

Expert Consultation on Implementation Science and Operational Research Priorities for Strengthening Access to Care and Treatment Services for MSM living with HIV

*Our goal is not just to treat individuals
but to stop an epidemic.... Treatment
helps a society be stronger.*

Cornelius Baker, FHI 360



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1. Introduction

Since 2011, with funding from the Bill & Melinda Gates Foundation, the Pangaea Global AIDS Foundation has supported the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) to make effective and efficient use of the best available HIV treatment tools; drugs, diagnostic tests and health care delivery systems. A final consultation in the series, held in Washington, DC from May 20-21, 2014, reaffirms the centrality of leadership by the affected communities—in this case men who have sex with men (MSM) who are living with HIV—in responding effectively to AIDS. The meeting was held in close partnership with the Global Forum on MSM & HIV (MSMGF).

Meeting participants included 30 global MSM leaders, predominantly from lower- and middle-income countries, many of them living with HIV and all of them longstanding experts in HIV among MSM the field. They gathered to inform the programmatic and research agenda on increasing engagement in the HIV treatment cascade for gay men and other MSM in lower- and middle-income countries. This included optimizing provision and mitigating barriers to services, with an emphasis on legally and socially constrained environments and providing evidence of good practice.

The meeting was also charged with helping to inform WHO's operationalization of its 2013 HIV treatment guidelines and the agency's Consolidated Guidelines on HIV Prevention, Care and Treatment for Key Populations, which were launched at the 2014 International AIDS Conference (IAC) in July 2014.

The findings, in addition to publication on the Pangaea website, were also presented at both the Pangaea/ITPC satellite at that conference and at the MSM pre-conference organized by MSMGF.

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2. About the co-sponsors: Pangaea and MSMGF

Pangaea Global AIDS Foundation

Pangaea's mission: Pangaea builds partnerships that improve the lives of people living with and most at-risk for HIV to ensure equitable access to prevention, testing, treatment and care. Pangaea is headquartered in Oakland, California (USA) with offices in Zimbabwe and strategic partnerships, including with AIDS Care China and the Fremont Center, USA. The foundation works with partners around the world to implement sustainable, comprehensive and evidence-informed HIV related programs through technical cooperation, research, policy and advocacy. Pangaea is a pioneer in implementation science.

Pangaea's vision: Pangaea envisions a world where people affected by HIV lead healthy and productive lives—regardless of circumstances of birth, gender, sexual orientation, or geography—in communities free from the threat of HIV.

Global Forum on MSM & HIV

The Global Forum on MSM & HIV (MSMGF) is an expanding network of advocates and other experts in health, human rights, research, and policy, working to ensure an effective response to HIV among men who have sex with men.

MSMGF works proactively to ensure policies accurately reflect the needs of MSM by directly engaging with bilateral and multilateral organizations like the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and UNAIDS, while working to increase the involvement of grassroots activists in decisions that shape the global response to HIV. MSMGF tracks funding flows, monitors human rights violations, educates policy makers and informs communities of MSM working at national, regional and global levels.

MSMGF also directly supports more than 30 community-based organizations across 20 countries serving communities of MSM through one-on-one technical assistance, peer-to-peer exchange, and onward funding. Technical support aims to improve the quality and access of health services, increase meaningful engagement of marginalized communities in various national AIDS planning processes, and strengthen advocacy leadership. MSMGF produces web seminars, develops training curricula, designs program management tools and disseminates strategic information to thousands of other advocates, health professionals, donors, implementers and policy makers across the planet.

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3. Objectives of the consultation

The meeting was convened by a Steering Group including representatives of Pangaea, MSMGF, WHO and two co-chairs, Dr. Paul Semugoma from the African Men for Sexual Health and Rights (AMSHer) and Dr. Stefan Baral, from the Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health. The objectives agreed in advance were to:

- review best practice approaches for the implementation of programs focused on MSM, with a focus on MSM living with HIV, to optimize provision and mitigate barriers to services;
- review tools focused on improving the cultural and clinical competence of the health sector in serving gay men and other MSM living with HIV; and
- characterize the implementation science research agenda focused on increasing engagement in HIV treatment programs for gay men and other MSM.

Also decided in advance was to produce a report (this document) summarizing

- recommendations to be considered in further articulating the operationalization of HIV treatment guidelines and broader key population guidelines (as they relate to delivering HIV treatment for MSM populations);
- examples of good practice in engaging MSM in HIV treatment and care and scalable examples of HIV treatment services for MSM in various social and political contexts; and
- implementation science research questions that should be considered to further understand how to provide comprehensive HIV-related services for MSM with HIV.

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4. Background to the meeting

For some time there has been a growing understanding of the need to address the needs of gay men and other MSM as a key affected population globally for HIV. Overall, according to WHO, MSM are 20 times more likely to be living with HIV than other reproductive age adults. This inequality must be confronted and strategies found to improve MSM's access to testing and treatment, whatever legal or social constraints may operate in particular countries.

As part of this, WHO constructed and consulted on Consolidated HIV Guidelines for Key Populations, to be published at the International AIDS Conference in 2014. These are evidence-based normative guidelines for HIV prevention, diagnosis, treatment and care for key populations, building on WHO's revised HIV treatment guidelines released in 2013. Though the 2014 guidelines were conceptualized as being generic to all key populations, they are particularly concerned with how to improve access and adherence to antiretroviral treatment (ART) for MSM and how to continue to work in legally constrained environments. They also recognized the need for 'how to' guidance specifically about working with MSM. A key part of this consultation was to assist them in this.

A fuller account of the WHO Guidelines process and issues can be found in Annette Verster's presentation to the meeting in Appendix 5.

Clear evidence of what may deter or enhance MSM from testing, accessing treatment and being retained in care was offered by the Global Men's Health & Rights Survey, conducted by MSMGF. The presentation of these survey findings is in George Ayala's presentation in Appendix 5. In summary, it identified key barriers, critical enablers and indicators for retention, all of which collectively offered clear pointers as to what should be done to improve services to MSM.

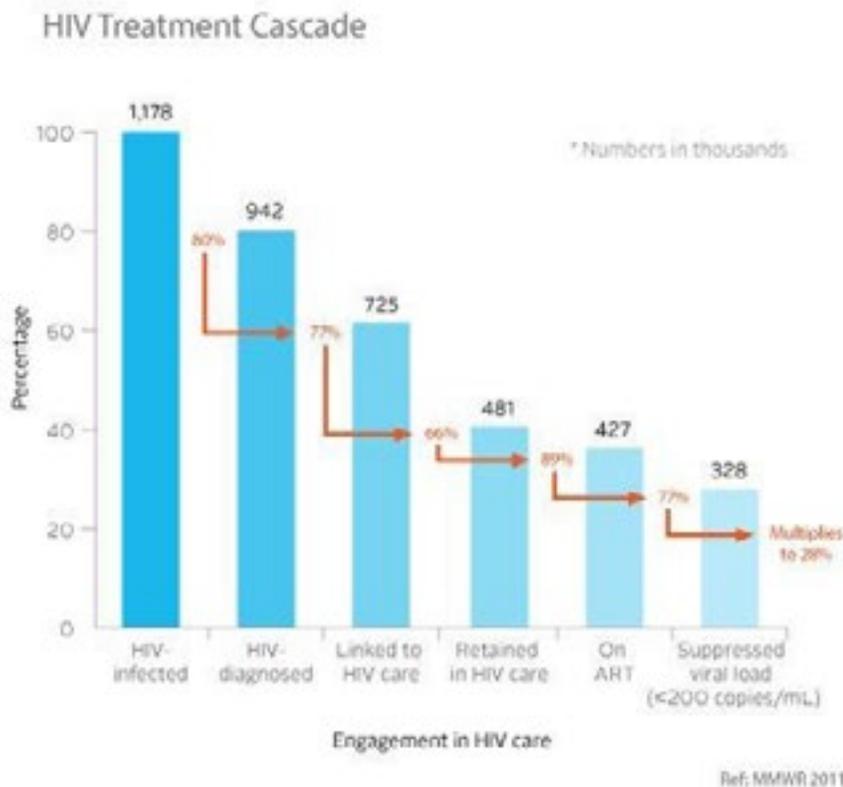
According to the survey's findings, while some determinants of dropout from the treatment cascade are relatively fixed (e.g., country income levels, age of people living with HIV), others can be more easily influenced. Community engagement was important for those who had known their HIV status for more than a year, while for those more recently diagnosed, access to treatment and comfort with provider were key to retention. Relationships with providers were clearly a crucial factor, with good ones tripling access to testing and increasing access to educational materials about HIV by 15 times. Connection to a gay community increased access to testing nine-fold.

In focus groups with African MSM and providers, the survey found that **critical enablers** were engagement with the gay community, connection to that community and comfort with provider, Key barriers identified in the focus groups, meanwhile, were the perception of homophobia,, past experience of homophobic violence and past experience of provider stigma.

Given these findings, any attempt to improve MSM's access to HIV treatment and care must recognize the importance of the social environment in any country for MSM. This would include taking into account the usefulness of attachment to a community of MSM and the key role that community-based organizations (CBOs) attached to the MSM or lesbian, gay, bisexual and transgender (LGBT) community are likely to play in service provision and support.

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The consultation was therefore called to identify implementation science and operational research priorities to strengthen access to care and treatment services for MSM living with HIV. The framework for this was the treatment cascade, as illustrated here (standard PGAF illustration), which identifies key stages along the journey to the goal of managing HIV successfully, usually defined as having an undetectable viral load. The treatment cascade also acts as a useful assessment tool for countries to define at what stage people with HIV drop out of support and where they most need to target service development.



For some countries, particularly low-income ones, viral load testing is unavailable or only partly available. It was agreed that under such circumstances, successful adherence to treatment and attendance at care services should be taken as a suitable proxy. The cascade is also impacted by wider social determinants and in particular by the availability of ART and the quality and capacity of health systems. Although treatment cascades vary among countries, the results of the survey highlighted agreed that it is important to prioritize the inclusion and retention of MSM at every level and in every country.

Participants also acknowledged that while their role was to concentrate on access to diagnostic, treatment and care services, the wider context of HIV (and in particular prevention services and messaging) should not and could not be ignored. Prevention messages can set the context for MSM's willingness (or not) to engage with HIV services and are part of the greater care

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continuum within which our current concerns are set. One participant noted the importance of thinking and acting more holistically in this regard:

We tend to serosort our organisations and we need to bring it all together – positive and negative, prevention and treatment

**Midnight Poonkasetwattana,
Asia Pacific Coalition on Male Sexual Health (APCOM)**

The meeting was held shortly after moves to criminalize same-sex activity and restrict related organizing in a number of countries, including Nigeria and Uganda, where legal constraints are now so severe that doctors are required to report suspected MSM. In others such as Russia, gay ‘propaganda’ laws restrict sexual health information and organizing among MSM. These developments have caused concern among researchers, donors and program managers about whether and how they can work with MSM in these countries. CBOs, and particularly emerging LGBT CBOs, whose work has been invaluable in reaching MSM, have been particularly targeted and restricted by these legal changes. WHO and others have identified the need for clear guidance on how to manage these challenges in service provision, community building, advocacy and ethics. Given the growing negative impact of legal environments in many parts of the world, there is an urgent need to ensure that such guidance reflects what is known by those within communities to improve or weaken MSM’s attachment to treatment and care.

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5. Overarching principles and key themes emerging from meeting discussions

A number of key themes emerged throughout the two days of presentations and discussions. Listed below are 10 of the main ones, all of which are reflected in the comprehensive recommendations and implementation science questions elsewhere in the report (Sections 6 through 8).

1. Clinical services, whoever they are provided by and in whatever setting they operate, should be sensitive to and respond to the needs of MSM, creating a positive experience for them from the initial HIV test onwards. Whatever the local setting, clinical services should provide a minimum package of care suitable to MSM. Training will be a key element in this.
2. HIV care and treatment services to MSM can be delivered in many different formats: within targeted MSM/LGBT services, in a men's health clinic or even in general population services. How best to provide them will be contingent upon local populations of MSM, local resources and local social attitudes. Providers and donors should be flexible in considering these options and support whatever delivery mechanism will reach and retain MSM with HIV.
3. Both clinical and CBO service along the continuum of treatment and care, should be considered equal partners in care efforts. CBOs in particular should be included as defined partners within service networks. CBOs and other community-provided services have an increasing role to play in HIV treatment and care for MSM alongside their acknowledged HIV prevention role.
4. Greater attention should be paid to developing and empowering communities of MSM and the sustainability of MSM-run CBOs in order to tailor programs and support greater self-management of treatment and care. Peer networks, trainers and treatment advocates are a key part of cost-effective HIV treatment and care and have a proven role in retaining people with HIV within the treatment cascade.
5. Treatment access and retention in care must be seen in a wider social context, including mental health, housing, poverty and employment, all of which impact upon MSM's ability to manage their health. Treatment and care services for MSM should be seen not only in the context of the treatment cascade but also within the wider continuum of HIV prevention, LGBT identities, social stigma and in some countries criminalization.
6. It is imperative that ways are found to work with and support MSM living with HIV in the increasing number of legally constrained environments as well as socially constrained environments where stigma is rife. Clinicians must be held accountable to their ethical duty to respect the confidentiality and human rights of all their patients. CBOs that continue to operate under difficult conditions in such environments must be targeted with

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opportunities for increasing their capacity so that they can advocate for the health needs of their communities better.

7. New ways of empowering and organizing MSM with HIV must be considered in legally constrained environments and other settings. Effective models of care need study and support. In particular, there is a clear and increasing role globally and locally for internet-based technologies and peer-to-peer support online. Donors and global bodies should encourage skills-sharing and good practice promulgation in this area.
8. MSM and MSM with HIV must be included in formulating and advising implementation science and operational research projects related to them. At the same time, both researchers and policy makers must ensure their work is accessible to and understandable by the MSM whose welfare it is intended to improve.
9. Donors and researchers have a responsibility to work together to make evidence informed decisions about HIV care and treatment for MSM, as well as learn afresh from experiences as new technologies in care develop. Donor and researchers should work towards developing harmonized metrics for assessment of programs which focus on structural approaches to care (such as stigma reduction) and consider the balance of funding between direct treatment and advocacy, particularly in those settings which have legal and social constraints for MSM with HIV.
10. In studying and supporting effective models of care, it is essential to build and support CBO and public health capacity to collect relevant data, to improve monitoring and evaluation (M&E) systems and to measure key areas such as quality of care and comfort with provider.

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6. Recommendations for the operationalization of HIV treatment guidelines and broader key population guidelines (as they relate to delivering HIV treatment for MSM)

6.1 Clinical HIV services, in any setting, need to ensure they are sensitive to the needs of MSM with HIV and provide a competent, welcoming and secure environment for them

Given what is known from the MSMGF study and other research about the importance of MSM feeling comfortable and secure with their health care providers, a major theme of the consultation was the importance of making clinical treatment and care services competent with and welcoming to MSM with HIV. The importance of deeds and not just words was encapsulated in comments from participants such as the following:

It is one thing to have clinical guidance, but how do we ensure that it reaches MSM on the ground more effectively?

Mohan Sundararaj, MSMGF

Multiple strategies have been adopted in pursuit of more effective implementation, including ensuring the visibility of MSM and gay-identified staff; presence of CBOs and other community groups in clinics; ensuring that clinics' publicity is couched in language used by MSM; and involving MSM at all levels of planning and decision making. However, it was also noted at the consultation that respect and attitude could be more important than identity.

Any clinic serving men should be able to offer a basic package of care to MSM as part of their services. Key components of this are:

- sensitivity training for all staff in contact with people living with HIV in offering non-judgmental services;
- competence training for all clinical staff in the health care and treatment needs of MSM, including involvement of MSM in that training;
- a clear understanding by clinicians of their ethical obligations to treat all patients;
- anal health, screening for sexually transmitted infections (STIs) and condoms and lubricant appropriate to anal sex; and
- culturally appropriate mental health services to support attendance and adherence.

It was strongly suggested that in future funding; donors should consider building competencies in, and sensitivities to, addressing the needs of key populations into their bid requirements. Patient satisfaction surveys and user feedback should also be a component of all M&E frameworks. Similarly, it is useful to survey those who fall out of care and try to find any patterns or common themes; sometimes this can be less about the clinical care provided and more about the environment.

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There are a range of tools already available and currently in development to support clinician sensitization and competency with MSM. They include the following:

- ‘From Top to Bottom’ and ‘MSM in Your Pocket’ are simple guides for clinical staff developed by Anova Health Institute in South Africa to support clinics in becoming more MSM-competent. These and a range of other resources and campaigns for MSM, particularly those who may not identify as gay, can be found at <http://www.health4men.co.za>.
- MSMGF in collaboration with the Johns Hopkins Bloomberg School of Public Health have produced a comprehensive training curriculum for providers, ‘Promoting the Health of Men Who Have Sex with Men Worldwide’, launched at the July 2014 International AIDS Conference. This single integrated multi-module curriculum comprehensively covers clinical and cultural competencies and is focused on lower- and middle-income countries with the goal of supporting organizations to independently launch provider training in the absence of external consultants. It can be found at: <http://www.msmsgf.org/promotinghealth>.

6.2 Treatment and care services for MSM can be delivered in a variety of formats and should be tailored to suit local conditions.

The consultation discussed the wide variety of formats in which services to MSM may be provided.

Gay- or MSM-targeted services may be most easily identifiable as competent and welcoming. However, they may also be shunned by MSM who do not identify, or want to be seen as identifying, as gay or MSM.

In some urban areas with a high level of LGBT visibility and community attachment, there may be the demand for such specific stand-alone services. In others, an MSM sub-clinic or designated weekly session may be attached more cost-effectively to a generalist or men’s service.

“Men who have sex with men share some behaviors but not necessarily an identity.”

**Kevin Rebe,
Anova Health
Institute**

Men’s health services have been used by a number of participants to attract MSM within a wider format. In some cases such efforts had proved successful; in others, however, there is still a failure in attending to the specific needs of MSM (e.g., provision of anal STI swabs). A key part of the problem lies with caregivers, as underscored by the following comment by meeting participant Carlo Oliveras of ITPC:

“Everything stops when you talk about anal sex—that’s where it gets iffy for a service provider.”

Generalist HIV treatment and care services should, of course, also be welcoming to MSM and in legally or socially constrained settings it may be the only way clinics can operate. Additionally, men who have sex with men often also have sex with women. However, many participants noted

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experiences of generalist services where MSM had been underserved or even actively made to feel unwelcome. In these settings, training for sensitivity is of paramount importance.

Also stressed as important was how services are marketed—for example, using the right language for the community, not being too overtly LGBT in socially constrained environments, involving CBOs in messaging, using word of mouth and online messaging via Facebook or apps.

Several examples were given of ways in which treatment and care services could be brought closer to MSM. Services can be provided in mobile clinics; in community organization settings; at transport hubs where they can be visited on the way to or from work; using MSM peer advocates to support those using services and to seek out those lost to follow-up; and involving MSM in the design and running of services.

Kevin Kapila of Fenway Institute (part of Fenway Health) outlined his organization's comprehensive package of MSM-friendly services, which include the following:

- testing at MSM sites through mobile testing vans maintained by community partners,
- close engagement with clinical services, thereby improving care linkage,
- using Grindr, Manhunt and other sex apps to support testing and contact tracing,
- looking at co-morbidities and harm reduction needs for those diagnosed,
- bringing in a range of services to the clinic to engage with the newly diagnosed,
- using peer advocates/health navigators—diverse MSM community members who will support, engage, and follow up on those who fail to attend,
- ongoing training for all staff and peer advocates, and
- brief on-site interventions for mental health such as motivational interviewing.

(More information about Fenway's approach can be found at <http://thefenwayinstitute.org>.)

Othoman Mellouk, from ITPC, recounted that in some countries in the Middle East and North Africa (MENA) region, clinics provide services to MSM within wider men's health services and MSM are willing to attend such clinics as long as they are not identified as being for MSM. However, some clinicians were found to be failing to undertake MSM-specific procedures such as anal examinations. Training was undertaken which improved clinicians' ability and willingness to provide anal examinations, but the need was identified for a how-to guide to setting up such a service successfully.

The Anova Health Institute's Health4Men project manages several sites specializing in MSM sexual health. In partnership with the South African National Department of Health, Health4Men is also tasked with institutionalizing MSM competence in an additional 160 public health clinics. This involves psychosexual sensitization, medical training and specialized mentoring of public health workers, followed by ongoing technical support and consultation. Health workers are trained not to assume that male clients only engage sexually with women by focusing on sexual behavior as opposed to sexual identity. This is particularly useful in environments where MSM

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may not identify as being either gay or bisexual and where such identities may be viewed as un-African. (More information is available at <http://www.health4men.co.za>.)

6.3 Clinical and CBO services should work together within service networks

The importance of CBOs and clinical services working together to improve access to HIV services for MSM was repeated throughout the meeting. While clinical staff have undoubted expertise in treatment and care, it is often CBOs that are engaged not only to act as an informal conduit to encourage gay men to access services but also as peer advocates, service navigators, adherence supporters and providers of advice and emotional support. They are also highly effective trainers in challenging stigma and increasing provider understanding of MSM.

Increasingly, some traditionally clinic-provided services are being provided through outreach in gay- and MSM-led CBOs, particularly testing services. Program managers and health services were challenged to go further and think about even greater integration of clinics and CBOs within service networks. For example, they might consider, as health technologies change and simplify, what more could be done simply and cost-effectively within CBOs—blood tests, treatment monitoring mental health services. Etc.

Closer relationships were seen as beneficial for both bodies as well as MSM. Improved engagement and connection can help increase treatment literacy and build capacity within CBOs while increasing sensitivity of and access to clinical services.

A good example of a program that has found a range of benefits in bringing clinical services and CBOs in serving MSM was presented by Paul Ngone of LVCT Health in Kenya. LVCT Health managed to involve MSM groups in its service provider training despite same-sex sexual activities being criminalized in the country. The organization found this not only improved provider attitudes but also established some MSM as key advisors within its care networks and a user voice within the wider service provider network. In turn, this increased linkage to HIV care and treatment and other critical services to MSM, such as access to condoms and lubricants and psychosocial support. However, LVCT Health also found that it was important to support the technical capacity of MSM groups involved in this work, including advocacy skills training, in order to maximize effectiveness. (More information about LVCT Health's work in this and other areas can be found at <http://www.lvcthealth.org>.)

6.4 The role of MSM communities and CBOs in HIV treatment and care should be acknowledged and supported

It is clear, both from the research done by MSMGF and others and from the responses of participants from both clinical and community backgrounds, that CBOs and peer networks (particularly those that are gay- or MSM-led), have a major role to play in increasing the competence and sensitivity of HIV service providers. They can also have a major influence on linkage to and retention in care and increasingly provide services themselves. In some legally constrained environments, it may well be that such CBOs and peer networks are the only way of maintaining some services to MSM. Given this, the consultation considered what could best be done to acknowledge and support their engagement and effectiveness.

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Meeting participants agreed that WHO, UNAIDS and the International AIDS Society (IAS) all have important roles in acknowledging and involving CBOs and in influencing national governments to do so as well. Similarly, donors can make meaningful CBO involvement a condition of grants. Funding leadership training for MSM in lower- and middle-income countries and peer networks to support such training would be helpful. In particular, supporting CBOs to explore areas such as social enterprise and other methods of widening their funding bases to reduce dependency on donor grants would improve sustainability.

Training programs to support MSM as trainers, treatment advocates and peer support workers already exist and these could be scaled up and adapted to local needs. Simple, obvious but too often ignored small changes could make a huge difference to CBO capacity. These may include, among a wide range of possibilities, supporting English-language skills, enabling greater access to global knowledge bases, making all online reports downloadable and printable in small sections for those with restricted access to web technology, producing simple language guides to the multitude of rights and policy documents, and including guidelines and other reports of use to MSM in gaining their rights to treatment and care.

The Bridging the Gaps program from the Dutch Ministry of Foreign Affairs supports CBOs for key populations (LGBT people, drug users and sex workers) in a variety of countries, offering capacity-building support and encouraging alliances, networking, leadership development and governmental engagement. The program is a joint effort by over 80 local partners in 16 countries working together with global networks and their Dutch partners to achieve universal access to HIV prevention, treatment, care, and support for key populations, and to have their rights fully respected. The LGBT program currently has projects in Botswana, Brazil, Costa Rica, Ecuador, Kenya, Kyrgyzstan, South Africa, Tajikistan, Ukraine and Zimbabwe. (More information about the program is available at <http://www.hivgaps.org>.)

The Centre for Development of People (CEDEP) in Malawi was supported by the U.S. Agency for International Development (USAID) to enhance engagement and increase leadership among MSM and other sexual minorities. CEDEP worked closely with other groups on human rights and established a successful advocacy program for health and human rights for MSM that has helped civil society resist the homophobic legal changes undertaken in some neighboring countries. The group has now become a key player in Malawi's national HIV planning process. (A case study report with recommendations for transferable lessons may be found at <http://futuresgroup.com/files/publications/Malawicasestudy.pdf>.)

6.5 Treatment and care for MSM with HIV exists within a wider social context to which attention must be given

It is well established that the ability of people to manage long-term treatment for a health care condition is affected by wider circumstances than their physical health. In addition to the community attachment identified above as having an important impact, issues associated with housing, employment, poverty and other factors can have an impact on attendance and adherence. For gay men and MSM, problems regarding all of the above may be exacerbated by the stigma attached to same-sex sexual practices in many countries whether or not there are legal

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constraints. Social isolation, insecure housing, poverty and stigma can result in mental health problems to which an HIV diagnosis may contribute further.

Participants also noted that HIV stigma may also exist within gay and MSM networks; thus, making LGBT groups HIV-sensitive may be necessary alongside work to do the same with clinicians. Mental health services were identified as a key component of any basic package of care for MSM. Good programs, such as that cited above from Fenway Health (Section 6.X), include identification of needs beyond the clinical and provide at least linkage to related services to support social needs of anyone newly diagnosed. Such services may also include support for dependency on alcohol or other drugs. In the case of Fenway Health, these services are actively brought in to the clinic setting in order to increase linkage.

Whether governmental or from civil society or elsewhere outside government, entities providing HIV prevention messaging also have a responsibility to not increase stigma and to not discourage engagement in testing and treatment by the way they portray people with HIV or the impact of HIV.

6.6 Clinicians and programs have an ethical duty to provide services to MSM with HIV despite any legal and/or social constraints in particular countries

Increasingly, and particularly in countries with legal constraints on sexual minorities or people living with HIV, clinicians and other health care providers can be caught in situations of dual loyalty to the expectations of their employer and government on the one hand, and their patients on the other. The disconnect may be reflected in how services are provided, as suggested by the following comment by meeting participant Tudor Kovacs from the Eurasian Coalition on Male Health (ECOM): “We see 2014 messages online but 1950s attitudes in our home countries.”

Consultation attendees acknowledged that while clinicians have a responsibility to uphold the law, they also have a duty to their patients to offer a confidential and safe environment in which health problems can be disclosed and managed.

The IAS Code Of Conduct on Human Rights and HIV Professionals asks clinicians to pledge (among other things) to provide an enabling human rights environment, to respect diversity and confidentiality and to involve key populations including MSM in the development and implementation of programs (<http://www.hivhumanrightscode.org/>.)

In addition to the ethical duties of clinicians to do so, it is also particularly important in the case of a transmissible and life-threatening condition such as HIV to ensure that people feel able to come forward for diagnosis and treatment in order to reduce onward transmission in addition to their own health care. Driving people with undiagnosed HIV underground, whether they are members of the MSM, sex worker or drug-using communities (or more than one), is an acknowledged and well-evidenced recipe for increasing an HIV epidemic.

Recommendations specific to legally constrained environments are considered in the next section of the report (Section 7), but there was also consideration during the consultation of the impact

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of social constraints. In both legally and socially constrained settings, there is a pressing need for better documentation of abuses. Support from donors and global agencies to undertake this documentation and to develop local advocacy around stigma and human rights, including training, will be important. While the manifestations of stigma may vary among countries, many would find it helpful to understand what may have worked elsewhere in combating it and in changing social attitudes to MSM and LGBT people. The sharing of experiences matters because the value of local advocacy cannot be overstressed:

Homegrown advocacy is always important. It's how we have the conversations with our neighbors, our families, our friends—we have to change society to change the law.

Cornelius Baker, FHI 360

The high levels of stigma and discrimination against LGBT groups in the Caribbean region have been associated with the high burden of HIV in MSM in the region. Eleven countries in the region continue to criminalize gay sex and two criminalize HIV transmission. A study published in *The Lancet* in 2012 estimated HIV prevalence among MSM in the Caribbean to be the highest in the world, at 25.4 percent.

The Caribbean Vulnerable Communities (CVC) is a coalition of non-governmental organizations (NGOs) founded by the late Dr. Robert Carr that provides frontline services to marginalized groups. Operating out of Jamaica, it brings together leading and emerging civil society experts in rights-based prevention, care, treatment and support across the Caribbean.

CVC has tried a range of strategies to tackle stigma. It has had limited success in getting politicians and celebrities to take a publicly pro-LGBT stand, with some agreeing but then retracting support. Where identifiable, political support has been very useful (e.g., with Mariela Castro, the daughter of Fidel Castro, in Cuba). CVC has been trying to build alliances with a broader base of organizations working towards social justice. As part of a regional Global Fund grant with Centro de Orientacion e Investigacion Integral (COIN) in Jamaica, CVC has engaged with the media in innovative training tailored to each country, bringing journalists and activists together to discuss rights-based issues. This effort has been successful in improving coverage of LGBT and MSM issues. It also taught CVC the importance of putting things in the language and at the level of those the coalition wants to influence. CVC is now also training CBOs in documenting human rights abuses through a human rights observatory.

The Jamaican National HIV/STI Programme (<http://www.nhpjamaica.org>) has an Enabling Environment and Human Rights Department, which covers:

- HIV-related workplace policies and programs,
- the National HIV-Related Discrimination Reporting and Redress System (NHDRRS),
- the Greater Involvement of Persons Living with HIV (the GIPA principle), and
- interventions to establish a policy and legal framework for discrimination reduction.

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The M-Coalition is the only regional HIV/AIDS advocacy network specifically devoted to the needs of MSM in the Arab world. Established in 2014, it aims to ensure an effective response to the rapidly escalating HIV epidemic among MSM in the Arab world, including the support, treatment and care needs of HIV-positive MSM through advocacy, information exchange, knowledge production, networking, and capacity-building activities at the local and regional level. The M-Coalition also strives to involve MSM and MSM living with HIV at all levels. (More information is available through Facebook, at <http://www.facebook.com/mcoalition?fref=ts>, with meeting presenters also stating that a full website was expected to be launched the July 2014 International AIDS Conference.)

6.7 Ways of working with new technologies, particularly online, must be developed and shared

There have been and continue to be many advances in HIV treatment and care—including new drugs, new diagnostics and novel methods of administration. In keeping up to date, services must be in a state of constant development. Services must also respond to wider developments, particularly in communication technology where online and social media are rapidly developing. Online communities of MSM, including MSM with HIV, are rapidly developing globally. Most importantly, some of the ‘hookup apps’ whereby MSM can identify others nearby have greater reach into non-MSM/LGBT identified men who are nevertheless having sex with other men.

“We know much more than we think we do”

**Ernest Massiah,
UNAIDS**

Consultation participants had made use of a variety of these new channels in producing innovative services and responding to the challenge of geographical spread and social stigma. Missteps or mistakes made in developing these services can be expensive; as such, there were strong calls for identification of good practice and sharing of successful strategies in this area. Given that social media strategies may be particularly useful in legally constrained environments (see Section 7) and can also, once set up, be highly cost-effective, donors should give thought to how best to showcase advances and work together to maximize their use in future programs.

There are a growing number of blogs from MSM with HIV, which are globally accessible. Key influencers, both globally and locally, can be helpful in online messaging about the importance of, for example, treatment adherence or clinic attendance. Online communication has the added attraction, for many, of confidentiality and controlled disclosure. It enables peer communication and self-help and allows highly personal or sensitive questions to be asked in relative anonymity. Caution is important since online communication can also be used to disseminate false information and stigma, which must be countered. Security of data is also a growing concern.

Social media, particularly Facebook, is increasingly important in Africa. According to meeting participant Anthony Adero, from Social Outreach Seattle, “Social media is a fundamental tool in changing people’s ideas about sexual health.” Another participant recounted how, after being exposed in national media as a homosexual, he was contacted by many other gay men via his Facebook page. Many people who do not have computers now have smart phones, which increasingly are capable of carrying and facilitating the use of apps.

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These new channels demand new ways of working and several participants outlined new uses for them. These included community building, online peer support, message boards, motivational video messages and campaigning. Social media was also found to be useful in informing MSM of their rights to treatment and care.

The “Test BKK: campaign and in particular its videos (www.testbkk.org), devised by APCOM for a coalition of Thai HIV organizations, was cited as a good example of a campaign using new technology but driven by the language, humor and understanding of the communities of MSM they sought to influence. APCOM is looking to expand this model to other cities in the region, under its Test BKK initiative.

‘Connecting The Dots’ is a five-year regional technology-based strategy from the B-Change Group, led by B-Change Foundation. It describes itself as “a blueprint for community engagement in a digital age of social media and Web 2.0” and is produced with the support of the United Nations Development Programme (UNDP). Phase I of the strategy covers five capital cities in Southeast Asia: Bangkok, Kuala Lumpur, Jakarta, Manila and Singapore. Organized as a start-up social enterprise, the B-Change group aims to improve well-being for young people and has so far released two Web apps, one for young people of diverse sexual orientations and gender identities (including but not limited to LGBT people) and one for gay men and other MSM living with HIV. The latter includes a range of tools from MSM messaging to support adherence to a Q&A engine and a service finder map. These apps aim to increase knowledge and strengthen support structures and work across several countries using different languages. (These apps and more information about the strategy can be found at <http://www.b-change.org/connecting-the-dots>.)

6.8 MSM living with HIV must be involved in research and their access to and understanding of it should be supported

If CBOs and communities of MSM are to contribute to improving access to and uptake of HIV treatment and care, they must also be involved in research related to these services and to MSM with HIV in general. While there is currently some involvement via CABs, there needs to be more across the board. MSM should be involved in the design, collection, analysis, interpretation and dissemination of data. Above all, they should be involved in specifying and prioritizing the questions that research is needed to answer and in part that was the rationale for this consultation.

In order to best achieve their involvement and engagement, there is a need for capacity building and funding to support MSM in lower- and middle-income countries to participate in research and policy forums. As discussed above in supporting greater capacity in CBOs generally, there is also a need to translate research findings into local languages and into plain English.

amfAR, the Foundation for AIDS Research, has developed Respect, Protect, Fulfill, produced in collaboration with the International AIDS Vaccine Initiative (IAVI), the Johns Hopkins University Center for Public Health and Human Rights and UNDP. It offers guidance on how best to engage MSM in research, including treatment interventions. amfAR also produced a useful guide to developing fundraising for CBOs. (More information about amfAR’s guidelines may be found at <http://www.amfAR.org/new-guidelines-to-respect-protect-fulfill-needs-of-men-who-have-sex-with-men-msm-in-hiv-research>.)

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6.9 Donors and researchers should work together to increase knowledge about implementation science and operational research, and to enhance accessibility to both

In discussing questions related to implementation science and operational research for the consultation findings, there was consideration of how much information already exists, and how findings could be better linked and disseminated.

In particular, M&E frameworks for individual programs currently often reinvent the same wheel or, worse, slightly different ones so that it is difficult to compare findings from different programs. An examination of evaluative measures for stigma projects discovered literally hundreds of different measurements used. Meeting participants were asked to consider what it would take to devise an agreed, simple set of internationally applicable M&E measurements or global metrics for, e.g., stigma reduction. These might include the impact of discrimination, stigma and criminalization on health; drop-off from the HIV care continuum; and linkage to and retention in care.

The meeting also recommended that existing research, both in HIV and in other long-term chronic health conditions, be revisited to see what may have been overlooked or what is now comparable with HIV due to treatment advances (e.g., issues of ageing).

6.10 The capacity of CBOs and others to collect and use relevant service data must be supported and increased

As noted in Section 6.8 regarding participation in research and policy forums, the capacity of CBOs and other civil society players to efficiently and usefully collect the most relevant service data is vital to improving the access to and retention in the treatment cascade for MSM with HIV. A number of participants noted that they regularly collected data required by funders or governments with little idea of how and even whether it was ever used.

Good M&E, quality and satisfaction measures should be useful both for funders and for service providers, and should contribute to constant improvement of a service or services. Too often such data are an external imposition little understood by those collecting the information. The findings need to be reflected back to those running and using services in language they can understand, so that they can use the knowledge. Donors and global programs have a major role to play in supporting such steps and in increasing research literacy among MSM and the CBOs that work with and for them.

In addition, given the scarcity of funding and competing priorities, good and easily understood data can help service providers to identify which MSM are likely to be at greatest risk of dropping out of the cascade and help with targeting preventive or remedial measures.

Trying to work in legally constrained environments requires an understanding of history and context; systematic documentation; storytellers matched to audience (funder to funder, researcher to researcher, etc.); respect for the community; resolve; and resources.

**George Ayala,
MSMGF**

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7. Recommendations for working in legally constrained environments

Legal constraints undeniably create challenges and barriers. Dr Paul Semugoma from AMSHeR observed, for example noted, “We cannot deal with stigma on the ground if it is codified in the law.”

However, among the key messages from the consultation were that donors, researchers and programs should never assume that just because there are legal constraints in a country, work couldn't be done with MSM there. Such work is never going to be easy, as underscored by the following comment from a meeting participant:

Of note is that there are a vast range of legal constraints of widely differing impacts, variably implemented. In some countries, even those with Sharia law, there are longstanding projects working with MSM. In others, a variety of strategies have been developed to allow ongoing support. In some, particularly those where laws have recently been enacted and are politically motivated and driven by popular and media support, there may be particular especially difficult (and immediately current) challenges. However, even there, regional networks, word of mouth and social media can operate across considerable barriers.

Donors and implementing partners should continue to support ongoing programs and research in legally constrained environments. It should not be assumed that targeted service provision and research with MSM couldn't be undertaken in such environments because the situation varies considerably among countries. Experience in some countries with longstanding legal constraints shows that incremental progress can be made.

Clinicians and service providers must abide by professional ethics and treat all patients. Although targeted MSM work is possible in some legally constrained environments and should be pursued where appropriate, it is of particular importance in such environments to tackle stigma among generalist health care providers and ensure that mainstream services do not discourage or discriminate against MSM (e.g., by threatening to report them to legal authorities). All providers must support MSM in seeking care and getting access to MSM-appropriate measures (e.g. anal health checks without expecting risk-taking disclosure). Ensuring such access and appropriate care may need international and regional leadership and clear guidance from clinical and public health bodies. The law is often only one part of a stigmatizing environment and may help facilitate and increase greater and broader-scale stigma from health care providers.

Novel methods of service delivery and peer support must be explored. Mobile apps and other online technologies including social media continue to be accessed by MSM in legally constrained environments and may well be the main method of contact/source of information for some. While not all have access to these apps and technologies, increasing numbers of MSM do and they must be considered as community service routes. Facebook is particularly favored in African countries and by Africans in the global diaspora, while most countries have some level of usage of hook-up apps such as Grindr, which could be approached to co-operate with health messaging.

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Capacity building, best practice and local champions should be supported. Global and regional bodies need to offer capacity building and best practice guidance to anyone prepared to provide a service to MSM in legally constrained environments. Mental health support is likely being of particular importance in such settings. Support for public health officials to speak out against homophobic legislation should be explored and given where possible and appropriate. Where LGBT groups do find it impossible to operate openly, more mainstream NGOs—such as The AIDS Support Organisation (TASO) in Uganda—should be approached to discuss how they could include MSM within their generalist services.

Research must be undertaken into the health and social impacts of legally constrained environments. The public health impact of homophobic legislation must be documented and proven. Civil society organizations should be supported to document human rights abuses, within the constraints of personal and organizational security. However, decisions made on political grounds may not easily be susceptible to logical, evidenced arguments. (These issues are explored in greater depth in Section 8 below.)

What can be funded, should be. The donor community must be encouraged to be flexible in ensuring support to MSM with HIV in legally constrained environments. They could, for example, usefully fund regional networks and online services that can help MSM across country borders. Something as simple as ongoing supplies of condoms and lube remains a vital service.

Resources must be developed to support working with MSM in legally constrained environments. Currently, the UNDP/WHO Asia-Pacific regional training package on providers serving MSM (‘The Time Has Come’) is cited as an example of a regional resource offering some advice on these issues to support clinicians continuing to work in legally constrained environments. Resources to support implementation of this training package are available through the dedicated ‘The Time Has Come’ micro-website. However, there is also a need for a dedicated resource that provides a range of possible options and practical examples for working with MSM in legally constrained environments alongside existing evidence for advocacy on the issue.

Different laws have differing impacts. Not all legally constrained environments have direct criminal sanctions on same-sex sexual activity. Restrictions on ‘homosexual propaganda’ can, for example, severely hinder giving information and raising awareness about HIV to MSM. Some country laws are less stringently applied, e.g., in parts of North Africa and Asia, or are intermittently applied. It is important for donors and program managers to be aware of current constraints; to that end, a simple global ‘live’ register of such laws and how/whether they are currently implemented—along the lines of hivtravel.org, the Global Database on Travel Restrictions—should be maintained and supported. The existing Global Criminalisation Scan developed by the Global Network of People Living with HIV (GNP+) could be the basis of this (see <http://criminalisation.gnplus.net>).

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Potential strategies, which should be explored, include:

- using an online platform across several countries in a region that covers some with legally constrained environments and others without (such as the Connecting The Dots strategy for Southeast Asia discussed above in Section 6.7);
- using online messaging and YouTube videos that can be accessed across borders (such as Test BKK, discussed in Section 6.7);
- using the forthcoming IAS Code of Conduct in clinician training;
- working to improve the understanding of journalists, particularly tabloid ones in-country but also internationally, as with COIN in the Caribbean;
- establishing a regional peer support network such as that recently launched in MENA countries;
- using human rights laws to directly challenge homophobic legislation, such as that currently being undertaken in Jamaica by the Human Dignity Trust (see <http://www.humandignitytrust.org/pages/OUR%20WORK/Our%20Cases/Jamaica>);
- reviewing and supporting research undertaken by the World Bank into the economic costs of homophobic legislation (more information is available at live.worldbank.org/economic-cost-of-homophobia); and
- supporting local LGBT groups in countries threatened by future homophobic legislation to make alliances with other human rights groups to maintain a broader front to challenge such steps, as was successful with COIN (see Section 6.6) and with CEDEP in Malawi (see <http://www.futuresgroup.com/files/publications/Malawicasestudy.pdf>).

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8. Identifying key implementation science and operational research questions to strengthen access to care and treatment for MSM living with HIV

During the consultation, participants were asked to define research questions whose answers would strengthen the access of MSM with HIV to diagnosis, treatment access and treatment retention. These emerged across all the sessions, culminating in a focused discussion on the second day. Below is a summary of the key questions asked across all the sessions, often in more than one.

It was recognized that although these were clearly still open questions for participants, there may be existing answers to them in research that has been done and forgotten, done and not widely circulated or done in a field other than MSM and HIV but nonetheless transferable to the current state of HIV treatment and care. Participants therefore agreed on the need, first of all, for a **comprehensive literature review of implementation science and operational research applicable to access to treatment and care for MSM with HIV**, to build on the knowledge outlined in the special edition of *The Lancet* published to coincide with the 2012 International AIDS Conference in Washington, D.C. The findings of the literature review must be in accessible language and format that make them easily understood across a wide readership.

How can MSM-sensitive HIV treatment and care services be built?

- What would an MSM-sensitive service look like in any given setting or country? What are the key factors that make a service MSM-friendly?
- How do can the service quality, cultural appropriateness and acceptability of MSM services be measured?
- What is the basic package of HIV care needed by MSM in all settings?
- What are the best ways to train providers to increase clinically and culturally competent care?
- How does the quality of counseling/advice around treatment inception impact on retention in care?
- How can the understanding of (including the key factors behind) dropouts from the treatment cascade for MSM be further refined? Are there factors common to all MSM?
- At what point and why are MSM most likely to fall off the cascade in any given setting? Are dropouts following diagnosis or entry into treatment similar in other long-term conditions (e.g., diabetes)? If different, why? And how do they vary by country?
- How does the HIV treatment cascade in any given country compare to other long-term, treatable conditions?

What are appropriate settings for services to MSM with HIV?

- Can it be predicted which model of care (general, LGBT/MSM only or men's health) will best serve MSM in any given country setting? What are the advantages and drawbacks of each model for MSM?
- Are comprehensive services the right approach or should HIV and MSM-friendly services be decoupled in small networks where there may exist significant HIV-related stigma within the communities of MSM?

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- Are men's health clinics appropriate models in stigmatizing settings to mask MSM work or are there adverse consequences, such as limited competency, at these clinics to address MSM health needs?
- What role do mobile and community clinics have to play in comprehensive services?

How can communities and CBOs be more directly engaged in the design and delivery of clinical services?

- What is the right mix of community and clinical services in terms of treatment and retention? Who can best and most cost-effectively deliver which elements of these services?
- What is the added value of CBOs and community-led services in addressing drop-off from the HIV care continuum?
- What is it about CBOs that leads to better linkage to and retention in care?
- How can we best integrate peer advocates and community empowerment mechanisms into service networks?
- What would the impact be, in service and cost-effectiveness terms, of a further shift towards community-based clinics and health services?
- "What is the package of interventions that a peer educator should have to hand?" (Kevin Rebe, Anova)

How can CBOs be strengthened and community mobilization for health be increased?

- What effective models exist of mobilizing communities of MSM with HIV for better health outcomes, particularly treatment retention?
- What are the best ways to measure and evaluate community advocacy, engagement and interventions and gather a coherent evidence base for the value of community involvement in clinical and other services?
- How can internet-based technologies be used to mobilize MSM communities and optimize health?
- How can CBOs and community activism be best supported and funded?
- What is needed to make guidelines and other policy documents more accessible to wider communities of MSM? Are there examples of good practice in this area?

What is the wider social context of treatment access for MSM with HIV?

- What value-added services contribute to retention in treatment programs? Which of these are country or region specific and which may be generalizable?
- What function do prevention messages have in influencing later linkage to and retention in services post-diagnosis? What are the benefits and related outcomes of linking prevention with treatment?
- What is the evidence for mental health services as part of the basic package of care?

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How can services best be provided to MSM in legally and socially constrained environments?

- How are existing services impacted by criminalization of MSM activities or organizing? How do they evolve or change and do they differ from other countries?
- What are the risks of conducting research in legally constrained environment and how can these best be managed? What are the ethical obligations of researchers in legally constrained environments?
- What is the quantifiable public health impact of criminalization?
- How can the financial/economic costs of criminalization or stigma to a government/country be assessed?
- How are HIV treatment and care services successfully supplied to MSM in countries with longstanding legally constrained environments (e.g., some MENA and Southeast Asian countries)?
- What is the role of social media and phone apps in maintaining community linkage and health messaging in legally constrained environments?
- How do criminalization and stigma affect mental health for MSM with HIV?
- What, if any, evidence already exists on the impact of criminalization on health behaviors?
- What evidence is needed to persuade governments about the detrimental impacts of criminalization? Or is such criminalization a political issue impervious to the evidence base, as with harm reduction measures for people who inject drugs in many countries?
- What ways can communities and activists engage with politicians and the media over antigay arguments? Where and when has advocacy work had a measurable health outcome and how can such outcomes be demonstrated to funders?
- “How do we change the discussion from ‘expenditure’ to ‘investment’?” (EM)

What is the best use of new models of care and technological advances?

- What is the role of social media and in particular mobile technology in improving testing, linkage to care and retention? What kinds of messages work best and which may not work so well?
- What examples are there of successful social media projects and what are the common pitfalls? What is the added value of utilizing internet-based communications technologies in mobilizing communities and optimizing HIV treatment?
- How can key influencers be harnessed via social media to get people into care and retain them in it?
- How do virtual communities of MSM and other online settings support or hinder diagnosis and treatment?
- What are the lessons learned from technology-driven interventions (such as developing online apps providing treatment information and peer communities for MSM with HIV in Asia, Europe and other regions), which can support improving future technology-based interventions?
- How can contact tracing be done in the era of online sex apps?

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How can MSM living with HIV be better involved in implementation science and operational research?

- How can community members be best involved in framing research questions and doing research?
- What are the different models of community involvement in research and how well do they work?
- What is the impact of CABs in research programs?
- How can implementation science research be simplified so that it is more inclusive and understood/accessed?

How can donors and researchers work together better to this end?

- How can development and health funders best be persuaded of the importance of addressing structural barriers to HIV services for MSM?
- How can stigma in relationship to health and service outcomes best be measured? How can M&E measurements in areas such as stigma reduction be standardized—what would it take to reduce the hundreds of current metrics to a small number of comparable indicators we can all agree on?

How can routine data collection and M&E be improved?

- How can appropriate utilization of existing data be ensured?
- How can intelligent, accessible data collection in clinics and CBOs be better supported and used to strengthen delivery?
- What are appropriate indicators of treatment success beyond viral load measurement?

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APCOM	Asia Pacific Coalition on Men's Health
ART	Antiretroviral therapy
CBO	Community-based organization
CVC	Caribbean Vulnerable Communities Coalition
IAS	International AIDS Society
LGBT	Lesbian, gay, bisexual and transgender
M&E	Monitoring and evaluation
MENA	Middle East and North Africa
MSM	Men who have sex with men
MSMGF	Global Forum on MSM & HIV
NGO	Non-governmental organization
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
WHO	World Health Organization

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APPENDIX 2: Attendees



Participants List

Implementation and Operational Research Priorities for Strengthening Access to Care and Treatment Services for MSM living with HIV- *Consultation Meeting, May 20-21, 2014*

Paul Semugoma semugoma@gmail.com South Africa (AMSHER)	Co-Chair	Carlo A. Oliveras Carlo.oliveras90@yahoo.com Puerto Rico (ITPC)
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Cornelius Baker cbaker@fhi360.org		Greg Millett Greg.millett@amfar.org

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**Expert Consultation:
Implementation and Operational Research Priorities for
Strengthening Access to Care and Treatment Services for MSM living with HIV
Washington DC, United States
May 20 – May 21, 2014**

Pangaea Global AIDS, in collaboration with the Global Forum on MSM (MSMGF), is hosting a consultation on “Implementation and Operational Research Priorities for Strengthening Access to Care and Treatment Services for MSM living with HIV”. This gathering of leading global expertise is to inform the programmatic and research agenda on increasing engagement in the HIV treatment cascade for gay men and other MSM in low and middle income countries, including optimizing provision and mitigating barriers to services. In addition to providing evidence of best practices, this meeting will help inform the World Health Organization’s (WHO) operationalization of its 2013 HIV treatment guidelines and consolidated guidelines on HIV prevention, care and treatment for key populations, which will be launched at the International AIDS Conference in July 2014.

Objectives

- To review best practice approaches for the implementation of programs focused on MSM with a focus on MSM living with HIV to optimize provision and mitigate barriers to services
- To review tools focused on improving the cultural and clinical competence of the health sector in serving gay men and other men who have sex with men living with HIV
- To characterize the implementation science research agenda focused on increasing engagement in HIV treatment programs for gay men and other men who have sex with men

Expected Outcome

A final report which details:

- Recommendations to be considered by the WHO in further articulating the operationalization of HIV Treatment Guidelines and broader Key Population Guidelines (as they relate to delivering HIV treatment for MSM populations).
- Examples of good practice in engaging MSM in HIV treatment & care and scalable examples of HIV treatment services for MSM in various social and political contexts.
- Implementation science research questions which should be considered in further understanding how to provide comprehensive HIV-related services for MSM with HIV.

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Tuesday May 20th (Day 1)

8:30 Welcome from Pangaea & MSMGF: Introduction of Co-Chairs

8:45 **Overview of task for next two days and review of objectives and expected outcomes.**

Ben Plumley

9:00 **Updates and recent developments in WHO Consolidated HIV Treatment Guidelines & Guidelines for Key Affected Populations**

Annette Verster

9:20 Questions/clarifications in plenary

Key Barriers, Facilitators and Critical Enablers to Implementing the WHO's Consolidated Guidelines for MSM. *George Ayala*

9:45 Table discussion

10:05 Report back from tables

10:15 **AM Break**

Testing & Treatment Service Delivery Developments and Current Practice for MSM – What works?

Facilitator: Kevin Rebe

10:35 Principles of service delivery for MSM/review of tools for providers

Mohan Sundararaj

10:55 Expert Panel *Paul Ngone, Laurindo Garcia, Kevin Kapila*

11:25 Plenary discussion/contributions & session summary.

Kevin Rebe

12:15 **Lunch**

Program Delivery: Tackling Legal Constraints

Facilitator: Billy Pick

1:15 Global overview of legal constraints *Othman Mellouk*

1:30 Expert Panel *Tudor Kovacs, Paul Semugoma, John Waters*

2:00 Plenary discussion & session summary *Billy Pick*

Program delivery: Tackling Social Constraints *Facilitator: Cornelius Baker*

2:45 Global overview of social constraints *Ron MacInnis*

3:00 Expert Panel *Midnight Poonkasetwattana, Anthony Adero, Carlo Oliveras*

3:30 Plenary discussion & session summary *Cornelius Baker*

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4:15 Summary of first day *Paul Semugoma, Stef Baral*

5:00 Reception

Wednesday May 21st (Day 2)

8:30 Welcome from Co-Chairs

What Are The Key Strategies to Advance the Operationalization of Treatment Guidelines for MSM at the Country level?

Facilitator Rafael Mazin

8:40 Speakers *Kevin Rebe, Midnight Poonkasetwattana*

9:00 Table discussions

9:30 Plenary report backs, discussion & session summary *Rafael Mazin*

10:30 AM Break

What Are The Key (implementation science and operations research) Questions to Help Strengthen Access to Care & Treatment Services for MSM Living with HIV?

Facilitator Pato Hebert

10:45 Speakers *Stef Baral, Ernest Massiah*

11:05 Table discussions

11:35 Plenary report back, discussion & session summary *Pato Hebert*

12:35 Lunch

Community engagement: How can we better support and resource MSM communities to deliver programs? –

Next steps: *Facilitator Ifeoma Udoh*

1:15 Expert Panel *John Waters, Pablo Aguilera, Laurindo Garcia*

1:45 Plenary discussion & session summary *Ifeoma Udoh*

2:45 PM Break

3:00 Meeting Conclusions and Key Future Actions

3:45 Where do we go from here? *Presentation Ben Plumley, facilitated discussion George Ayala*

3:45 Meeting summary, thanks and farewell

4:00 *Stef Baral, Paul Semugoma*

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APPENDIX 4: Key documents

These documents were used in preparation for the meeting. Others cited as good practice examples can also be found in Appendix 6.

1. **Access to Basic HIV-Related Services and PrEP Acceptability among Men Who Have sex with Men Worldwide: Barriers, Facilitators, and Implications for Combination Prevention**
Ayala, G. et al, Journal of Sexually Transmitted Diseases Volume 2013, Article ID 953123
2. **Homophobia as a Barrier to HIV Prevention Service Access for Young Men Who Have Sex With Men**
Santos, GM, et al Journal of Acquired Immune Deficiency Syndrome, Volume 63, Number 5, August 15, 2013, *Letter to the Editor*
3. **Homophobic legislation and its impact on human security**,*Keletso Makofane, Jack Beck, Micah Lubensky & George Ayala*[IU1]
African Security Review, 23:2, 186-195
4. **Internalized Homophobia and Reduced HIV Testing Among Men Who Have Sex With Men in China**
Thomas Pyun, Glenn-Milo Santos, Sonya Arreola, Tri Do, Pato Hebert, Jack Beck, Keletso Makofane, Patrick A. Wilson and George Ayala
Asia Pac J Public Health published online 18 February 2014 DOI: 10.1177/1010539514524434
5. **Syndemic conditions associated with increased HIV risk in a global sample of men who have sex with men**
Santos G-M, Do T, Beck J, et al. Sex Transmitted Infect Published Online First 8 December 2013
doi:10.1136/sextrans-2013-051318

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APPENDIX 5: Presentations

**Updates and recent developments in WHO Consolidated HIV Treatment Guidelines
Guidelines for Key Affected Populations**

Annette Verster

**Key Barriers, Facilitators and Critical Enablers to Implementing the WHO's Consolidated
Guidelines for MSM.**

George Ayala

Principles of service delivery for MSM/review of tools for providers

Mohan Sundararaj

Tackling Criminalization: Why is this Central to HIV Program Delivery?

George Ayala

Program Delivery: Tackling Social Constraints for MSM and HIV

Ron MacInnis

Providing Health Services to MSM Lessons Learned by Health4men

Kevin Rebe

Implementation Science Priorities for MSM

Stefan Baral

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APPENDIX 6: Summary of links to reports, organizations and recommended good practice projects

Pangaea

<http://www.pgaf.org>

MSMGF

<http://www.msmgf.org>

amfAR's Respect, Protect, Fulfill

<http://www.amfAR.org/new-guidelines-to-respect-protect-fulfill-needs-of-men-who-have-sex-with-men-msm-in-hiv-research/>

Anova Health Institute

<http://www.health4men.co.za>

Bridging the Gaps

<http://www.hivgaps.org>

CEDEP (Malawi) case study report [http://](http://www.futuresgroup.com/files/publications/Malawicasestudy.pdf)

www.futuresgroup.com/files/publications/Malawicasestudy.pdf

Connecting the Dots, B-Change

<http://www.b-change.org/connecting-the-dots>

Fenway Health/Fenway Institute

<http://thefenwayinstitute.org>

GNP+ Global Criminalisation Scan

<http://criminalisation.gnpplus.net>

HIV travel site

<http://www.hivtravel.org>

Human Dignity Trust

<http://www.humandignitytrust.org/pages/OUR%20WORK/Our%20Cases/Jamaica>

Jamaican National HIV/STI Programme

<http://www.nhpjamaica.org>

LVCT Health

<http://www.lvcthealth.org>

M-Coalition (MENA)

<http://www.facebook.com/mcoalition> (full website planned to be launched at the July 2014 International AIDS Conference)

Test BKK

<http://www.testbkk.org>

The Time Has Come (UNDP/WHO training package)

http://asia-pacific.undp.org/content/rbap/en/home/library/hiv_aids/all-hhd-publications/

World Bank on economic costs of homophobic laws

live.worldbank.org/economic-cost-of-homophobia