

Recommended package of interventions for HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for men who have sex with men

Policy brief



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Introduction

In 2022, the World Health Organization (WHO) published the *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*. These guidelines outline a public health response to HIV, viral hepatitis and sexually transmitted infections (STIs) for five key populations (men who have sex with men, sex workers, people in prisons and other closed settings, people who inject drugs and trans and gender diverse people).

In this policy brief, we give an update on those parts of the guidelines which are relevant for men who have sex with men.

Background

The term men who have sex with men refers to all men who engage in sexual relations with other men. It is a term used in public health and social science, including in surveillance for the purposes of identifying sexual risk practices and sexual transmission of infections, including HIV, and is used in the WHO *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations*. However, the term gay, bisexual and other men who have sex with men is also used, particularly when speaking about communities. In this document we will use both terms.

HIV, viral hepatitis and STI epidemics, particularly among key populations including gay, bisexual and other men who have sex with men, continue to be fuelled by harmful laws and policies, including those that criminalize sex work, drug use or possession, and diverse forms of gender expression and sexuality. Some policy guidelines also fail to acknowledge the existence of same sex relations, or address the diverse needs of gay, bisexual and other men who have sex with men. In addition, pervasive stigma and discrimination, gender-based discrimination and violence, lack of community empowerment and other violations of human rights conspire to reduce access to health services and negatively affect how these services are delivered. This places constraints on the ability of individuals to lead full lives, including through optimal sexual health. In many settings this contributes to avoidable and increased risk of HIV, viral hepatitis and STIs (1-11).

Many countries have laws, regulations or policies that present barriers to effective HIV, viral hepatitis, STI and other health services for key populations, including criminalization of gender identity or expression, and sexual relations between people of the same sex. In 2021, 69 countries criminalized consensual same-sex sexual acts between adults (12). Other harmful practices include forced anal examinations, which are used to investigate or punish alleged same-sex behaviour between consenting men or transgender women (13) (14-16). These legal barriers have measurable, detrimental effects on health, shown by modelling and other research (14-16), with some studies showing the negative effect of criminalization of same-sex practices on HIV prevalence and access to prevention, diagnosis and treatment services (17, 18).

Gay, bisexual and other men who have sex with men are often particularly subjected to stigma, discrimination and negative attitudes related to their behaviour, sexual orientation, gender identity or engagement in sex work – and doubly so if also living with HIV (also criminalized in many settings), viral hepatitis or STIs. Many also face intersecting forms of discrimination on the basis of their age, sex, race or ethnicity, physical or mental health status, disability, nationality, asylum or migration status, or criminal record. This is the basis for discrimination which is common in many health facilities and law enforcement services.

The effects of stigma and discrimination against key populations can manifest in delayed testing and missed diagnoses, poor retention in treatment programmes and poor treatment outcomes, concealment of health status and, in general, poor uptake of health services (19-31).

The experience of violence is a common occurrence among key populations and can take various forms – physical, sexual or psychological. It can be perpetrated by different people, including intimate partners, clients, family members, strangers, service providers, law enforcement officers and others

in positions of power (32-35). Violence can be fuelled by the imbalance in the power dynamics of gender – by prejudice and discrimination against persons perceived to depart from conventional gender and sexuality norms and identities. Other characteristics such as age, disability or race can increase vulnerability to violence. Also, multiple structural factors influence vulnerability to violence, including discriminatory or harsh laws, policing practices, and cultural and social norms that legitimize stigma and discrimination. Experience of violence has been shown to negatively impact on the health of men who have sex with men (34-38).

Recommended package of interventions

Enabling interventions to address structural barriers

The essential package of interventions for men who have sex with men includes enabling interventions to address structural barriers as a priority, including the decriminalization of same-sex sexual behaviour.

Legal reforms such as decriminalizing consensual same sex sexual relationships; legal recognition of transgender or gender diverse status; lowering the age of consent for accessing health services; and considering exceptions to a standard age of consent policy (such as mature minors) are critical enablers. They can change a hostile environment for key populations to a supportive environment.

There are many interventions designed to reduce stigma and discrimination in health care settings, with some randomized controlled trials and observational studies showing positive effects (22, 39-50). However, given the heterogeneous nature of the interventions and outcomes measured, meta-analyses are often not possible, and systematic reviews do not clearly indicate which are the most effective interventions when it comes to reducing stigma and discrimination in health care settings (51-54). Instead, it is useful to consider a range of interventions that can address different aspects of stigma and discrimination (24, 54).

Community empowerment means increasing key population communities' control over their health by addressing the structural constraints to health, human rights and well-being; making social, economic and behavioural changes; and improving access to health services. Community empowerment can take many forms, such as fostering key population-led groups and key population-led programmes and service delivery; meaningful participation of people from key populations in designing and operating services; peer education or navigation; task shifting to key population peers; self-care; implementation of legal literacy and service programmes; and ensuring civic space in which key populations can function without fear of reprisals. Community empowerment can also build solidarity and address the stigma and discrimination that exists within communities of gay, bisexual and other men who have sex with men.

The health sector has an important role to play in addressing violence against gay, bisexual and other men who have sex with men by providing judgement-free comprehensive health services, including the following: sexual health services; providing referrals to other support services; gathering evidence through data and research; fostering prevention policies in other sectors; and advocating for violence to be recognized as a public health problem and for resource allocation (55). The health sector also has a role in calling out interventions such as conversion therapy and forced anal examinations, which can be considered by some as medical interventions but are in fact human rights abuses and acts of violence. Those who experience sexual violence need timely access to post-rape care, including post-exposure prophylaxis for HIV and other STIs, hepatitis B (HBV) immunization and psychosocial care and support, as well as referrals to legal services (56). Efforts to address violence against people from key populations must involve other sectors along with the health sector. For example, law enforcement practices can increase the risk of violence faced by key populations. Indeed, law enforcement officers themselves can be perpetrators. Work with law officers can involve training on the human rights of key populations, as well as promoting accountability for rights-based law enforcement (57). It is also important to monitor and document incidents of violence, both as evidence for advocacy and to inform programme design. Documenting the levels of violence faced by key populations is often the first step in creating awareness.

Health interventions

WHO recommends that national programmes prioritize access to a range of health interventions for men who have sex with men in all settings. These are essential for impacting health interventions and include HIV, STI and viral hepatitis prevention, including providing condoms and lubricant; HIV pre-exposure prophylaxis (PrEP); HIV post-exposure prophylaxis (PEP); HBV vaccination; and access to HIV, STI and viral hepatitis diagnosis, treatment and care. Hepatitis A outbreaks among gay, bisexual and other men who have sex with men can also occur and could be prevented with vaccination (1, 2, 4, 7, 9).

Those interventions essential for broader health, and to which access for gay, bisexual and other men who have sex with men should be ensured, include screening and addressing mental health issues, and harmful alcohol and drug use.

While WHO does not have specific recommendations about anal health or anal cancer, people living with HIV are at least 20 times more likely to be diagnosed with anal cancer than uninfected people (58), and this can disproportionately affect men who have sex with men. Like cancer of the cervix, anal cancer is associated with human papillomavirus (HPV) and the HPV vaccine can prevent infection with HPV in all people. Cytological screening can be performed for anal cancer and its precursors, known as anal high-grade squamous intraepithelial lesions, particularly for people who engage in anal sex, including men who have sex with men and trans and gender diverse people.

Special considerations related to chemsex

Chemsex¹ is when individuals engage in sexual activity while taking stimulant drugs such as methamphetamine, mephedrone or other gamma-hydroxybutyrate (GHB). Chemsex typically involves multiple participants, the use of multiple drugs (including injecting drug use), and occurs over a prolonged time, for example, in group sex or orgy parties (59-61). There have been increasing reports of chemsex in some communities of gay, bisexual and other men who have sex with men (60), more often in high income settings in Europe and North America. A recent qualitative scoping review, however, of sexualized drug use and chemsex among gay, bisexual and other men who have sex with men and transgender women found it to be increasingly common in Asia (62, 63), with anecdotal evidence that it is also increasing in other parts of the world. Chemsex, without proper support and access to health interventions, may be associated with unprotected sex and injecting, as well as with other health risks (61, 64).

While there is limited research on chemsex, qualitative studies have shown that gay, bisexual and other men who have sex with men value and prefer the following approaches to reducing harms associated with chemsex (64-68):

- specialist chemsex services (for example, specialized counselling with a single professional about both drug and sex-related issues);
- tailored, non-judgemental, peer-led services focusing on the principles of harm reduction rather than cessation of drug use;
- integrated sexual health and HIV, STI and viral hepatitis services; and
- more chemsex-specific information and education to be available through various modalities that include explanations of potential risks.

Addressing chemsex requires a comprehensive, impartial and person-centred approach. This can include integrated mental health, sexual and reproductive health, access to sterile needles and syringes and opioid dependence treatment services, with linkages to other evidence-based prevention, diagnostic and treatment interventions.

1 Chemsex is also known by other names, such as slam sex (associated with injecting drug use), party and play, or sexualized drug use.

Mpox and men who have sex with men

In 2022–2023 a multi-country outbreak of mpox (formerly monkeypox) occurred, primarily affecting communities of gay, bisexual and other men who have sex with men. While reported cases declined in early 2023, the 2022 outbreak did highlight the importance of strengthening health systems and services – particularly community-based services – that provide HIV and STI interventions so that they can respond to outbreaks. The outbreak also revealed the impact of structural barriers and the importance of communities in responding to emerging health issues.

In the 2022 mpox outbreak around 50% of the cases among those with known HIV status were living with HIV. Furthermore, data suggest that people living with HIV, especially if they are not receiving effective treatment for HIV, are at increased risk of severe mpox (69, 70). Additionally, new HIV diagnoses made among people presenting with mpox suggests the need to include HIV testing within comprehensive mpox case management. Based on test results, the need for combined HIV risk assessment and prevention, as well as referral to HIV care, can be determined. The association between mpox severity and untreated HIV suggests that people not aware of their HIV status need to know it, and access antiretroviral treatment and achieve viral suppression in order to reduce mpox morbidity and mortality.

Due to its epidemiology, the mpox outbreak in newly affected countries has reinforced stigma and discrimination towards men who identify as gay or bisexual, people who are transgender, and sex workers. Eliminating stigma, discrimination and other structural barriers is a key strategy both to achieve global health sector HIV targets and to stop mpox transmission.

While evidence about what works to prevent and treat mpox is rapidly evolving (71), WHO advises increasing awareness of the ways mpox is transmitted and of the signs and symptoms of mpox among communities of gay, bisexual and other men who have sex with men. Treatment of mpox is limited to supportive care, but trials are ongoing for better treatments. For individuals at high-risk of exposure, including men who have sex with men in many settings in the 2022–2023 outbreak, primary prevention vaccination is recommended. Please see the WHO website for updated guidance on mpox.

These interventions are not in order of priority.

The interventions listed here have been categorized as follows:

1. Essential for impact: enabling interventions

This includes all interventions recommended to reduce structural barriers to health services access for key populations.

2. Essential for impact: health interventions

This includes health sector interventions that have a demonstrated direct impact on HIV, viral hepatitis and STIs in key populations.

3. Essential for broader health

This includes health sector interventions to which access for key populations should be ensured, but do not have direct impact on HIV, viral hepatitis or STIs.

Essential for impact: enabling interventions

Removing punitive laws, policies and practices

Reducing stigma and discrimination

Community empowerment

Addressing violence

Essential for impact: health interventions

Prevention of HIV, viral hepatitis and STIs

Condoms and lubricant

Pre-exposure prophylaxis (PrEP) for HIV

Post-exposure prophylaxis (PEP) for HIV and STIs

Hepatitis B vaccination²

Addressing chemsex

Diagnosis

HIV testing services

STI testing

Hepatitis B and C testing

Treatment

HIV treatment

Screening, diagnosis, treatment and prevention of HIV-associated tuberculosis (TB)

STI treatment

Hepatitis B and C treatment

Essential for broader health: health interventions

Anal health

Mental health

Screening and treatment for hazardous and harmful alcohol and other substance use

2 It is also suggested to offer other vaccinations as indicated and feasible, such as those for hepatitis A, mpox and HPV.

References

1. Beebejaun K, Degala S, Balogun K, Simms I, Woodhall SC, Heinsbroek E, et al. Outbreak of hepatitis A associated with men who have sex with men (MSM), England, July 2016 to January 2017. *Eurosurveillance*. 2017;22(5):30454 (<https://doi.org/10.2807/1560-7917.es.2017.22.5.30454>).
2. Chen G-J, Lin K-Y, Hung C-C, Chang S-C. Hepatitis A outbreak among men who have sex with men in a country of low endemicity of hepatitis A infection. *The Journal of infectious diseases*. 2017;215(8):1339-40 (<https://doi.org/10.1093/infdis/jix123>).
3. Falla AM, Hofstraat SHI, Duffell E, Hahné SJM, Tavoschi L, Veldhuijzen IK. Hepatitis B/C in the countries of the EU/EEA: a systematic review of the prevalence among at-risk groups. *BMC Infect Dis*. 2018;18(1):79 (<https://doi.org/10.1186/s12879-018-2988-x>).
4. Freidl GS, Sonder GJ, Bovée LP, Friesema IH, van Rijckevorsel GG, Ruijs WL, et al. Hepatitis A outbreak among men who have sex with men (MSM) predominantly linked with the EuroPride, the Netherlands, July 2016 to February 2017. *Eurosurveillance*. 2017;22(8):30468 (<https://doi.org/10.2807/1560-7917.es.2017.22.8.30468>).
5. Jin F, Dore GJ, Matthews G, Luhmann N, Macdonald V, Bajis S, et al. Prevalence and incidence of hepatitis C virus infection in men who have sex with men: a systematic review and meta-analysis. *Lancet Gastroenterol Hepatol*. 2021;6(1):39-56 ([https://doi.org/10.1016/s2468-1253\(20\)30303-4](https://doi.org/10.1016/s2468-1253(20)30303-4)).
6. Malekinejad M, Barker EK, Merai R, Lyles CM, Bernstein KT, Sipe TA, et al. Risk of HIV Acquisition Among Men Who Have Sex With Men Infected With Bacterial Sexually Transmitted Infections: A Systematic Review and Meta-Analysis. *Sex Transm Dis*. 2021;48(10):e138-e48 (<https://doi.org/10.1097/olq.0000000000001403>).
7. Ndumbi P, Freidl GS, Williams CJ, Mårdh O, Varela C, Avellón A, et al. Hepatitis A outbreak disproportionately affecting men who have sex with men (MSM) in the European Union and European Economic Area, June 2016 to May 2017. *Eurosurveillance*. 2018;23(33):1700641 (<https://doi.org/10.2807/1560-7917.es.2018.23.33.1700641>).
8. Ong JJ, Baggaley RC, Wi TE, Tucker JD, Fu H, Smith MK, et al. Global Epidemiologic Characteristics of Sexually Transmitted Infections Among Individuals Using Preexposure Prophylaxis for the Prevention of HIV Infection: A Systematic Review and Meta-analysis. *JAMA Netw Open*. 2019;2(12):e1917134 (<https://doi.org/10.1001/jamanetworkopen.2019.17134>).
9. Ooi C, Kong FYS, Lewis DA, Hocking JS. Prevalence of sexually transmissible infections and HIV in men attending sex-on-premises venues in Australia: a systematic review and meta-analysis of observational studies. *Sex Health*. 2020;17(2):135-48 (<https://doi.org/10.1071/sh19150>).
10. Tsuboi M, Evans J, Davies EP, Rowley J, Korenromp EL, Clayton T, et al. Prevalence of syphilis among men who have sex with men: a global systematic review and meta-analysis from 2000-20. *Lancet Glob Health*. 2021;9(8):e1110-e8 ([https://doi.org/10.1016/s2214-109x\(21\)00221-7](https://doi.org/10.1016/s2214-109x(21)00221-7)).
11. Werber D, Michaelis K, Hausner M, Sissolak D, Wenzel J, Bitzegeio J, et al. Ongoing outbreaks of hepatitis A among men who have sex with men (MSM), Berlin, November 2016 to January 2017–linked to other German cities and European countries. *Eurosurveillance*. 2017;22(5):30457 (<https://doi.org/10.2807/1560-7917.es.2017.22.5.30457>).
12. International Lesbian Gay Bisexual Trans and Intersex Association (ILGA). State sponsored homophobia report. 2021 (<https://ilga.org/state-sponsored-homophobia-report/>).
13. Cichowitz C, Rubenstein L, Beyrer C. Forced anal examinations to ascertain sexual orientation and sexual behavior: An abusive and medically unsound practice. *PLoS Med*. 2018;15(3):e1002536 (<https://doi.org/10.1371/journal.pmed.1002536>).
14. Millett GA, Jeffries WLt, Peterson JL, Malebranche DJ, Lane T, Flores SA, et al. Common roots: a contextual review of HIV epidemics in black men who have sex with men across the African diaspora. *Lancet*. 2012;380(9839):411-23 ([https://doi.org/10.1016/s0140-6736\(12\)60722-3](https://doi.org/10.1016/s0140-6736(12)60722-3)).

15. Millett GA, Peterson JL, Flores SA, Hart TA, Jeffries WLt, Wilson PA, et al. Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: a meta-analysis. *Lancet*. 2012;380(9839):341-8 ([https://doi.org/10.1016/s0140-6736\(12\)60899-x](https://doi.org/10.1016/s0140-6736(12)60899-x)).
16. Santos GM, Makofane K, Arreola S, Do T, Ayala G. Reductions in access to HIV prevention and care services are associated with arrest and convictions in a global survey of men who have sex with men. *Sex Transm Infect*. 2017;93(1):62-4 (<https://doi.org/10.1136/sextrans-2015-052386>).
17. Piot P, Karim SSA, Hecht R, Legido-Quigley H, Buse K, Stover J, et al. Defeating AIDS—advancing global health. *The Lancet*. 2015;386(9989):171-218 ([https://doi.org/10.1016/s0140-6736\(15\)60658-4](https://doi.org/10.1016/s0140-6736(15)60658-4)).
18. Stannah J, Dale E, Elmes J, Staunton R, Beyrer C, Mitchell KM, et al. HIV testing and engagement with the HIV treatment cascade among men who have sex with men in Africa: a systematic review and meta-analysis. *The lancet HIV*. 2019;6(11):e769-e87 ([https://doi.org/10.1016/s2352-3018\(19\)30239-5](https://doi.org/10.1016/s2352-3018(19)30239-5)).
19. Ayhan CHB, Bilgin H, Uluman OT, Sukut O, Yilmaz S, Buzlu S. A systematic review of the discrimination against sexual and gender minority in health care settings. *International Journal of Health Services*. 2020;50(1):44-61 (<https://doi.org/10.1177/0020731419885093>).
20. Costa AB, B. de Moura Filho J, M. Silva J, A. Beloqui J, Espindola Y, F. de Araujo C, et al. Key and general population HIV-related stigma and discrimination in HIV-specific health care settings: results from the Stigma Index Brazil. *AIDS care*. 2021:1-5 (<https://doi.org/10.1080/09540121.2021.1876836>).
21. Fitzgerald-Husek A, Van Wert MJ, Ewing WF, Grosso AL, Holland CE, Katterl R, et al. Measuring stigma affecting sex workers (SW) and men who have sex with men (MSM): A systematic review. *PLoS One*. 2017;12(11):e0188393 (<https://doi.org/10.1371/journal.pone.0188393>).
22. Friedland BA, Sprague L, Nyblade L, Baral SD, Pulerwitz J, Gottert A, et al. Measuring intersecting stigma among key populations living with HIV: implementing the people living with HIV Stigma Index 2.0. *Journal of the International AIDS Society*. 2018;21(Suppl Suppl 5) (<https://doi.org/10.1002/jia2.25131>).
23. Hatzenbuehler ML, O'cleirigh C, Mayer KH, Mimiaga MJ, Safren SA. Prospective associations between HIV-related stigma, transmission risk behaviors, and adverse mental health outcomes in men who have sex with men. *Annals of Behavioral Medicine*. 2011;42(2):227-34 (<https://doi.org/10.1007/s12160-011-9275-z>).
24. Joint United Nations Programme on HIV/AIDS. Evidence for eliminating HIV-related stigma and discrimination — Guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination in six settings. Geneva: UNAIDS; 2020 (<https://www.unaids.org/en/resources/documents/2020/eliminating-discrimination-guidance>).
25. Krishnaratne S, Bond V, Stangl A, Pliakas T, Mathema H, Liljeston P, et al. Stigma and judgment toward people living with HIV and key population groups among three cadres of health workers in South Africa and Zambia: analysis of data from the HPTN 071 (PopART) trial. *AIDS patient care and STDs*. 2020;34(1):38-50 (<https://doi.org/10.1089/apc.2019.0131>).
26. Leks H-M, Siegel K, Leider J. Felt and enacted stigma among HIV/HCV-coinfected adults: the impact of stigma layering. *Qualitative health research*. 2011;21(9):1205-19 (<https://doi.org/10.1177/1049732311405684>).
27. Lyons CE, Olawore O, Turpin G, Coly K, Ketende S, Liestman B, et al. Intersectional stigmas and HIV-related outcomes among a cohort of key populations enrolled in stigma mitigation interventions in Senegal. *AIDS (London, England)*. 2020;34(Suppl 1):S63 (<https://doi.org/10.1097/qad.0000000000002641>).
28. Peitzmeier SM, Grosso A, Bowes A, Ceesay N, Baral SD. Associations of stigma with negative health outcomes for people living with HIV in the Gambia: implications for key populations. *JAIDS Journal of Acquired Immune Deficiency Syndromes*. 2015;68:S146-S53 (<https://doi.org/10.1097/qai.0000000000000453>).

29. Rogers S, Tureski K, Cushnie A, Brown A, Bailey A, Palmer Q. Layered stigma among health-care and social service providers toward key affected populations in Jamaica and The Bahamas. *AIDS care*. 2014;26(5):538-46 (<https://doi.org/10.1080/09540121.2013.844762>).
30. Rueda S, Mitra S, Chen S, Gogolishvili D, Globerman J, Chambers L, et al. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ open*. 2016;6(7):e011453 (<https://doi.org/10.1136/bmjopen-2016-011453>).
31. Yam EA, Pulerwitz J, Almonte D, García F, del Valle A, Colom A, et al. Stigma among key populations living with HIV in the Dominican Republic: experiences of people of Haitian descent, MSM, and female sex workers. *AIDS*. 2020;34:S43-S51 (<https://doi.org/10.1097/qad.0000000000002642>).
32. Blondeel K, De Vasconcelos S, García-Moreno C, Stephenson R, Temmerman M, Toskin I. Violence motivated by perception of sexual orientation and gender identity: a systematic review. *Bulletin of the World Health Organization*. 2018;96(1):29 (<https://doi.org/10.2471/blt.17.197251>).
33. Finneran C, Stephenson R. Intimate partner violence among men who have sex with men: A systematic review. *Trauma, Violence, & Abuse*. 2013;14(2):168-85 (<https://doi.org/10.2471/blt.17.197251>).
34. Miltz AR, Lampe FC, Bacchus LJ, McCormack S, Dunn D, White E, et al. Intimate partner violence, depression, and sexual behaviour among gay, bisexual and other men who have sex with men in the PROUD trial. *BMC Public Health*. 2019;19(1):1-17 (<https://doi.org/10.1186/s12889-019-6757-6>).
35. Poteat T, Ackerman B, Diouf D, Ceesay N, Mothopeng T, Odette K-Z, et al. HIV prevalence and behavioral and psychosocial factors among transgender women and cisgender men who have sex with men in 8 African countries: A cross-sectional analysis. *PLoS medicine*. 2017;14(11):e1002422 (<https://doi.org/10.1371/journal.pmed.1002422>).
36. Davis DA, Morales GJ, Ridgeway K, Mendizabal M, Lanham M, Dayton R, et al. The health impacts of violence perpetrated by police, military and other public security forces on gay, bisexual and other men who have sex with men in El Salvador. *Culture, health & sexuality*. 2020;22(2):217-32 (<https://doi.org/10.1080/13691058.2019.1582801>).
37. Dunkle KL, Wong FY, Nehl EJ, Lin L, He N, Huang J, et al. Male-on-male intimate partner violence and sexual risk behaviors among money boys and other men who have sex with men in Shanghai, China. *Sex Transm Dis*. 2013;40(5):362-5 (<https://doi.org/10.1097/olq.0b013e318283d2af>).
38. Russell M, Chen M-J, Nochajski TH, Testa M, Zimmerman SJ, Hughes PS. Risky sexual behavior, bleeding caused by intimate partner violence, and hepatitis C virus infection in patients of a sexually transmitted disease clinic. *American journal of public health*. 2009;99(S1):S173-S9 (<https://doi.org/10.2105/ajph.2007.126383>).
39. Batey DS, Whitfield S, Mulla M, Stringer KL, Durojaiye M, McCormick L, et al. Adaptation and implementation of an intervention to reduce HIV-related stigma among healthcare workers in the United States: piloting of the FRESH workshop. *AIDS patient care and STDs*. 2016;30(11):519-27 (<https://doi.org/10.1089/apc.2016.0223>).
40. Fernandez A, Tan K-A, Knaak S, Chew BH, Ghazali SS. Effects of brief psychoeducational program on stigma in Malaysian pre-clinical medical students: a randomized controlled trial. *Academic Psychiatry*. 2016;40(6):905-11 (<https://doi.org/10.1007/s40596-016-0592-1>).
41. Flanagan EH, Buck T, Gamble A, Hunter C, Sewell I, Davidson L. "Recovery speaks": a photovoice intervention to reduce stigma among primary care providers. *Psychiatric Services*. 2016;67(5):566-9 (<https://doi.org/10.1176/appi.ps.201500049>).
42. Geibel S, Hossain SM, Pulerwitz J, Sultana N, Hossain T, Roy S, et al. Stigma reduction training improves healthcare provider attitudes toward, and experiences of, young marginalized people in Bangladesh. *Journal of Adolescent Health*. 2017;60(2):S35-S44 (<https://doi.org/10.1016/j.jadohealth.2016.09.026>).

43. Happell B, Byrne L, Platania-Phung C, Harris S, Bradshaw J, Davies J. Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International journal of mental health nursing*. 2014;23(5):427-34 (<https://doi.org/10.1111/inm.12077>).
44. Li L, Liang L-J, Wu Z, Lin C, Guan J. Assessing outcomes of a stigma-reduction intervention with venue-based analysis. *Social psychiatry and psychiatric epidemiology*. 2014;49(6):991-9 (<https://doi.org/10.1007/s00127-013-0808-6>).
45. Li L, Lin C, Guan J, Wu Z. Implementing a stigma reduction intervention in healthcare settings. *Journal of the International AIDS Society*. 2013;16:18710 (<https://doi.org/10.7448/ias.16.3.18710>).
46. Mak WW, Cheng SS, Law RW, Cheng WW, Chan F. Reducing HIV-related stigma among health-care professionals: a game-based experiential approach. *AIDS care*. 2015;27(7):855-9 (<https://doi.org/10.1080/09540121.2015.1007113>).
47. Odeny TA, Penner J, Lewis-Kulzer J, Leslie HH, Shade SB, Adero W, et al. Integration of HIV care with primary health care services: effect on patient satisfaction and stigma in rural Kenya. *AIDS research and treatment*. 2013;2013 (<https://doi.org/10.1155/2013/485715>).
48. Pulerwitz J, Oanh KTH, Akinwolemiwa D, Ashburn K, Nyblade L. Improving hospital-based quality of care by reducing HIV-related stigma: evaluation results from Vietnam. *AIDS and Behavior*. 2015;19(2):246-56 (<https://doi.org/10.1007/s10461-014-0935-4>).
49. Siegel J, Yassi A, Rau A, Buxton JA, Wouters E, Engelbrecht MC, et al. Workplace interventions to reduce HIV and TB stigma among health care workers—where do we go from here? *Global public health*. 2015;10(8):995-1007 (<https://doi.org/10.1080/17441692.2015.1021365>).
50. Srithanaviboonchai K, Stockton M, Pudpong N, Chariyalertsak S, Prakongsai P, Chariyalertsak C, et al. Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. *BMC public health*. 2017;17(1):1-11 (<https://doi.org/10.1186/s12889-017-4172-4>).
51. Feyissa GT, Lockwood C, Woldie M, Munn Z. Reducing HIV-related stigma and discrimination in healthcare settings: a systematic review of guidelines, tools, standards of practice, best practices, consensus statements and systematic reviews. *J Multidiscip Healthc*. 2018;11:405-16 (<https://doi.org/10.2147/jmdh.s170720>).
52. Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? *Journal of the international AIDS Society*. 2009;12(1):1-7 (<https://doi.org/10.1186/1758-2652-12-15>).
53. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. *BMC Medicine*. 2019;17(1):25 (<https://doi.org/10.1186/s12916-019-1256-2>).
54. Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *Journal of the International AIDS Society*. 2013;16:18734 (<https://doi.org/10.7448/ias.16.3.18734>).
55. World Health Organisation. Evidence brief: Violence against women. Intimate partner and sexual violence against women. Geneva: WHO; 2019 (<https://iris.who.int/handle/10665/329889>).
56. World Health Organization. Caring for women subjected to violence: A WHO curriculum for training health-care providers. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/330084>).
57. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO Clinical and policy guidelines. Geneva: World Health Organization; 2013 (<https://iris.who.int/handle/10665/85240>).
58. Grulich AE, Van Leeuwen MT, Falster MO, Vajdic CM. Incidence of cancers in people with HIV/AIDS compared with immunosuppressed transplant recipients: a meta-analysis. *The Lancet*. 2007;370(9581):59-67 ([https://doi.org/10.1016/s0140-6736\(07\)61050-2](https://doi.org/10.1016/s0140-6736(07)61050-2)).

59. Harm Reduction International. Chemsex and Harm Reduction for Gay Men and Other Men Who Have Sex With Men: Briefing Note. London: Harm Reduction International; 2021 (<https://hri.global/publications/chemsex-and-harm-reduction-for-gay-men-and-other-men-who-have-sex-with-men/>).
60. McCall H, Adams N, Mason D, Willis J. What is chemsex and why does it matter? : British Medical Journal Publishing Group; 2015 (<https://doi.org/10.1136/bmj.h5790>).
61. Schreck B, Victorri-Vigneau C, Guerlais M, Laforgue E, Grall-Bronnec M. Slam Practice: A Review of the Literature. European Addiction Research. 2021;27(3):161-78 (<https://doi.org/10.1159/000511897>).
62. Kelly-Hanku A. A qualitative scoping review of sexualised drug use (including Chemsex). 2021 (https://www.apcom.org/wp-content/uploads/2021/02/Report_summay-SDU-in-Asia_v6.pdf).
63. Maxwell S, Shahmanesh M, Gafos M. Chemsex behaviours among men who have sex with men: a systematic review of the literature. International Journal of Drug Policy. 2019;63:74-89 (<https://doi.org/10.1016/j.drugpo.2018.11.014>).
64. Tomkins A, Vivancos R, Ward C, Kliner M. How can those engaging in chemsex best be supported? An online survey to gain intelligence in Greater Manchester. International journal of STD & AIDS. 2018;29(2):128-34 (<https://doi.org/10.1177/0956462417719643>).
65. Bedi A, Sewell C, Fitzpatrick C. Peer-led education may be an effective harm reduction strategy for men who have sex with men engaging in ‘chemsex’. International journal of STD & AIDS. 2020;31(4):392-3 (<https://doi.org/10.1177/0956462419898614>).
66. Bourne A, Reid D, Hickson F, Torres-Rueda S, Steinberg P, Weatherburn P. “Chemsex” and harm reduction need among gay men in South London. Int J Drug Policy. 2015;26(12):1171-6 (<https://doi.org/10.1016/j.drugpo.2015.07.013>).
67. Herrijgers C, Poels K, Vandebosch H, Platteau T, van Lankveld J, Florence E. Harm Reduction Practices and Needs in a Belgian Chemsex Context: Findings from a Qualitative Study. International journal of environmental research and public health. 2020;17(23):9081 (<https://doi.org/10.3390/ijerph17239081>).
68. Tan RKJ, Wong CM, Mark I, Chen C, Chan YY, Ibrahim MAB, et al. Chemsex among gay, bisexual, and other men who have sex with men in Singapore and the challenges ahead: A qualitative study. International Journal of Drug Policy. 2018;61:31-7 (<https://doi.org/10.1016/j.drugpo.2018.10.002>).
69. Angelo KM, Smith T, Camprubí-Ferrer D, Balerdi-Sarasola L, Díaz Menéndez M, Servera-Negre G, et al. Epidemiological and clinical characteristics of patients with monkeypox in the GeoSentinel Network: a cross-sectional study. Lancet Infect Dis. 2023;23(2):196-206 ([https://doi.org/10.1016/s1473-3099\(22\)00651-x](https://doi.org/10.1016/s1473-3099(22)00651-x)).
70. Mitjà O, Alemany A, Marks M, Lezama Mora JI, Rodríguez-Aldama JC, Torres Silva MS, et al. Mpox in people with advanced HIV infection: a global case series. Lancet. 2023;401(10380):939-49 ([https://doi.org/10.1016/s0140-6736\(23\)00273-8](https://doi.org/10.1016/s0140-6736(23)00273-8)).
71. United Nations Development Programme. Addressing Mpox (Monkeypox): Effective Science and Rights-Based Responses. New York: UNDP; 2023 (<https://www.undp.org/publications/addressing-mpox-monkeypox-effective-science-and-rights-based-responses>).

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LGBT center in Mongolia.
Members of the LGBT center in their office.

