean.”

Partnering with NGOs and CBOs that have experience in dealing with MSM and related hidden sub-populations such as commercial sex workers and transgender individuals can facilitate a continuum of health education, prevention, screening, and treatment which incorporates communities and civil society institutions into the health sector. This, in turn, helps empower individuals in their risk reduction, self-care and health-seeking behaviors. The clinic and community health care efforts should serve as cross-referral sources to facilitate both access to, and retention in health care.

Similarly, recognition should be given to environments that have been successful in attracting and maintaining contacts with gay and other MSM populations, including those that place MSM in the broader context of all men, as well as settings that place YMSM in the broader context of youth-friendly resources. An appropriate approach may be to provide services to vulnerable groups within in a broader community health clinic so as to be less politically contentious for the dominant community.

Refer to Annex 8: Community-Clinic Interaction.

Considerations for Working with YMSM

Specific outreach programs and support services oriented to YMSM should address the following considerations:

- **Embrace technology:** The Internet can serve as a powerful tool to enable YMSM to access information and resources on public health issues. Thus, it is important to ensure that school and public libraries do not use software programs that filter out YMSM websites or restrict access to information on healthy sexuality. For many youth, the Internet is a virtual lifeline of support. However, not all youth have confidential access to computers and/or the Internet. Therefore resources and services must also be provided in other ways to ensure that outreach efforts are not class-based and only serving those youth who have the economic and/or geographic means to access them. In LAC Region countries, Internet cafés are an inexpensive option for YMSM to access the Internet, and they should be considered useful educational tools.
- **Network with professional service providers:** Help educate local public health professionals, social workers, nurses, teachers, counselors, and medical professionals on YMSM

issues. For many youth, these professionals will be the first line of support they seek out when questions or difficulties arise. Public health organizations can work with these professionals to ensure that they understand and respect confidentiality guidelines and ethical codes of conduct that pertain to working with YMSM.

- **Address transportation issues:** For many youth, both in rural and urban settings, transportation is the most significant barrier to service. Programs should consider providing travel stipends, bursaries, car pools, charter buses, or a travel buddy system. Successful programs designed to meet the needs of YMSM must address travel limitations if they are to achieve designated goals and outcomes.
- **Develop inclusive resource collections:** Organizations are encouraged to work with local school or public libraries to ensure their holdings are inclusive of YMSM topics and issues. Often YMSM-themed books are censored or challenged. This deprives youth access to information that depicts their lives and communities. Without access to the Internet, libraries can serve as an oasis for many YMSM.
- **Evaluate new and existing programs:** Limited research has been conducted on the needs and experiences of YMSM accessing health care services. Therefore, it is important to create a database of exemplary practices that can help to inform future practice, influence policy development, and facilitate targeted funding opportunities.
- **Create local alliances:** Young men who have sex with men often value their independence and autonomy. Many youth may be skeptical of outside interventions. To help address this barrier to service, organizations should seek to build local community partnerships and “home-grown” strategies that are designed to meet the needs of YMSM. One way to build these alliances is to partner with local colleges, universities, or community groups to develop YMSM support groups. Young men who have sex with men from local and surrounding communities can be encouraged to attend these programs, which may also become sites for primary public health intervention and outreach support.

In all programs, it is especially important to always maintain a person’s confidentiality and anonymity. Coming out and coming-to-terms processes are unique for each individual, and are affected by a wide array of individual and social factors. Many rural and ethno-cultural communities are often tightly knit, and well connected. As a result, many YMSM are hesitant in accessing supports and services, for fear that word will be spread about them. Emphasizing confidentiality and maintaining anonymity can help to dissuade these fears and, in turn, encourage youth to seek out sources of support. Perhaps above all else, the most important aspect is to simply be visible. The very presence of supportive programs, services, and adult MSM and allied role models can give young people a sense of hope and possibility for their future. Even if youth never attend these programs they will know that supports are available should they ever need them.

Recommended strategies for designing HIV-specific outreach programming targeting YMSM indicate such programming should be:

- Peer driven with program decisions made by YMSM;
- Explicit about sexual practices and condom usage (e.g., materials discuss how to use condoms for anal intercourse);
- Culturally relevant and inclusive of issues such as race, ethnicity, gender (i.e., messages makes sense to particular ethno-cultural populations, and acknowledge diversity within diversity);
- on-going and conducted in safe non-homophobic spaces (e.g., group activities happen in a place designated for YMSM);

- Tailored to YMSM issues and perceptions of HIV risk (e.g., focus groups are used to understand the specific community and cultural factors that lead to high-risk behaviors); and
- Focused on skill-building (e.g., teaching YMSM how to negotiate safer sex practices and/or refusal skills).

Young men who have sex with men from diverse cultural and ethnic minority backgrounds also face diverse and increased risk factors that may expose them to greater risk factors. In many cultural settings, homosexuality is seen as a distinctly “Western” or “Caucasian” phenomenon, “disease,” or “social disorder.” This cultural standpoint places enormous pressure on youth in these contexts who may be coming out or coming-to-terms with a non-heterosexual and/or HIV-positive identity.

Conclusion

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 (e.g., HIV), 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/reparative 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;
- Inadequate capacity to deal with non-heterosexual sexualities;
- Serious limitations to provide services for under age youth (e.g., counseling, testing); and
- 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.

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.

ACHIEVING 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

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.

of very limited reach and effectiveness, and 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 who have sex with men must 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 YMSM) must be in place. These algorithms should be an essential part of routine youth health services 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 sex-

ual 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 populations 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.

Bibliography

GREY LITERATURE

Alma Ata Declaration, International Conference on Primary Health Care, Alma Ata, USSR, September 1978.

Association of Ontario Health Centres (AOHC). Paths of Inequity, Vehicles for Change: Taking Action on the Social Determinants of Health. Association of Ontario Health Centres, Toronto, 2006.

Foundation for AIDS Research (amfAR). MSM, HIV, and the Road to Universal Access - How Far Have We Come? Foundation for AIDS Research, New York, 2008.

Gay and Lesbian Medical Association (GLMA). Healthy People 2010 - Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health. Gay and Lesbian Medical Association, San Francisco, 2001.

Joint United Nations Program on HIV/AIDS (UNAIDS). HIV and Sex Between Men: Policy Brief. Joint United Nations Program on HIV/AIDS, Geneva, 2006.

Joint United Nations Program on HIV/AIDS (UNAIDS)/World Health Organization (WHO). Report on the Global AIDS Pandemic, 2008. Joint United Nations Program on HIV/AIDS/World Health Organization, Geneva, 2008.

Mexico City Declaration on Sex Education in Latin America and the Caribbean, 1st Meeting of Ministers of Health and Education to Stop HIV and STIS in Latin America and the Caribbean, Mexico City, August 2008.

National Association of Community Health Centres (NACHC). Reaching Out to “Other” Special Populations: Providing Services to Lesbian, Gay, Bisexual, and Transgender Patients. National Association of Community Health Centers, Washington, DC, 2007.

US Department of Health and Human Services (DHHS). Agency for Healthcare Research and Quality (AHRQ). National Healthcare Quality Report 2005. US Department of Health and Human Services, Agency for Healthcare Research and Quality, Rockville, MD, USA, 2006.

World Health Organization (WHO). Defining Sexual Health: Report of a Technical Consultation on Sexual Health, World Health Organization, Geneva, 2002.

World Health Organization (WHO). Commission of Social Determinants of Health. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. World Health Organization, Geneva, 2008.

World Health Organization (WHO). World Health Report, Primary Health Care (Now More Than Ever), World Health Organization, Geneva, 2008.

World Health Organization (WHO). World Health Organization Commission on the Social Determinants of Health (WHO CSDOH). Report of the WHO Commission on the Social Determinants of Health. World Health Organization, Geneva, 2008.

World Health Organization (WHO). Resolution of the 62nd World Health Assembly: Primary Health Care, Including Health System Strengthening. World Health Organization, Geneva, May 2009.

Bibliography *(continued)*

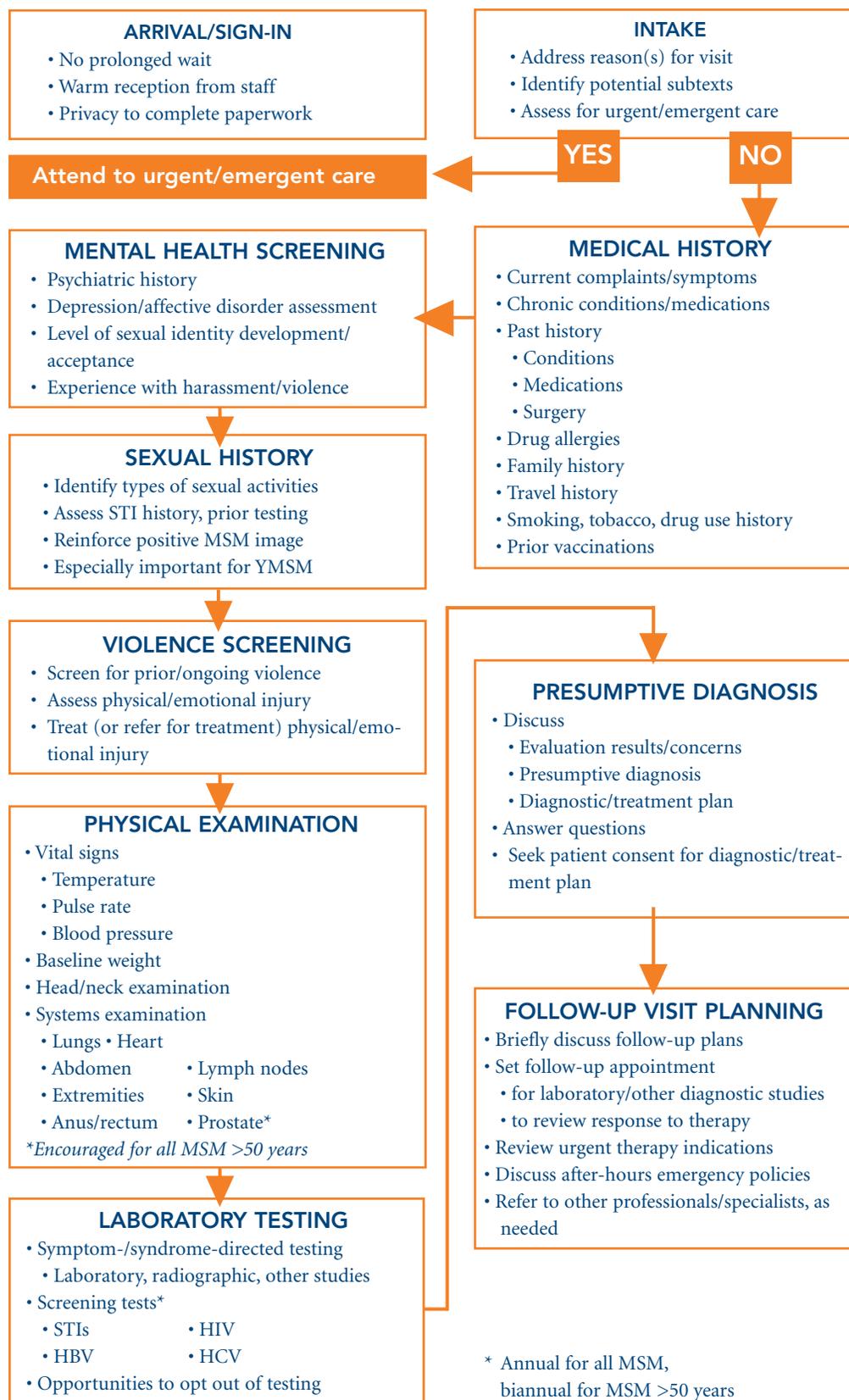
PEER-REVIEWED LITERATURE

- Anderson LM, Scrimshaw SC, Fullilove MT, et al. Culturally competent health care systems. A systematic review. *Am J Prev Med.* 2003;24:68-79.
- Arah OA, Westert GP, Hurst J, Klazinga NS. A conceptual framework for the OECD Health Care Quality Indicators Project. *Int J Qual Health Care.* 2006;18:5-13.
- Baral S, Sifakis F, Cleghorn F, and Beyrer C. Elevated risk for HIV infection among men who have sex with men in low- and middle-income countries 2000-2006: a systematic review. *PLoS Med.* 2007;4:e339.
- Bastos F, Caceres C, Galvao J, Veras MA, and Castilho EA. AIDS in Latin America: assessing the current status of the epidemic and the ongoing response. *International Journal of Epidemiology.* 2008;37:729-737.
- Beehler JP. Confronting the culture of medicine: gay men's experiences with primary care physicians. *Journal of the Gay and Lesbian Medical Association.* 2001;5:135.
- Bell R. ABC of sexual health: homosexual men and women. *BMJ.* 1999;318:452-455.
- Bonvicini KA, Perlin MJ. The same but different: clinician-patient communication with gay and lesbian clients. *Patient Education & Counseling.* 2003;51:112-122.
- Caceres C, Konda K, Pecheny M, et al. Estimating the number of men who have sex with men in low and middle income countries. *Sex Transm Infect.* 2006;82(Suppl 3):iii3-iii9.
- Cassell EJ. The nature of suffering and the goals of medicine. *N Engl J Med.* 1982;306:639-645.
- Cole SW, Kemeny ME, Taylor SE, et al. Elevated physical health risk among gay men who conceal their homosexual identity. *Health Psychology.* 1996;15:243-251.
- Coleman, E. Developmental stages of coming out. *J Homosex.* 1982:31-43.
- Donabedian A. Methods for deriving criteria for assessing the quality of medical care. *Med Care Rev.* 1980;37:653-698.
- Donabedian A. The quality of care. How can it be assessed? *JAMA.* 1998;260:1743-1748.
- Garofalo R, Wolf RC, Wissow LS, et al. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch Pediatr Adolesc Med.* 1999;153:487-493.
- Garafalo R, Harper GW. Not all adolescents are the same: addressing the unique needs of gay and bisexual youth. *Adolesc Med.* 2003;14:595-611.
- Grimshaw J, Eccles, Thomas R, et al. Toward evidence-based quality improvement: evidence (and its limitations) of the effectiveness of guidance dissemination and implementation strategies 1966 -1998. *J Gen Intern Med.* 2006;21:S14-S20.
- Harper GW, Schneider M. Oppression and discrimination among lesbian, gay, bisexual, and transgendered people and communities: a challenge for community psychology. *Am J Community Psychol.* 2003;31:243-252.
- Irwin H. Doctor-patient communication competency. *Austr J Communication.* 1991;18:14-31.

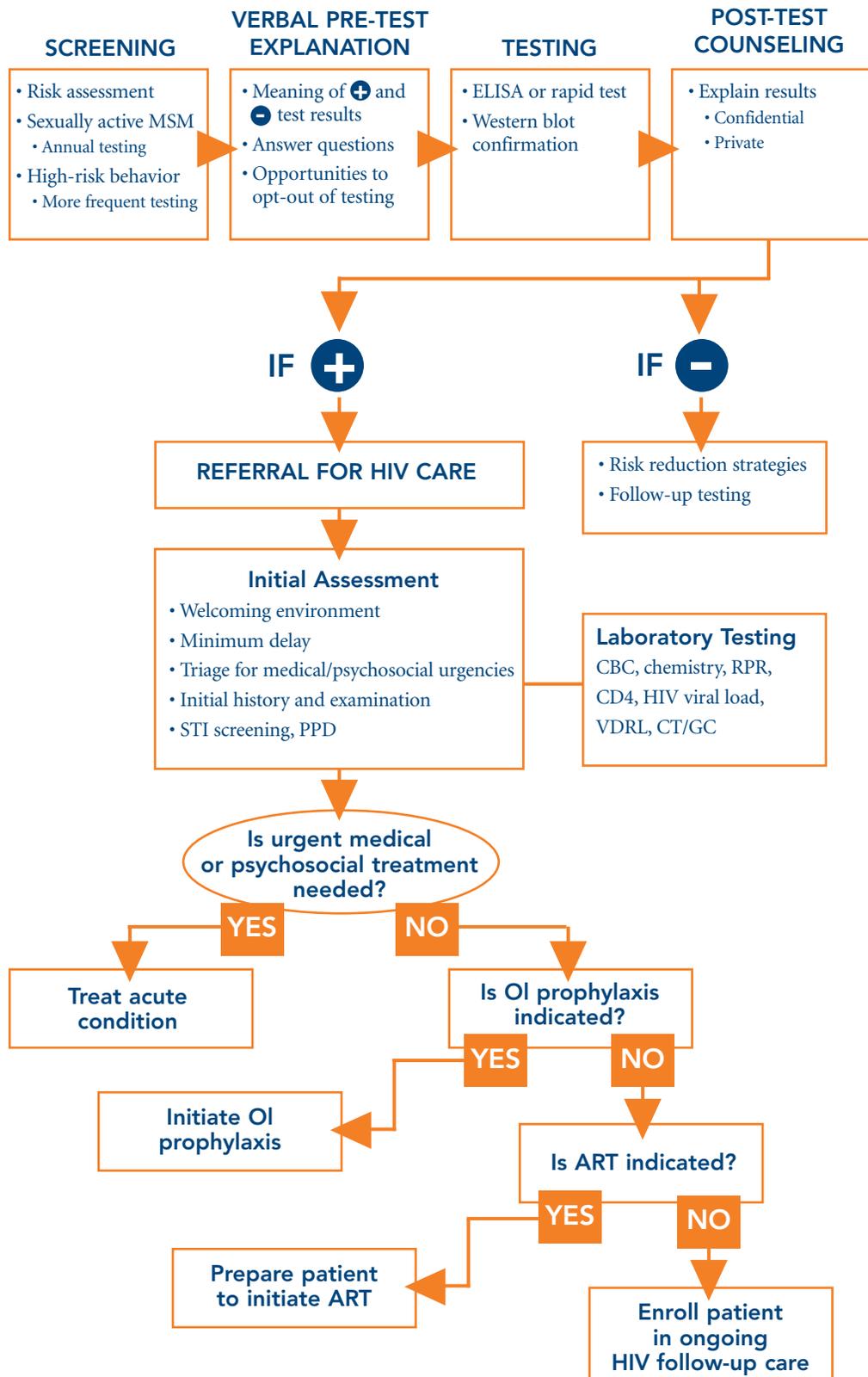
Bibliography *(continued)*

- Kimmel SB, Mahalik JR. Body image concerns of gay men: the roles of minority stress and conformity to masculine norms. *J Consult Clin Psychol*. 2005;73:1185-1190.
- Klein J, McNulty M, Flatau CN. Adolescents' access to care: teenagers' self-reported use of services and perceived access to confidential care. *Arch Pediatr Adolesc Med*. 1998;152:676-682.
- Knight D. Health care screening for men who have sex with men. *Am Fam Physician*. 2004;69:2149-2156.
- Makadon HJ, Mayer KH, Garofalo R. Optimizing primary care for men who have sex with men. *JAMA*. 2006;296:2362-2365.
- Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin*. 2003;129:674-97.
- Mills TC, Paul J, Stall R, et al. Distress and depression in men who have sex with men: the Urban Men's Health Study. *Am J Psychiatry*. 2004;161:278-285.
- Novack DH. Therapeutic aspects of the clinical encounter. *J Gen Intern Med*. 1987;2:346-355.
- Pitt E, Dolan-Soto D. Clinical considerations in working with victims of same-sex domestic violence. *Journal of the Gay and Lesbian Medical Association*. 2001;5:163-169.
- Remafedi G. Suicide and sexual orientation: nearing the end of controversy? *Arch Gen Psychiatry*. 1999;56:885-886.
- Remafedi G. Fundamental issues in the care of homosexual youth. *Med Clin North Am*. 1990;74:1169-1179.
- Ryan C, Futterman D. Lesbian and gay youth: care and counseling. *Adolescent Medicine: State of the Art Reviews*. 1997;8:207-374.
- Saavedra J, Izazola-Licea JA, Beyrer C. Sex between men in the context of HIV. *Journal of the International AIDS Society*. 2008;11:9.
- Samargia L, Saewyc EM, Elliott BA. Foregone mental health care and self-reported access barriers among adolescents. *Journal of School Nursing*. 2006;22:17-24.
- Savin-Williams RC. A critique of research on sexual-minority youths. *J Adolesc*. 2001;24:5-13.
- Schneider A, Ingram H. Social construction of target populations: implications for politics and policy. *American Political Science Review*. 1993;87:334-347.
- Spiro H. What is empathy? Can it be taught? *Ann Intern Med*. 1992;116:843-846.
- Stall R, Paul JP, Greenwood G, et al. Alcohol use, drug use and alcohol-related problems among men who have sex with men: The Urban Men's Health Study. *Addiction*. 2001;96:1589-1601.
- Swearingen SG, Klausner JD. Sildenafil use, sexual risk behavior, and risk for sexually transmitted diseases, including HIV infection. *Am J Med*. 2005;118:571-577.
- Williamson I. Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research*. 2000;15:97-107.

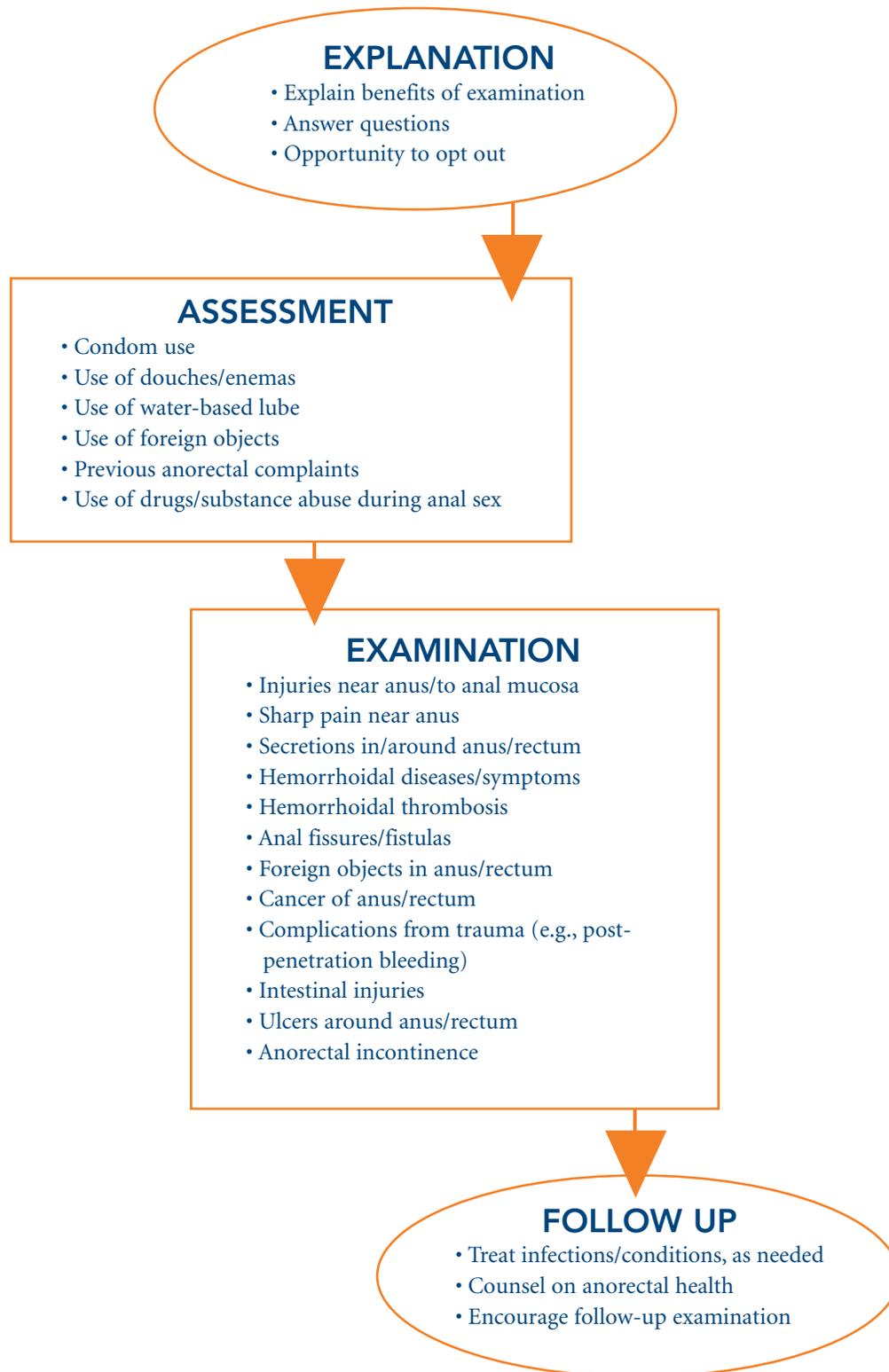
Annex 1: First Clinical Evaluation



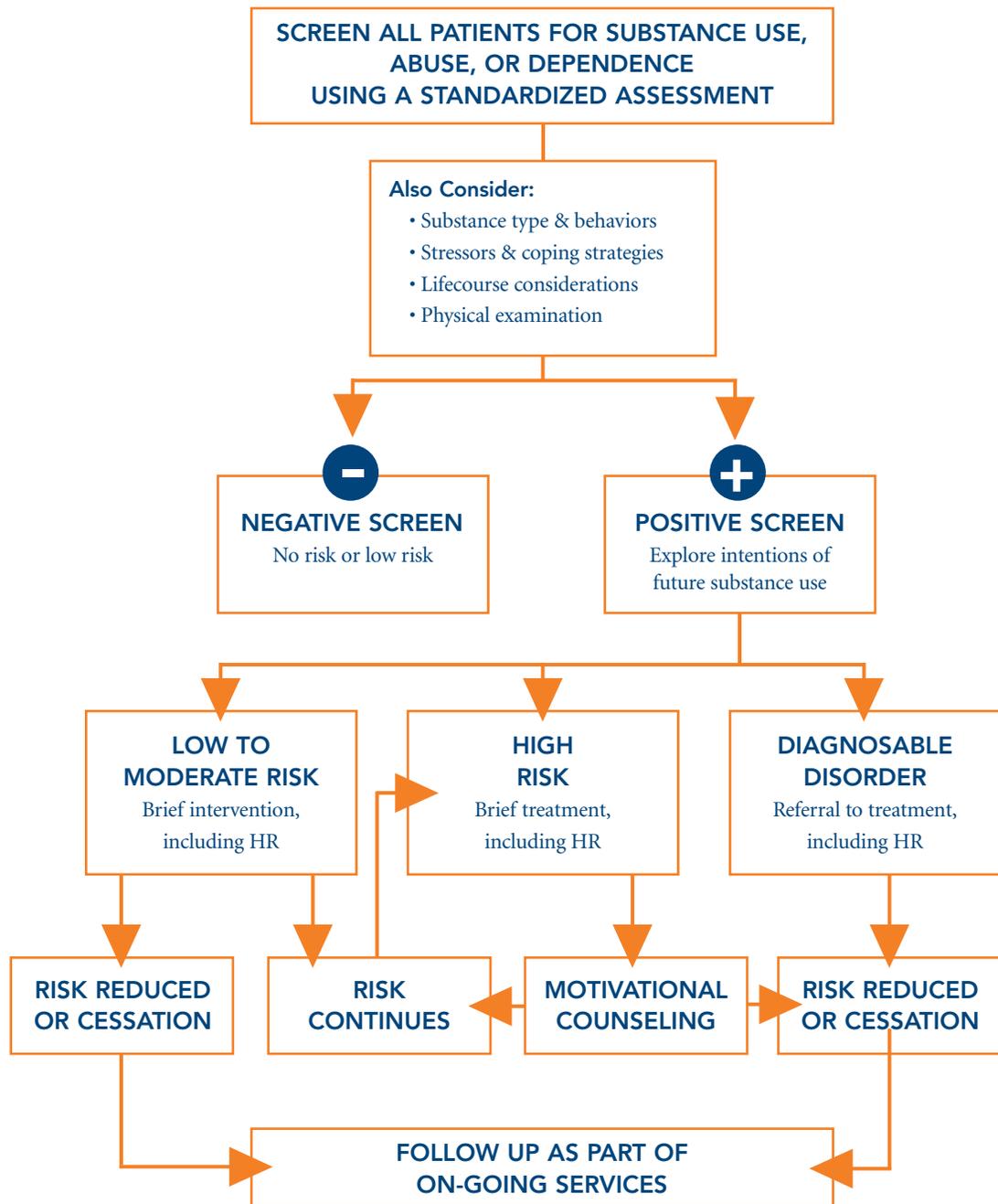
Annex 2: HIV Risk and Infection



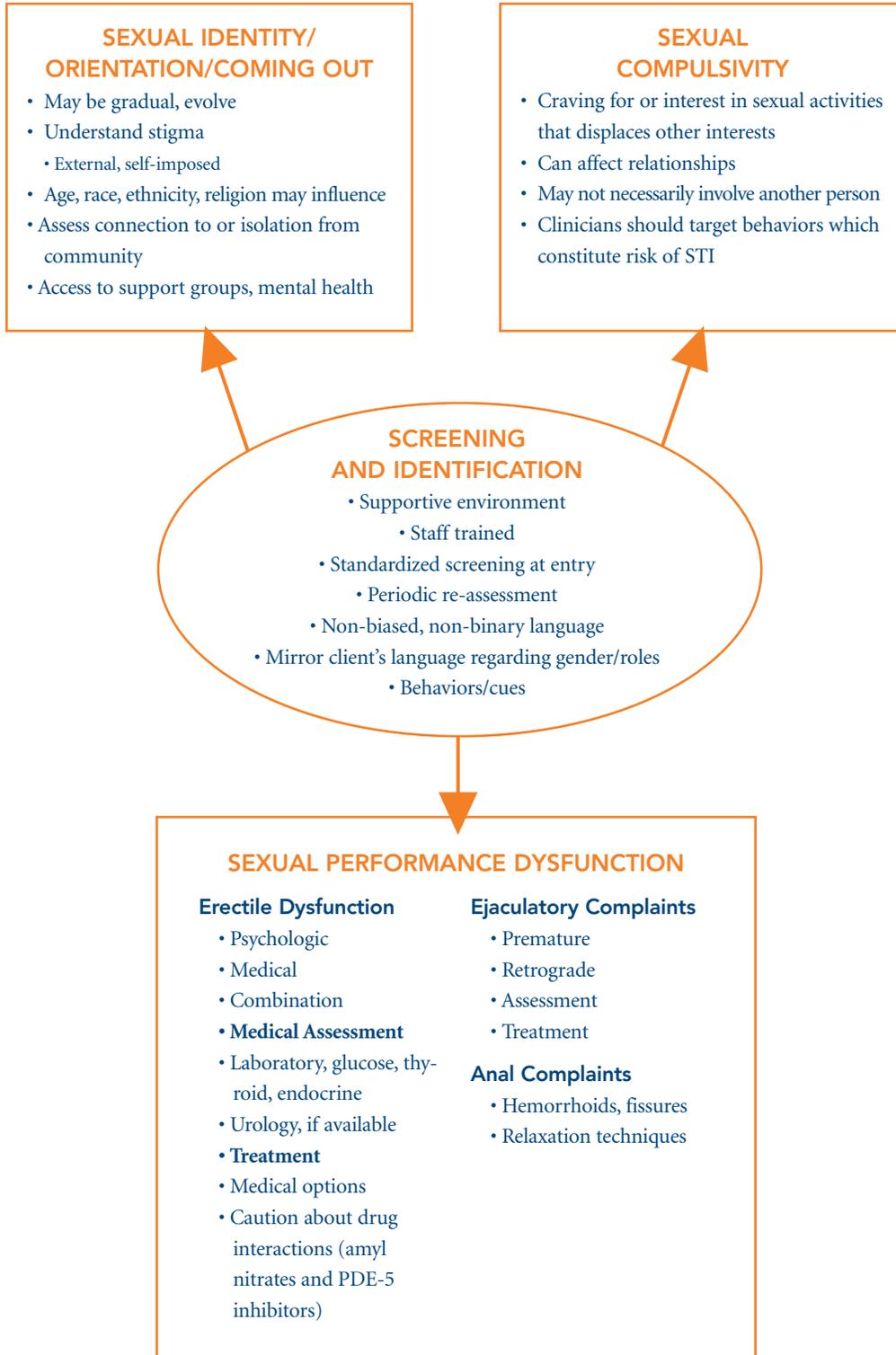
Annex 3: Anorectal Health



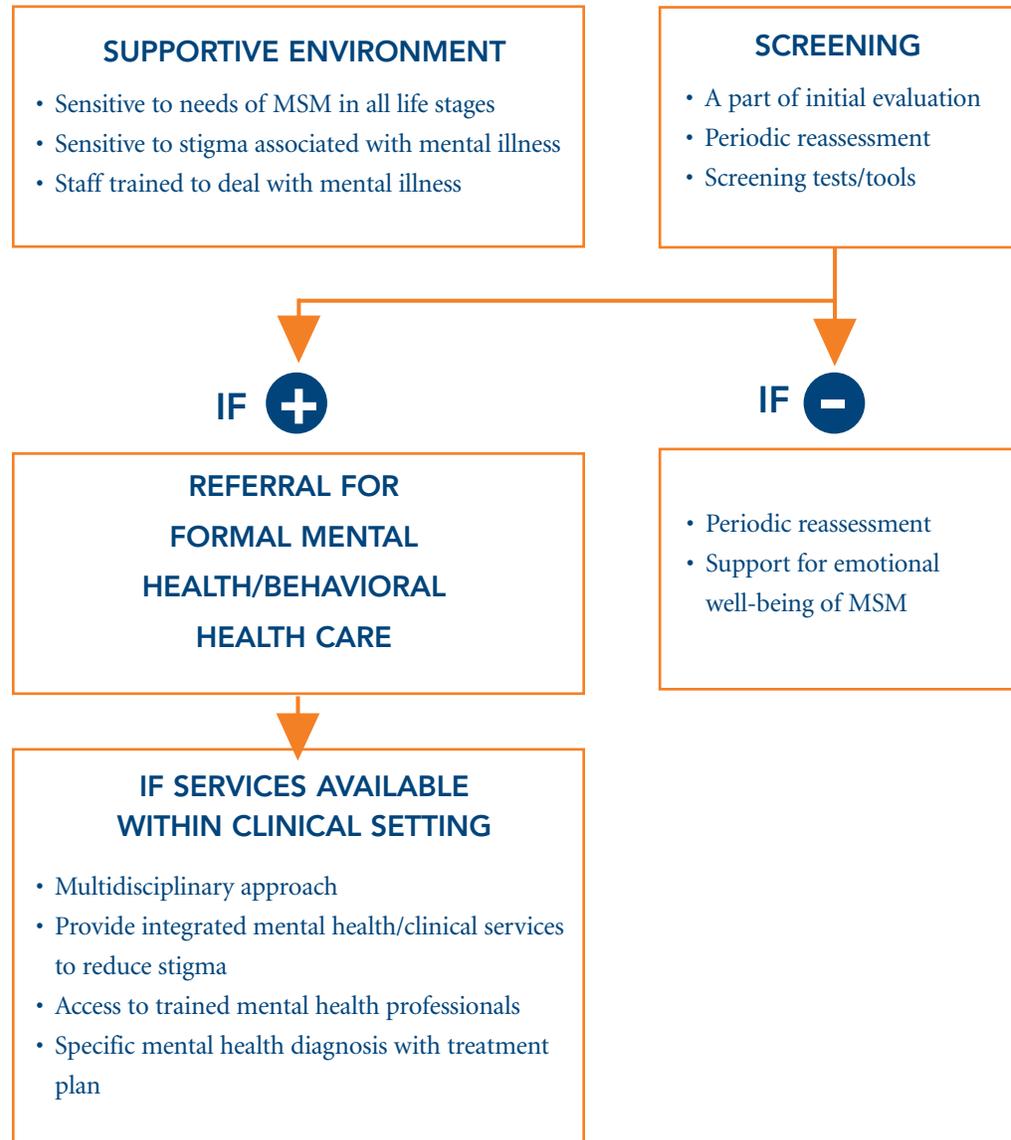
Annex 4: Substance Use



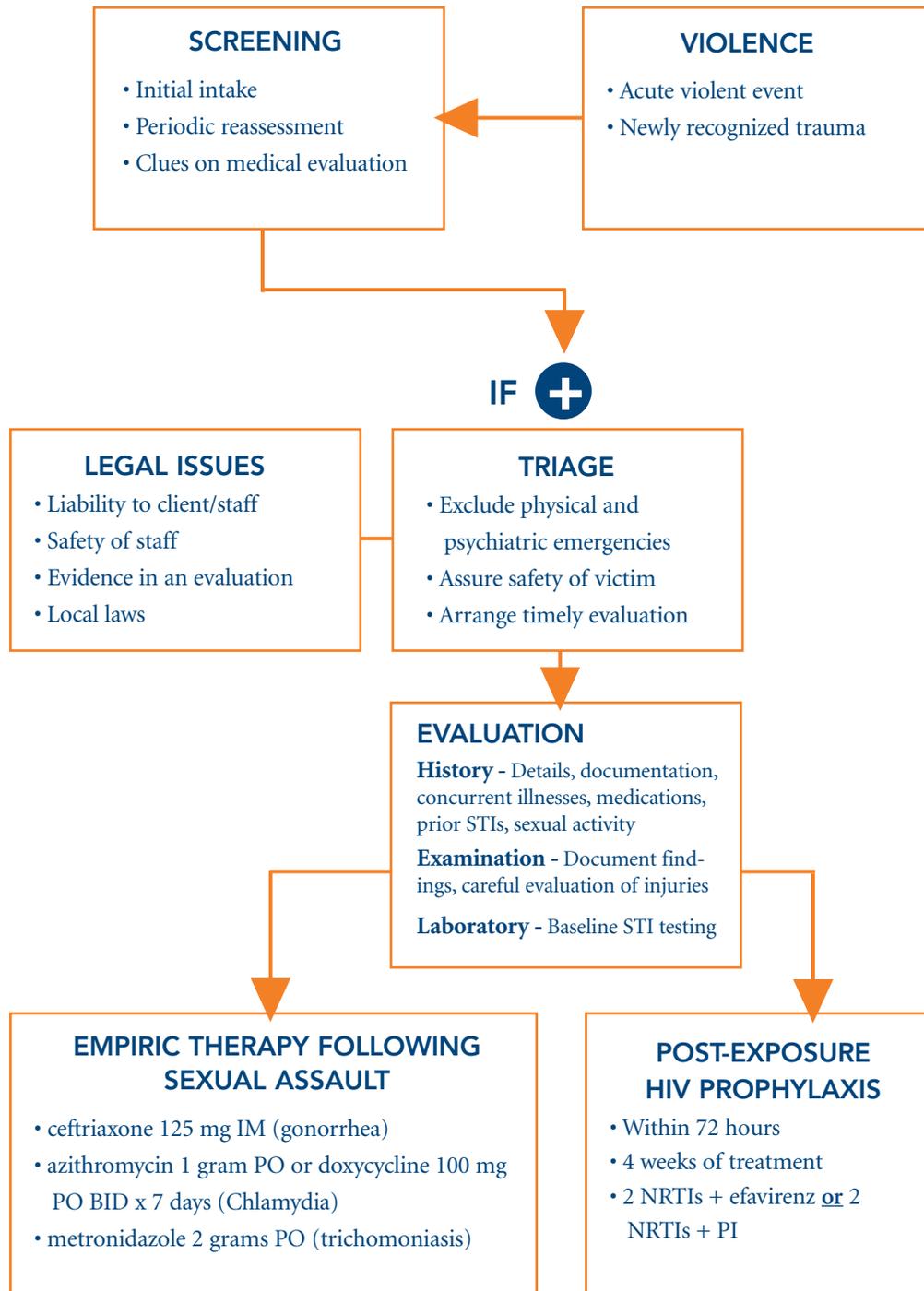
Annex 5: Sexual Concerns



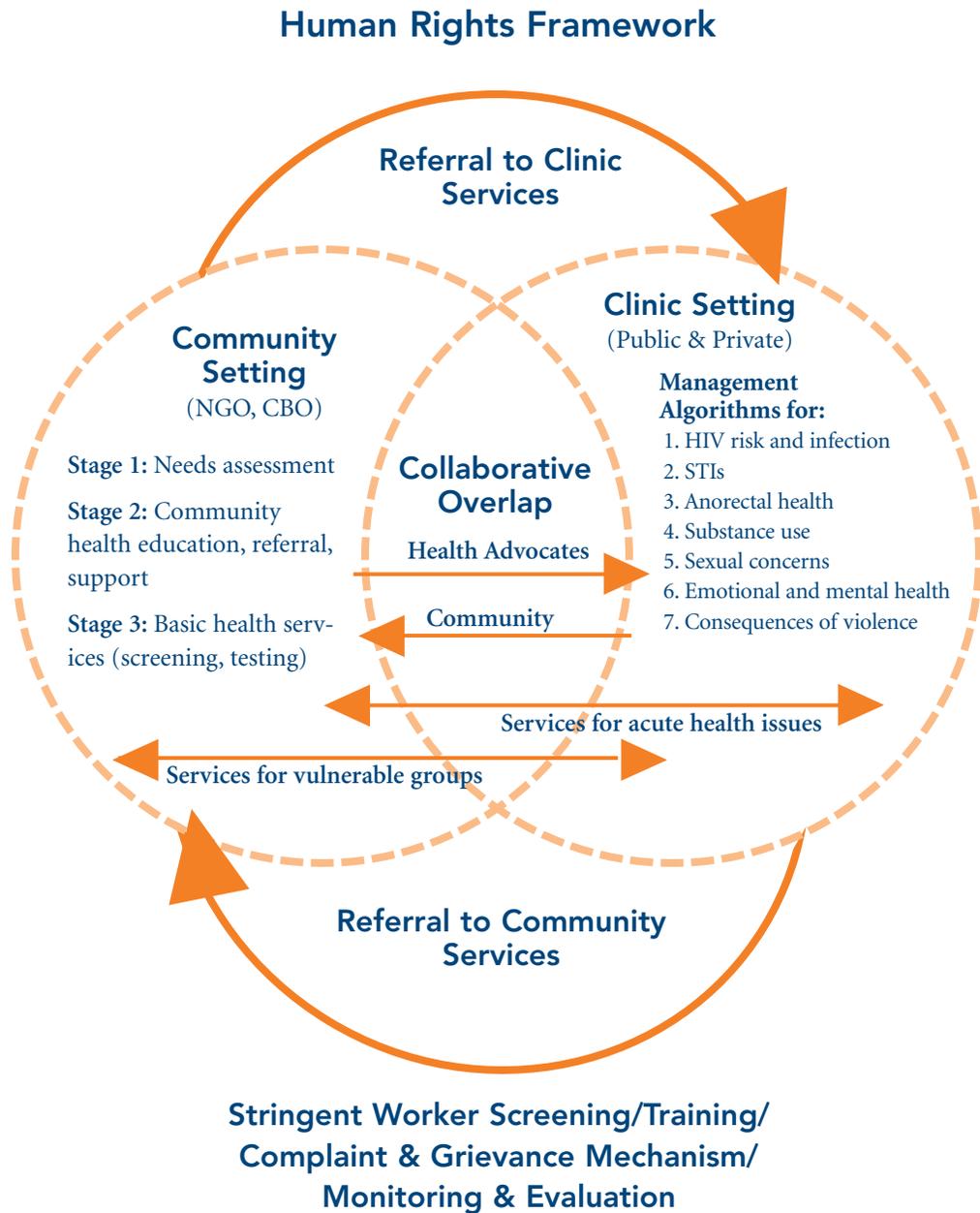
Annex 6: Emotional and Mental Health



Annex 7: Consequences of Violence



Annex 8: Community-Clinic Interaction



Participants in the Regional Consultation

Francisco Javier Arellano (Programa VIH/SIDA de la Ciudad de México, México)
Brigitte Aubel (APROFA, Chile)
José Arturo Bauermeister (University of Michigan, USA)
Oswaldo Braga (Ministry of Health, Brazil)
Pablo Brítez (Organización SIGLA, Argentina)
Alejandro Brito (Letra eSe, México)
Carlos Caceres (Universidad Peruana Cayetano Heredia, Peru)
Sonja Caffè (PAHO HIV Caribbean Office, Trinidad and Tobago)
Bilali Camara (UNAIDS, Caribbean Office, Trinidad and Tobago)
Alex Carballo-Dieguez (Columbia University, New York, USA)
Rolando Cedillos (Hospital Rosales, El Salvador)
Pedro Chequer (UNAIDS, Brazil)
Raquel Child (UNFPA, Panama)
Barbara Clarke (Public Health Agency of Canada)
Eli Coleman (University of Minnesota, USA)
Dimitri de Gruben (UNFPA, Panama)
Abdiel Ivan Diaz (Ministry of Health, Panama)
Arturo Diaz-Betancourt (Letra eSe, México)
Jeff Dodds (Manitoba Health and Health Living, Canada)
Elisabeth Ferraz (BEMFAM, Brazil)
Joao Ferreira Pinto (University of Texas, El Paso, USA)
Carlos Garcia de Leon (CENSIDA, México)
Enrique Gomez-Bastidas (Universidad Autonoma de Baja California, México)
Alex Gonzales (Fenway Institute, Boston, USA)
Andrea Gonzalez (Programa VIH/SIDA de la Ciudad de Mexico, México)
Cesar A. Gonzalez (University of Minnesota, USA)
Janet Gutierrez de Ochomongo (Centro de Salud de ITS/VIH/SIDA, Guatemala)
Anthony Hron (Jamaican Network of Seropositives, Jamaica)
José Antonio Izazola (CENSIDA, Mexico)
Mario Kloenmoedig (CARIFLAGS, Curacao)
Rhonda Kropp (Public Health Agency of Canada)
Vivian Lopez (UNICEF, Panama)
Rafael Mazin (PAHO, Washington, DC, USA)
William Miller (CDC/GAP, Guatemala)

Ken Morrison (Futures Group, USA)
Rosemarie Munhoz (UNAIDS, Panama)
Diego Postigo (PAHO, Panama)
Cristina Puentes-Markides (PAHO, Washington, DC, USA)
Rebeca Ramos (AFMES, USA)
Toni Reis (ABGLT, Brazil)
Gary Remafedi (University of Minnesota, USA)
Mayra Rosa Rodriguez (CENESEX, Cuba)
Michael Ross (University of Texas, USA)
Mirta Ruiz de Diaz (CEPEP, Paraguay)
Jorge Saavedra (AIDS Healthcare Foundation, The Netherlands)
Leonardo Sanchez (ASA, Dominican Republic)
Manuel Sepulveda (Consultant, UNESCO, Chile)
Diego Solares (Consultant, PAHO, USA)
Cheikh Traore (UNDP, USA)
Veriano de Souza Tertto (ABIA, Brazil)
John Waters (COIN, Dominican Republic)
Kristopher Wells (University of Alberta, Canada)
David Wheeler (Consultant, IAPAC, USA)
José M. Zuniga (IAPAC, Washington, DC, USA)

The overall coordinator of the process was Rafael Mazin (PAHO, Washington, DC, USA), with the support of Beatriz Garcia-Entero (PAHO, Washington, DC, USA). Individuals who contributed to drafting and finalizing this document included Rafael Mazin (PAHO, Washington, DC, USA), David Wheeler (Consultant, IAPAC, USA), Don des Jarlais (Consultant, IAPAC, USA), José Arturo Bauermeister (University of Michigan, USA), and José M. Zuniga (IAPAC, Washington, DC, USA), with the support of Job Acosta (IAPAC, Washington, DC, USA) and Scott Wolfe (Consultant, IAPAC, Canada). Maristela Monteiro (PAHO, Washington, DC, USA) contributed to the revision of the Substance Use section.



**Pan American
Health
Organization**



*Regional Office of the
World Health Organization*

ISBN 978-92-75-13088-9



9 789275 130889