JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

PROMOTING THE HEALTH OF MEN WHO HAVE SEX WITH MEN WORLDWIDE:

A TRAINING CURRICULUM FOR PROVIDERS

“A young gay man who I know reported to us an experience at the hospital where he had gone to seek treatment for a potential sexually transmitted infection. The nurses literally laughed at him when he divulged his sexual orientation during sexual history taking. They called each other and made a spectacle of him. … Men who have sex with men stay away from services because they fear being ridiculed.”

—

26-year-old gay man and HIV professional, sub-Saharan Africa

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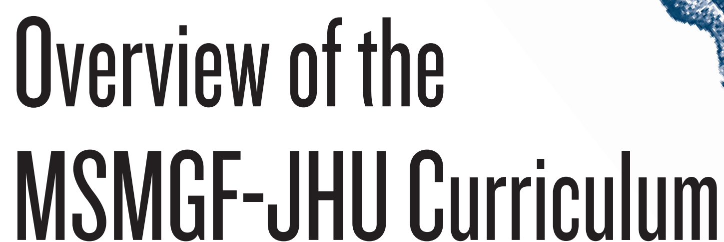
Overview of the MSMGF-JHU Curriculum



Gay men and other men who have sex with men (MSM) around the world face significant challenges to accessing healthcare services. Discomfort with a healthcare provider for fear of being ridiculed, harassed, or even denied care altogether is one key barrier. This is sobering considering that MSM shoulder higher rates of HIV and other sexually transmitted infections (STI) compared to adults in the general population. In addition to HIV and other STIs, gay men and other MSM present in the clinical setting with a range of unique health needs, therefore requiring providers to be uniquely qualified to deliver care to this population.

Knowledge, skill, and sensitivity needs among healthcare providers to handle health issues of concern to gay men and other MSM are inadequately addressed by general medical education curricula the world over. For providers to fulfill their ethical obligation to serve all people seeking care, they must receive specific guidance on promoting the health of gay men and other MSM in their communities.

Currently, a broad range of tools for training providers in specific local and regional contexts exists to address these needs. However, these tools – or the resources to develop them – are unavailable in far too many settings globally. Therefore, the need persists for a comprehensive tool to train healthcare providers that can be locally adapted with minimal resources. In places where engagement and training efforts with providers are ongoing, such a framework can strengthen and complement those efforts.

THE MSMGF-JHU CURRICULUM FOR PROVIDERS

The **Global Forum on MSM & HIV (MSMGF)**, in partnership with **Johns Hopkins University (JHU)**, developed a training curriculum that aims to provide local community groups serving gay men and other MSM with the ability to independently implement training programs to build cultural and clinical competency among healthcare providers serving their communities. The curriculum leverages the strengths of existing training tools while drawing from up-to-date and emerging research and clinical guidance on the health of gay men and other MSM. With a strong focus on sex positivity, the curriculum shifts away from the disease model, in which negative health outcomes are viewed as embarrassing "diseases" that are the consequences of socially unacceptable behavior. It instead centers on a sexual health and harm reduction framework, focusing on health as a basic human right with sexual health as only one component of health more broadly. Organized across nine distinct modules, the curriculum is designed for easy use by trainers to impact healthcare providers' knowledge, attitudes, and skills on a range of clinically relevant topics.

WHAT ARE THE NINE MODULES?

The titles of the nine modules in the MSMGF-JHU curriculum are listed in the text box below. The introductory modules are designed to normalize same-sex sexuality and promote a broad understanding of the contexts in which gay men and other MSM navigate their healthcare needs. Subsequent modules offer specific provider-led strategies for increasing access to and quality of care for gay men and other MSM. These strategies include, for example,

creating an enabling clinical environment, taking a complete and accurate sexual history, and effectively managing HIV and other STIs among gay men and other MSM.

WHAT'S IN EACH MODULE?

Each module is designed to be delivered as a stand-alone training or in conjunction with other modules from the curriculum depending on local training needs. Each module is approximately 20 pages containing:

- Up-to-date technical information on a range of sub-topics
- One or more pre-reading assignments
- A ten-item pre- and post-test for assessment of learning
- Useful tips for facilitators
- One or more group activities
- At least one case study
- Additional readings and resources

MSMGF-JHU Curriculum: Module Titles

1. Understanding Gay Men and Other MSM
2. Sexuality and Health
3. Barriers to Health
4. Creating a Friendlier Environment
5. Promoting Mental Health
6. Taking a Sexual History
7. Supporting Gay Men and other MSM Who Use Drugs and Alcohol
8. Interventions for HIV and STI Prevention
9. Clinical Care for HIV and other STIs

ARE THERE ANY ACCOMPANYING MATERIALS?

In addition to the curriculum's main content and guidance on facilitation techniques, which are chiefly directed at training facilitators, a participant's guide and deck of PowerPoint slides to accompany each module are available for download from www.msmgf.org/promotinghealth

Instruments to evaluate the process and outcomes of the training are also provided. The evaluation tools are designed to assess:

- Participant learning needs before the training.
- Participant knowledge, attitudes, and skills once before the training and again after the training for any individual module or series of modules.
- Overall participant satisfaction with the training.

Tools are also provided to conduct follow-up surveys with both providers and their clients during the months and years following training to assess sustained outcomes.

WHO IS THIS FOR?

This training curriculum is intended for individuals and organizations interested in training local healthcare providers on health issues of concern to gay men and other MSM. The main curriculum content is directed to training facilitators and aims to supply them with practical approaches to training design and help them incorporate principles of adult learning theory to result in the most effective training possible. Facilitators should familiarize themselves with the training materials in as much depth as possible before the training.

The curriculum and accompanying materials are designed to allow for implementation while requiring only minimal additional resource input. As appropriate and necessary, facilitators can also adapt numerous aspects of the curriculum, including group activities, case studies, and pre-readings, among others, to ensure that the training content aligns with the local context and specific training needs.

Pilot Test with GALZ, Zimbabwe

FIGURE 1 Training participants completing a small group activity

MSMGF and JHU partnered with a local partner, GALZ, in Zimbabwe to pilot test the curriculum as a quality-control step in the curriculum development process. While the curriculum had already been verified for technical accuracy by the Technical Advisory Board of experts, other aspects of the training, such as teaching methods, relevance of content, course materials, timing, and flow of the training design were to be tested.

The primary aim of the pilot training were to assess the curriculum's effectiveness in increasing health-care providers' knowledge, attitude and clinical skill so that they can deliver quality care to gay men and other MSM in a legally constrained environment.

In the interest of safety and security, participants were referred and invited by their peers. 30 participants attended the training. Participants, a majority of whom were physicians, came from both public and private Zimbabwean health institutions, international NGOs, human rights organizations, and government bodies, including the AIDS and TB unit, which is the national HIV coordinating body of the country. Most participants lived and worked in Harare, but some traveled from Bulawayo and Victoria Falls to attend the training.

PILOT TRAINING DESIGN

Of the nine modules, five of the curriculum's nine modules were presented over two days, including:

1. Module 1: Understanding Gay Men and Other MSM.
2. Module 2: Sexuality and Health
3. Module 3: Barriers to Health
4. Module 4: Creating a Friendlier Environment
5. Module 6: Taking a Sexual History

The facilitators and GALZ staff tailored the training to fit the Zimbabwean context, focusing on aspects that were particularly relevant to the needs of the local community. The training was highly participatory and drew heavily from participants' own experiences to facilitate learning. Each module contained one or more activities to enhance participant engagement and generate discussion. Throughout the training, efforts were made to maintain a positive, respectful, and comfortable atmosphere to create a safe space for participants to explore both positive and negative issues related to gay men and other MSM. Interest in the topic was high and participants were comfortable having open discussions about highly-sensitive topics. In addition to the training participants, members of the local gay community were also invited to attend and share their own experiences as well.

TRAINING EVALUATION

Study design and Instruments

The training evaluation used a pre-test/post-test design using anonymous questionnaires to assess changes in participant knowledge of, comfort with, and attitudes toward MSM and MSM-related health issues, including barriers to care. Participants completed one questionnaire before the training and a similar questionnaire following the training's completion. Pre-test and post-test questionnaires were matched using numerical codes to allow for the anonymous assessment of intra-individual changes.

The 20-item pre-test questionnaire contained a series of multiple choice, true/false, and Likert-type or ordinal categorical questions drawn from the Pre-Post Assessments provided at the end of each module. These were used to collect data concerning provider clinical behaviors, comfort providing care to gay men and other MSM, and knowledge of MSM and MSM-related health issues. To assess provider attitudes toward homosexuality, several items were included from the Homosexuality Attitude Scale developed by Mary E. Kite and Day Deaux, which uses a series of Likert-type questions to assess stereotypes, misconceptions, and anxieties about homosexuals.[1] This scale has high internal consistency ($\alpha > 0.92$) and good test-retest reliability ($r = 0.71$).

The post-test questionnaire contained items identical to those on the pre-test questionnaire to assess provider behavior, knowledge, comfort, and attitudes, but included several additional items collecting demographic data such as participant age, current gender identity, sex assigned at birth, and self-identified sexual orientation. The post-test instrument also contained a series of items with space for participants to provide qualitative feedback of the training.

"I came to this workshop not too sure what to expect. The greatest thing I learned is acceptance, to know that people are different. As a healthcare practitioner, you don't choose your patients, but your patients choose you. Regardless of someone's sexual orientation, you are supposed to treat them according to the oath you take when you finish medical school. This was very empowering and I am thankful for that."

– Physician (Male) and Pilot Training Participant, Zimbabwe

Data Analysis

Participant knowledge of gay men and other MSM was represented by the number of knowledge-related items answered correctly on the pre-test and on the post-test. The change in participant knowledge over time was considered to be the difference between the post-test score and the pre-test score calculated for each individual. For each item that used a Likert-type or other ordinal categorical scale, each scale level was assigned a numerical value. Change over time for these items was assessed by taking the difference between the post-test response and the pre-test response. After exploration of the data, responses of "strongly agree" and "agree" were combined, as were responses for "strongly disagree" and "disagree."

To assess overall change over time in participant knowledge, the mean knowledge score was calculated for the pre-test and for the post-test separately. For Likert-type and ordinal categorical items, the proportion of participants who "strongly agreed/agreed" or "strongly disagreed/disagreed" were calculated for each time point. As these were paired data and normality assumptions were not met, scores were compared using non-parametric Wilcoxon signed-rank tests at a significance level of 0.05.

Results

Twenty-three participants completed the pre-test and 26 completed the post-test. Of these, 21 pre/post-test pairs were able to be matched. Nineteen participants answered all questions.

The mean score on knowledge items increased from 8.0 before the training to 9.8 after the training, a statistically significant increase of 1.8 points ($p<0.01$) (Table 1). In addition to showing increased knowledge, participants reported feeling more comfortable providing care to gay men and other MSM. The proportion who disagreed that a healthcare provider who morally objects to homosexuality cannot provide appropriate services to gay men and other MSM increased from 47% to 76% ($p=0.02$). A statistically significant increase from 31.6% on the pre-test to 81.0% on the post-test ($p=0.02$) was seen in the proportion of participants who reported being comfortable creating a welcoming environment for MSM. Additionally, the proportion of participants who reported being comfortable discussing anal sex with their clients increased by 25.1%, though this did not reach statistical significance.

"Before I came to this workshop, I have never actually met a member of the gay community. After attending this workshop, I came to understand the barriers that exist in my country to serve MSM. As an individual, I have also realized the steps I could take such being more sensitive to the needs of MSM."

Physician (Female) and Pilot Training Participant

Concerning attitudes toward homosexuality, the proportion of participants who disagreed that acceptance of homosexuality aids in the deterioration of morals increased from 28.6% to 76.2% ($p<0.01$) and the proportion who disagreed that homosexuals are more likely than heterosexuals to commit deviant sexual acts increased from 57.9% to 71.4%, but did not reach statistical significance.

Participant attitudes toward confidentiality and the need to form ties with LGBT organizations did not change significantly. The proportions of participants who agreed with on importance of these two items before the training were 95.2% and 94.7% respectively. After the training, both were 90.5% ($p>0.10$).

Item	Pre-Test	Post-Test	Change	p-value
Knowledge of MSM issues (mean score)	8.0	9.8	1.8	<0.01
Participants would feel comfortable discussing anal sex with clients	36.8%	61.9%	25.1%	0.1
Participants would feel comfortable providing friendly sexual health services to MSM	31.6%	81.0%	49.4%	0.02
Participants believe they are ethically obliged to maintain confidentiality regarding same-sex behavior, even where it is criminalized	95.2%	90.5%	4.7%	>0.1
Participants believe it is important to develop relationships with LGBT organizations	94.7%	90.5%	4.2%	>0.1
Participants disagree that homosexuals are more likely to commit deviant sexual acts than are heterosexuals	57.9%	71.4%	13.5%	>0.1
Participants disagree that acceptance of homosexuality aids in the deterioration of morals	28.6%	76.2%	47.6%	<0.01
Participants believe it is impossible for a provider who morally objects to homosexuality to provide appropriate services to gay men	52.6%	23.8%	28.8%	0.02

TABLE 1. Select results of pre- and post-training assessments

DISCUSSION

The aims of this pilot training were to 1) increase participant knowledge of MSM and MSM-related health issues, including barriers to care, 2) improve participant attitudes toward gay men and other MSM, and 3) improve participant skill and confidence in providing friendly and appropriate services to gay men and other MSM. Overall, the results of this evaluation show that each of these goals was achieved in relationship to the modules that were implemented.

Participants' overall knowledge of MSM and MSM-related health increased statistically significantly over the course of the training. At post-test, participants were more familiar with the unique health needs of gay men and other MSM, the primary causes of health issues for this population, and the barriers they face when accessing healthcare services. These participants are better prepared not only to care for gay men and other MSM in the clinical setting, but also to recognize and possibly work to address the significant barriers faced by gay men and other MSM when accessing healthcare more broadly.

Beyond being equipped with greater knowledge of gay men and other MSM and their unique health needs, participants displayed improved attitudes toward homosexuality and reported feeling substantially more comfortable providing care to MSM. Statistically significantly more participants recognized that as healthcare providers, they not only have the obligation to but are actually able to provide care to gay men and other MSM even if they as an individual carry personal moral objections to homosexuality. This increase in comfort levels, especially coupled with the reported attitudinal improvement, can help build healthcare providers who are capable of delivering ethical person-centered care. These providers become some of the most important players in the environment where gay men and other MSM navigate their healthcare needs. Beyond improving comfort and attitudes within the clinical setting,

FIGURE 2 Training facilitators (right) with members of the MSMGF/JHU team

however, changing attitudes toward homosexuality is critically important for reducing the stigma and discrimination experienced by gay men and other MSM in their everyday lives. Because healthcare providers are often respected members of their communities, these individuals can be quite influential in improving conditions for gay men and other MSM even outside of the healthcare setting.

Finally, of note is that the proportions of participants who understood the importance of confidentiality and building relationships with LGBT groups were high before the training and remained high after the training. Nearly all participants in the training recognized that their obligation lies with their client, even in settings where same-sex behavior is criminalized. As confidentiality is the cornerstone of provider-client relationships, especially when working with gay men and other MSM, this finding is particularly important. Similarly, community engagement and having links to LGBT groups as resources for both client and provider is important when working with gay men and other MSM. Finding that participants understand this importance is especially reassuring.

CURRICULUM MODIFICATIONS FOLLOWING PILOT TESTING

In addition to accomplishing the aims of the training, this pilot training provided the MSMGF/JHU team with valuable information that was fed back into the curriculum to improve it in several ways. Both small- and large-scale modifications were made to make the curriculum more user friendly for both trainer and participant, and to make the training materials more effective at enhancing overall learning. Following the pilot test, the structure of the curriculum was modified substantially. This was done by reordering topics, adding new material, or removing duplicative or unnecessary content within several individual modules, but also by modifying the overall order of modules. The final structure facilitates development of broad understandings of gay men and other MSM before covering specific aspects of and barriers to care for this population, before finally focusing on specific clinical skills and treatment recommendations.

The pilot training also informed other modifications, such as enhancing and expanding facilitator's notes, providing additional resources throughout, and revising the accompanying PowerPoint slides and handouts. Facilitator's tips were added throughout the curriculum to suggest teaching methods that are particularly effective, to point out topics that require additional stress or time to cover adequately, or to provide the facilitator with further guidance on how to effectively engage participants.

CONCLUSION

This pilot training showed that the MSMGF-JHU curriculum was effective in accomplishing its goals of improving participant knowledge, attitudes, and comfort with respect to gay men and other MSM. It showed that the content is appropriate for the intended audience and that the material is both relevant and necessary. However, a longer term evaluation follow-up is necessary to ensure that healthcare providers who were trained demonstrate their sensitivity and responsiveness to MSM health needs adequately as reflected in the quality of the care they deliver. Plans are currently underway to track the healthcare providers over the course of the year and to also gather survey data from their clients.

REFERENCES

1. Kite ME, Deaux D. Attitudes Toward Homosexuality: Assessment and Behavioral Consequences. *Basic and Applied Social Psychology* 1986; **7**(2): 137-62.

Technical Advisory Board

A team comprised of staff from MSMGF and JHU as well as expert consultants joined forces to conduct the necessary research and develop the curriculum's written content. This team was guided by a 15-member Technical Advisory Board whose names are listed here:

George Ayala (USA)
Chris Beyrer (USA)
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Martin Choo (Malaysia)
Rafael Mazin (USA)
Ken Mayer (USA)
Billy Pick (USA)
Kevin Rebe (South Africa)
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Eduard Sanders (Kenya)
Paul Semugoma (South Africa)
Igor Toskin (Switzerland)
Frits Van Griensven (Thailand)
Rodney Vanderwarker (USA)

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Many other individuals contributed directly or indirectly to the curriculum at various stages. These include our Bridging the Gaps partners in Latin America and Africa; former and current staff members, interns, and students at the MSMGF and JHU; Maria Phelan and Catherine Cook (Harm Reduction International); Liesl Messerschmidt (in leading the development of the evaluation tool); Keletso Makofane (for conducting a statistical analysis of results from the pilot training); Wayne Sy (for generating the facilitator's guidelines) and Clarence Yah (for assistance in early research and writing of the curriculum content).

Before You Begin Your Training

WHAT TO EXPECT

Working with adults

This curriculum is specifically made with an audience of adult healthcare providers in mind. As a facilitator, it is important to act in a manner that is appropriate for your audience. Adults are autonomous, capable, and self-directed learners and would like to be treated as such. Be sure to guide their learning instead of simply lecturing.

Talking about Gay men and other MSM

The nature of this curriculum expects you as the facilitator to be well prepared to talk about potentially sensitive topics such as sexual health, non-heterosexual identities, and specifically gay men and MSM health. It is important to suspend your pre-existing beliefs about gay men and other MSM to provide a neutral tone to facilitating discussion.

Dealing with hostility and emotions

Your audience may have varying types of reactions to the information that you present to them — which include anger, hostility, and other pronounced emotions. Appropriately pace your discussions to give your audience the space they need to unpack their emotions and existing beliefs. Be sure to establish ground rules so productive discussions do not turn into heated arguments.

A constantly evolving learning environment

Adapt your facilitation techniques to the different needs that may arise during your workshop. Because certain participants have different learning styles, you must tailor your technique to their needs. In addition, these needs may change throughout the training so be ready to modify your approach accordingly.

Logistical challenges

The learning environment is very important to the learning process. As such, it is important to make sure that your curriculum materials fit with the setting of your workshop. Unforeseen logistical challenges such as poor timing, unreadable visuals, or an uncomfortable room temperature may prove to be distracting to participants so it is your job as the facilitator to be vigilant and prepare things ahead of time so your workshop will begin and end smoothly and in a timely manner.

KNOW YOUR AUDIENCE

Next, you should know your audience. While it would be safe to assume that every participant is a health care provider —or at the very least, interested in the field of MSM healthcare — participants have unique backgrounds, belief systems, and needs over which you have no control. It is important that you take these factors into consideration.

The following list includes some important factors to consider:

- Gender
- Age
- Race
- Sexual Orientation
- Gender Identity
- Cultural/Ethnic background
- Educational attainment
- Region (e.g., which state/province; rural or urban; etc.)
- Religion and/or Spiritual practice
- Previous experience with and knowledge of gay men's and other MSM's health
- Attitudes toward MSM, gay men and sexual health issues
- Skill level in delivering healthcare to gay men and other MSM

Knowing these would paint a clearer picture of your target audience that would help you assess the potential needs of your participants. For example, cultural taboos pertaining to MSM may exist that would hinder discussion. Knowing these beforehand would help you prepare to frame certain topics more effectively.

In addition, knowing what your participants expect from the training may prove to be useful. Your participants may have different reasons for why they're attending. It is important to keep these in mind so that you can address each participant's expectations to the best extent possible.

REACHING YOUR AUDIENCE

Audience participation

Successful workshops hinge on your audience members actively participating in the discussion. It is your job as the facilitator to inspire discussion by providing a safe, comfortable, and stimulating environment for participants to share their thoughts. Be sure not to pressure anyone to speak or step into a role before they are ready!

Using humor

When discussing sensitive topics such as the ones presented in this curriculum, it might help to use humor as a tool to reduce stress. However, it should be used sparingly and appropriately without offending anyone in the group.

Fostering respect

Some participants may be more vocal about their opinions and beliefs than others. It is your job as the facilitator to respect the differing viewpoints from your audience so they do not feel discouraged from expressing a different opinion.

Inspiring introspection

According to adult learning theory, adults are motivated by information or tasks that they find meaningful. Encouraging your participants to relate the new information to their everyday lives will inspire critical thinking and expedite learning.

FACILITATOR'S CHECKLIST

Months before the workshop

- ☐ Reserve your room
- ☐ Think about what additional personnel support you'll need (e.g. someone to help you keep time)
- ☐ Make sure it's an adequate size for your expected audience
- ☐ Prepare ahead group and participatory activities
- ☐ Keep up-to-date with information about MSM and gay men, sexual health, and HIV especially from your region
- ☐ Research relevant local information by consulting with local community members and CBOs

The day before the workshop

- ☐ Have materials ready for your activities (i.e. paper, pens, etc.)
- ☐ Make sure slideshows and other visuals are finalized and readable
- ☐ Make a final tally of numbers so you have enough space for everyone
- ☐ Print our handouts and other necessary accompanying materials
- ☐ Visit the venue of the training to make sure things are in order

The day of the workshop

- ☐ Arrive early
- ☐ Adjust room temperature to a comfortable level, if possible
- ☐ Set up electronic devices for the workshop and make sure everything works!
- ☐ Greet every person as they come in
- ☐ Be an active listener
- ☐ Give simple instructions
- ☐ Keep track of time
- ☐ Encourage all participants to speak candidly
- ☐ Build an honest and authentic relationship with participants
- ☐ Remain neutral to participants' opinions

Utilizing guest speakers from the community

In order to contextualize your training so that it is relevant, it will be important to invite experts and leaders from the community to share their experiences and knowledge of local gay men and other MSM. These speakers will bring credibility in reflecting their on-the-ground expertise and will prove invaluable for your audience to hear.

COMMON FACILITATION TECHNIQUES

There are a tremendous amount of resources available on the internet and in the written literature about facilitation techniques. Here are some ideas for you to consider for your training:

Icebreakers

Learning about potentially sensitive topics such as gay men and other MSM health alongside unfamiliar faces could be uneasy for participants — some more than others. Incorporating icebreakers into your curriculum would ease the tension and encourage interaction among participants.

"Parking Lot"

It might be helpful to provide a space in front of the workroom to write interesting questions that come up during discussion that you may want to come back to later. This allows you to manage your time while managing the needs of your participants. If time absolutely does not permit discussion, provide resources so your participants could do additional research at home.

Allow your participants to provide feedback, instill empowerment, and respect for their autonomy. Adults are self-directed learners and it is your job as the facilitator to be flexible to your audience's needs.

Working in small groups

When dividing people into groups, encourage participants to work with people they haven't worked with before. If needed, randomly assign the groups yourself. After group work, be sure to have each group report back. Keep in mind that more groups (with fewer members in each one) will encourage participation from more people but reporting back will take more time.

Role-playing

Role-playing is often done in pairs but group role-playing may be possible. You may consider this technique when the group convenes for a longer training and there has been time to build trust. These scenarios are done all at the same time so the participants feel more at ease with their partner or group. The facilitator can check in with each pair or group to offer advice or to answer any questions. After the role-playing, be sure to ask them to report back to the class to discuss how the activity went.

Strategic breaks

Strategically place your breaks after topics that had heavy discussions. Participants may need some time to unpack and analyze all the new information on their own time. It might be a good idea to ask an open-ended question for participants to reflect on before going into a break. This way, the participants are still engaged and the time is used effectively.

Using multimedia

Incorporating different modes of presenting new information proves to be useful in facilitating learning. Be sure to include a mixture of still images, videos, audio, and live, interactive content in your presentation. Not only does this keep your audience from getting bored, but it will also help reinforce the material with the use of varied instructional methods.

Tools for Evaluating Your Training

Any training is only as valuable as the impact it creates. In this case, impact is best seen as an increase in the quality of and access to services. There are many aspects around a training that can be assessed for impact. We provide this series of evaluations and surveys so that implementing organizations may adapt and use as they deem appropriate and relevant for each context. Guidance and examples of tools are provided for the following:

A. **Learning Needs Assessment:** to better prepare for adaptation of the curriculum in your local communities

B. **Background Information:** to collect meaningful information about your audience

C. **Pre-Post Assessment:** to test for participant knowledge, attitude, and skills in various topic areas

D. **Post-workshop Evaluation:** Evaluate workshop processes and effectiveness such as overall satisfaction

E. **Follow-up Surveys**: Assess longer-term impact by targeting healthcare providers who were trained and their clients

The assessment tools may be used by implementing organizations as they deem necessary – in entirety, or by choosing those tools and questions that work best for them, or by modeling their own questions after the sample ones provided.

Monitoring so that the results and impact of the curriculum are not lost is important. We designed the assessment tools to help implementers determine whether or not – and how – the curriculum is creating an impact around various aspects of the provider-client relationship. They also provide information on effective processes and approaches, facilitation styles, and training logistics.

We designed these tools with flexibility in mind, so that implementing organizations would be able to best use them to capture a wide range of information on what is working and what is not, what is expected, what is needed, and what needs reinforced to strengthen healthcare delivery by providers as experienced by gay and other MSM clients. As such, in some of the tools, questions are suggested samples only (Learning Needs Assessment and Follow-up Surveys), built around different topics. Questions aim to address, depending on the tool, issues of knowledge and attitude, hopefully skill, and ultimately structural changes. We worded sample questions intentionally to capture the most information from particular respondents.

We provide brief instructions for both data collection, and analysis and application of findings, to help ensure the exercises are meaningful for implementing organizations in the absence of more rigorous statistical analysis.

A. LEARNING NEEDS ASSESSMENT

The Learning Needs Assessment is meant to help implementing organizations best adapt the curriculum to meet the needs of their target community, or target participants. Questions below are suggestions only. They are a combination of qualitative and quantitative questions that focus on *interest*, *prior exposure*, *expectation*, and *methodological opinion*, as well as (optional) a few *knowledge* and *attitude* questions. Conduct this assessment early during the training preparation period, targeting a half dozen or more providers/future training participants.

Depending on the findings, implementing organizations and facilitators will have a better sense of what current knowledge and practice is, and where the gaps are, as well as what future participants expect from the training. In this way, implementing organizations can better determine which modules of the curriculum to focus on during the training, and how best to deliver those modules to participants.

Data Collection: Approach healthcare providers who will be invited to attend the training, to avoid raising expectations among those who will *not* be invited. Introduce yourself to the healthcare provider, briefly explain the purpose of the assessment, and describe the curriculum and training. If the provider is willing to take 10 minutes to complete the assessment, provide them with a hard copy and a pen and return in 10-15 minutes. Assessments should be spontaneous and self-directed. Do not answer questions about the assessment questions, to avoid influencing the responses. Assessments are anonymous.

Analysis and Application of Findings: Assessment reviewers should be familiar with each of the curriculum modules. If responses to knowledge questions closely align with key messages from given modules, it may be possible to skip those modules during the training. If responses are incorrect and do *not* closely align with key messages from given modules, then those modules should be included in the training. For questions of training expectations including methodology, implementing organizations should consider the answers when adapting the curriculum for local presentation.

Interest

1. What information is important to you that you hope to learn more about? *Check all that apply.*
   - ☐ Sex, sexuality and sexual health
   - ☐ Mental health and general health promotion
   - ☐ Barriers to healthcare access by gay and other MSM
   - ☐ Creating a friendlier environment for gay and other MSM clients
   - ☐ Drugs and Alcohol
   - ☐ Interventions for HIV and STI Prevention
   - ☐ Clinical care for HIV and other STIs for gay and other MSM clients
   - ☐ Other ______________________________

Prior Exposure

2a. Have you ever attended a training on the unique healthcare and HIV needs of gay men and other MSM?

☐ Yes ☐ No

2b. If yes, describe when, who conducted it, and how many days the training was.

When: ________________________________

Training Organization: __________________

____

Number of Days: _______________________

Expectation

3. How will learning about the healthcare needs of gay men and other MSM be helpful to you as a provider?

____

____

____

4. How will learning about the healthcare needs of gay men and other MSM be helpful for your clients?

____

____

____

____

Methodological Opinion

5. What type of training materials do you prefer? *Check all that apply.*

   ☐ Books
   ☐ Handouts
   ☐ PowerPoint presentations
   ☐ Video, Audio
   ☐ Internet links
   ☐ Other ______________________

6. What training methods do you prefer? *Check all that apply.*

   ☐ Online/Internet reading
   ☐ Online/Internet group discussion
   ☐ Training workshop lecture style
   ☐ Highly participatory training workshop
   ☐ Discussion groups
   ☐ Peer training
   ☐ Direct interaction with gay and other MSM communities
   ☐ Other ______________________

____

Knowledge

7. All MSM identify as "gay."

   ☐ True ☐ False

8. Reparative therapy is useful to treat same-sex behaviors.

   ☐ True ☐ False

9. All gay men and other MSM engage in anal sex.

   ☐ True ☐ False

10. Do you conduct sexual histories with all your clients?

   ☐ Yes ☐ No

11. What is your obligation as a healthcare provider to serve gay and other MSM clients?

____

____

____

____

12. Do you currently offer HIV treatment as prevention services to your gay and other MSM clients?

   ☐ Yes ☐ No

13. What level of stigma and discrimination do you think gay men and other MSM face in your community?

   ☐ There is no stigma against MSM in my community
   ☐ There is little stigma against MSM
   ☐ There is a lot of stigma against MSM

14. How do you think the stigma relates to the ability of gay and other MSM clients to access services?

   ☐ It doesn't at all
   ☐ It makes it slightly more difficult to access services
   ☐ It makes it very difficult to access services
   ☐ It makes it impossible to access services
   ☐ Other ______________________

____

15. What 3 things can providers do to improve the healthcare experience of gay and other MSM clients?

   i. ______________________________
   ii. ______________________________
   iii. ______________________________

B. BACKGROUND INFORMATION

The background Information tool captures demographic, geographic, and training participant contact details.

Data Collection Instructions (Background Information): Provide all participants with hard copies of the background information questions. Please allow 5 minutes to complete, preferably on the morning before the training begins, or immediately following completion of the last training presentation.

1. What is your name? ______________________

____

2. Where do you work?

- ☐ Urban city or town
- ☐ Rural area or village

3. What would best describe your professional job position/title? *Check the one that best applies.*

- ☐ Physician
- ☐ Nurse
- ☐ Community worker
- ☐ Social worker
- ☐ Health educator
- ☐ Outreach worker
- ☐ Clinic administrator
- ☐ Lab technician
- ☐ Health researcher
- ☐ Other ______________________________

____

4. How old are you?

- ☐ 18–24 years
- ☐ 25–34 years
- ☐ 35–44 years
- ☐ 45–54 years
- ☐ 55–64 years
- ☐ 65 and over

5. What is your current gender?

- ☐ Male
- ☐ Female
- ☐ TransMale/Transman
- ☐ TransFemale/Transwoman
- ☐ Genderqueer
- ☐ Additional Category __________________

____

- ☐ Decline to state

6. Which best describes you?

- ☐ Gay/MSM
- ☐ Lesbian/WSW
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Other ______________________________

____

- ☐ Decline to state

7. Please provide your contact details below. These will be used for further communications from the training facilitators, and amongst your fellow participants. If you do not wish to be included in further communications, you may leave these blank.

Email ________________________________

____

Mailing Address __________________________

____

____

____

Phone Number __________________________

____

C. PRE-POST ASSESSMENT

At the conclusion of each module in the curriculum is an assessment to measure participant knowledge. Implement this too twice: (i) immediately before presenting a module, and (ii) immediately after. It is intentionally short and not meant to take more than 5-10 minutes to complete. Facilitators will need to have two copies of the assessments for each participant, one labeled "Pre" and one labeled "Post."

This assessment is an invaluable resource to learn whether the information presented, and the methodologies used, are having an impact on the *knowledge* and *attitude* of providers attending the training. Are participants learning new things from the training modules? Have they changed their attitude based on this knowledge? Responses can also alert facilitators to areas that remain unclear to participants, and that might need reinforcement and follow-up as time allows during the remainder of the training.

Data Collection Instructions: Provide all participants with hard copies of the Pre-assessment just before presenting on the module. Responses are anonymous. Allow 5-10 minutes maximum to respond to the questions, individually, then collect for review later in the day.

Following presentation of the module, distribute Post-assessments with the same questions to all participants. Responses are anonymous. Allow 5-10 minutes maximum to respond to the questions, and then collect for review later in the day.

Clearly label the assessments "pre" and "post."

Analysis and Application of Findings: When reviewing the assessment results later that day, note any differences between the pre- and post-assessments. Pay particular attention to both responses that changed, and responses that did not change. Did knowledge increase? Are there still gaps in understanding? Reviewing pre-post assessment responses on the same day is important to allow facilitators to make time during the remainder of the training to reinforce any messages or review any information that the assessment findings show to be insufficiently understood by participants.

See the end of each module in the curriculum for these assessments.

D. POST-WORKSHOP EVALUATION

This post-workshop evaluation tool will help determine whether the implementing organization and facilitator(s) met participant training expectations. It is an evaluation of *process* (presentation and content), not knowledge or skill. It is important if the implementing organization would like to gauge the effectiveness of the training methodology and facilitation, and the receptiveness of the content delivered. It is comparable to the Learning Needs Assessment.

Data Collection Instructions (Post-training Evaluation): Conduct the Post-training evaluation immediately after completing all final module presentation activities. Provide all participants with hard copies of the post-training evaluation tool. Allow 10 minutes to complete. Responses are confidential and must be answered privately by participants.

Analysis and Application of Findings (Post-training Evaluation): A brief report (1-2 pages) highlighting feedback should be provided to everyone involved in implementation of the curriculum training, and in particular the facilitator(s). Findings are important not only to gauge effectiveness of process and methodology for this training, but towards planning trainings in the future.

Presentation

1. How would you rate the training facilitation?
   - ☐ Very effective
   - ☐ Somewhat effective
   - ☐ Not effective

2. The facilitators were: (*Check all that apply.*)
   - ☐ Familiar with the content
   - ☐ Unfamiliar with the content
   - ☐ Able to encourage group participation
   - ☐ Discouraging of group participation and interaction
   - ☐ Able to convey information clearly
   - ☐ Unable to convey information clearly
   - ☐ Able to respond to questions effectively
   - ☐ Unable to respond to questions effectively
   - ☐ Comfortable with discussing sensitive information
   - ☐ Uncomfortable with discussing sensitive information
   - ☐ Able to establish rapport with the participants
   - ☐ Unable to establish rapport with the participants
   - ☐ Other ______________________________

   ____

3. What suggestions do you have for the facilitators/trainers to further improve their presentation?

   ____

   ____

   ____

   ____

4a. What did you think of the training venue?
   - ☐ Very good
   - ☐ Good
   - ☐ Not good

4b. What would have made a better training venue?

   ____

   ____

   ____

   ____

5. Describe the coordination and logistics, any problems you encountered, and suggest any improvements.

   ____

   ____

   ____

   ____

6a. How effective did you find the group activities?

- ☐ Extremely effective
- ☐ Somewhat effective
- ☐ Not effective

6b. How would you improve group activities?

____

____

____

____

7. What types of training materials were used, and how effective were they? *Check all that apply, and rate on a scale of 1–3 with 1 = extremely effective, 2 = somewhat effective, 3 = not effective.)*

- ☐ Books, rank: _____
- ☐ Handouts, rank: ____
- ☐ PowerPoint presentations, rank: _____
- ☐ Video, Audio, rank: _____
- ☐ Internet links, rank: _____
- ☐ Other ______________________________

____

Content

8. How would you improve the content of the training? (Would you change anything, and if yes, what?)

____

____

____

____

9a. What was the most important module of the curriculum covered? *Note that all Modules may not have been covered. Please check only one below from amongst those that were presented.*

- ☐ *1. Overview*
- ☐ 2. Sex, Sexuality and Sexual Health
- ☐ 3. Mental Health Promotion
- ☐ 4. Overcoming Barriers
- ☐ 5. Creating a Friendlier Environment
- ☐ 6. Health Implications of Sexual Practices
- ☐ 7. Assessing Health Status
- ☐ 8. General Health Promotion Strategies
- ☐ 9. Clinic*al Care for HIV and other* STIs

9b. Why was this module so important?

____

____

____

____

10a. Rate the information covered. *Note that not all of the below may have been covered. Check those that apply, and rank each on a scale of 1–3 with 1 = well covered, 2 = mentioned, 3 = not addressed.*

- ☐ Sex, sexuality and sexual health, rank: _____
- ☐ Mental health and general health promotion, rank: _____
- ☐ Overcoming barriers to healthcare access by gay and other MSM, rank: _____
- ☐ Creating a friendlier environment for gay and other MSM clients, rank: _____
- ☐ Health implications of sexual practices amongst gay and other MSM, rank: _____
- ☐ Assessing health status of gay and other MSM clients, rank: _____
- ☐ Clinical care for HIV and other STIs for gay and other MSM clients, rank: _____

10b. What topics do you wish had been covered in more detail?

____

____

____

____

11. How do you intend to apply what you have learned in your profession?

____

____

____

____

E. FOLLOW-UP SURVEYS

This MSMGF envisions that implementing organizations will want to conduct a series of surveys several months to a year following training on the curriculum. Follow-up surveys assess the level of information retention and application of knowledge learned as manifested by improved *attitude* and *skills*, changes to *clinical practice*, as well as introduction of other *structural changes*. These surveys may be implemented at 3, 6, 9, and/or 12 months following the training.

Questions below are suggestions, and for both clients and provider participants. Based on what information is desired, implementing organizations may adjust the questions. When formulating questions, those that begin with "helper" words will provide more information: what, when, where, why, how, who. Findings may highlight the need for further training and follow-up, and provide evidence of need when approaching a donor.

Data Collection Instructions for Surveys with Clients: Preferably, interview clients away from the clinical setting (at drop-in centers, safe houses, meeting places, etc.), though clinic-based exit-interviews may be appropriate in some settings. Ensure that respondents are clients of providers who attended the curriculum training, and that their confidentiality is guaranteed. Survey interviewers may choose to ask the questions and record responses, or provide hard copies for self-response. Allow 20 minutes to complete the survey.

Data Collection Instructions for Surveys with Providers/Participants: Preferably, interview provider participants at their clinical settings. This will allow the interviewer the opportunity also to observe the clinic setting and take notes on the environment, the level of privacy, the appropriateness of materials displayed, etc. Survey interviewers may choose to ask the questions and record responses, or provide hard copies for self-response. Allow 20-30 minutes to complete the survey.

Analysis and Application of Findings: A brief report (3-4 pages) highlighting key findings from the follow-up evaluation should be provided to everyone involved in implementation of the curriculum training. Findings are important to gauge retention of information, application at the clinic level in terms of changes in behavior and improved skills, and even whether structural changes within the clinical setting are being introduced. Compare findings with the objectives of the curriculum, and use them to identify areas for further follow-up and reinforcement of information with provider participants.

Clients:

1. During your most recent clinic visit, how were you asked about your gender on the intake form?

____

____

____

____

2a. During your most recent clinic visit, were you asked about your sexual history?

☐ Yes ☐ No

2b. If yes, who took your sexual history?

____

____

2c. Did the person taking your sexual history explain why they were asking questions about your sexual life?

☐ Yes ☐ No

2d. Did the person taking your sexual history ask about the genders of all your partners?

☐ Yes ☐ No

3. During your most recent clinic visit, was confidentiality guaranteed?

☐ Yes ☐ No

4. During your most recent clinic visit, did you feel you had privacy to talk freely?

☐ Yes ☐ No

5a. During your most recent clinic visit, did you feel respected by everyone in the clinic, from security to reception to nurse to doctor?

☐ Yes ☐ No

5b. if No, when did you *not* feel respected, and by whom?

____

____

6. During your most recent clinic visit, were there materials posted that represented sexual diversity?

☐ Yes
☐ No
☐ Didn't notice

7a. During your most recent clinic visit, did you notice any changes in provider behavior and attitude compared to the last visit?

☐ Yes ☐ No

7b. If yes, please describe, and indicate whether they are positive or negative changes:

____

____

____

____

8a. During your most recent clinic visit, were there any changes to the types of healthcare services offered compared to the last visit?

☐ Yes
☐ No
☐ Didn't notice

8b. If yes, what were the changes, and indicate whether they are positive or negative:

____

____

____

____

9. What further changes would you like to see at the clinic? Please describe in detail.

____

____

____

____

Provider Participants:

1. How did the curriculum training change your understanding of the experiences of gay men and other MSM who try to access healthcare and other services?

____

____

____

____

2. How did you apply what you learned from the training in your clinical practice?

____

____

____

____

3. What steps did you take to engage other healthcare professionals at your clinic in the health issues of gay men and other MSM? Which healthcare professionals?

____

____

____

____

4. The following is an example of an appropriate question for an MSM-friendly intake form: "Current relationship status: ___Single ___Married ___Separated ___Divorced ___Widowed."

   ☐ True ☐ False

5. How do you ask about gender on the client intake form?

   ____
   ____
   ____
   ____

6. Do you take a sexual history with every client?

   ☐ Yes ☐ No

7. Do you ask about the gender of all the sexual partners of a client when taking their sexual history?

   ☐ Yes ☐ No

8. How do you assure your clients that their responses to the sexual history are confidential?

   ____
   ____
   ____
   ____

9. Have you posted materials at your clinic that represent sexual diversity?

   ☐ Yes ☐ No

10. Do you have educational materials available that speak to issues of gay men and other MSM?

    ☐ Yes ☐ No

11. What new gay and MSM-client friendly clinical services, if any, have you introduced since the training?

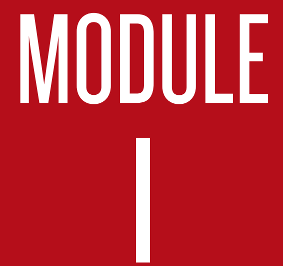
    ____
    ____
    ____
    ____

12. Following the training, what resources, if any, have you sought out to further your knowledge of the health needs of gay and other MSM clients?

    ____
    ____
    ____
    ____

13. What further changes would you like to see at your clinic? *Please describe in detail.*

    ____
    ____
    ____
    ____



Understanding Gay Men and Other MSM

LEARNING OBJECTIVES

After completing this module, participants will be able to:

1. Define the term men who have sex with men (MSM) and describe sexual practices common among gay men and other MSM.
2. Identify the unique health issues faced by gay men and other MSM.
3. Discuss the provider's role in addressing the health needs of gay men and other MSM in local settings.

INTRODUCTION

In nearly every country where reliable evidence exists, gay men and other MSM shoulder a disproportionate burden of HIV and other sexually transmitted infections (STI) when compared to other adults.[1] In low- and middle-income countries, gay men and other MSM are approximately 19 times more likely to be living with HIV when compared with the general population. In high-income countries, the situation is similar to worse, with HIV incidence among gay men and other MSM steadily increasing within certain sub-groups (e.g., young gay black men in the United States).

HIV and other STIs are not the only health issues faced by gay men and other MSM. Accruing evidence indicates that they present with a host of other unique health needs, require sensitive and targeted services to meet those needs, and face significant barriers when accessing life-saving healthcare services.[2] These barriers occur at multiple levels and result from widespread stigma and social discrimination experienced by gay men and other MSM in their daily lives.[3-6]

Homophobia is one of the main drivers of poor health outcomes among gay men and other MSM.[7] A large proportion of gay men and other MSM continue to lack basic prevention knowledge and avoid seeking primary or sexual healthcare altogether due to perceived homophobia or discomfort talking about their sexuality with their providers.[3]

Healthcare providers, as key actors in the health system, play a critical role in promoting the sexual health of gay men and other MSM. Knowledge among healthcare professionals on MSM-related health issues is, and remains, inadequately addressed by mainstream healthcare education and in HIV-related training curricula. This is especially true in low- and middle-income countries.

This overview Module 1 covers basic concepts and terminology to increase overall understanding of gay men and other MSM. It describes sexual practices common among gay men and other MSM, illustrates their unique health needs, and clarifies the oft-believed myths concerning homosexuality and closely related concepts. It raises the issue of provider roles and responsibilities by outlining principles of effective clinical practice to better prepare them to work with gay men and other MSM.

MODULE OVERVIEW

1. Who are MSM?
2. Evidence for male-to-male sex
3. Key terminology
4. Myths concerning homosexuality
5. Common sexual practices of gay men and other MSM
    - Penetrative anal sex
    - Other sexual practices
6. Relationships among gay men and other MSM
7. Unique health needs of gay men and other MSM
    - Higher rates of HIV and other STIs
    - Greater risk for developing mental health problems
    - Physical and sexual violence
8. Current global HIV and health trends among gay men and other MSM
9. MSM and the health system
10. Provider roles and responsibilities
11. Discussing sex with clients
12. Principles for effective clinical practice and engagement with gay men and other MSM
13. The importance of focusing on gay men and other MSM
14. Key points from the module

FACILITATOR'S TIP

This module provides a broad overview on health issues of concern to gay men and other MSM. It can be used as a stand-alone module if necessary.

Before starting the module, we recommend a set of exercises (e.g., ice-breakers) to introduce the trainers, participants, and others present, and develop rapport.

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 1 at:

http://www.huffingtonpost.com/2014/04/04/uganda-aids-group-gay-law_n_5092692.html.

QUESTIONS FOR DISCUSSION

1. In a case such as Uganda's, the law criminalizes not only same-sex behavior, but also threatens to undermine public health efforts by criminalizing healthcare workers for allegedly "promoting homosexuality". In such a situation, where does the healthcare provider's obligation lie, with the law or with the client?
2. In light of this article, what can healthcare providers do to ensure that their clients receive adequate care while also ensuring their own personal security? What role does client confidentiality play in this situation?
3. The program under question, the Makerere University Walter Reed Project, is funded by the United States government's PEPFAR program. What role do international funders play in ensure that the human rights of all individuals are respected, protected, and fulfilled?

FACILITATOR'S TIP

Ask the group the question: "What barriers might prevent gay men and other MSM from identifying themselves or discussing their sexuality in settings where you have worked before or where you currently practice?"

WHO ARE MSM?

Men who have sex with men and the corresponding acronym 'MSM' refer to all men who engage in sexual and/or romantic relations with other men, inclusive of the large variety of settings/contexts in which male-to-male sex takes place, across multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular 'community'. The term MSM in this document is used because of its inclusiveness, and because this behavior-based term is a lens through which to see HIV-related and other health and rights vulnerabilities. A broad spectrum of homosexual and homo-social acts, identities and communities form a continuum of sexual and gender self-expression. It is important to acknowledge and respect local terms used by men across diverse cultures and societies (e.g., gay, bisexual) through which men identify and affiliate in relation to their gender identity, sexuality and sexual practice. It is also important to recognize the importance and distinct needs of interlinked identities and populations, including HIV+ MSM, transgender people, sex workers, people who use drugs, and youth. Irrespective of identity, there can be common experiences of social exclusion, sexual otherness, marginalization, stigma, discrimination, and/or violence among MSM. Similarly, there can also be common experiences of support, affinity and community.

Not all MSM engage in sex exclusively with other men. Many MSM are married to women, have children, and continue to have sex with both men and women.

MSM also include gay and bisexual men and other MSM who:

- Do not identify as gay or bisexual
- Are male sex workers
- Are male-identified transgender individuals and have sex with other men
- Are heterosexually identified men but may engage in situational sex with other men (e.g., in prisons, boarding schools, military barracks)
- Identify across a range of culturally unique identities (e.g., *kothis* and *panthis* in India)

EVIDENCE FOR MALE-TO-MALE SEX

Researchers have attempted to measure the prevalence of male-to-male sex in the general population for a long time. A recent United States study indicates that while 3.8% of Americans surveyed identified as lesbian, gay, bisexual, or transgender (LGBT), 8.2% reported that they had engaged in same-sex behavior.[8] This variation signals the presence of both overt and covert sexual identities among MSM. A recent meta-analysis on lifetime prevalence of sex between men found similar estimated results based on a range of figures for MSM in East Asia, South and Southeast Asia, Eastern Europe, and Latin America, while other studies have verified the presence of MSM in Africa.[9-13] These statistics provide compelling evidence for the existence of same-sex behavior the world over, even in locations that deny the existence of gay men and other MSM. Furthermore, as MSM are not likely to admit their sexual behaviors to researchers, epidemiologists, or government officials out of fear of stigma or discrimination, these numbers are typically underestimates. This is truer in countries where same-sex behavior is highly stigmatized, socially rejected, and/or criminalized by law. As of 2013, 77 countries criminalize same-sex behavior, sometimes with harsh sentences.[14] This underscores the fact that gay men and other MSM can and do choose to remain invisible in the health system, thus making the provision of healthcare for gay men and other MSM challenging.

KEY TERMINOLOGY

In the healthcare setting, it is important to distinguish between sexual behavior, sexual orientation, and sexual identity as separate concepts. When talking to clients who may be gay men or other MSM, one should be familiar with these and other terms used in the clinical context.

» **Homosexual or same-sex sexual behavior:** Sexual acts between people of the same sex.

» **Sexual orientation**: An enduring emotional, romantic, or sexual attraction to another person of a different sex or gender, the same sex or gender, or to both sexes and more than one gender. The American Psychological Association states that people have "little or no choice about their sexual orientation."[15, 16]

» **Sexual identity**: The label people use to describe themselves in relationship to their sexuality. While a proportion of MSM may choose to identify sexually as gay or bisexual, some relate to other culturally unique identities, or remain identified as heterosexual while engaging in same-sex behaviors.[17]

» **Gender:** a social construct reinforced by attitudes, feelings, behaviors, (and clothing) associated with a person's sex assigned at birth.

» **Gender identity:** An individual's sense that they are male, female, or transgender.

» **Gender expression:** The way an individual communicates gender within a culture through clothing, communication patterns, interests, or other means. An individual's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not

reflect their gender identity.[18]

- **Transgender:** Literally, "across gender" or "beyond gender," transgender is a community-based term that describes a wide variety of cross-gender behaviors and identities. Transgender is not diagnostic, and does not imply a medical or psychological condition. Transgender individuals are those whose gender identities are not the same as the sex they were assigned at birth. "Trans" is sometimes used as another term for a variety of transgender identities, as is "trans people" or "transpeople." For more transgender-related terminology, visit the webpage: http://transhealth.ucsf.edu/trans?page=protocol-terminology.

Sexual behavior, sexual orientation, and sexual identity are three separate concepts that may or may not be related.

It is important to avoid making assumptions regarding clients' sexuality based on gender identity or expression.

MYTHS CONCERNING HOMOSEXUALITY

There are many misconceptions, myths, and stereotypes concerning gay men and other MSM.[18] These myths further marginalize and challenge these individuals' meaningful integration into society. It is helpful to get healthcare providers to think about their individual attitudes and misperceptions towards gay men and other MSM, and clarify myths using scientific evidence and facts.[18]

1. **Myth:** "Sex between men does not exist in my country or community."

   Fact: Gay men and other MSM exist in all cultures, societies, and geographic locations. Ignoring or criminalizing same-sex behavior does not mean the people who engage in them do not exist.[9]

2. **Myth:** "Homosexuality is a choice."

   Fact: Globally, scientists agree that sexual orientation is not a choice, but rather the result of a complex interaction of biological and environmental factors.[19, 20] To say that homosexuality is a choice implies that gay men and other MSM, or even heterosexual people, can change their sexual orientation at will. This is not accurate. Gay men and other MSM cannot change their sexual orientation at will. Homosexuality is a normal expression of human sexuality and any attempts to change or "cure" one's sexual orientation through so-called "reparative therapies" will both fail and cause harm including depression, anxiety, suicidality, and in some, a loss of sexual feeling altogether. Such attempts have been denounced by most authoritative medical bodies including the Institute of Medicine (IoM), the World Health Organization (WHO), and the American Medical Association (AMA).[21, 22]

3. **Myth:** "Homosexuality is a mental disorder."

   Fact: Homosexuality is not a mental disorder, neither is it abnormal.[23] The American Psychiatric Association Diagnostic and Statistical Manual (APA DSM) removed "homosexuality" as an illness over 40 years ago, in 1973. Many entities, both Western and non-Western alike, have followed suit.[24-28]

4. **Myth:** "Gay men and other MSM have pathological characteristics."

   Fact: Ideas that gay men and other MSM have characteristics such as pedophilia, or that they become homosexual because of traumatic childhoods or abuse, only serve to fuel prejudice. Scientific data show that homosexual orientation is not correlated with pedophilia, nor is homosexuality "caused" by traumatic events.[29,18]

5. **Myth:** "HIV is a gay disease."

   Fact: While it is true that HIV was first identified among gay men in the United States in 1981, it is inaccurate to assume that HIV is a "homosexual disease." HIV does not preferentially target any one group based on sexual orientation. In some regions of the world, such as sub-Saharan Africa, heterosexual sex acts account for the majority of new HIV infections.[7] Aside from sexual transmission, other modes of HIV transmission include vertical transmission from parent to child, blood transfusions, and transmission through shared needles during injection drug use.

GROUP ACTIVITY

Naming potential facilitators and barriers to healthcare access[18]

Objective: This activity aims to help participants name potential facilitators and barriers for gay men and other MSM while accessing healthcare with the use of direct quotes from the population. It also encourages participants to think about personal strategies that they can employ to overcome these barriers.

Main activity: Ask someone from the group to read aloud each of the following quotes. Alternatively, you may divide the larger group in half and have each smaller group discuss one of the questions below.

Quote #1: "Some of them don't treat us with respect. Sometimes, if you were having sex without a condom and maybe you get an STI, then you go to the clinic, the nurse will ask questions like: 'What was in here?' – she means in the anus. And that makes us afraid of going to the clinic to get treatment on time and that's why many gay men get sick."

Quote #2: "I once went to the clinic and there were two gay men at the clinic. Apparently, one of them had an STI. A nurse said to them that she wasn't expecting them to have the flu but an STI, because they sleep around and God is punishing them."

Questions for Discussion: Facilitate a conversation by asking for reactions to the two quotes, and by posing the following questions to see what answers the group(s) come up with. You can ask one or more participants to come forward and write down the group's ideas on a flipchart.

1. What aspects of a healthcare setting encourage gay men and other MSM to access care freely?
2. What aspects of a healthcare setting discourage gay men and other MSM from accessing care freely?
3. How can services in your healthcare setting be improved to support gay men and other MSM?

Summarize key findings: Provide a summary of the discussion generated by the group, pointing to strategies that are easy to implement versus those that require additional resources or buy-in.

COMMON SEXUAL PRACTICES OF GAY MEN AND OTHER MSM

Like heterosexual individuals, gay men and other MSM engage in a wide range of sexual activities.

FACILITATOR'S TIP

Based on the introduction to common sexual practices among gay men and other MSM, ask the group which sexual practices are also practiced by heterosexuals, and which practices are unique to gay men and other MSM.

Penetrative Anal Sex

A sexual act commonly associated with gay men and other MSM is penetrative anal sex, defined as a sexual act that involves the insertion of the penis into the anus.

When a man engages in penetrative anal sex with another man, he can take one of two roles: that of the "insertive" partner (commonly known as the *active* partner, or *top*), or that of the "receptive" partner (*passive* partner, or *bottom*). Some men may prefer only one of these roles, whereas others may engage in both roles (*versatile*).

Penetrative anal sex without condoms is not always risky, and is not the only sex in which gay men and other MSM engage. Gay men and other MSM practice a wide range of sexual activities, some of which may carry risk in specific circumstances.

Penetrative anal sex can be a highly pleasurable activity that may or may not carry additional health implications. For example, when two HIV-negative partners engage in unprotected anal intercourse, the risk for transmission of HIV is zero. This may change for individuals engaging in unprotected sex when the HIV or STI status of either partner is unknown, or when one of the partners is living with HIV and is viremic. While the consistent and correct use of condoms with condom-compatible lubricants can significantly reduce HIV and STI transmission in those instances, many gay men and other MSM acknowledge challenges to accessing these basic prevention technologies, and to using them effectively or consistently.

Note: It is nearly impossible for HIV transmission to occur when individuals living with HIV are on antiretroviral therapy (ART) and measure an undetectable viral load. Although research confirming the prevention potential of treatment was predominantly conducted among heterosexual couples, current emerging research conducted with gay men and other MSM suggests that the prevention potential is true for same-sex male couples as well.[30]

There are important anatomical and physiological considerations needed to understand sexual health in the context of penetrative anal sex. The structure and biology of the anus and rectum can render penetrative anal sex more vulnerable to the transfer of bodily fluids due to the following reasons:[18]

- There is no natural lubrication in the anus.
- The anus has limited elasticity.
- The colon and rectum have only a single layer of epithelial cells.
- Without lubrication, the anus and rectum may be susceptible to minor tears.

- Fecal matter containing bacteria may be present.
- There are many inflammatory cells (with CD4 receptors) under the surface in the rectum. Since HIV targets these cells, this makes infection with the virus more likely.

Other Sexual Practices

Beyond penetrative anal sex, there are wide varieties of sexual practices in which gay men and other MSM may engage. These include, but are not limited to:

- Kissing and hugging.
- Dry sex or rubbing, which involves rubbing bodies or body parts together using similar movements as penetrative sex but without penetration.
- Frottage, where two men rub their penises together.
- Masturbation (self and mutual).
- Oral sex (fellatio).
- Anal stimulation, either oral (analingus or "rimming") or digital. Digital can include fingering or fisting.
- Thigh sex, which involves inserting one's penis between the thighs of the partner.
- Using sex toys to stimulate the penis, anus, or other body parts.

GROUP ACTIVITY

Talking about sex anonymously[45]

Objective: This activity aims to help participants explore difficulties in discussing sexuality by having them express their own views about what sex is in a way that feels safe. It also encourages participants to think about why gay men and other MSM may be especially hesitant to discuss their sexuality with a provider.

Main Activity: Ask participants what comes to mind when they hear the word "sex." How does sex look or feel to them? Instruct them to write their thoughts down on a piece of paper. Encourage them to be as descriptive as they can. Tell them that these will be read anonymously. If certain participants are not comfortable, tell them that it is okay not to submit the paper.

Once they finish, instruct them to fold the paper for collection. Afterward, these entries may be read aloud by the facilitator or shuffled and handed back to participants to be read aloud anonymously.

Questions for Discussion: Once the comments have been read aloud, facilitate a discussion around the difficulties of speaking about sex with a provider using the following questions.

1. What was it like disclosing personal information like that?
2. How did anonymity affect your writing or thought process?
3. Given the heightened stigma and discrimination targeted against gay men and other MSM, how might talking about sex be especially difficult for them?

Summarize key findings: Provide a summary of the discussion generated by the group. Especially point out why gay men and other MSM may have difficulties in discussing their sexuality with a provider.

- Group sex with more than one partner simultaneously.
- Watersports or sexual acts that involve urine.
- Sexual role-playing and power exchange (e.g. bondage and discipline, dominance and submission).

RELATIONSHIPS AMONG GAY MEN AND OTHER MSM

As with heterosexual individuals, relationships among gay men and other MSM can take on many forms and change over time.[31] Some may choose a long-term monogamous relationship with only one primary partner, whereas others may be in open relationships with one or more primary partners and have multiple sexual partners. Some may choose to abstain from sex altogether.

Tips for Healthcare Providers:

- Do not assume that your client is monogamous or not-monogamous with their long-term partner or that all their sexual partners are involved emotionally or not.
- Maintain an open, non-judgmental attitude when discussing relationships and sexual partners.
- Listen to how the client describes their partner(s) and mirror their language. Some terms to describe a primary partner include "lover," "significant other," "partner," "life partner," "friend," "roommate," "husband," or "spouse" (even if not legally married). Terms like "lover," "sex partner," "trick," or "friend" may describe a casual or anonymous sexual partner. These terms will vary by context.
- If the client does not give any clues, the term "partner" is usually an acceptable way to start.

UNIQUE HEALTHCARE NEEDS OF GAY MEN AND OTHER MSM

Gay men and other MSM experience unique issues and health needs in addition to the basic health needs that everyone faces.[18] The following are health concerns that gay men and other MSM commonly present with:

Higher Rates of HIV and other STIs

Gay men and other MSM are, on average, more likely to be infected with HIV and STIs when compared to adults in the general adult population in nearly every nation where such data are available.[7] STIs are difficult to diagnose and treat, especially in resource-limited settings, and are a serious public health concern for gay men and other MSM. Infection with an STI increases susceptibility to HIV. The following table outlines some common STIs among gay men and other MSM:

INFECTION	HOW TRANSMITTED	SYMPTOMS
Chlamydia	Oral, anal, and vaginal sex	» Often asymptomatic » Discharge from the penis » Painful or frequent urination
Gonorrhea	Oral, anal, and vaginal sex	» Often asymptomatic » Discharge from the penis » Painful or frequent urination
Syphilis	» Oral, anal, and vaginal sex » Contact with sores	» Painless sore (chancre) » Flu-like symptoms » Damage to major body systems if untreated
Hepatitis A	Primarily through rimming (oral-anal contact)	» Weakness » Dark urine » Yellow skin and eyes » Enlarged liver
Hepatitis B	» Oral, anal, and vaginal sex » Injection drug use » Sharing injection equipment	» Weakness » Dark urine » Yellow skin and eyes » Enlarged liver » Can result in liver cancer
Hepatitis C	Primarily through blood-to-blood contact (i.e., shared needles)	» Often asymptomatic » Nausea » Fever » Loss of appetite » Dark urine » Abdominal pain » Enlarged liver » Yellow skin and eyes » Can result in liver failure or cancer
Herpes	» Oral, anal, and vaginal sex » Sometimes through intact skin with no sores	» Often asymptomatic » Painful blisters on genitals, anus or mouth that break into open sores
Human Papillomavirus (HPV)	» Anal and vaginal sex » Contact with infected skin	» Often asymptomatic » Some get genital warts (can also occur in and around the anus)

TABLE 1.1 STIs common among gay men and other MSM

Adapted from HIV Counselor Perspectives.[32]

The reasons for higher HIV and STI rates among gay men and other MSM have been linked to social discrimination and homophobia. There is a range of contextual factors that leave gay men and other MSM more vulnerable to HIV. These contextual factors are important for healthcare providers to understand so that they can deliver better care for their clients. Some are listed below:

1. *Cultural, religious, and political stigmatization:* Gay men and other MSM may delay or avoid seeking health- or HIV-related information, care, and services as a result of perceived homophobia within the healthcare system and community.[33] If an individual's disclosure of their sexual behavior results in harassment or outright rejection, this individual will be less likely to disclose information regarding their health or sexuality in the healthcare setting.[34]
2. *Poor availability of - or access to - condoms, condom-compatible lubricants, and other HIV-related prevention technologies:* In many settings, gay men and other MSM still do not have access to comprehensive HIV prevention services or even basic materials like condoms and condom-compatible lubricants.[34, 35] If condoms are used consistently and correctly, they are highly effective in preventing the sexual transmission of HIV and STIs. Condom-compatible lubricants should be used in order to decrease the chances of condom breakage.[36] However, in many settings, even where condoms are available, access to condom-compatible lubricants and other newer prevention technologies remains a problem.
3. *Unprotected anal sex with serodiscordant, viremic partner(s), or partner(s) of unknown HIV status:* There is no natural lubrication, and limited elasticity, in the anus, making tearing more likely and increasing the chance for acquiring HIV and STIs when engaging in unprotected receptive anal intercourse with a partner who is HIV positive and viremic, or whose serostatus is unknown. The colon and rectum have only a single layer of epithelial cells, and the fecal matter present there may contain harmful and opportunistic bacteria.[18]

There is no innate connection between homosexuality and psychopathology. Gay men and other MSM do not have a mental disorder.

Mental health and psychosocial factors: There is no innate association between homosexuality and psychopathology. Experiences of social discrimination, rejection, isolation, and marginalization can elevate the risk for mental health problems among gay men and other MSM.[37, 38] The resulting stress and other mental health challenges may lead to increased risk-taking behaviors and reduced health-seeking behaviors, which may result in increased rates of HIV and other STIs.[39]

Greater Risk for Developing Mental Health Problems

According to the United States Centers for Disease Control and Prevention (CDC), gay men and other MSM are at heightened risk for major depression, bipolar disorder, and generalized anxiety disorder, the

common basis of which is likely homophobia.[36] Sustained levels of stress as a result of homophobia can lead to co-morbid conditions among gay men and other MSM that typically occur in conjunction with other mental health problems.[40] The results of recent meta-analyses demonstrate that gay men and other MSM experience depression and anxiety and therefore cope by using alcohol and drugs at higher rates than non-MSM. Literature also suggests that gay men and other MSM are at a two-fold to four-fold greater risk for suicide attempts over their lifetime.[41]

Physical and Sexual Violence

Physical and sexual violence against men remains an ignored area within clinical science research and practice globally.[31] Many gay men and other MSM, especially those who are visible in their communities, are subject to harassment, physical violence, and rape.[42] Many men who have these experiences will not come forward to disclose and discuss them due to shame or fear, thereby missing opportunities for care.[18]

CURRENT GLOBAL HIV AND HEALTH TRENDS AMONG GAY MEN AND OTHER MSM

The epidemics of HIV among gay men and other MSM continue to expand globally across all regions. Although 93 of 196 countries had not reported on HIV prevalence in MSM in 2011, the incidence and prevalence of HIV among gay men and other MSM are almost always higher than in the general population. There are many reasons for this, many of which were discussed above. Some others include:

- Large social networks among gay men and other MSM.
- High probability of transmission per act during unprotected receptive anal intercourse.
- High levels of undiagnosed or untreated STI infections among gay men and other MSM.
- Poor adherence to ART, especially in low-income settings.[43]

The following figures are from Beyrer et al., from the *Lancet* article, “Global epidemiology of HIV infection in men who have sex with men.”[43]

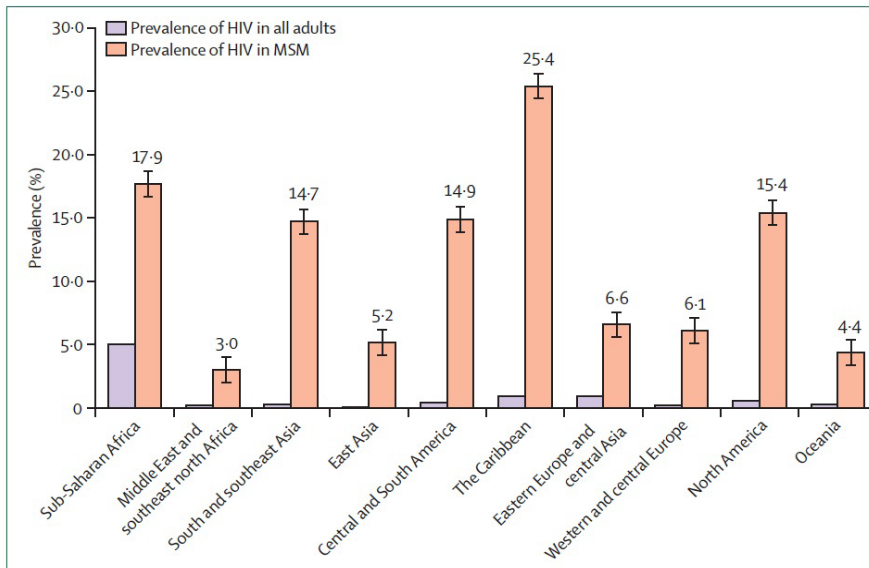


FIGURE 1.1 Global prevalence of HIV in MSM compared with regional adult prevalence reported by UNAIDS, 2010

Figure 1.1 shows aggregate HIV prevalence estimates in MSM by region derived from a comprehensive literature search. The pooled HIV prevalence ranged from a low of 3.0% in the Middle East and North Africa region to a high of 25.4% in the Caribbean. Notice that the prevalence of HIV among MSM as compared to all adults is significantly higher in every context included.

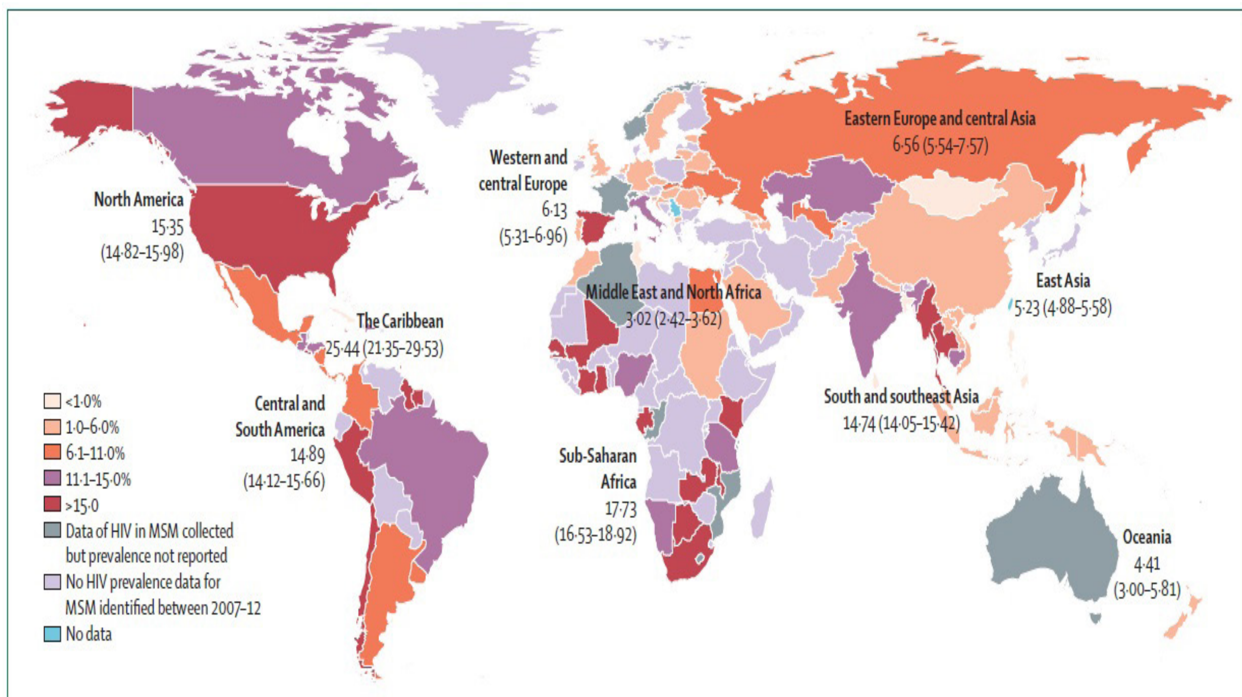


FIGURE 1.2 Global HIV prevalence in MSM, from studies published in 2007-2011

Data are prevalence (95% CIs)

Figure 1.2 shows HIV prevalence in MSM in countries where prevalence data were not available through peer-reviewed publications, behavioral surveillance reports, or UN General Assembly on Drugs (UNGASS) reports. Many countries, primarily in Africa and the Middle East, have no HIV prevalence data for MSM between 2007 and 2012.

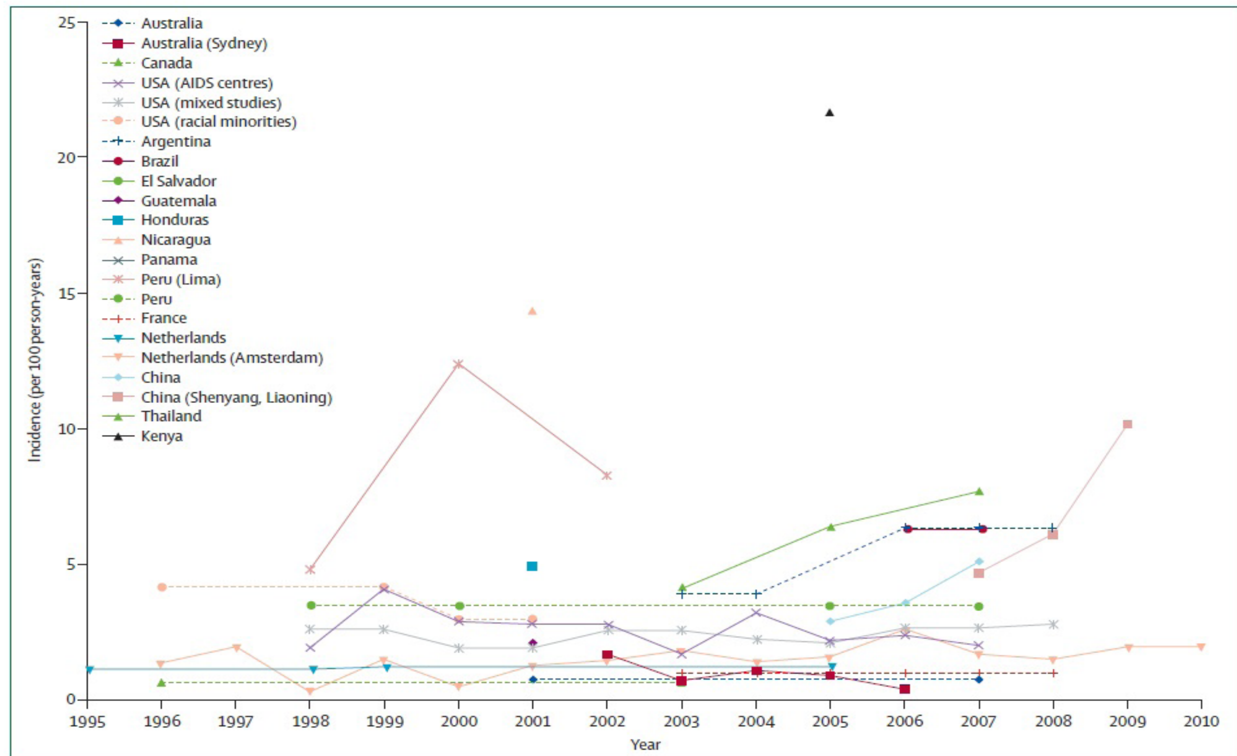


FIGURE 1.3 HIV incidences in MSM populations, 1995-2010.

In Figure 1.3, dashed lines represent cohort studies that report only total incidence over the study period. While authors were contacted for yearly incidence, these data were not provided or not available. The figure shows HIV incidence in MSM from 15 countries using data from 27 peer-reviewed publications. Notice that there is no evidence for decline of HIV incidence. Rather, the epidemic appears sustained at a constant level, with China and Thailand showing rising rates of HIV infection. Overall, incidence remains sustained at levels sufficient for epidemics in the MSM population to continue, and in some cases expand.

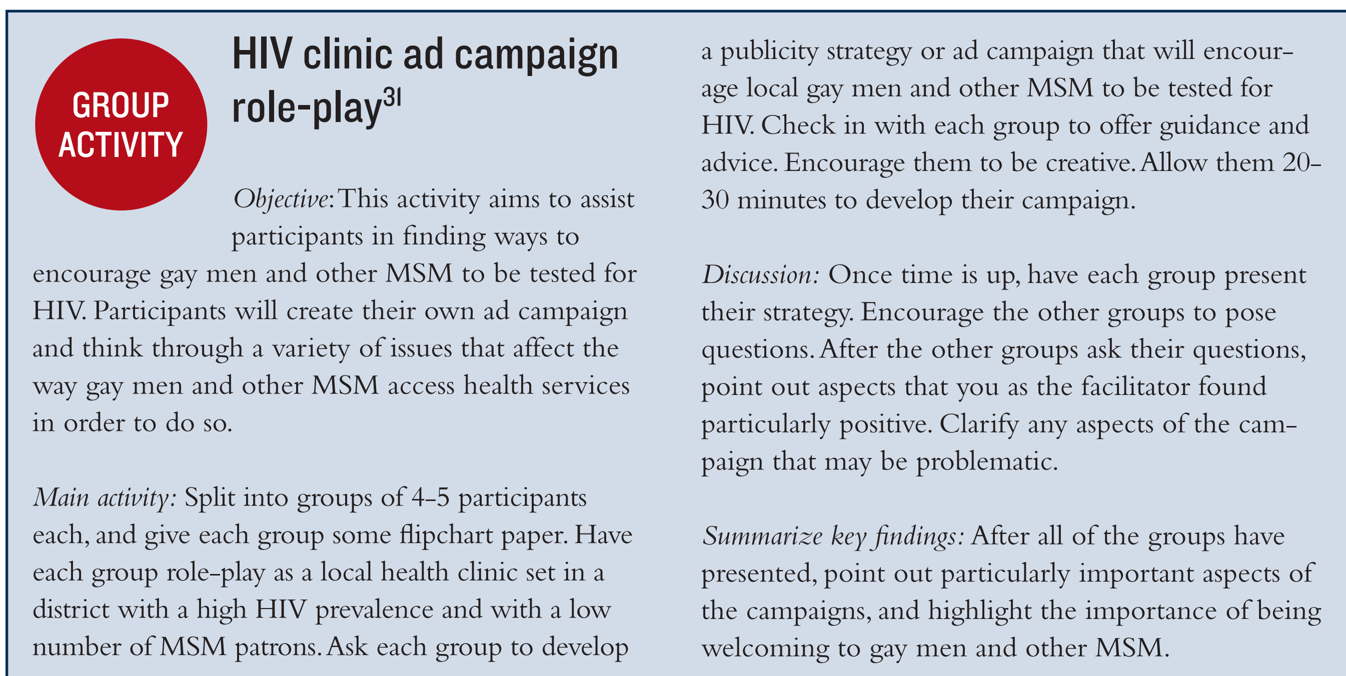
MSM AND THE HEALTH SYSTEM

Historically, gay men and other MSM have been underserved or ignored in healthcare delivery. This is due to a wide variety of individual, community, and structural factors that either cause gay men and other MSM to avoid seeking healthcare services, or cause a lack of access to healthcare services, thus making them invisible in the HIV epidemic and difficult to reach with information and services they may need. Homophobia in the healthcare setting can make it particularly difficult for gay men and other MSM to access vital care and support. The conceptual framework that

follows, developed by the Global Forum on MSM and HIV (MSMGF)[34], shows the interplay between these factors and the facilitators and barriers to healthcare seeking by gay men and other MSM. Healthcare providers can wholly or partially address many of the structural barriers in this framework with appropriate education and provision of unbiased services to address these barriers.

	Structural	Community/Interpersonal	Individual	
Facilitators	• Safe spaces • Comprehensive, tailored health & mental health services	• Stable relationships • Family support • Community engagement	• Financial resrouces • Sustainable work • Education	Sexual Health
Barriers	• Criminalization • Sexual prejudice • Discrimination • Cultural norms • Poverty • Insensitive/uniformed providers	• Extortion • Blackmail • Ridicule • Eviction • Job termination • Violence	• Fear • Poor self-worth • Depression • Suicide • Anxiety • Substance abuse • Delay/avoidance of services • Treatment interruption	
Critical Enablers	• Political will • Laws, policies and practices	• Mobilization • Organizational capacity • Provider sensitization • Education & training • Social connectivity	• Linkage to care and comprehensive services	Service Access

FIGURE I.4 Conceptual Framework of Facilitators, Barriers, and Critical Enablers for Service Access Among MSM



GROUP ACTIVITY

HIV clinic ad campaign role-play[31]

Objective: This activity aims to assist participants in finding ways to encourage gay men and other MSM to be tested for HIV. Participants will create their own ad campaign and think through a variety of issues that affect the way gay men and other MSM access health services in order to do so.

Main activity: Split into groups of 4–5 participants each, and give each group some flipchart paper. Have each group role-play as a local health clinic set in a district with a high HIV prevalence and with a low number of MSM patrons. Ask each group to develop a publicity strategy or ad campaign that will encourage local gay men and other MSM to be tested for HIV. Check in with each group to offer guidance and advice. Encourage them to be creative. Allow them 20–30 minutes to develop their campaign.

Discussion: Once time is up, have each group present their strategy. Encourage the other groups to pose questions. After the other groups ask their questions, point out aspects that you as the facilitator found particularly positive. Clarify any aspects of the campaign that may be problematic.

Summarize key findings: After all of the groups have presented, point out particularly important aspects of the campaigns, and highlight the importance of being welcoming to gay men and other MSM.

All healthcare providers carry the ethical responsibility to provide equitable care to gay men and other MSM regardless of their personal, moral, or religious beliefs.

PROVIDER ROLES AND RESPONSIBILITIES

According to the WHO, one primary objective of the health system is to provide high quality health services to all people when and where they need them. Primary care is often the first point of contact that gay men and other MSM have with the health system.[33] Some healthcare providers will serve gay men and other MSM who engage in behaviors that conflict with their personal, moral, or religious principles. Here, the role of providers must be clear with respect to their ethical imperative to provide care for *all* community members. Providers who object to providing care to gay men and other MSM because of their personal anti-homosexual beliefs can harm their clients' health, which is in direct opposition to their obligation to provide care without discrimination.[44] Like the majority of people, gay men and other MSM rely on their healthcare providers to understand their needs and deliver care in a sensitive, responsive, and non-judgmental manner.

A provider who delivers ethical, person-centered care becomes one of the most important players in the environment where gay men and other MSM navigate their healthcare needs. Clients must trust their provider in order to divulge sensitive information, and a provider with a stigmatizing attitude may actually harm their clients' health. By understanding the nature of their own attitudes and prejudices, providers may become better prepared not only to address barriers to care-seeking, but to encourage care-seeking behavior for all clients.

DISCUSSING SEX WITH CLIENTS

This introductory section aims to increase provider comfort talking about sex and sexual health in the clinical setting. Subsequent modules on clinical care cover this in more detail.

When taking the sexual history of a client, providers must try to get as much detail as possible to properly understand the sexual health implications of their client's sexual behaviors. It is common to ask about the number of sexual partners in a certain time period, but this does not provide sufficient information to properly support a client. Some other questions to consider, within a certain time period, include:

1. In what kind of sex did the client partake (e.g., oral, vaginal, anal)?
2. If it was anal sex, which role did the client take (e.g., insertive/top or receptive/bottom)?
3. Was this sex with a regular partner, a casual partner, or both?
4. If relevant and appropriate, did the client use condoms? How frequently? How about lubricants? What kind of lubricants?

FACILITATOR'S TIP

Ask the group how comfortable or uncomfortable they feel talking about sex with their clients, not necessarily just their gay or other MSM clients. Discuss with the group how they might (or do) talk about same-sex sexual behavior with gay men and other MSM who present to the clinical setting with their wife and/or family, stressing the importance of and need for confidentiality.

It may make providers feel very uncomfortable or embarrassed to ask about these practices, but by gaining more information about clients' sexual practices, providers will better understand their client's personal healthcare needs. Over time, this will feel more natural and any discomfort will subside.

Following are some important things to remember when communicating with clients:[31]

- Do not assume all clients are heterosexual.
- Do not assume sexual orientation, identity, or behavior and gender identity based on appearance.
- Listen to clients and the way they describe themselves and their partners.
- Ask clients what sexual identity terms they prefer, as asking usually does not offend.
- If you make a mistake, apologize and ask the client what they prefer. Most will appreciate the good intention.
- Following are a few general tips for conducting successful sexual history interviews with clients:
- Use professional, comfortable body language, gestures, tone of voice, and proximity to create a non-threatening environment to put your client at ease.
- Explain matters of confidentiality to the client.
- Reassure the client that it is acceptable to ask why questions are relevant.
- As appropriate, use open-ended questions to encourage the client to give in-depth descriptions, rather than questions that result in "yes" and "no" answers.
- Speak with language appropriate to the client's level of education that is not biased to age, gender, race, religion, sexual orientation, or culture.
- Ask the client to clarify any confusing answers.

PRINCIPLES FOR EFFECTIVE CLINICAL PRACTICE AND ENGAGEMENT WITH GAY MEN AND OTHER MSM

The following are a few basic principles to assist providers when engaging with gay men and other MSM for effective clinical practice:[33]

- Examine one's own ethical responsibilities towards gay men and other MSM, and adopt a non-judgmental attitude.
- Ensure confidentiality and anonymity with no compromise to the safety and health of gay men and other MSM.
- Strive for the most effective communication possible with gay men and other MSM to elicit a thorough social and sexual history in a respectful and compassionate manner.
- Pursue further education regarding the health needs of gay men and other MSM, and barriers to their care. Share knowledge gained with colleagues.
- Model leadership by being proactively involved in strategies to mitigate discrimination against gay men and other MSM in clinical settings.

THE IMPORTANCE OF FOCUSING ON GAY MEN AND OTHER MSM

Gay men and other MSM exist in all cultures and societies and encompass all races, ethnicities, religions, and social classes. Eliminating health disparities and enhancing efforts to improve health are necessary to ensure that gay men and other MSM can lead healthy lives.

Promoting health for gay men and other MSM requires specific attention from healthcare and public health professionals. In order to do this effectively, we must understand the history of oppression and discrimination that gay men and other MSM face, and work to address the social determinants affecting their health. The many benefits of addressing health concerns and reducing disparities include reductions in disease transmission and progression, improved mental and physical well-being, reduced healthcare costs, increased longevity, and an overall healthier and happier life for gay men and other MSM.

KEY POINTS FROM THE MODULE

- Gay men and other MSM exist in all cultures, societies, and geographies.
- The wide variety of myths that exist concerning gay men and other MSM only further fuel stigma and discrimination against them.
- Gay men and other MSM engage in a wide range of sexual practices beyond the often-stereotyped act of penetrative anal sex.
- Gay men and other MSM have unique health needs relating to HIV and STIs, mental health, and physical or sexual violence.
- The HIV epidemics among gay men and other MSM continue to expand across the globe for reasons relating to stigma, discrimination, and other barriers that create a lack of access to health services for this population.
- Stigma and discrimination within the healthcare system is a major barrier to gay men and other MSM receiving appropriate health services. Healthcare providers must not let their own personal beliefs interfere with providing services to their gay or other MSM clients.
- Taking the sexual history of all clients in an open, unassuming, and non-judgmental manner will help ensure optimal care provision for gay and other MSM clients.
- The many benefits of addressing health concerns and reducing disparities among gay and other MSM clients include improved mental and physical well-being, reduced healthcare costs, increased longevity, and an overall healthier and happier life.

PRE-POST ASSESSMENT

1. All men who have sex with men are gay.

   [ ] True [ ] False

2. ______________________ refers to the label that people use to describe themselves in terms of to whom they are romantically or sexually attracted.

3. Which of these is *not* true concerning gay men and other MSM?

   a. Gay men and other MSM exist in all cultures, societies, and geographic locations.

   b. Homosexuality is likely the result of the complex interaction of biological factors and environmental factors.

   c. HIV preferentially targets gay men and other MSM because of their sexual orientation.

   d. Many gay men and other MSM do not engage in anal sex.

4. It is possible and advisable to change one's sexual orientation from homosexual or bisexual to heterosexual through reparative therapy.

   [ ] True [ ] False

5. Which of these are factors that causes gay men and other MSM to be at higher risk for HIV than their non-MSM peers?

   a. Stigma and discrimination

   b. Criminalization of same-sex behaviors

   c. Gay men's homosexual sexual orientation

   d. Insensitive or uninformed providers

   e. Responses a, b, and d

   f. All of the above

6. Healthcare providers have an obligation to serve all clients regardless of whether their sexual behavior conflicts with the provider's personal beliefs or morals.

   [ ] True [ ] False

7. Which of these are benefits of placing importance on the health of gay men and other MSM?

   a. Reduced disease transmission and progression

   b. Improved physical and mental well-being

   c. Reduced healthcare costs

   d. Increased longevity

   e. All of the above

8. Which of these STIs produces painless sores (also called chancres), flu-like symptoms, and damage to major body systems if left untreated?

   a. Chlamydia

   b. Human papillomavirus (HPV)

   c. Syphilis

   d. Herpes

   e. Hepatitis B

9. Healthcare providers should assume the sexual orientation of their clients based on their appearance.

   [ ] True [ ] False

10. A provider who delivers ethical, person-centered care is one of the most important players in the environment where gay men and other MSM navigate their healthcare needs.

    [ ] True [ ] False

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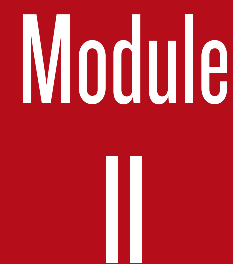


Sexuality and Health

LEARNING OBJECTIVES

After completing this module, participants will be able to:

1. Define basic concepts concerning male sexuality.
2. Describe the anatomy and physiology of male sex organs
3. Understand the importance of sexual health among gay men and other men who have sex with men (MSM).

INTRODUCTION

Sexuality is the way people express themselves sexually. Understanding sexuality helps us understand how important sexual expression is in a person's life, which in turn influences the partners they choose, the sexual acts in which they engage, and the level of satisfaction and pleasure they experience.

Scientific evidence confirms that same-sex behavior is a normal expression of human sexuality. Like all humans, gay men and other MSM express their sexuality in a range of both sexual and non-sexual ways that involve love, intimacy, relationships, romance, dating, courting, marriage, family, children and community.

To better serve gay men and other MSM in healthcare settings, this module provides information on same-sex sexuality. It also gives an anatomical overview of the male sexual and reproductive organs, and the sexual health needs of gay men and other MSM. Finally, it discusses the need for healthcare providers to serve their clients in a non-judgmental, compassionate, and respectful manner.

MODULE OVERVIEW

1. Key concepts
2. Male reproductive system
3. Sexual practices of gay men and other MSM
4. Normalizing anal sex
5. Sexual concurrency

6. Situational same-sex behavior
7. Gay men and other MSM in long-term relationships
8. Why talk about sexual health?
9. The larger context
10. Sexual and reproductive rights of gay men and other MSM
11. Key points from the module

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 2 at:

http://www.unaids.org/en/media/unaids/contentassets/documents/pressstatement/2014/02/20140228_PS_ZeroDiscrimination_en.pdf

FACILITATOR'S TIP

Engage in a meaningful discussion behind each of the sexual rights mentioned in the table above to understand their implications for the sexual health of gay men and other MSM. In order to save time, have participants pick two or three and discuss the health implications of having or not having those rights with another participant or in a small group, and then feed back to the larger group.

QUESTIONS FOR DISCUSSION

1. What is the significance of Zero Discrimination according to you? Does it apply to gay men and other MSM?
2. Do all your clients experience Zero Discrimination at your clinical setting? Why and why not?
3. What are steps can you take in order to ensure Zero Discrimination for all your clients, not just gay men and other MSM?

GROUP ACTIVITY

Perceptions of Sexual Health

Objective: This activity aims to help participants explore their perceptions of sexual health.

Main activity: Ask the participants what sexual health means to them personally. Write their responses on flipchart paper. Then, go through the definitions to identify anything missed. Some examples include:

- Healthy ways of having sex
- Healthy functioning of sexual organs
- Not having sexually transmitted infections (STIs)
- Knowledge and practice of safer sex
- Knowledge of sexual anatomy and function
- Experiencing sexual pleasure
- Mental peace about sex and sexuality
- Positive attitude about sexuality

Summarize key findings: Provide a summary of the discussion generated by the group surrounding perceptions of sexual health, highlighting how sexual health for gay men and other MSM is similar.

KEY CONCEPTS

The following table may provide an additional overview of concepts to consider when interacting with clients.

Sexuality	According to the World Health Organization (WHO), "A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is [therefore] experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors."[1]
Sexual Health	According to the WHO, sexual health is "A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[1]
Sexual Rights	Sexual health cannot be achieved or maintained without respect for – and the due protection of – universal human rights. The WHO identifies several critical rights in the realization of sexual health that are included in a working definition below.[2] The rights to equality and non-discrimination The right to be free from torture or cruel, inhumane, or degrading treatment or punishment The right to privacy The right to the highest attainable standard of health (including sexual health) and social security The right to marry and found a family with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage The right to decide the number and spacing of one's children The right to information and education The right to freedom of opinion and expression The right to an effective remedy for violations of fundamental rights The right to assembly, which is not included in this list, is also critical for gay men and other MSM to ensure equal treatment and integration into broader society.

TABLE 2.1 Key Concepts

MALE REPRODUCTIVE SYSTEM

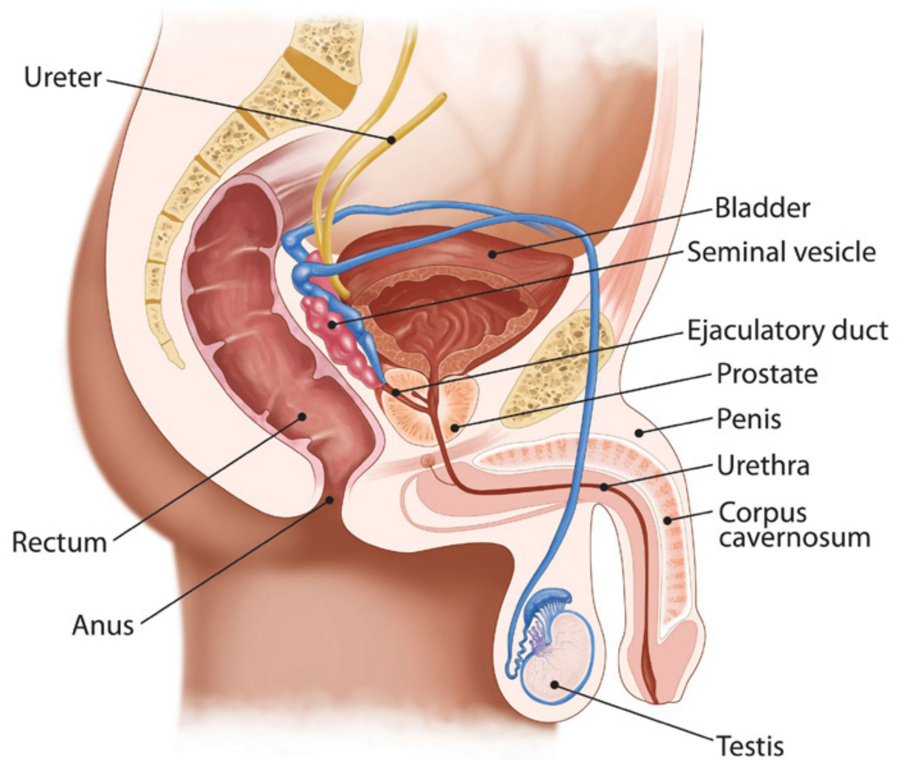
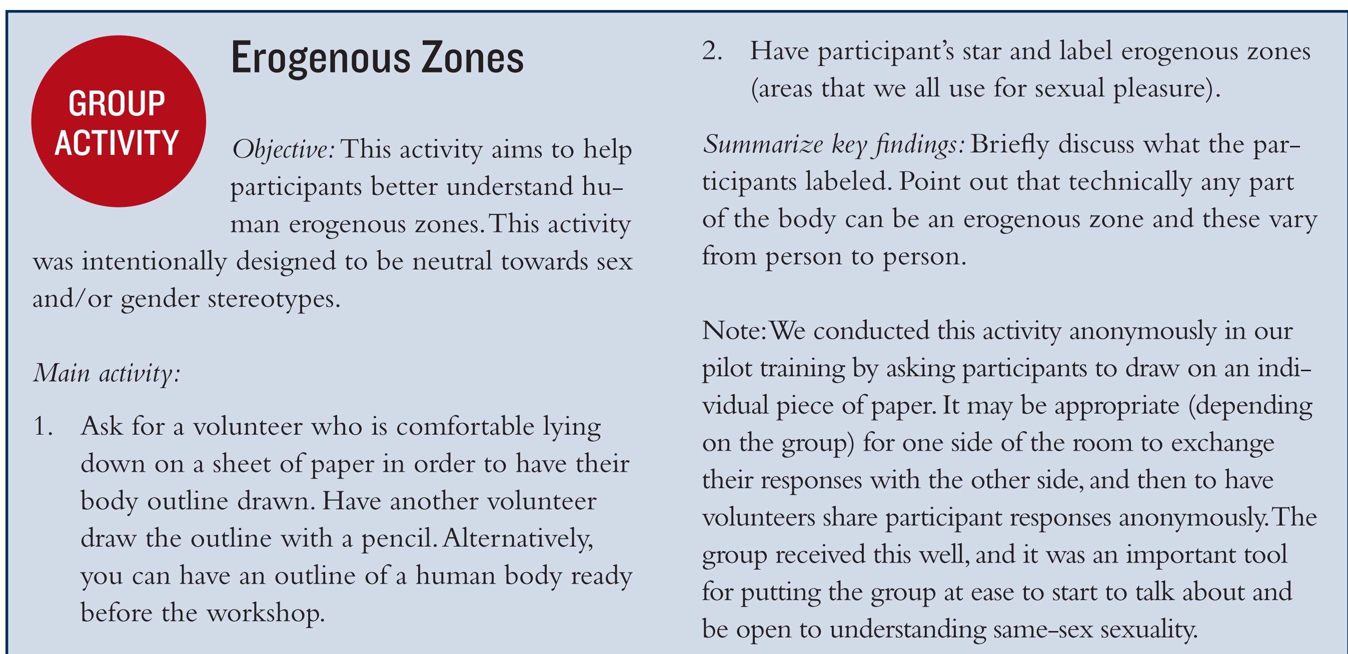


FIGURE 2.1 Human Reproductive Systems: Male Anatomy

MALE EXTERNAL SEX ANATOMY[3, 4]		
ORGAN	**DESCRIPTION**	**FUNCTION**
Penis/Glans Penis	» A man's reproductive and sex organ » Formed of three columns of spongy tissue that fill with blood during sexual excitement, causing an erection » Has a shaft and glans (head) that has many nerve endings and is very sensitive	» Passage of urine and sperm » Pleasure
Foreskin	» Retractable tube of skin that covers the glans » May be removed by circumcision either in infancy or later in life » Where the foreskin attaches to the underside of the penis is called the frenulum and a portion of it usually remains after circumcision	» Protection of the glans penis
Scrotum	» A sac of skin divided into two parts enclosing the internal reproductive organs – the testes	» May keep the testes at a slightly cooler temperature than the body, promoting sperm production » May also protect the testes from the contractions of abdominal muscles

MALE INTERNAL SEX ANATOMY		
Testes	» Two ball-like glands inside the scrotum, also called testicles » Sensitive to the touch	» Produce sperm and hormones, including testosterone
Cremaster	» Muscle that covers the testes » Automatically responds to temperature or stimulation of the front or inner surface of the thigh	» Raise or lower the testes to regulate their temperature
Epididymis	» Tightly coiled tube on top of and behind each testicle » Lead from each testicle to each vas deferens	» Stores sperm before ejaculation
Vas Deferens	» Long narrow tubes that connect each epididymis to each ejaculatory duct	» Transport mature sperm to the urethra during ejaculation
Prostate Gland	» Walnut or golf ball-sized gland at the base of the bladder » Sensitive to pressure and to the touch » The male "G-spot"	» Secretes a semi-alkaline fluid that constitutes a significant portion of semen
Cowper's Glands	» Pea-sized structures located on the sides of the urethra just below the prostate gland » Also called bulbourethral glands	» Produce a clear, slippery fluid that empties directly into the urethra (pre-ejaculate or pre-cum) » Lubricate the urethra and neutralize any acidity that may be present due to residual drops of urine in the urethra
Seminal Vesicles	» Pair of small tubular glands below the bladder	» Produce seminal fluid
Urethra	» Tube from the bladder through the penis to the outside of the body	» Carries urine, pre-ejaculate, and semen to the urethral opening

TABLE 2.2 Internal and External Male Anatomy



GROUP ACTIVITY

Erogenous Zones

Objective: This activity aims to help participants better understand human erogenous zones. This activity was intentionally designed to be neutral towards sex and/or gender stereotypes.

Main activity:

1. Ask for a volunteer who is comfortable lying down on a sheet of paper in order to have their body outline drawn. Have another volunteer draw the outline with a pencil. Alternatively, you can have an outline of a human body ready before the workshop.
2. Have participant's star and label erogenous zones (areas that we all use for sexual pleasure).

Summarize key findings: Briefly discuss what the participants labeled. Point out that technically any part of the body can be an erogenous zone and these vary from person to person.

Note: We conducted this activity anonymously in our pilot training by asking participants to draw on an individual piece of paper. It may be appropriate (depending on the group) for one side of the room to exchange their responses with the other side, and then to have volunteers share participant responses anonymously. The group received this well, and it was an important tool for putting the group at ease to start to talk about and be open to understanding same-sex sexuality.

SEXUAL PRACTICES OF GAY MEN AND OTHER MSM

Penetrative anal sex was covered in Module 1 (see page XX), along with brief descriptions of diverse sexual practices often applicable to heterosexuals also. The following table will help healthcare providers increase their understanding of how sexual practice is linked to sexual health. This has implications for non-judgmental and respectful sexual history taking, and for whom, how, and what health information is delivered.

Penetrative anal sex	Inserting one's penis into the partner's anus. Anal intercourse is a common sexual practice among gay men and other MSM. There is no HIV transmission risk associated with condomless anal sex with partners who are HIV negative and little or no transmission risk with HIV-infected partners on treatment (with an undetectable viral load). There is also little or no HIV transmission risk associated with the correct and consistent use of condoms with a condom-compatible lubricant.
Kissing and hugging	Mutual touching of lips, tongue, and sometimes the exchange of saliva. These are universal and safe practices. HIV is not transmitted through saliva so there is no risk. Some STIs, such as herpes, can potentially be transmitted through kissing and hugging alone, and do not require specific sexual behavior.
Dry sex or rubbing	Rubbing bodies or body parts together using similar movements as penetrative sex but without penetration.
Frottage	Rubbing body parts together for sexual excitement.
Masturbation (self / mutual)	Very common sexual activity, with some 98.5% of gay men reporting that they have masturbated within the last year.[5] Mutual masturbation, where one man masturbates another man, is a no-risk activity.
Oral-penile sex (fellatio)	Inserting one's penis into the partner's mouth. Very common sexual activity. HIV and some STIs can be transmitted through oral sex. The risk for HIV transmission is especially very low.
Oral-anal sex (rimming)	Stimulating the anus using one's tongue. Common practice among gay men and other MSM. Rimming cannot spread HIV, but there is risk for the spread of parasites as well as some STIs - especially hepatitis A - that can be spread by small quantities of fecal matter entering the performing partner's mouth.
Fingering or fisting	Stimulating the anus by rubbing or penetrating using one's finger or fist. Many men enjoy when their partner digitally stimulates the anus. Provided there are no cuts or bleeding, fingering is a no risk activity for HIV. Fisting poses a greater chance of tearing rectal tissue, but if proper measures are taken, it is not considered high risk.
Thigh sex	Inserting one's penis between the thighs of the partner to imitate penetrative intercourse.
Sex toys	Using sex toys to stimulate the penis, anus, or other body parts and erogenous zones. Many men enjoy using sexual toys for stimulation. These can be penile, anal, both, or be used for stimulation of other erogenous zones. Using sex toys individually poses no risk for the spread of HIV or STIs. When sharing sex toys they should be washed with soap and water after each use. Alternatively, using condoms on sex toys may prevent transmission of certain STIs like herpes.

Group sex	Group sex is sex with more than one partner in the same session. The individual acts involved pose the same risk for HIV and other STIs as they do one-on-one. Thus, the number of people involved alone does not increase risk or vulnerability.
Watersports	Sexual acts that involve urine. There is evidence that between 3-12% of men have engaged in sexual activities involving urine.[5] Because HIV is not present in urine, there is no risk for transmission involved in this activity.
BDSM/fantasy/role play	The acronym BDSM stands for "bondage and discipline, dominance and submission, sadism and masochism." It involves the full spectrum of mainstream sexual practices, but also includes elements of sexual role-playing, dominance, and power exchange. Fantasy and role-play also include acting out particular fantasies or characters during sex. These activities generally do not pose any risk for HIV or STIs but warrant a discussion about the health needs arising from specific sexual acts taking place in the broader context of BDSM.

TABLE 2.3 Sexual Practices of Gay Men and other MSM

Adapted from UNESCO Peer Education and Outreach for MSM[6]

NORMALIZING ANAL SEX

Some societies assert that only penile-vaginal sex is normal. Any other form of sexual activity, including anal sex, is regarded as "abnormal." Gay men and other MSM as well as heterosexual couples engage in anal intercourse. This appears to be true for almost all populations, age groups, and countries. Studies have reported more than 20% of heterosexuals in the Americas, across Sub-Saharan Africa, and elsewhere engage in anal intercourse.[7] In fact, there is evidence that the absolute number of heterosexual women who engage in unprotected anal intercourse is larger than the number of gay men and other MSM engaging in the practice.[8] For this reason, health providers should ask all clients about their sexual practices and not assume that only gay men or other MSM engage in anal intercourse.

Anal intercourse is not only a practice of gay men and other MSM. It is an almost ubiquitous practice across all populations, age groups, and countries.

SEXUAL CONCURRENCY

Sexual concurrency refers to the sexual pattern of having more than one sexual partner at the same time. Sexual concurrency is reported among gay men and other MSM just like it is reported among heterosexuals.[9, 10] Beyrer et al, when exploring concurrency in Malawi, Namibia, and Botswana, found that nearly 54 percent of MSM had both male and female sexual partners in the previous six months, and approximately 34 percent of men studied were married to women. Many gay men and other MSM get married or have female partners because of heteronormative societal expectations.

Sexual concurrency by itself does not pose health risks but can present health needs based on the nature of individual sexual practices.[11, 12] Providers must be prepared to respectfully assess the health implications of such concurrent partnerships by engaging in open, sex-positive, and non-judgmental discussions with their clients.

SITUATIONAL SAME-SEX BEHAVIOR

Men who live or work in environments such as the military, boarding schools, and mines, or men who are in prisons, may engage in sex with other men. Although situational, they raise the need for health information and access to prevention technology for men who find themselves in such circumstances.[13, 14]

GAY MEN AND OTHER MSM IN LONG-TERM RELATIONSHIPS

As with heterosexual relationships, condom use in established same-sex couples is low. Many of these relationships are monogamous relationships with known and concordant HIV status, limiting the need for condoms. As with both heterosexual and homosexual partners, some relationships are not monogamous or a partner's HIV status may be unknown. New HIV infections have been recorded in individuals who are in long-term stable relationships suggesting a mediatory role for healthcare providers to encourage their clients to talk about their sexual needs more openly and honestly with their partners. In some cases, couples may need to enter into negotiations to come to an agreement about what is acceptable and unacceptable with regards to engaging sex outside the relationship. In addition to mediating and leading open communication, the healthcare provider must address relationships and sexual health needs arising from those relationships in a respectful, compassionate and non-judgmental manner. It is important not to stigmatize the partner living with HIV and/or an STI but instead link them to care and facilitate access to treatment as appropriate. They may also benefit from other kinds of support such as referrals to couples counseling, community support groups, and sexual health education events.

Couples-based counseling and testing approaches for male couples may be an effective strategy to have open conversations about sexual health needs. This is also applicable to those men who are in stable relationships and can include facilitating a range of negotiations without coercion. Key issues that could come up are:[15, 16, 17]

1. Disclosure of one's HIV or STI status to one's partner or partners (or getting tested together)
2. Desire for and openness about relationships outside of the primary partnerships
3. Explicitly discussing the nature of open relationships and understanding corresponding health needs
4. Prioritizing the health goals for everyone involved at the individual level

WHY TALK ABOUT SEXUAL HEALTH?

HIV/AIDS was first identified among gay men and other MSM in North America, Western Europe, and Australia in the early 1980s. Despite the fact that globally the majority of new HIV infections are heterosexually transmitted, the initial reality shaped early responses to the epidemic, causing stigma associated with HIV and gay men and other MSM.[12] According to the United States Centers for Disease Control and Prevention (CDC), gay and bisexual men in the United States are more than 40 times as likely to contract HIV as are other men and women.[18] Outside of the United States, gay men and other MSM are more likely to be living with HIV when compared with adults within the general population in almost every context in which they have been studied. Recent evidence suggests that this is true not only in high-income countries but also in low- and middle-income countries in Africa, Asia, Latin America and the Caribbean, Eastern Europe, and Central Asia.[15, 19, 20] Many of the biological, social, structural, and behavioral factors that we have looked at to this point serve to put gay men and other MSM at increased risk of HIV infection.

In addition to HIV, gay men and other MSM are vulnerable to STIs. Particular infections include:[21]

- Syphilis: 64 percent of new cases are among MSM[22]
- Gonorrhea: 20-36 percent of new cases are among MSM[23, 24]
- Chlamydia
- Viral hepatitis A/B
- Herpes simplex virus (HSV)
- Human papillomavirus (HPV)
- Methicillin-resistant staphylococcus aureus (MRSA)

Many STIs, such as syphilis, gonorrhea, and herpes, are associated with increased risk for HIV infection. STIs like syphilis and herpes that cause ulcers or lesions on the genitals or rectum allow HIV to enter a person's bloodstream more easily. Because the immune system will send additional white blood cells - cells that HIV infects - to the area to fight the STI, the person becomes more vulnerable to HIV infection. Additionally, men who have HIV and who have gonorrhea often have higher concentrations of HIV in their semen than men who have HIV without gonorrhea, which may increase chances of HIV transmission on a per-act basis.[25]

Given HIV statistics among gay men and other MSM, placing more importance on the health needs of this population is essential. The needs of gay men and other MSM must not be discussed in the context of HIV solely, however. Some experts believe that gay men and other MSM are tired of hearing the same messages regarding condom use and HIV, and that the very fact that the gay and MSM community is so closely tied to the disease may be part of the problem.[25]

As stated earlier, sexual health is:

> "…A state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled."

This definition suggests the need for positive and respectful approaches to sexual health among gay men and other MSM that consider not only the physical illnesses of HIV and STIs, but also broader concerns around intimacy, relationships, and sexual pleasure.[26]

THE LARGER CONTEXT

Gay men and other MSM do not face sexual health issues solely because of behavioral factors. The social determinants of health, namely social, political, economic, and healthcare factors, greatly influence health inequities. Negative attitudes about homosexuality can and do harm gay and other MSM's health. Ilan Meyer describes four interrelated stress processes, termed "minority stress" that gay men and other MSM experience because of homophobia:[27]

1. Concrete experiences of discrimination based on sexual orientation
2. The stress of expecting such events to occur, thus creating anxiety
3. Concealment of one's sexual orientation and the constant fear of discovery and discrimination
4. Internalizing (or starting to believe oneself) the negative social messages about gay people, known as internalized homophobia

Internalized homophobia often compounds and interacts with other areas of an individual's life where gay men and other MSM experience discrimination. Depending on the country in which they live, stigma and discriminatory consequences of racism, economic inequities, and belonging to a sexual minority can interact in unique ways to result in negative health outcomes. All of these factors combine to create a set of problems that occur together and amplify each other. Some researchers are now calling for studies that focus on the resilience of gay men and other MSM, rather than just focusing on their deficits.[28, 29]

It is clear that there is need for new approaches to addressing the sexual health of gay men and other MSM. These approaches must emphasize the impact of homophobia and other determinants of health on the well-being of gay men and other MSM, and focus on achieving and enjoying sexual health as part of a fulfilling life.[25] There are emerging

community-based approaches to HIV prevention that address anti-gay stigma such as sexual orientation-affirming school-based interventions, social marketing campaigns to promote family acceptance, and interventions to promote community connectedness and involvement. All of these campaigns serve to address anti-gay stigma to lead to better all-around health.[30]

SEXUAL AND REPRODUCTIVE RIGHTS OF GAY MEN AND OTHER MSM

Having access to the highest attainable standard of health is a human right, yet the needs of gay men and other MSM are often neglected in discussions about sexual health programs and services through silence, denial, or outright exclusion. Globally, many gay men and other MSM are victims of wide-spread and ongoing human rights abuses.[31] Dozens of countries continue to criminalize same-sex behavior between consenting adults even though this violates protections against discrimination in the International Covenant on Civil and Political Rights. As such, direct and respectful engagement with gay men and other MSM, and their broad acceptance by society and actors within the health system, forms the basis for designing robust programmatic and policy responses that are appropriate, relevant, and sensitive.

KEY POINTS FROM THE MODULE

- Sexuality, including same-sex behavior within a proportion of the population, is natural to being human.
- Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality. It is not merely the absence of disease, dysfunction, or infirmity.
- Sexual identity, attraction, behavior, gender, gender identity, and gender expression are fluid concepts that do not always align with each other and may change over time.
- Gay men and other MSM engage in a wide range of sexual activities. Not all engage in anal sex.
- Like heterosexual people, many gay men and other MSM have sexually concurrent partnerships with more than one individual.
- Not all gay men and other MSM have sex exclusively with men. Some also have sex with women.
- Gay men and other MSM do not face sexual health issues solely because of behavioral factors. The social determinants of health also greatly influence health inequities.
- Understanding the factors that may undermine the sexual and reproductive health of gay men and other MSM forms the basis for designing robust programmatic and policy responses that are respectful, appropriate, relevant, and sensitive.

PRE-POST ASSESSMENT

1. ______________________ describes the characteristics that a society or culture delineates as masculine or feminine at a particular place and time.

2. Which of these are components of sexual orientation?

   1. Sexual attraction 2. Sexual behavior
   3. Gender identity 4. Sexual identity

   a. All of the above

   b. 1 and 2 only

   c. 1, 2, and 4 only

   d. 3 and 4 only

3. Receptive anal sex is pleasurable for gay men and other MSM because of stimulation of the:

   a. Cowper's gland

   b. Prostate gland

   c. Bartholin's gland

   d. Skene's gland

4. It is safe to assume that those men who express gender in heteronormative ways are not gay men or other MSM?

   [ ] True [ ] False

5. Healthcare providers must be prepared to play a mediatory role in helping couples talk about their sexual health needs open and honestly.

   [ ] True [ ] False

6. Many times, gay men and other MSM will marry women and have children due to social pressures from the society in which they live.

   [ ] True [ ] False

7. Same-sex behavior and penetrative anal sex between men are normal aspects of human sexuality.

   [ ] True [ ] False

8. Gay men and other MSM are more likely to be living with HIV and other STIs solely because of behavioral factors.

   [ ] True [ ] False

9. ______________________ are the application of existing human rights to sexuality and sexual health.

   They must be respected and protected in order for sexual health to be fulfilled.

10. The primary difference between men with different sexual orientations is whom they are attracted.

    Otherwise, men with differing sexual orientations can be considered the same.

    [ ] True [ ] False

ADDITIONAL RESOURCES

For more on Sex, Gender, and Sexuality, please see:

It's Pronounced Metrosexual, http://itspronouncedmetrosexual.com/

Planned Parenthood Federation of America, http://www.plannedparenthood.org/

For more on intersex conditions, please see:

The Intersex Society of North America, http://www.isna.org/

Dreger, A. D. Hermaphrodites and the Medical Invention of Sex. Boston: First Harvard University Press. 1998.

For more on anatomy and sexual practices of gay men and other MSM, please see:

Wolfe, D. Men Like Us: The GMHC Complete Guide to Gay Men's Sexual, Physical, and Emotional Well-Being. Ballantine Books. 2000.

ACON Health, http://www.acon.org.au/mens-health/sex-and-sexual-wellbeing/What-Sex-Do-Gay-Men-Have

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Barriers to Health

LEARNING OBJECTIVES

After completing this module, participants will be able to:

1. Identify barriers, facilitators, and critical enablers that impact access to and utilization of healthcare services.
2. Describe how stigma undermines the health of gay men and other men who have sex with men (MSM).
3. Identify the advocacy role of providers in mitigating barriers to healthcare access.

INTRODUCTION

Gay men and other MSM experience social discrimination targeted against them in many ways, precluding them from accessing necessary healthcare services. While some of these barriers and experiences are within the health system, other factors such as laws concerning homosexuality, or the lack of proper legal recourse in the case of human rights abuses, impede the ability of gay men and other MSM to talk about their sexuality or health issues with their healthcare providers.

It is important for providers to be equipped with knowledge concerning the social context in which gay men and other MSM navigate their healthcare needs so that they can create a safe and welcoming environment within their respective healthcare settings. Structural barriers have the potential to exacerbate vulnerability and therefore can increase high-risk behaviors and HIV and STI transmission among gay men and other MSM.

This module is designed to increase provider understanding of the well-known barriers faced by gay men and other MSM, and how they may negatively affect health outcomes.

MODULE OVERVIEW

1. Conceptual Framework: Facilitators, barriers, and critical enablers to service access
   - » Structural-level factors
   - » Community and interpersonal-level factors
   - » Individual-level factor

2. What are the stigma and discrimination?
    - Stigma
    - DiscriminationIndividual-level factor
    - Homophobia
3. Stigma within the gay community
4. HIV-related stigma
5. Link between social discrimination and health
    - Criminalization and HIV prevention
    - Internalized homophobia and sexual health
    - Mental health
    - Homophobia and the health system
6. The role of health professionals in advocacy on behalf of gay men and other MSM
7. Key points from the module

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 3 at:

http://globalvoicesonline.org/2011/10/27/
hong-kong-sexual-orientation-conversion-advocated-by-government/.

QUESTIONS FOR DISCUSSION

1. Is sexual conversion therapy an appropriate intervention for gay men and other MSM? Why? Why not?
2. Are there instances or examples that you can think of where government law and policy may render harm to gay men and other MSM in your country?
3. What are some of your guiding principles that help providers deliver competent and high-quality care regardless of a client's sexual identity and behavior or gender expression?

CONCEPTUAL FRAMEWORK: FACILITATORS, BARRIERS, AND CRITICAL ENABLERS TO SERVICE ACCESS

There are many ways to understand social discrimination targeted against gay men and other MSM. In this module, we will refer to a Conceptual Framework (below) developed by the Global Forum on MSM and HIV (MSMGF) based on major findings from the 2012 Global Men's Health and Rights Study (GMHR).[1] This framework demonstrates the strong

	Structural	Community/Interpersonal	Individual	
Facilitators	• Safe spaces • Comprehensive, tailored health & mental health services	• Stable relationships • Family support • Community engagement	• Financial resrouces • Sustainable work • Education	Sexual Health
Barriers	• Criminalization • Sexual prejudice • Discrimination • Cultural norms • Poverty • Insensitive/uniformed providers	• Extortion • Blackmail • Ridicule • Eviction • Job termination • Violence	• Fear • Poor self-worth • Depression • Suicide • Anxiety • Substance abuse • Delay/avoidance of services • Treatment interruption	
Critical Enablers	• Political will • Laws, policies and practices	• Mobilization • Organizational capacity • Provider sensitization • Education & training • Social connectivity	• Linkage to care and comprehensive services	Service Access

FIGURE 3.1 Conceptual Framework of Facilitators, Barriers, and Critical Enablers for Service Access Among MSM

relationships between structural-level, community and interpersonal-level, and individual-level factors that influence how gay men and other MSM access health services. This includes both HIV services specifically and sexual health services more broadly. We will begin by discussing higher-level structural barriers and facilitators to accessing health services before moving to community/interpersonal-level factors, and finally factors at the individual-level. Evidence for Male-to-male Sex

Researchers have attempted to measure the prevalence of male-to-male sex in the general population for a long time. A recent United States study indicates that while 3.8% of Americans surveyed identified as lesbian, gay, bisexual, or transgender (LGBT), 8.2% reported that they had engaged in same-sex behavior.[8] This variation signals the presence of both overt and covert sexual identities among MSM. A recent meta-analysis on lifetime prevalence of sex between men found similar estimated results based on a range of figures for MSM in East Asia, South and Southeast Asia, Eastern Europe, and Latin America, while other studies have verified the presence of MSM in Africa.[9-13] These statistics provide compelling evidence for the existence of same-sex behavior the world over, even in locations that deny the existence of gay men and other MSM. Furthermore, as MSM are not likely to admit their sexual behaviors to researchers, epidemiologists, or government officials out of fear of stigma or discrimination, these numbers are typically underestimates. This is truer in countries where same-sex behavior is highly stigmatized, socially rejected, and/or criminalized by law. As of 2013, 77 countries criminalize same-sex behavior, sometimes with harsh sentences.[14] This underscores the fact that gay men and other MSM can and do choose to remain invisible in the health system, thus making the provision of healthcare for gay men and other MSM challenging.

Structural-level Factors

Structural determinants of health include the social, economic, organizational, political, and legal factors that contribute to the access or utilization of healthcare services or to social inequities.[2,3] Higher-order structural factors play a significant role in determining access by gay men and other MSM to healthcare services.[1,4,5] These structural barriers are outlined in Table 4.1 below.

Homophobia	A barrier to accessing health services in many settings.[1,6] It plays a significant role by making healthcare services inappropriate or inaccessible for gay men and other MSM, and impedes the response to HIV and AIDS.
Social norms	Cultural norms that predominantly align with heteronormative attitudes may also serve to cement homophobia in various social and healthcare settings. The pressure felt by gay men and other MSM to acquiesce to traditional social norms may lead them to get married, have a girlfriend, or pretend to have a girlfriend in order to hide sexual behavior and maintain social standing.[1] This need to hide real identity may have a negative impact on health and the perceived freedom to readily seek or receive the services needed.
Provider stigma and insensitivity	Healthcare providers who are unfamiliar with issues of concern to gay men and other MSM may express stigma against this population.[1] Many gay men and other MSM would rather avoid the healthcare system than be treated poorly by providers.
Poverty	Poverty is a barrier to accessing healthcare services by everyone, not only gay men and other MSM. Those who are poor may not have the resources to access services. Gay men and other MSM often feel the need to hide their sexual behavior from employers, landlords, teachers, and family members in order to maintain their livelihoods.[1] This may lead gay men and other MSM to hide their sexual behaviors from healthcare providers for fear of being exposed, leading to insufficient or inappropriate healthcare services.
Criminalization	Criminalizing same-sex behavior affects the health of gay men and other MSM. Criminalization increases social discrimination and stigma. Additionally, criminalization may lead to a climate of impunity that validates this stigma and discrimination and allows for blackmail, extortion, and violence again gay men and other MSM. Those who fear discussing their sexual behaviors with healthcare providers because of criminalization have difficulty accessing HIV prevention services, may be misdiagnosed, may have delayed diagnoses, and often delay treatment for illnesses.

TABLE 3.1 Structural Barriers

Despite the existence of these structural barriers, there are factors that may moderate them as well. A few such facilitators include:

Safe space	Spaces where gay men and other MSM can meet and engage with peers and safely receive friendly services in a respectful manner.
Mental health services	Structural barriers place a constant burden of stigma and discrimination on gay men and other MSM, which in turn places them at higher risk for mental health issues. Receiving mental health services may help them deal with fear, self-loathing, and other issues.
Comprehensive healthcare	Healthcare services that comprehensively address all the needs of gay men and other MSM, rather than simply HIV needs, facilitate accessing services and may minimize the stigma associated with HIV.

TABLE 3.2 Structural Facilitators

» Community and Interpersonal-level Factors

Gay men and other MSM face widespread social exclusion from families and friends, and within cultural, religious, and healthcare institutions. This inhibits their ability or willingness to disclose their sexual orientation or behaviors, and serves as a barrier to appropriate healthcare services. In a study published by the MSMGF, MSM identified a variety of community and interpersonal barriers to healthcare, such as experiencing:[2]

1. Extortion
2. Blackmail
3. Ridicule
4. Eviction
5. Job termination
6. Violence

These barriers influence the ways in which gay men and other MSM interact with the health system and the decisions they make about their own health and sexual lives. Additionally, damage to interpersonal relationships may lead to poor self-esteem and self-worth, depression, and anxiety.

In the MSMGF study, several factors were identified that may be used to mitigate these barriers. These facilitating factors generally involve creating a supportive social environment that gay men and other MSM use to navigate through their lives. These factors are:[2]

1. Community engagement
2. Family support
3. Stable relationships

» **Individual-level Factors**

Following the conceptual framework to the individual level, we see how the higher-level structural, and community and interpersonal factors, affect gay men and MSM as individuals. Higher-level factors limit access to education, employment, and a sustainable income, or cause gay men and other MSM to live in an environment with constant stigma and discrimination. These factors may lead to living in fear or experiencing negative mental health outcomes. Some barriers at the individual level include:[2]

1. Fear of being recognized as gay or MSM
2. Poor self-worth
3. Depression
4. Anxiety
5. Suicidality

Facilitators including financial resources, sustainable work, and education may moderate these barriers. Education prepares gay men and other MSM to work in better or higher-paying jobs, and provides them with a sense of worth and the ability to advocate for themselves.[2]

WHAT ARE STIGMA AND DISCRIMINATION?

Stigma and discrimination underlie many of the barriers to engagement with health services by gay men and other MSM.

Underlying many of the barriers in the MSMGF Conceptual Framework are stigma and discrimination. Documentation of stigma and discrimination against gay men and other MSM exists in a wide variety of contexts. Stigma and discrimination are the underlying causes of many of the disparities between gay men and other MSM and the general population.

» **Stigma:** An attitude that is deeply discrediting, and reduces the bearer from a whole and usual individual to a tainted, discounted one.[7] Stigma is an attribute that shames an individual or group of individuals in the eyes of others. People express stigma externally, or keep it internal (see Table 4.3). One manifestation of stigma is discrimination. Though stigma does not always lead to discrimination, negative attitudes associated with stigma continue to be harmful to gay men and other MSM.

At the individual level, there are three primary manifestations of stigma.[8] These are:

1. **Enacted Stigma:** The external expression of stigma through actions, including a wide variety of actions such as those shown in Table 3.3 under "Signs of External Stigma." These experiences are common among gay men and other MSM. In one 2009 study in

the United States, across sexual orientation groups, gay men and other MSM reported the highest levels of enacted stigma, with 24.9 percent reporting antigay violence, 28.1 percent reporting antigay property crimes, 21.1 percent reporting having had an object thrown at them, and 63.0 percent reporting having experienced verbal abuse because of their sexual orientation.9 Examples of enacted stigma in the healthcare setting are the denial of healthcare to gay men and other MSM, or having to sit in a separate section of the waiting area from other clients.

2. **Felt Stigma:** The internal expectation of experiencing stigma because one knows that homosexuality is often stigmatized. Others need not overtly express stigma behaviorally in order to effect the lives of those towards which it is directed. Felt stigma is shown to affect how people behave under certain situations.[9] Felt stigma is often what leads gay men and other MSM to modify their behavior by attempting to "act straight" or hide their sexual behaviors to preemptively avoid enacted stigma. This can significantly affect the lives of gay men and other MSM.

3. **Internalized Stigma:** Accepting stigma as part of one's own value system, also known as "internalized homophobia." Feeling stigmatized does not necessarily mean that one accepts stigma as part of oneself. It encompasses the negative feelings that one has about oneself because of homosexuality or same-sex behaviors. Because of internalized stigma, self-esteem may suffer and gay men and other MSM may experience shame, depression, anxiety, suicidality, or a variety of other negative health outcomes.[10, 11]

Globally, HIV prevention services are estimated to reach less than one in ten gay men and other MSM.

Signs of External Stigma	Signs of Internal Stigma
» Avoidance of MSM » Rejection of MSM » Moral judgment » Stigma by association » Gossip » Unwillingness to invest in MSM » Discrimination » Abuse of human rights » Violence » Housing or employment discrimination	» Self-exclusion from services or opportunities » Perceptions of self (low self-esteem) » Social withdrawal » Overcompensation (MSM believing that they must contribute more than other people) » Avoiding being open about sexual orientation » Not seeking healthcare » Mental health issues » Suicidality

TABLE 3.3 Signs of Stigma[12]

FACILITATOR'S TIP

If possible, invite open members of the gay or MSM community to join the session to help healthcare providers identify, discuss, and understand stigma and discrimination against gay men and other MSM.

Note: This was done during the pilot training of this curriculum. Several men from the gay community were invited to share stories of personal experiences with small groups of participants. Before the information for this module was presented to the large group, participants divided into groups of 5-6 with one community member in each group. Each community member shared positive and negative experiences from both in and out of the health system, and held a discussion about what made these experiences positive or negative. They highlighted barriers at the structural level, community and interpersonal level, and individual level. Participant feedback indicated that this was well received and greatly enhanced understanding of key concepts from this module.

» **Discrimination:** When behaviors or actions are perpetrated that lead to inequality, inequity, or unfairness based on the belonging or perceived belonging of an individual to a particular group.[13] In many contexts, gay men and other MSM are the victims of discrimination on a daily basis. This discrimination causes harm and puts gay men and other MSM at risk for a wide variety of negative health outcomes.

» **Homophobia:** The irrational hatred, fear, or intolerance of homosexuality or gay men and other MSM. Homophobia is often the result of misunderstanding and prejudice and helps fuel the myths, stereotypes, stigma, and discrimination that can lead to violence against gay men and other MSM.12 Gay men and other MSM who are gender non-conforming are more likely to experience homophobia.

Furthermore, homophobia is a barrier to an effective HIV and AIDS response. Globally, HIV prevention services are estimated to reach less than one in ten gay men and other MSM. Fewer than half of gay men and other MSM in low- and middle-income countries have access to knowledge about HIV.[14, 15] When compared to the general population, gay men and other MSM bear a disproportionate burden of the HIV epidemic in many countries, as shown by the examples in Figure 4.2, which reflect the broader global trend.[16]

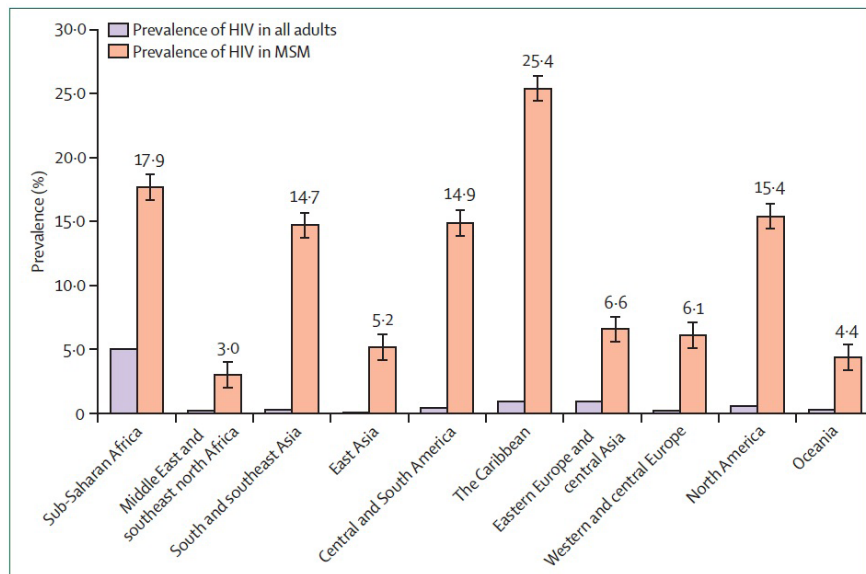

FIGURE 3.2 Global prevalence of HIV in MSM Compared with Regional Adult Prevalence Reported by UNAIDS, 2010[17]

GROUP ACTIVITY

Rotational brainstorm naming stigma and discrimination toward MSM[37]

Objective: This is the first of a two-part activity to start participants thinking about ways in which gay men and other MSM experience stigma and discrimination in various contexts.

Main activity: Set up 6 (or more) blank sheets of paper on different walls as stations, with a topic per paper/station labeled "family," "school," "clinic," "public space," "community," "workplace," etc.

Rotational Brainstorm: Divide the participants into small groups and assign each group to one station. Hand out markers and ask each group to write on the paper the potential ways in which gay men and other MSM experience stigma or discrimination in that particular setting. Explain that after a few minutes, groups will be asked to rotate in a clockwise direction to the next station and add new points to it that are not already written.

Questions for Discussion: Ask each group to present the points at one station (the one they started with). Then discuss the following questions:

1. What are some of the common features across the different places?
2. What are the common attitudes/feelings in all settings toward gay men and other MSM?
3. What is the potential impact of such experiences among gay men and other MSM?

Summarize key findings: Close the session by summarizing the main points, highlighting the ways in which experiences of stigma and discrimination are similar or different across contexts

STIGMA WITHIN THE GAY COMMUNITY

Gay men and other MSM are a group that faces much stigma and prejudice from outside of the gay community. However, there are a number of minority groups that face stigma from within the gay community itself. This is because of the additional stigmatizing identities that gay men and other MSM wear. Stigma from within the gay community can be based on:

» Ethnicity: Being a member of a racial minority[18, 19]
» Rural background
» Religion
» Perceived socioeconomic status
» Perceived engagement in sex work
» Perceived promiscuity
» HIV status
» Gender expression[20]

HIV-RELATED STIGMA

Regardless of one's sexual orientation or behavior, an HIV diagnosis can lead to significant stigma and discrimination. Among gay men and other MSM living with HIV this can double the stigma they face. In a 2008 study in Vietnam, nearly all of the participants living with HIV

experienced some form of stigma and discrimination.[21] Another study in Vietnam showed high amounts of stigmatizing beliefs even among adolescents.[22] Additionally, stigmatizing attitudes toward people living with HIV are found among healthcare providers themselves.[23, 24] A study among healthcare providers and people living with HIV in Grenada, Trinidad, and Tobago witnessed passive neglect and even active refusal to provide care.[25] This was particularly evident when a client was perceived to be gay or bisexual.

The causes of HIV stigma are many and include:

- Lack of knowledge about HIV
- Exaggerated fears of HIV infection
- Misperceptions about HIV transmission
- Negative representations of people living with HIV in the media[21]
- Association of HIV with illegal or immoral behavior[2]

The stigma associated with HIV may be experienced through various forms of discrimination including loss of family and community support, loss or denial of housing, and loss of employment and income.2 The additional layer of stigma associated both with being gay or MSM and living with HIV can make it difficult for gay men and other MSM to access prevention services and lead to reduced quality of life.26

The following Figure 3.3 shows the links between the causes of HIV-related stigma and the effects it may have on the lives of those living with HIV.

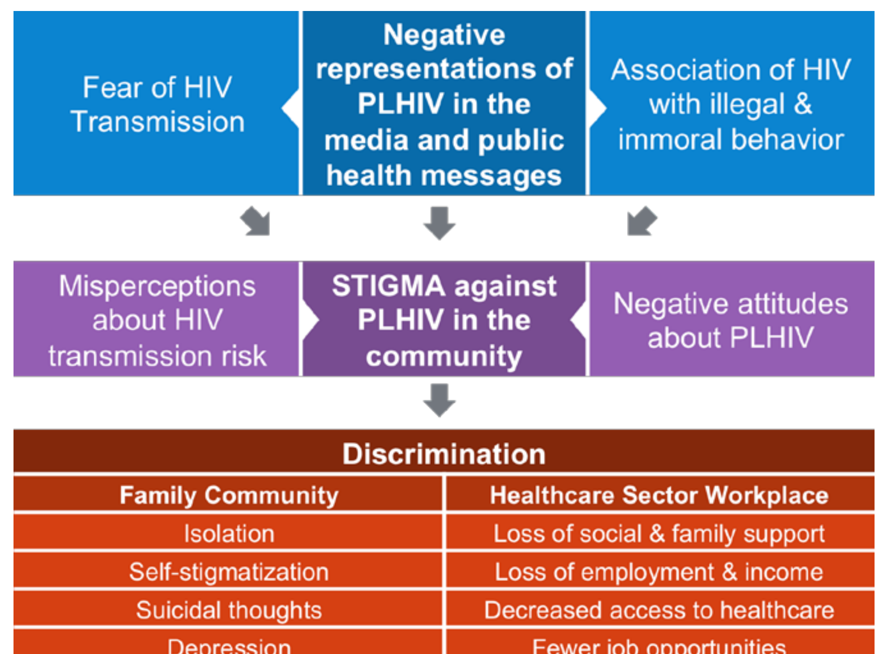

FIGURE 3.3 Diagram of Stigma and Discrimination against People Living with HIV (PLHIV) in Ho Chi Minh City: Causes, Effects, Relationships[2, 21]

GROUP ACTIVITY

Addressing stigma targeted against gay men and other MSM[37]

Objective: This activity is a follow-up to the previous one. It will help participants think through the causes of stigma and discrimination, and help them identify ways to overcome the causes.

Main activity: Divide participants into the same number of groups as before. Assign each group to a previously completed station. Ask them to read what is written at the station and discuss the following:

1. What are the causes of the stigma and discrimination in the identified setting?
2. What can we do to solve or challenge these forms of stigma and discrimination?

(*Optional:* Ask participants to prepare a short role-play to show the stigma and discrimination in their place.)

Ask each group to:

1. Present the role play (if done), and/or
2. Present their ideas on the causes of and solutions to stigma and discrimination at their place.

Summarize key points: Summarize the key points relating to causes of stigma and discrimination and how to overcome the causes as developed by the group.

LINK BETWEEN SOCIAL DISCRIMINATION AND HEALTH

We discussed the definitions of stigma and discrimination and the types of stigma that gay men and other MSM face. Using the MSMGF Conceptual Framework, we also looked at the barriers, facilitators, and critical enablers affecting healthcare access for gay men and other MSM. In this section, we will discuss some of the ways in which social discrimination interferes with the health of gay men and other MSM. There are many inflammatory cells (with CD4 receptors) under the surface in the rectum. Since HIV targets these cells, this makes infection with the virus more likely.

Criminalization of same-sex behavior is a major barrier to gay men and other MSM leading healthier and happier lives.

» Criminalization and HIV Prevention

Currently, 77 out of 193 countries criminalize same-sex behavior between consenting adults in one form or another. Governments place obstructive laws from criminalization of specific same-sex behaviors to the arrest and detention of those providing services to people engaged in same-sex behaviors.[5] A recent study in Senegal by Poteat et al, investigated publicized arrests of homosexuals.[27] Findings showed that the negative publicity surrounding arrests increased scrutiny and stigma of gay men and other MSM, that this increased scrutiny heightened fear and increased hiding among gay men and other MSM, and that arrests ultimately led to a decrease in the uptake and provision of HIV-related services. These findings are not unique to Senegal.

Beyond making it difficult to study gay men and other MSM, discriminatory laws lead to the underrepresentation of gay men and other MSM in program development and in health surveillance.

Even when laws are not enforced, their mere presence may serve as justification for abuse, discrimination, stigma, and homophobia against gay men and other MSM.

Criminalization negatively affects HIV prevention and the response to HIV and AIDS. In general, countries that criminalize same-sex behavior have a higher prevalence of HIV as compared to those that do not. The odds of HIV infection among gay men and other MSM compared to the general population are several times higher in African and Caribbean countries that criminalize homosexual activities than in neighboring countries where same-sex behavior is legal.[28]

Beyond the factors already discussed, the study in Senegal shows that enforcement of laws against same-sex behavior limited the ability of healthcare providers to provide HIV-related services including education, provision of condoms and lubricants, and treatment of STIs for gay men and other MSM.[27] Countries that criminalize same-sex behavior devote fewer resources to HIV services for gay men and other MSM, fail to monitor or track HIV in these men, and even repurpose donor funds intended for gay men and other MSM.[29] In Guyana, for example, HIV programs for gay men and other MSM are often limited to small-scale behavioral interventions since criminalization makes it difficult for government health agencies to address HIV in this population.[29] Even in instances where organizations do attempt to provide HIV services for gay men and other MSM, they risk labeling for promoting illegal activities. In Uganda and Nigeria, healthcare workers face the threat of punishment if they do not report people who disclose same-sex behavior.[30, 31]

While decriminalization of same-sex sexual practices is a necessary step in promoting an enabling environment in which gay men and other MSM can be cared for, it is not sufficient in and of itself. Even in countries where same-sex behavior is legal or protected, stigma and discrimination continue to impede the involvement of gay men and other MSM in HIV prevention, treatment, and care.

» Internalized Homophobia and Sexual Health

Studies have shown that gay men and other MSM who experience high levels of stigma and discrimination engage in behaviors that could potentially result in higher HIV and other STI rates. Threats or violence by partners, family members, or others targeted against gay men and other MSM are associated with higher rates of unprotected anal intercourse.[32] In Uganda, internalized homophobia and stigma was associated with higher rates of unprotected anal intercourse.[15] In China, expectations of gender roles was associated with higher levels of felt stigma, which in turn was associated with higher rates of unprotected anal intercourse.[33]

» Mental Health

Stigma and discrimination at all levels are associated with poor mental health outcomes among gay men and other MSM. The stress and social isolation associated with stigma, discrimination, and homophobia may lead to increased rates of depression, anxiety, and suicidality. In the United States, gay men and other MSM who live in states with discriminatory laws against same-sex couples exhibit hopelessness, chronic worry, and hyper-vigilance, which are common psychological responses to perceived discrimination.[34] Additionally, stigma and discrimination are associated with higher rates of drugs and alcohol use, which may result in additional health needs for gay men and other MSM.

» Homophobia and the Health System

Because friendly services for gay men and other MSM are not readily and easily available everywhere, gay men and other MSM often seek health services in mainstream healthcare settings. Homophobia in the health system may have a detrimental effect on the health of gay men and other MSM. Some healthcare providers display homophobic attitudes when offering services even if they claim to be accepting and neutral toward homosexuality.[2, 35] Many providers lack specialized knowledge on how to care for the unique health needs of gay men and other MSM and may express, intentionally or unintentionally, disapproval and prejudice. In a 2013 study in Jamaica and the Bahamas, not only had most healthcare provider respondents not received training on the health needs of gay and other MSM, but they also expressed very negative judgments.[24] In some instances, healthcare providers cited biblical excerpts, chastised men for their sexuality, and even brought in other staff to "look at the MSM."1 Additionally, misinformed policies within health systems can result in poorer quality services, self-segregation, and poorer health outcomes for gay men and other MSM.

In healthcare settings where men are worried about facing stigma, evidence shows that they are less likely to provide a complete or accurate sexual history, and less likely to openly discuss their sexuality.[36] They may also avoid the health system altogether.

» Higher Rates of HIV and other STIs

Gay men and other MSM are, on average, more likely to be infected with HIV and STIs when compared to adults in the general adult population in nearly every nation where such data are available.[7] STIs are difficult to diagnose and treat, especially in resource-limited settings, and are a serious public health concern for gay men and other MSM. Infection with an STI increases susceptibility to HIV. The following table outlines some common STIs among gay men and other MSM:

Healthcare providers play a central role in reducing stigma and discrimination both in the healthcare setting and in the wider community.

THE ROLE OF HEALTH PROFESSIONALS IN ADVOCACY ON BEHALF OF GAY MEN AND OTHER MSM

Healthcare providers play a central role in reducing stigma and discrimination against gay men and other MSM. By educating themselves about the realities in which gay men and other MSM live, and the barriers they face in their everyday lives, healthcare providers will be able to reduce the amount of stigma, discrimination, and homophobia against these men in a variety of settings. In the healthcare setting, providers must work to promote a welcoming atmosphere for gay men and other MSM, and pass their knowledge on to their coworkers to help ensure they extend respectful and dignified treatment to all clients. Healthcare providers often carry respect outside of the healthcare setting as well. They can thus help teach families and communities to treat gay men and other MSM like any other member of the community, empower MSM to participate in community activities, and lobby local authorities to provide support to gay men and other MSM.

Case Study

Chike is a 17-year old gay male in Abuja, Nigeria. He lives with his parents in a small shack on the outskirts of the city. Same-sex behavior is criminalized in Nigeria with harsh punishments. His mother is aware that he is involved in a same-sex relationship and does not approve of his sexual orientation.

Recently, Chike developed a few lesions around his anus. After suffering for several weeks, the pain became unbearable and his mother took him to the general hospital. At the hospital, he told the doctor the reason for his visit and the doctor asked a lot of probing questions. He eventually had to tell the doctor that he had been having anal sex with partners of unknown HIV and/or STI status. The doctor was angry with him and asked him to leave immediately, saying, "I don't treat people like you." The doctor shouted so that everyone could hear, including Chike's mother, who also became very angry.

After the hospital incident, where he did not receive treatment, Chike was afraid that word about his sexual orientation would spread in his community. He knew that people in his community would ostracize him if they knew.

Questions for discussion:

1. What types of issues is Chike facing in his life?
2. Identify the barriers preventing Chike from receiving the care he needs.
3. Are there ways in which the clinic could improve Chike's experience? If so, what are those?

Summarize key points: Summarize the main points that emerged from the discussion of the case study. Highlight the key ways in which to overcome barriers and negative experiences for gay men and other MSM.

KEY POINTS FROM THE MODULE

- There are various factors ranging from higher-order structural factors to lower-level individual factors that affect how gay men and other MSM engage with the health system.
- Stigma and discrimination underlie the barriers gay men and other MSM face when engaging with the health system.
- All types of stigma – enacted, felt, and internalized – result in gay men and other MSM not being open with their healthcare providers about their sexual behaviors. They may also avoid the health system altogether.
- Criminalization of homosexuality or same-sex behavior has a highly negative effect on the health of gay men and other MSM.
- The additional layer of stigma associated both with being gay or MSM and living with HIV can make it difficult for gay men and other MSM to access prevention services, and lead to a reduction in quality of life.
- Healthcare providers play a central role in reducing stigma and discrimination against gay men and other MSM by educating themselves about the realities in which gay men and other MSM live, and the barriers they face in their everyday lives.

PRE-POST ASSESSMENT

1. Criminalization of homosexuality is an appropriate public health strategy because this reduces the chances for gay men and other MSM to engage in same-sex behavior.

   [ ] True [ ] False

2. Avoiding treatment and care is one of many negative health behaviors that gay men and other MSM present with in the face of outright social discrimination.

   [ ] True [ ] False

3. In which of the following circumstances are gay men and other MSM least likely to discuss their sexuality with their provider?

   a. When it is legal in the country to engage in same-sex behavior and social protections exist for the gay community.

   b. When all frontline staff within a clinic have undergone sensitivity training to deal with gay and MSM clients.

   c. When a provider tells their gay/MSM client that it is morally wrong to engage in anal sex.

   d. When healthcare settings openly welcome gay men and other MSM.

4. Government laws and policies can be in contradiction with ethical and non-judgmental delivery of healthcare.

   [ ] True [ ] False

5. Which of these behaviors targeted at gay men and other MSM may place them at higher risk for HIV than their non-MSM peers?

   a. Blackmail

   b. Eviction from home

   c. Violence

   d. Allof the above

6. _______________ is an attribute that shames an individual or group of individuals in the eyes of others.

7. Which of the following are *not* signs of external stigma?

   a. Avoidance of MSM altogether

   b. Employment discrimination

   c. Gossip

   d. Non-judgmental delivery of care

   e. All of the above

8. Which of the following are *not* signs of internalized stigma?

   a. Low self-esteem

   b. High-risk behavior

   c. Suicidality

   d. All of the above

9. Gay men and other MSM should be encouraged to enter heterosexual marriages in order to promote their own health.

   [ ] True [ ] False

10. Which one or more of the following actions can a provider undertake to ultimately improve the health of gay men and other MSM?

    a. Seek education and knowledge about homosexuality

    b. Pass their knowledge on to other coworkers

    c. Reach out to families and communities to advocate on behalf of gay men and other MSM

    d. Speak to local authorities and provide support for gay men and other MSM

    e. All of the above when it is safe to do so

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Creating a Friendlier Environment

LEARNING OBJECTIVES

After completing this module, participants will be able to:

1. Understand why gay men and other men who have sex with men (MSM) may avoid seeking care.
2. Identify strategies for creating safer and friendlier environments for gay men and other MSM to access care.
3. Understand the importance of communication and confidentiality while engaging with gay men and other MSM in clinical settings.

INTRODUCTION

Gay men and other MSM experience a variety of barriers to receiving appropriate healthcare services. Many delay seeking care or receive inappropriate care because of homophobia or discrimination by healthcare providers and institutions. One important way to help overcome these barriers is to ensure that the healthcare service environment is respectful and welcoming to gay men and other MSM. When clients feel welcome and safe, it creates an enabling environment for them to build trusting relationships with healthcare professionals. This can alleviate concerns of discrimination, and can lead to better quality healthcare. Providers can take positive steps to promote the health of gay men and other MSM by examining their practices and policies, and by providing staff training. There are simple ways to make the healthcare service environment of any clinical setting more welcoming.

This module begins by discussing why gay men and other MSM might avoid seeking healthcare or avoid disclosure. It addresses the importance of culturally competent care before discussing the Ottawa Charter and key strategies to reimagine a friendlier environment for your gay and other MSM clients.

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 4 at:

http://msmgf-blog.blogspot.com/2014/01/respect-protect-and-pleasure-ms-j.html.

QUESTIONS FOR DISCUSSION:

1. What did the healthcare providers do differently that made one experience so welcoming and the other not?
2. What factor did the environment play in the different experiences? How did this affect the client's experience?
3. What are the typical societal or personal biases about same-sex behavior that can negatively affect individual and public health and healthcare delivery? What can be done to change these biases?

MODULE OVERVIEW

1. Anticipating concerns about discrimination
2. The importance of culturally competent care for gay men and other MSM
3. The Ottawa Charter
4. Key areas for reorienting services for gay men and other MSM
5. Communication
6. Intake forms
7. Key points from the module

ANTICIPATING CONCERNS ABOUT DISCRIMINATION

The importance of creating a safe environment in which gay men and other MSM can access care is essential to the reduction of stigma and discrimination. This is crucial, as stigma and discrimination decrease access to healthcare services for this population, or may cause gay men and other MSM to avoid seeking healthcare services altogether.

Homophobia persists among many healthcare providers, generating mistrust in the health system by gay men and other MSM. Research documents the prevalence of anti-gay discrimination in healthcare settings and negative attitudes directed toward gay and MSM clients by their providers.[1-3] Since homophobia among healthcare providers is often widespread, many gay men and other MSM come to expect that they will experience stigma and discrimination when visiting their healthcare provider. Providers who anticipate this expectation will be better prepared to address their clients' concerns.[4] By understanding the nature of their own attitudes and prejudices, healthcare providers will become better-prepared not only to address barriers to care-seeking for gay men and other MSM, but also may choose to work with the wider community and advocate for the needs of all clients.

FACILITATOR TIP

Have participants brainstorm other reasons why people (gay and other MSM) in their community avoid regular check-ups. A good place to do this would be after the Power point slide on "Disclosure."

THE IMPORTANCE OF CULTURALLY COMPETENT CARE FOR GAY MEN AND OTHER MSM

An important step to overcoming the barriers mentioned in this module and in previous modules is to train healthcare providers in culturally competent care for gay men and other MSM. Culturally competent care is defined as healthcare that is sensitive to and knowledgeable about the health beliefs and behaviors, the epidemiology and disease risks, treatments, and treatment outcomes, of specific client populations.[5-7] Culturally competent care for gay men and other MSM requires that providers: [7]

FIGURE 4.1 Culturally Competent Care
Adapted from Barratt, 2009[8]

Culturally competent healthcare values cross-cultural communication, which may be especially important with populations such as gay men and other MSM who often have difficulty disclosing their sexual behaviors to their healthcare providers. Non-disclosure may lead to lack of access to healthcare services, poor client healthcare management, inaccurate clinical decisions, and poor health outcomes. Gay men and other MSM need to feel comfortable discussing their sexual histories with their healthcare providers. A healthcare provider's communication style is an important factor in client willingness to disclose sexual orientation.

THE OTTAWA CHARTER

In 1986, the World Health Organization (WHO) organized the first International Conference on Health Promotion in Ottawa, Canada. This conference launched a series of actions among international organizations, national governments, and local communities to achieve the goal of "Health for All" by the year 2000 and beyond, through better health promotion.[9] The Ottawa Charter sets standards for building appropriate services for healthcare clients using a comprehensive, multi-strategy approach. According to the WHO and the Ottawa Charter, health promotion action means:

1. Building healthy policies
2. Creating supportive environments
3. Strengthening community actions
4. Developing personal skills
5. Reorienting healthcare services

The health promotion emblem stands for the approach to health as outlined in the Ottawa Charter.

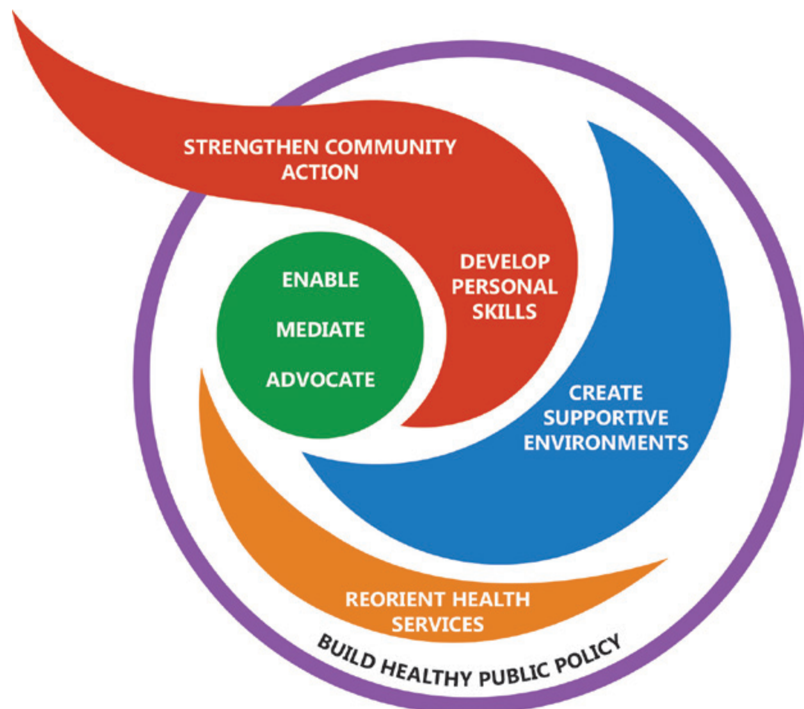

FIGURE 4.2 The Health Promotion Emblem[9]

The five actions of health promotion as outlined in the Charter concern the vital health of gay men and other MSM, and other marginalized populations across the globe. Laws and policies that criminalize or otherwise negatively affect gay men and other MSM must be eliminated while building a healthier policy environment in a great number of countries

FACILITATOR TIP

Ask the participants to consider what it means to reorient healthcare services. How can you change the attitudes of staff? How can you make the waiting room more welcoming? How can you involve gay men and other MSM in the clinic?

globally. There is a need to work with communities to strengthen the local healthcare response for gay men and other MSM, and build supportive environments. We must also work with individuals to empower them to take their health into their own hands. Finally, healthcare providers have the power to reorient their services to better enable gay men and other MSM to live healthy lives.

KEY AREAS FOR REORIENTING SERVICES FOR GAY MEN AND OTHER MSM

There are many ways to reorient or reimagine services to make them more welcoming and friendlier for gay men and other MSM. When doing so, it is useful to seek out the advice and input of members of the local gay and MSM community, and to ask clients to be involved. This demonstrates that their views are valued and there is commitment to addressing their healthcare needs. In particular, it helps develop a sense of ownership in the healthcare service by members of this community. This section will more deeply explore key areas that may be modified to overcome barriers to healthcare for gay men and other MSM using a series of standards as presented by I-TECH.[4]

CLIENT RIGHTS

To ensure protection of client rights, establish comprehensive policies that prohibit discrimination in the delivery of healthcare services to gay men and other MSM. All staff should be required to agree to these policies under their terms of employment. Written policies should be posted in a visible location and be available as brochures or pamphlets for clients to see. Gay and other MSM clients report that they often look for subtle cues such as these in the environment to determine acceptance.[10]

When anti-discrimination policies are not followed, there should be a procedure in place for clients to file and resolve complaints with a designated person within your organization's healthcare service environment responsible for ensuring compliance. The complaint procedures should be available in writing and easily accessible to clients. All employees should be given written notice that discrimination based on gender identity or sexual orientation will be subject to appropriate disciplinary actions.

FACILITATOR TIP

Have the group develop action steps to improve service quality. Identify personal and environmental factors that may contribute to create an environment of respect, trust, and communication. Discuss the importance of attitudes and competencies of each staff member (for example, from guards at the entrance to the providers).

CLINIC STAFF

The presence of peers as staff at the clinic often comforts gay men and other MSM. One way of ensuring that a clinic's environment is friendly for gay men and other MSM is to support and encourage the visibility of any staff that are lesbian, gay, bisexual, or transgender (LGBT). LGBT staff may be actively recruited as well. There must be policies in place that favor diversity and prohibit harassment of staff based on sexual orientation or gender identity. In addition, written policies should explicitly extend the

same benefits including health, life, or disability insurance, to all families including those of gay men and other MSM. All appropriate personnel should receive comprehensive and accessible training on issues related to gender identity and sexual orientation.

CLINIC RECEPTION

Clinic reception staff, as the usual first point of client contact, must be comfortable with gay men and other MSM. They should be familiar with providers within the agency with experience dealing with the issues of gay men and other MSM, and with culturally appropriate referrals for these clients. Investment in receptionist skill development is necessary, as is training them to use culturally appropriate language (to avoid labels, to ask clients how they wish to be addressed, etc.). A few key elements of a good reception include staff:

- Being open and friendly
- Creating unique client identifiers to ensure correct but confidential identification of clients and their information
- Clarifying how identifying information may be used with client's permission. For instance:
  - Information needed: Where do you live?
  - Explanation: So we may contact you if necessary. (Ask permission first in situations where clients may reside with family or friends who are not aware or supportive of the client's sexual orientation.)
- Reassuring confidentiality

SERVICE PLANNING AND DEVELOPMENT

Clinic services should be culturally competent in dealing with gay and other MSM client issues. Four critical elements help create competent, respectful service:

1. *Staff training on gay men and other MSM and transgender culture:* All staff should be familiar with issues affecting gay men and other MSM and how they pertain to the services provided by the clinic. This ensures that services are culturally competent in gay and other MSM and transgender issues. On-going training programs on diversity, harassment, and anti-discrimination should utilize specially developed materials on gay men and other MSM. They should be mandatory for all staff. During the course, participants should implement what they are learning, and use the trainers as a resource. It may also be helpful to invite the facilitators, other participants, or open members of the gay or MSM community from this training to speak to the full staff.
2. *Identify staff with special skills or an understanding and acceptance of MSM issues*: It is important to identify staff that understand and accept gay men's and other MSM issues or with special skills when it comes to

issues affecting gay men and other MSM. To do so, ask providers to discuss this training at a staff meeting and share key lessons learned from the training. Being attentive to individuals who are especially interested and, if appropriate, speaking to them individually can help recruit them to form a working group to help increase staff sensitivities.

3. *Develop a gay and other MSM-sensitive referral and resource list:* It is also important to have a list of resources to direct gay or other MSM clients who have specific health concerns. Providers can approach gay, LGBT, or MSM organizations in the area and ask for their help; go to bars, clubs, or other venues and pick up local newspapers or newsletters to identify local organizations. Calling these resources can ensure their ongoing cooperation. Another thing providers can do is to confirm that both clinical and non-clinical organizations listed reflect the values that are sensitive to gay men and other MSM.

4. *Develop a relationship with the MSM community in the area:* Developing relationships with the MSM community in the area will go a long way in making services more approachable for gay men and other MSM. Creating visibility can be important, but in many places, it can be unsafe to do in environments where gay men and other MSM may come for healthcare. Providers may also seek out LGBT groups in the area and invite representatives to meetings to discuss how to better integrate them into the work of the organization, if appropriate. These may be one-on-one meetings with one or more staff. As providers work with these groups or individuals to create a friendlier environment for gay men and other MSM, they will have more opportunities to change attitudes and become increasingly comfortable dealing with sexual health issues of concern to gay men and other MSM.

CONFIDENTIALITY

Assurance of confidentiality is critical for gay men and other MSM, especially for those who are not open about their sexuality or same-sex behaviors.

Confidentiality is the cornerstone of sexual healthcare and may even be more important for gay men and other MSM given their often-hidden nature, especially in areas where same-sex behavior is highly stigmatized or criminalized. All information about sexual orientation and gender identity issues must be kept confidential and there must be written policies in place that explicitly state that such information is to be considered highly sensitive and treated accordingly.

Staff should receive comprehensive training on data collection and reporting, including the rights of minors. It should be made clear to clients that reporting sexual behavior and gender identity on forms and records is purely optional, and written notice should be given about instances when this information would be shared or disclosed, whether it be as aggregate or individual information, and whether personal identifiers may also be disclosed. Clients should be informed of how and by whom such information may be used. Additionally, all consultations should be kept strictly confidential with appropriate privacy procedures.

In some countries, adherence to client confidentiality may present a conflict with the law. For example, in some countries, the continual expansion of criminal sanctions against homosexual behavior has resulted in legal mandates directed at healthcare providers who are in turn expected to report homosexual behavior to law enforcement officials. In such cases (dual loyalty), the healthcare provider's obligation is always to the client. Breach of confidentiality in such instances can lead to unintentional harm to the client and may pose a threat to accessibility and availability of quality services for all gay men and other MSM within that local community.

All minor clients should be informed of their rights. Intake, assessment, and treatment procedures for minors should all be sensitive to sexual orientation and gender identity. Minors should be educated about any mandated reporting laws and their implications, and of their rights concerning confidentiality and treatment without parental consent. Safety and security again takes precedence in the handling of information related to minor clients. Therefore, information regarding a minor client's sexual orientation or HIV status should not be disclosed to parents or caretakers if it is not the client's preference and/or has the potential to harm to the client or threaten their access to services. Healthcare providers should also strive to ensure treatment access and access to additional healthcare services to minor clients depending on their unique needs.

COMMUNITY RELATIONS

Ensuring that an organization providing healthcare services is seen by the gay and other MSM community to be a welcoming space is very important. Advertising and promotional materials used should clearly indicate non-discrimination policies, and these materials should accurately reflect the level and quality of services available to gay men and other MSM. If appropriate, community programs that the organization runs should include gay men and other MSM from the community.

Another way to ensure a good relationship with the community is to have a Board of Directors that is inclusive of gay men and other MSM. The process for electing or appointing members to this board should reach out to gay men and other MSM, and effort should be taken to cultivate a culture where all members of the board work for issues concerning gay men and other MSM.

COMMUNICATION

Beyond environmental cues and inclusive policies, healthcare providers also play a major role in creating a welcoming environment for gay men and other MSM.[11] First, healthcare providers must educate themselves on MSM health topics. Not all healthcare providers will become experts, but they should be familiar with the health concerns of this population.[12] Oftentimes, training on LGBT issues in medical schools is limited, so the healthcare provider may need to turn to other trainings or publications to become knowledgeable of this population's needs.[13]

Regardless of their knowledge, healthcare providers can create a welcoming environment by taking an open and non-judgmental sexual and social history.[11] Do not make assumptions about sexual orientation or gender identity based on appearance or behavior. Rather, ask open-ended questions. Homophobia or perceived homophobia in the healthcare setting may hinder disclosure of sexual behaviors or the provision of a full history by the client. By being open and non-judgmental, healthcare providers will make it easier for their clients to openly communicate. A few additional tips to consider during the client interview include:[14]

It may take time for providers to feel comfortable discussing sexual health and behaviors with their clients. It is not necessary to have all of the answers right away. A focus group study with bisexual men in Boston, United States, showed that those healthcare providers who were perceived as "good providers" were those who were willing to listen to their clients and learn, rather than presenting with any expectation that they were already knowledgeable about gay and other MSM issues. It is okay for a healthcare provider to explain that they are still learning and growing in understanding, even if there are a few miscommunications.

INTAKE FORMS

Because intake forms are one of the first encounters clients have with a clinic, they are an important way to make clients feel welcome. A few points to consider:[14]

- The language used on all forms should be inclusive throughout and reviewed for any wording that assumes heterosexuality. For example:
    - Use gender-neutral terms (partner or spouse instead of husband or wife).
    - Replace "marital status" with "relationship status," include terms such as "partnered" in addition to "married," and consider adding "multiple partners" as an option.
    - Inquire about the gender of the spouse or partners, and whether the two are married to each other.
    - Allow for same-gender parents in questions about families.
    - Allow for optional self-identification in categories including:
        - Gender identity
        - Sexual orientation
        - Relationship status
    - Provide an option for further written explanation of any categories.
- In regards to confidentiality, include information about who will see the information, how it will be used, and whether it will be included in the client's medical record.
- Allow the client to decline to answer any question for any reason.
- Offer clients a "Bill of Rights" that describes the organization's commitment to non-discrimination, confidentiality, and culturally sensitive care.

KEY POINTS FROM THE MODULE

- There are many reasons gay men and other MSM may avoid the healthcare system, including stigma and discrimination from healthcare providers and an unwelcoming, unfriendly environment.
- An important step to overcoming the barriers mentioned here and in previous modules is to train healthcare providers in culturally competent care for gay men and other MSM.
- The Ottawa Charter sets standards for building good services for clients using a comprehensive, multi-strategy approach.
- There are many areas of healthcare services, including client rights, clinic staff and reception, service planning and development, confidentiality, communication, and community relations that may be reoriented and reimagined to ensure a welcoming, respectful, friendly environment.
- Intake forms should not assume heterosexuality and should ensure clients of their rights and confidentiality.

GROUP ACTIVITY

Standards for Clinics (from I-TECH Worksheets)

Ask participants to break up into 10 groups (this might mean pairs as opposed to groups depending on how many participants there are) to look at each of the 10 Standards.

Standards:

1. Employ qualified gay men or other MSM staff where possible
2. Ensure a workplace free of discrimination and harassment for gay men and other MSM staff
3. Develop and post policies for non-discriminatory service development
4. Have complaint procedure for violation of anti-discriminatory policies in place
5. Train clinic reception staff to be sensitive to gay men and other MSM and follow procedures
6. Provide services that are culturally competent in gay men's and other MSM issues
7. Ensure confidentiality as a cornerstone of sexual healthcare provision
8. Maintain confidentiality of a consultation through privacy procedures
9. Address gay and other MSM youth and children's issues
10. Seek gay men and other MSM community input to Board of Directors

Go over the instructions listed on Worksheet 4.1 (following) with participants.

- Use the example provided to clarify instructions
- Ask participants if they have any questions
- Allow 15 minutes for groups to work
- Follow the instructions listed after the worksheet for a large group debrief

Have groups report back to the larger group.

- Ask each group or pair to briefly report back about their Standard
- Show slide 23 with points from Worksheet 4.1 for groups to use during their presentation

Move on to Worksheet 4.2

- Ask participants to review the Key Areas and Standards and to choose one for the first priority of their clinic
- Refer participants to worksheet 4.2
- Ask participants to complete the questions for next steps for their clinic on their own
- Follow instructions for a large group debrief following the worksheet

WORKSHEET 4.1

Standards for Clinics

Standard: ______________________________

Barriers:

Facilitators:

Allies:

Strategies

WORKSHEET 4.2

Next Steps

Standard: ______________________________

1. What is next for our clinic in this area?

2. What can I do to help implement this step?

3. By when will I do this (timeline)?

4. Who can help me at the clinic – be my support?

PRE-POST ASSESSMENT

1. ______________________________________ _ is defined as healthcare that is sensitive to and knowledgeable about the health beliefs and behaviors, the epidemiology and disease risks, and treatment outcomes of specific client populations.

2. Lack of trust in healthcare professionals limits the dialogue between the client and the healthcare provider, making it difficult to provide appropriate care.

   [ ] True [ ] False

3. The following is an example of an appropriate question for a gay men's and other MSM friendly intake form:

   Current Relationship Status:

   [ ] True [ ] False

4. When it is safe to do so, which of these is a visual cue to show that your clinic is gay men's and other MSM friendly?

   a. Posters or signs showing male couples

   b. Presence of LGBT magazines in the clinic

   c. Posting a non-discrimination policy that includes gay men and other MSM

   d. Presence of gay or other MSM staff

   e. All of the above

5. Only clinical staff like physicians and nurses need to be familiar with the issues facing gay men and other MSM. Non-clinical staff do not need to be trained because they do not provide direct care for gay men and other MSM.

   [ ] True [ ] False

6. In order to take the first step towards the provision of culturally competent care, it is most imporrtant for a healthcare provider to:

   a. Be an expert on gay men's and other MSM health

   b. Hire only gay men and other MSM staff

   c. Be aware of their own values and beliefs on gender, sexuality, and other issues and how these might affect their provision of healthcare for clients

   d. Be 100 percent confident when speaking about gay men's and other MSM issues

7. ____ sets standards for building good healthcare services for clients using a comprehensive, multi-strategy approach, which includes 1) building healthcare policy, 2) creating supportive environments, 3) strengthening community action, 4) developing personal skills, and 5) reorienting healthcare services.

8. It is impossible for a healthcare provider who morally objects to homosexuality to provide appropriate care to gay men and other MSM.

   [ ] True [ ] False

9. Assurance of _________________________________ __ is critical for sexual healthcare, but especially for those gay men and other MSM who are not open about their sexual behavior.

10. It is important to develop relationships with local LGBT organizations and to have a community resource list for your gay men and other MSM clients.

    [ ] True [ ] False

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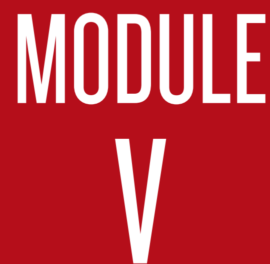

Promoting Mental Health

LEARNING OBJECTIVES:

After completing this module, participants will be able to:

1. Understand factors that fuel negative mental health outcomes among gay men and other men who have sex with men (MSM).
2. Describe common mental health issues faced by gay men and other MSM.
3. Describe basic strategies for approaching mental health with gay men and other MSM.

INTRODUCTION

Gay men and other MSM can experience chronic and high levels of mental distress and related challenges as a result of rejection, isolation, and marginalization.[1-4] Research suggests that gay men and other MSM are at increased risk for major depression, bipolar disorder, and generalized anxiety disorder, the common basis of which is likely homophobia.[5] Sustained stress can also lead gay men and other MSM to cope by using drugs and alcohol or even to contemplate suicide.[6]

This module provides a review of common challenges gay men and other MSM face from a mental health perspective and the factors that drive those challenges. It also provides basic guidance for how healthcare providers can better support their clients to care for their mental health.

MODULE OVERVIEW

1. Factors leading to poor mental health outcomes among gay men and other MSM
   - Criminalization
   - Discrimination within healthcare settings
   - Reparative therapies
   - Family rejection
   - Difficulty in coming out
   - Maturing and late adulthood
2. Common mental health issues for gay men and other MSM
   - Anxiety
   - Depression
   - Suicide

- » HIV-related stress disorder
- » Sexual problems
- » Eating disorders
- » Physical and sexual violence

3. The importance of relationships and community building
4. Addressing mental health in the clinical setting
5. Key points from the module

PRE-READING ASSIGNMENT

Please find the pre-reading assignments for Module 5 at:

Reading 1: Ugandan tabloid article,

http://lezgetreal.com/2011/01/editor-of-ugandan-tabloid-which-outed-gays-says-rolling-stone-will-defy-court-order/

Reading 2: The minority stress perspective, http://www.apa.org/pi/aids/resources/exchange/2012/04/minority-stress.aspx

QUESTIONS FOR DISCUSSION

1. What are some of the myths that the author of the Rolling Stone article holds in writing about gay men and other MSM?
2. In what ways might proclaiming such negative falsehoods to a wide audience affect the mental well-being of gay men and other MSM in Uganda or elsewhere?
3. Using minority stress theory discussed in the second reading, what stressors do gay men and other MSM experience as a result of homophobic assaults in the media? In what ways might gay men and other MSM respond to those stressors positively or negatively?

FACTORS LEADING TO POOR MENTAL HEALTH OUTCOMES AMONG GAY MEN AND OTHER MSM

Many gay men and other MSM demonstrate resilience, or the ability to end up healthy human beings despite facing severe discrimination and marginalization, while others present with mental health challenges. Social discrimination has been described as a key factor leading to poor mental health outcomes in gay men and MSM across diverse settings.[7] This discrimination is well documented in settings around the world, regardless of the cultural, social, political, economic, or legal environment.[8-10] Discrimination manifests itself in many ways, including personal hardships like harassment, ridicule, rejection, or violence but also higher-level structural factors like discriminatory policies or violations of human rights.

» Criminalization

Seventy-seven countries currently criminalize same-sex sexual behavior between consenting adults. Penalties range from fines or imprisonment to death.[11] These discriminatory laws are more common in countries in Sub-Saharan Africa, the Caribbean, and the Middle East.[12] Beyond violating basic rights, criminalization has made gay men and other MSM more vulnerable to poor health outcomes, decreased access to health services, and created iniquities in access to and affordability of needs like housing and work. Repealing laws criminalizing same-sex behavior is an important step toward combating prejudice against gay men and other MSM. However, decriminalization must be accompanied by work at the grassroots level to address societal attitudes.

Other consequences of criminalization of same-sex sexual behavior include:

- Underrepresentation of gay men and other MSM in the development and implementation of policies and programs.
- Lowered client participation in and discouragement of staff from working in programs for gay men and other MSM.
- Lack of surveillance and resources for research concerning gay men and other MSM.

Laws criminalizing same-sex behavior need not be enforced to cause harm. Their mere existence in the penal code serves as justification for abuse, discrimination, stigma, and homophobia.[12]

» Discrimination within Healthcare Settings

Healthcare providers have a responsibility to provide equitable care to gay men and other MSM regardless of their personal religious or moral beliefs.

Gay men and other MSM often experience stigma and discrimination in healthcare settings, either because of their real or perceived same-sex behavior. These stigmatization experiences occur during regular check-ups, testing, diagnosis, drug dispensing, and dental procedures, among others. In some settings, non-verbal gestures and disparaging remarks have been witnessed in the healthcare system.[7] In others, gay men and other MSM are made to sit in a separate waiting area or providers refuse to touch them for fear of HIV. Gay men and other MSM who face stigma or discrimination from their healthcare provider are less likely to discuss their sexuality openly and are more likely to provide incomplete or inaccurate sexual histories, making it difficult for the provider to provide optimal care.[13] Healthcare providers have the responsibility to provide equitable care to all individuals, including gay men and other MSM, regardless of their personal religious or moral beliefs.

» Reparative Therapies

Attempts to cure or prevent homosexuality are unethical and can cause harm such as depression, anxiety, or suicidality.

Reparative therapies, also known as conversion therapies, are a group of harmful interventions whose aim is to change an individual's sexual orientation from homosexual to heterosexual. Any attempts to reform or "cure" someone's sexual orientation using these "therapies" will not only fail, but may cause harm, including depression, anxiety, suicidality, and, in some cases, a loss of sexual feeling altogether.

Homosexuality is not a mental disorder, but a normal expression of human sexuality

Homosexuality is not a mental disorder, but a normal expression of human sexuality. Major health institutions around the world have adopted this position:

- The American Psychiatric Association declassified homosexuality as a mental disorder in the Diagnostic and Statistical Manual (DSM) in 1973.[14]
- The World Health Organization (WHO) removed homosexuality as a psychiatric disorder from its International Classification of Diseases, 10th Revision in 1992.[15]
- The Japanese Psychiatric Body removed homosexuality from its list of psychiatric disorders in 1995.
- The Norwegian Psychiatric Association General Assembly overwhelmingly accepted homosexuality as a non-pathological understanding in 2000.
- The Chinese Psychiatric Association endorsed the fact, in a non-Western context, that homosexual behavior does not signal the need for psychopathological intervention in 2001.[16]
- In July 2009, the Delhi High Court in India noted that "there is almost unanimous medical and psychiatric opinion that homosexuality is not a disease or a disorder and is just another expression of human sexuality."[17]
- In 2013, the president of the World Psychiatric Association came out as a gay man and called for ending treatment of homosexuality as a mental illness.[18]

In cases where clients themselves express the desire to change sexual orientation, the most effective and appropriate therapeutic response that results in maximum mental health benefit is provider-initiated support, acceptance, and validation of same-sex sexual orientation.

Family Rejection

In many cases, family members who do not accept an individual's sexual orientation request reparative therapies, as they are not fully aware of the harms such interventions can cause. Research correlates family rejection such as this with negative health outcomes among lesbian, gay, bisexual, and transgender (LGBT) people. LGBT young adults who experience high levels of family rejection during adolescence are 8.4 times more likely to attempt suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to use drugs, and 3.4 times more likely to report unprotected sexual intercourse when compared with peers who report no or low levels of family rejection.[19] In situations where a family member has difficulty accepting someone's sexual orientation, healthcare providers should provide scientific data around the normality of same-sex orientation and connect the family member to local resources to help them accept their family member without feeling guilt, shame, prejudice or judgment.

Difficulty in Coming Out

Coming out refers to a period when an individual becomes aware of their sexual orientation and recognizes that they are sexually attracted to members of the same sex.[20] Coming out is not merely related to the disclosure of one's sexual orientation, but is a complex emotional and psychological process that may take months or years. The coming

out process often involves a period of confusion that ends in the formation of a sexual identity with which the individual is comfortable.[21] During this time, some experience personal crises related to their sense of self, especially if they feel their sexual orientation conflicts with their own, society's, or their family's expectations of them. Feelings of shame, guilt, and fear may be overwhelming, and risk for depression and suicidality may be heightened.[22]

FACILITATOR'S TIP

Consider having participants role-play with one participant acting as the healthcare provider and the other participant acting as the client. Ask them to role-play a scenario wherein the client is attempting to tell the provider that they are gay or have recently engaged in same-sex behavior.

How easy or difficult was this for either individual. Was the provider sensitive or receptive? What specific factors increase or decrease discomfort?

Deciding how and when to come out is ultimately the decision of the individual. Coming out is healthy and is correlated with less stress. However, it may not be appropriate for someone to come out in settings where disclosing one's sexual orientation can result in violence or in further stigmatization. Healthcare providers must remain sensitive to the safety concerns of their gay and other MSM clients in the context of disclosure and must strictly uphold confidentiality agreements.

» Maturing and Late Adulthood

Aging can be a stressful process for anyone. However, it gains particular significance for gay men and other MSM. One study of 2,560 LGBT people aged 50 to 95 showed that older gay men and other MSM are less likely to be partnered or married, more likely to live alone, and more likely to have fewer children than their non-MSM peers.[23] Compounding this is the fact that many subcultures within the gay or MSM community place great value on youth, body beauty, fitness, virility, and potency, resulting in both explicit and implicit ageism. A 2004 study reported that 44% of older gay men "feel disconnected from or even unwelcomed by younger generations of LGBT people."[24]

These factors mean that the aging gay man or other MSM may have less social and financial support, and that they are at higher risk for social isolation, which has been linked to poor mental and physical health outcomes, cognitive impairment, premature chronic disease, and death.[25] For instance, the previously mentioned study also found higher rates of disability and mental health issues in older LGBT people than their heterosexual peers. Twenty-nine percent of gay male and 36% of bisexual male older adults exhibited symptoms of depression as well as elevated rates of anxiety. The results for suicide were particularly alarming with 37% of gay men and 39% of bisexual men having seriously considered suicide and many reporting that these considerations were related to their sexual orientation.

COMMON MENTAL HEALTH ISSUES FOR GAY MEN AND OTHER MSM

Stigma, discrimination, and homonegativity contribute significantly to the negative mental health outcomes of gay men and other MSM.

Due in no small part to experiences of marginalization and discrimination, gay men and other MSM are vulnerable to a variety of mental health issues. The harassment, discrimination, and homonegativity experienced by gay men and other MSM contribute significantly to anxiety and are linked to depression and other mental health disorders. The following section is intended to give healthcare providers a broad overview of the mental

health issues common in gay men and other MSM. This module does not provide guidance on how to make a clinical diagnosis around any mental health illness. It is hoped that the resources contained here will help healthcare providers increase their knowledge and sensitivity to mental health problems in order to make referrals when necessary.

» Anxiety

Anxiety is a normal emotion and is closely related to fear.[20] However, when anxiety becomes excessive, is difficult to control, and affects an individual's everyday life, it becomes a disorder and must be adequately managed. Some symptoms of anxiety disorders include:

- Fear, uneasiness, and worry
- Sweating
- Shaking
- Racing heart
- Nausea
- Dizziness
- Shortness of breath
- Chills or hot flashes

Evidence shows that gay men and other MSM are at increased risk for anxiety disorders, likely because they often must conceal their sexual behaviors or identities because of fear, shame, or guilt. In one study, 33% of black MSM reported feeling anxiety.[26] In another in India, 24% of MSM experienced anxiety.[27] Studies show that MSM often have lower self-esteem than non-MSM men and may experience additional social anxiety as well.[28]

» Depression

It is normal for most people to have "ups and downs". Depression, however, is far more than simply a bad mood. It is a prolonged mood disorder that may drastically affect an individual's daily life. Some symptoms of depression include:

- Feeling sad, hopeless, worthless, guilty, or bad about oneself
- Being unable to enjoy things that would usually be pleasurable
- Feeling apathetic and lacking motivation to act
- Feeling tired and having no energy
- Feeling lonely and cut off from other people
- Difficulty in concentrating
- Sleeping badly – either sleeping too much or too little
- A change in eating habits – either eating too much or too little
- Contemplating suicide

Gay men and other MSM are prone to depression for many of the reasons already discussed: continual stigma and discrimination, social isolation, rejection, and loneliness. Many gay men and other MSM live in societies where their sexuality is viewed as criminal or pathological. If a client presents with several symptoms of depression, they may require referral to a skilled mental healthcare provider.

GROUP ACTIVITY

Strategies for self-care

Objective: This activity is designed to highlight the importance of dealing with self-stigma. It offers strategies to use to cope with the stress caused by stigma and discrimination and to build self-esteem. It will also help participants:

1. Understand low self-esteem is a contributing factor to HIV risk for MSM
2. List strategies for beginning the process of addressing low self-esteem

Main activity: Explain to the participants that stigma and discrimination can lead to stress and low self-esteem. These are contributors to a community's vulnerability to HIV risk, and should be addressed. Ask participants how they manage stress.

Lead the participants in a relaxation exercise, focused on the breath or walking. Good resources are available for this online. See Jack Kornfield's instructions for sitting meditation:

http://www.jackkornfield.org/meditations/sitting-Meditation.php

You may also lead the group in a small exercise that introduces the practice of positive aspirations. Ask the participants to repeat the following:

- May I love myself just as I am.
- May I feel self-worth and well-being.
- May I trust this world.
- May I make a difference in the lives of people I touch.

Explain that clearly stated aspirations like the above serve as helpful reminders and can have a positive effect and come to being.

Exercise is also an important facilitator of well-being. Ask the participants to get up from their seats and follow the facilitator in a combination of jumping jacks, sit-ups, and push-ups. Allow this to continue for 5 minutes. Ask the participants how they feel after the exercise. Are they energized? Explain that a regular exercise routine can be a very supportive way to eradicate self-stigma.

End the exercise with a positive visualization exercise. Ask participants to close their eyes and relax. Ask them to think about a time when they felt good about themselves. It could relate to the successful completion of a project, a time when they stood up for their rights, or just a time when they were carefree and relaxed. This serves as a positive note on which to end the exercise.

Questions for discussion: After completing the exercise, ask the participants:

1. How do they feel about themselves?
2. What did they learn about the importance of self-care and nurturing one's self-esteem?
3. What suggestions can healthcare providers offer their clients for self-care?

Summarize key points: Explain the importance of any community of people coming together as a group on a regular basis. This exercise is fun, is a great way to decompress and de-stress, and also serves as a key step in community collectivization. Healthcare providers may encourage their clients to join a local community group that has regular meetings.

For one example screening scale for anxiety and depression, please see:

Ultra-Brief Screening Scale for Anxiety and Depression
http://www.psychiatrictimes.com/all/editorial/psychiatrictimes/pdfs/scale-PHQ4.pdf

Suicidality

Research suggests that LGBT adolescents attempt suicide at higher rates when compared with their heterosexual peers.[29] The strongest risk factor for suicide is a history of previous attempts. As previously

noted, LGBT individuals who experienced family rejection were eight times more likely to attempt suicide. Family connectedness, caring adults, and school safety serve as protective factors from suicide for LGBT individuals.

Current suicide risk assessment tools do not provide the necessary guidance for mental healthcare professionals to tailor assessments for gay men and other MSM. However, healthcare providers must take suicide seriously and should be familiar with local and national resources available in their own community or country context. They should have a list of mental health professionals who are trained to handle suicide-related mental health concerns. In addition to what may be locally available, additional resources are included at the end of this module.

» HIV-related Stress Disorder

While gay men and other MSM living with HIV often experience dual stigma associated both with HIV and with same-sex behavior, those living with HIV may also experience specific instances over the course of the illness that cause physical harm or additional psychological stress.[30] Life-threatening illness is recognized in the DSM as a stressor that can lead to a posttraumatic stress response.[31] However, rather than shame, humiliation, or guilt, this response is primarily associated with fear and helplessness.[30,32] Some instances associated with HIV that can cause this response, are:

- Trauma associated with receiving an HIV diagnosis
- Beginning HIV treatment
- Lack of access to treatment
- Fear of disclosing HIV status to partner, family, or friends
- Treatment-related side effects
- Distress caused by life-long treatment
- HIV-related discrimination and marginalization

FACILITATOR'S TIP

Ask the group to generate a list of problems that could potentially affect the mental health of gay men and other MSM newly diagnosed with HIV. Then, ask the group to suggest possible strategies for assisting such a client in the clinical setting.

» Sexual Problems

Sexual problems may be common in some gay men and other MSM.[33] These may include issues related to:[34]

- Desire
- Sexual aversion
- Excitement and arousal
- Orgasm
- Sexual pain disorders
- Sexual compulsivity

Additional sexual problems in gay men and MSM are related to anal sex, HIV and sexually transmitted infections, erectile dysfunction, difficulty in ejaculation, and lack of sex drive or interest in sex.

Though not always the case, these problems may arise or persist longer in the presence of mental health issues like depression or psychological stress. Sexual dysfunction, in turn, can impact overall psychological well-being and lead to significant stress within relationships. Where

available, referral to psychological or specialized services may be necessary. If psychological distress is the cause of the sexual problem, then addressing the distress will likely solve the sexual problem.

» Eating Disorders

The connection between physical health and body image is fundamental. How we feel about our bodies affects how we treat our bodies, particularly with regard to what we choose to eat. Studies have found a relationship between body image dissatisfaction and dietary lifestyle, overeating, over-exercising, and the development of eating disorders.[35, 36] With few exceptions, studies have found that gay and bisexual men are significantly more likely to develop eating disorders and have higher rates of dissatisfaction with their bodies compared to heterosexual men.[37, 38] In a sub-culture heavily focused on appearance, individuals who view themselves as inadequate or marginalized may be at increased risk of developing an eating disorder.[39]

» Physical and Sexual Violence

Physical and sexual violence against gay men and other MSM remains an ignored area within clinical science research and practice around the world.[40] However, male-on-male rape, other forms of sexual assault, and domestic violence between same-sex partners are seen in many settings worldwide. Gay men and other MSM, especially those who are visible in their communities, are often subject to harassment, physical violence, and rape.[41] The following are a few points about sexual violence targeted against gay men and other MSM:

- Men can be raped or sexually coerced, including at home, the workplace, school, on the streets, in the military, in prisons, and in police custody.
- Rates of domestic violence in same-sex relationships are similar to rates of domestic violence toward heterosexual women.[42] Approximately 40% of gay and bisexual men report having experienced domestic violence.
- Approximately one in six men has experienced traumatic or abusive sexual experiences in childhood.[45] Research shows that gay men and other MSM are more likely to have had these experiences than their heterosexual peers.[43, 44] Additionally, such abuse is associated with increased rates of HIV and high-risk behaviors.[45]
- Gay men and other MSM who have suffered violence may be unwilling to speak openly about these issues because of shame, fear, or guilt. They also may not report these crimes because of negative attitudes or indifference from law enforcement officials.
- Local resources for men who experience sexual violence are often scarce. Those who do provide services for men often lack appropriate training regarding violence against gay men and other MSM specifically.

- Gay men and other MSM who are violently attacked, abused, or raped often present with mental health challenges such as anxiety or post-traumatic stress disorder as well as legal issues because of these experiences. If possible, providers should familiarize themselves with organizations in their area that provide services for male victims of violence and those who specialize in dealing with cases of rape or sexual assault.

THE IMPORTANCE OF RELATIONSHIPS AND COMMUNITY BUILDING

In spite of widespread stigma and discrimination, gay men and other MSM tend to demonstrate resilience, or the ability to end up healthy human beings even in the face of severe social stressors. Social support from family, friends, or partner(s) is an important facilitator of this well-being. Despite the stereotype that gay men and other MSM are not able to maintain stable relationships, studies show that they do maintain long-lasting relationships as a primary source of support and affection even in socially unsupportive environments.[46-48]

Beyond healthy and stable relationships, studies of gay and lesbian adults suggest that locating a community and developing a support system are fundamental elements in protecting against risks imposed by homophobia. LGBT groups provide support in the community and outreach to vulnerable individuals.

ADDRESSING MENTAL HEALTH ISSUES IN THE CLINICAL SETTING

Trained mental health professionals are best able to assess and treat mental health concerns presented by gay men and other MSM. Providers who are not adequately trained in mental health should not attempt to diagnose a client's mental health status. However, all healthcare providers should be familiar with the factors that affect mental health of gay men and other MSM as well as with commonly presenting issues within a given clinical setting. Concerning gay men and other MSM, all healthcare providers can take steps to:

Affirmation of same-sex sexual orientation may help reduce the effects of social discrimination and stigma experienced by gay men and other MSM.

1. Provide affirmation of same-sex sexual orientation.
2. Recognize the factors that lead to distress in the lives of gay men and other MSM.
3. Provide accurate and up-to-date scientific information regarding the normality of same-sex orientation to clients and their family members.
4. Familiarize themselves with a range of coping skills and strategies to suggest to help clients manage stress.
5. Prepare themselves to provide tools and resources from the community. This should include linkages to community-based organizations and gay-led groups. Providers should also have a list of local mental health professionals who are sensitive to the needs of gay men and other MSM and can provide ethical high-quality care.[49]

FACILITATOR'S TIP

Make this available as a handout and ask participants to review these guidelines. You may ask small groups of 2-4 participants to review 2-3 guidelines each, depending on the size of the training group. Then ask the group to share their thoughts about how differently they may approach gay men and other MSM in a clinical session now that they are aware of these guidelines. Do participants have any suggestions to modify these guidelines so that they are more applicable to their local context or client population?

Providers should review the following guidelines developed for psychological practice with lesbian, gay, and bisexual clients.[50]

1. Psychologists strive to understand the effects of stigma and its manifestations in the lives of lesbian, gay, and bisexual people.
2. Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses.
3. Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe.
4. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.
5. Psychologists strive to recognize the unique experiences of bisexual individuals.
6. Psychologists strive to distinguish issues of sexual orientation from those of gender identity when working with lesbian, gay, and bisexual clients.
7. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.
8. Psychologists strive to understand the experiences and challenges faced by lesbian, gay, and bisexual parents.
9. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.
10. Psychologists strive to understand the ways in which a person's lesbian, gay, or bisexual orientation may have an impact on their family of origin and the relationship with that family of origin.
11. Psychologists strive to recognize the challenges related to multiple and often conflicting norms, values, and beliefs faced by lesbian, gay, and bisexual members of racial and ethnic minority groups.
12. Psychologists are encouraged to consider the influences of religion and spirituality in the lives of lesbian, gay, and bisexual persons.
13. Psychologists strive to recognize cohort and age differences among lesbian, gay, and bisexual individuals.
14. Psychologists strive to understand the unique problems and risks that exist for lesbian, gay, and bisexual youth.
15. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals with physical, sensory, and cognitive-emotional disabilities experience.
16. Psychologists strive to understand the impact of HIV and AIDS on the lives of lesbian, gay, and bisexual individuals and communities.

17. Psychologists are encouraged to consider the impact of socioeconomic status on the psychological well-being of lesbian, gay, and bisexual clients.
18. Psychologists strive to understand the unique workplace issues that exist for lesbian, gay, and bisexual individuals.
19. Psychologists strive to include lesbian, gay, and bisexual issues in professional education and training.
20. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.
21. In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings.

FACILITATOR'S TIP

Emphasize that this module is not meant to prepare health providers to treat mental health problems, but rather to familiarize them to these issues in gay men and other MSM. If needed, healthcare providers should refer clients with mental health problems to a qualified mental health care provider.

KEY POINTS FROM THE MODULE

- Homosexuality is not a mental disorder
- Experiences of stigma and discrimination put gay men and other MSM at higher risk for developing a mental disorder
- Gay men and other MSM experience additional stress while coming out and during certain life stages such as aging
- Appropriate affirmation of same-sex behavior and counseling can minimize the effects of stigma and assist gay men and other MSM in their wellbeing.
- Support from community based organizations or groups can be protective against social isolation and harmful effects of homophobia

PRE-POST ASSESSMENT

1. Homosexuality is currently classified as a mental illness in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

   [ ] True [ ] False

2. Most studies have shown that reparative therapies that attempt to cure an individual of their homosexuality are highly efficacious.

   [ ] True [ ] False

3. Examples of stigma and discrimination toward gay men and other MSM by health providers include:

   a. refusing needed care
   b. refusing to touch a gay or MSM client
   c. using harsh or abusive language
   d. blaming the gay or MSM client for their health status
   e. all of the above

4. ______________________ refers to a period when a gay man or other MSM becomes conscious of his sexual orientation or identity and the fact that he is sexually and/or emotionally attracted to other men.

5. Affirming one's same-sex orientation and reflecting a positive view of homosexual identities and relationships are strategies to address the negative influences of stigma and discrimination on gay and other MSM clients.

   [ ] True [ ] False

6. Experiences of stigma and social discrimination put gay men and other MSM at higher risk of developing a mental disorder such as anxiety or depression.

   [ ] True [ ] False

7. It is not possible for a man to be raped.

   [ ] True [ ] False

8. Which of these is NOT a consequence of the criminalization of homosexuality?

   a. Decreased access to health services, housing, and/or work for gay men and other MSM
   b. Increased likelihood of disclosure of same-sex behavior by gay men and other MSM
   c. Deterrence of health workers from providing services to gay men and other MSM
   d. Higher rates of stigma and discrimination toward gay men and other MSM

9. Younger gay men usually exhibit higher rates of depression, anxiety, and suicidality than older gay men.

   [ ] True [ ] False

10. Social support from partners, family, or the community facilitates the health and well-being of gay men and other MSM.

    [ ] True [ ] False

ADDITIONAL RESOURCES

For more on supporting adolescent gay men and other MSM, please see:

» Society for Adolescent Health and Medicine. Recommendations for Promoting the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Adolescents: A Position Paper of the Society for Adolescent Health and Medicine. Journal of Adolescent Health. 52(4): 506-510; 2013.

For more on aging in gay men and other MSM, please see:

» The National Resource Center on LGBT Aging,
http://lgbtagingcenter.org/

» Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders,
http://www.sageusa.org/

For more on eating disorders, please see:

» National Eating Disorders Association,
https://www.nationaleatingdisorders.org/sites/default/files/ResourceHandouts/LGBTQ.pdf

For more on mental health challenges associated with HIV, please see:

» University of California, San Francisco
http://hivinsite.ucsf.edu/hiv?page=pb-daily-mental#S8X

For more on suicide, please see:

» Fact Sheet on LGBT Youth and Suicide,
http://www.suicidology.org/c/document_library/get_file?folderId=262&name=DLFE-594.pdf

» Warning Signs of Suicide,
http://www.suicidology.org/resources/mutlimedia-resources/suicide-warning-signs

» How to assess someone who is at risk for suicide,
http://cebmh.warne.ox.ac.uk/csr/clinicalguide/assess.html

» What to do if someone is having suicidal thoughts,
https://www.suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard_AssessingRisk_GREEN.pdf

For more on domestic violence among gay men and other MSM, please see:

» LAMBDA GLBT Community Services
http://www.lambda.org/DV_background.htm

» Center for American Progress
http://cdn.americanprogress.org/wp-content/uploads/2012/12/domestic_violence.pdf

For more on addressing the mental health needs of gay men and other MSM, please see:

» American Psychological Association,
http://www.apa.org/pi/lgbt/resources/index.aspx

» American Psychological Association
http://www.apa.org/pi/lgbt/resources/biblio.aspx#7b

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Taking a Sexual History

LEARNING OBJECTIVES:

After completing this module, participants will be able to:

1. Take a comprehensive sexual history sensitively.
2. Describe the various steps of health assessment.
3. Assess the health status of sexual partners.

INTRODUCTION

Health providers play a central role in the prevention and treatment of health conditions that affect gay men and other men who have sex with men (MSM). Experts recognize that health promotion occurs largely at the individual level and is effectively facilitated by meaningful health assessments and behavior modification techniques. However, gay men and other MSM are less likely than their non-MSM peers to receive adequate assessment, treatment, and prevention of health problems. Providers who are able to assess affectively the risks their clients face are better able to promote the overall health of their gay or other MSM clients.

This module provides an in-depth discussion of how to take a comprehensive sexual history of a gay or other MSM client. It stresses the importance of confidentiality when taking a sexual history, presents the barriers to sexual history taking as well as how to overcome these barriers. It then discusses key communication issues when taking the sexual history of a gay or MSM client, giving specific questions to ask during the course of the sexual history interview. Finally, it explores motivational interviewing before ending with a brief section on charting of sexual history.

MODULE OVERVIEW

1. Confidentiality
2. Barriers to sexual history taking
   - Provider barriers
   - Client barriers
3. Steps for addressing barriers
4. Asking about same-sex behavior in men

5. Key communication issues
6. Questions to include and how to ask them
   - Assess the partner situation
   - Assess sexual practices
   - Assess sex partner meeting venues
   - Assess HIV and STI status of client and partners
   - Assess condom use
   - Assess drug and alcohol use
   - Ending the interview
7. Motivational interviewing
8. Charting sexual history
9. Key points from the module

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 6 at:

http://icap.columbia.edu/news-events/detail/reaching-msm-with-hiv-prevention-care-and-treatment-services-in-rwanda

QUESTIONS FOR DISCUSSION

1. In Rwanda, there is strong cultural resistance to homosexuality and many people believe that homosexuality does not exist in their country. What are some of the ways that these beliefs may have resulted in low levels of access and utilization of HIV services in Rwanda?
2. The article mentions that the reluctance of gay men and other MSM to seek healthcare services because of fear of stigma and discrimination was a key challenge for the program. In response, the International Center for AIDS Care and Treatment Programs (ICAP) employed targeted outreach activities, including involvement of the local MSM community in several ways. In what ways did ICAP involve the local community? Why was this involvement so critical to the success of the program?
3. What are some of the barriers to gay men and other MSM accessing services in your community? How might these barriers be addressed?

CONFIDENTIALITY

Confidentiality is the cornerstone of all provider-client relationships, but gains special significance when working with gay men and other MSM.

Confidentiality is critical to all provider-client relationships. This is true not only for gay and other MSM clients, but for all clients. However, confidentiality gains special significance when working with gay men and other MSM. Many gay men and other MSM do not disclose their sexuality or sexual behavior to their healthcare provider because doing so could result in harassment, blackmail, violence, or even imprisonment in some

countries. Providers should discuss confidentiality and its limits with their clients. Assuring clients that any information provided during a session will not be shared without their express permission may help alleviate any fears or concerns held by the client. Clients who are afraid of negative consequences of disclosure are less likely to engage productively in counseling and less likely to receive the full benefits of the session. Assuring clients that privacy and confidentiality will be respected should be a priority of each session.

GROUP ACTIVITY

Developing a Confidentiality Statement[3]

Objective: This activity is designed to help participants think more deeply about issues of confidentiality. In this activity, participants will think through how to develop their own confidentiality statements.

Main activity: Divide the participants into small groups and instruct each group to develop its own confidentiality statement. Key elements of the statement should include:

1. The information covered by the policy.
2. Who has access to the medical record.
3. How test results will remain confidential.
4. Instances when maintaining confidentiality is not possible.
5. Policy for sharing information with insurance companies (if appropriate).

Allow time for the participants to think through what they will include in their policy.

You may choose to begin this discussion by discussing client rights and responsibilities. An example of such a document is found in the Fenway Health Brochure here: http://www.fenwayhealth.org/site/DocServer/Patient_Rights_Brochure_Fenway_Health_English.pdf?docID=11141

Discussion: Have each group present their policy. Encourage the other groups to pose questions about the presenters' work. After the other groups ask questions, point out aspects that you as the facilitator felt were particularly positive and clarify any aspects that were problematic.

Summarize key findings: After all of the groups have presented, highlight important aspects of the created policies and the importance of confidentiality when working with gay men and other MSM.

BARRIERS TO SEXUAL HISTORY TAKING

Statistically speaking, every healthcare provider who interacts with more than twenty male clients per day will have at least one gay or other MSM client.[1] These clients are often not recognized as such. Taking a complete and accurate sexual history is critical to providing appropriate care, but gay men and other MSM are often reluctant to volunteer their true sexual history to a provider who they perceive to be judgmental. There are many barriers to taking a sexual history:

» **Provider barriers**
- Lack of experience or discomfort with asking questions.
- Discomfort or inability to respond to issues that arise.

- Homophobia, anti-gay bias, or heterosexism.
- Inability to understand consensual same-sex sexual behavior between adults as normal expression of sexuality. Making false assumptions regarding sexual behavior and level of risk.
- Uncertainty in how to help a client feel comfortable, particularly with regard to discussing same-sex relationships.
- Lack of time.

» **Client Barriers:**

- Embarrassment or shame.
- Perception of stigma from a healthcare provider.
- Lack of awareness of sexual health issues.
- Differences between doctor and client.
  - Age gender, skin color, appearance, ethnicity, national origin, sexuality, culture, wealth, social class, sexual orientation.

FACILITATOR'S TIP

Before covering this section, have the participants brainstorm ways to overcome the barriers presented above.

STEPS FOR ADDRESSING BARRIERS

Most of the barriers presented in the previous section can be overcome by planning ahead and becoming educated about clients and how to take their sexual history. Though it is common to feel uncomfortable discussing matters of sexuality with clients, most providers already possess the skills necessary to do so. Over time and with practice, providers will feel more comfortable and discussing sexuality will become easier. Though each individual will develop their own personal style, here are a few specific tips relating to sexual history taking and communication:

The majority of barriers can be overcome by planning ahead and becoming educated on clients and how to take their sexual history.

» Develop a policy indicating when to initiate a sexual risk assessment.

» Determine how sexual risk assessments will be integrated into the clients' overall care.

» Identify specific questions to ask.

» Develop a plan for how to respond to information that might surface.

» Train staff on how to perform a sexual risk assessment.

ASKING ABOUT SAME-SEX BEHAVIOR IN MEN

By asking all male clients about same-sex sexual behavior, not only will the provider become comfortable, but the client may also become more comfortable knowing that all clients are asked the same questions. This section presents several tips for asking about same-sex behavior in male clients. Providers should:[2]

» **Ask about same-sex behavior in all male clients**

Providers should ask all male clients about same-sex or bisexual behavior regardless of the client's age, sexual identity, or marital status.

They should not assume that a man who presents as "masculine" will not engage in same-sex behavior. Gender expression is not indicative of sexual behavior.

» **Ask about same-sex behavior even in married men**

Simply because a man is married to a woman does not mean that he does not engage in sex with other men. It is beneficial to ask about same-sex behavior even if the client is married to a woman.

» **Ask about same-sex behavior across all age groups**

Gay men and other MSM come in all age groups. Providers should not assume that only younger men will practice same-sex behavior.

» **Ask about opposite-sex behavior even in self-identified gay men**

Self-identified gay men may have female partners and may even marry and have children in order to fulfill societal expectations. Asking about female partners is important so the provider can refer clients and their partners to appropriate services.

» **Ask about steady male partners of self-identified gay men**

Providers should ask self-identified gay male clients about any long-term partners they may have. This is important not only for referral and partner testing, but also for assessing a client's network of social support.

KEY COMMUNICATION ISSUES

Providers might feel that clients will be surprised by questions about sexual health, but most clients actually welcome them. Providers should simply begin by preparing the client so they are aware that these types of questions are to come.[3] Providers should also:[1]

» Develop rapport with the client while being sensitive to concerns about confidentiality and assuring the client that they can speak freely without fear of judgment.

» Explain the importance of taking a sexual history. Providers should tell the client they should be open during the interview because these questions will help the provider give optimal care, even though the questions may be sensitive.

» Never assume the client is either heterosexual or homosexual.

» Use gender-neutral language when talking about sexual or emotional partners.

» Use the same language as the client when talking about sexual behavior and identity.

Underscore that the interview is part of routine care, emphasizing confidentiality and the desire to provide quality care. A few key issues are:[3]

- **Avoid making assumptions**: Assumptions based on gender, age, marital status, disability, or other characteristics are not necessarily true. For example, a male client who is married to a woman may not be sexually monogamous with their spouse and does not necessarily have sex with only women.
- **Be nonjudgmental, direct, and specific:** Doing so with questions about sexual behavior is a good way to normalize the behavior and make the client comfortable. Providers should cultivate self-awareness of their own judgments and how these judgments affect their work so that they can "check" their judgments at the door. They should also be aware of their non-verbal communication to avoid coming across as judgmental.
- **Ask open-ended questions**: Questions that require more than a yes or no answer help to open the dialogue between the provider and client encouraging a more complete history.

FACILITATOR'S TIP

Each participant will have his or her own unique way of asking questions. As you present this section, ask participants to share how they would ask questions to elicit information from clients. It may also be helpful to have participants think through how to ask these questions in their local language.

Examples of statements to introduce the sexual history and reinforce confidentiality include:[3]

"As I do with all of my clients, in order to provide you with the best possible care, I am going to ask you several straightforward questions related to your current and past sexual activity. I will also ask questions about drug and alcohol use."

"Everything we discuss is strictly confidential and will stay between you and me."

"I take a sexual and alcohol/drug use history with all of my clients as part of their health assessment. This is important in order to provide optimal care. I know that these subjects are very personal. Please know that I will not divulge this information to anyone."

QUESTIONS TO INCLUDE AND HOW TO ASK THEM

The following section explores specific topics and questions to ask when taking a sexual history. The following are courtesy of the MSM Toolkit by Fenway Health in Boston, MA, USA.[3]

- **Ask about sexual partners**

  Begin with open-ended questions to initiate an open conversation. A good way to start is by stating:

  "Tell me about your recent sexual partners."

If it does not come out clearly, providers can probe further for specific information such as the gender of sexual partners, the number of sexual partners, and the nature of the relationships with these partners (steady and casual partners).

> *"Do you have sex with men, women, both, or neither?"*
>
> *"How many sexual partners do you have?" or*
>
> *"How many sexual partners have you had in the past six months?*
>
> *"Does your primary partner have other sexual partners?"*

» Ask about sexual practices

The goal is to identify the types of sexual contact in which the client has engaged so health risks can be evaluated. Providers should ask about vaginal, oral (insertive and/or receptive), and anal (insertive and/or receptive) sexual acts. They may also enquire about oral-anal contact (rimming) or digital-anal contact (fingering or fisting) as these may also carry health risks. For instance, there is risk for enteric parasitic infections or hepatitis with rimming or rectal fissures with fisting. When asking about sexual practices, providers should avoid labels such as "gay," "homosexual," or "straight" because many men do not identify as gay even if they engage in sexual acts with other men. If the provider is uncomfortable using colloquial terms like "top," "bottom," "rimming," or "fisting," they can use descriptive terms instead.

Example questions to ask for information about sexual practices include:

> "Do you have oral sex?"
>
> If yes, *"Do you put your penis in your partner(s)' mouth? Do partners put their penises in your mouth?"*
>
> "Do you have anal sex?"
>
> If yes, *"Do you put your penis in your partner(s)' anus?" or "Have you been a top?"*
>
> *"Have your male partners put their penises in your anus?" or "Have you been a bottom?"*

» Ask about venues where client meets sexual partners

Providers should ask whether their client meets partners at bars or clubs, on the Internet, at circuit parties, at bathhouses, and at public venues. They should also ask about recent travel and sex abroad. This is for epidemiological reasons such as antibiotic resistance or STIs less common locally. Some men may engage in sex with men or riskier sex only when traveling. Providers should also ask about exchange of sex for money, drugs, or shelter.

Example questions to ask for information about sexual partner meeting venues include:

"How do you meet your sexual partners?"

"Have you had sex abroad recently?" and "Does your sexual behavior change when you travel outside of your home area on vacation or business trips?"

"Have you ever exchanged sex for money, drugs, shelter, or anything else?"

» **Ask about experience with condom use and other prevention modalities**

As appropriate, providers should ask clients about the frequency and consistency with which they use condoms and the circumstances surrounding their condom use. Some clients may never use condoms or may use them differently with casual partners than with regular partners. They may use condoms only for certain types of sexual acts, such as anal intercourse but not oral sex. It may be best to ask an open-ended question since clients may provide more information this way.

One way to ask for information about condom use is:

"Tell me about your experience with condom use."

» **Ask about known HIV and STI status of the client and their sexual** partners

Providers should ask about the client's HIV and other STI status and that of their sexual partners.

Example questions to ask for information about HIV or other STI status include:

"Have you ever been tested for HIV?"

If yes, *"When were you last tested for HIV? What was the result?"*
If no, *"What are the reasons you haven't been tested for HIV? Do you have any concerns regarding HIV testing?"*

"Have you been tested for STIs?"

If yes, *"When were you last tested for STIs. What was the result?"*

If no: *"What are the reasons you haven't been tested for STIs?*

FACILITATOR'S TIP:

You may choose to review one or two sexual history taking tools and then ask the participants to come up with their own sexual history taking guide as an exercise.
Two good examples are:
http://www.stdhivtraining.org/resource.php?id=4&ret=resource_search
http://www.anovahealth.co.za/images/uploads/rebe_presentation.pdf

Do you have any concerns regarding STI testing?"

"On how many occasions have you had sex with a partner who you know is HIV positive?"

» **Ask about drug and alcohol use**

Gay men and other MSM, like others, use drugs and alcohol for any number of reasons. Literature suggests that gay men and other MSM use drugs and alcohol as a mechanism for coping with stigma and homophobia. In the context of sexual history taking, providers should ask about drug use in a nonjudgmental and non-stigmatizing manner. Providers should not assume that reported drug use automatically means sexual risk behavior or dependence.

Example questions to ask for information about drug and alcohol use include:

"Tell me about your alcohol use."

"What has been your experience with drugs?"

Summarize the client's response to questions. This assures the client that the provider is listening and helps clarify misunderstandings.

Ending the interview: By the end of the interview, the client may have questions or concerns that they were not ready to discuss earlier. Providers should give the client an opportunity to voice these concerns:

"What other things about your sexual health and sexual practices would you like to discuss today?"

Motivational interviewing is an evidence-based approach to behavior change that works to create motivation to change within the client.

MOTIVATIONAL INTERVIEWING

Once the sexual history has been taken and the provider understands the risk behaviors in which the client has engaged, they may counsel the client to reduce their risk of acquiring HIV or another STI. Motivational interviewing is a person-centered counseling method that focuses on exploring and resolving ambivalence about change and works to create motivation within the client to facilitate this change. It is an established, evidence-based practice to help individuals change behavior. It does not impose change, but rather supports it in a manner that is congruent with the client's own values and concerns. Motivational interviewing uses collaborative, goal-oriented communication and generally relies on four (sometimes broken to five) general principles:[4]

Express empathy: By showing the client they are able to see the world as the client sees it, the provider creates an environment in which clients can openly and honestly express their experiences.

Develop discrepancy: Discrepancy occurs when the client perceives a mismatch between where they are and where they would like to be. Developing discrepancy involves assisting the client to see that their current behaviors place them in conflict with their values or goals. This makes them more likely to be motivated to change.

Roll with resistance: In motivational interviewing, resistance occurs when there is a conflict between the client's and the provider's views of the issue or solution or when the client feels that their autonomy is being infringed upon. When this occurs, providers should not confront the client, but rather "roll with it" to work to de-escalate the situation and avoid a negative interaction.

Support self-efficacy: Self-efficacy is one's belief in one's own ability to reach goals. In motivational interviewing, providers assist clients in believing that change is possible by focusing on previous successes and highlighting skills and strengths that the client already possesses.

Motivational interviewing has proven to be effective at initiating change in many fields, including cigarette smoking, drug and alcohol use, and HIV prevention among people who use injection drugs.[5] Among gay men and other MSM, motivational interviewing has been shown to be acceptable and feasible to deliver in a variety of settings. It is largely equivalent to other active treatments for behaviors such as drug use and sex without a condom, at least in the short-term.[6] However, the effectiveness of motivational interviewing as an intervention has shown limited success in reducing the risk of acquiring a new STI or HIV infection. As such, more work is required to craft more effective HIV prevention programming for gay men and other MSM.

GROUP ACTIVITY

Taking a sexual history

Objective: This activity helps participants practice and feel more comfortable asking questions relating to sex and sexuality to their clients.

Main activity: Ask participants to form pairs or groups. Then, either using an existing sexual history taking tool or one that the participants create, ask them to role play the questions they would ask to elicit information from their clients when taking a sexual history. Have participants go through each of the parts in the above section. Take turns being the provider and the patient. Try changing the personalities of the patient. Try one who is reluctant to divulge information versus one who provides a lot of detail of sexual exploits. Compare participants' questions to the examples given.

Discussion: After, facilitate a brief discussion about any difficulties participants encountered and how they felt while taking the sexual history. Discuss aspects that would be similar or different when taking the sexual history of a gay man or other MSM.

Summarize key findings: Summarize the key points that were elicited during the discussion, particularly highlighting aspects important for working with gay men and other MSM.

CHARTING SEXUAL HISTORY

Office practices vary greatly in how to handle charting of sexual history. Each system has its own benefits and limitations. Some systems keep all client information in one centralized record. This is convenient for providers but may pose challenges in terms of confidentiality. Other systems have a separately-designated section of each record for confidential information. This is better for confidentiality but means that providers must review two charts and may overlook potentially important information. Other systems use codes for test results and diagnostic information. This may create problems if the system is too complex or difficult to decipher. A few questions to consider when determining which charting system to use include:

» Do client history forms include questions regarding sexual history? If not, how will this information be documented if a sexual history is done? How will updated versions be documented?

» Do client history forms provide for self-identification in categories such as gender identity, sexual orientation, marital and family status? Do these forms provide the option for further written explanation?

Regardless of the system used, it is important to remember that clients must have access to their records and must easily be able to understand the information that has been documented.

KEY POINTS FROM THE MODULE

» Assuring gay and other MSM clients of confidentiality helps them feel comfortable and be open while taking their sexual history.

» A large number of barriers to the taking of a proper sexual history exist. These barriers range from higher-level factors such as homophobia or heterosexism to lack of provider knowledge to lower-level factors such as lack of time.

» Most barriers to sexual history taking can be overcome by planning ahead and becoming educated on how to take sexual history.

» Providers should ask about same-sex or bisexual behavior in all male clients regardless of the client's age, sexual identity, or marital status.

» Providers should avoid making assumptions and be as nonjudgmental, direct, and specific and possible.

» Providers may feel uncomfortable at first, but sexual history taking will become easier and more comfortable over time and with practice.

» Motivational interviewing is an evidence-proven counseling method that helps clients change behaviors.

» Keeping all client information in one centralized record is an easy-to-use system, but may pose problems for confidentiality. Consider a system with separate sections for sensitive information.

PRE-POST ASSESSMENT

1. Gay men and other MSM are less likely than their non-MSM counterparts to receive adequate assessment, treatment, and prevention of health problems.

   [ ] True [ ] False

2. ________________________ is an established, evidence-based, person-centered counseling method that focuses on exploring and resolving ambivalence about change and works to create motivation within the client to facilitate a change in behavior.

3. Which of these is a barrier to the taking of a proper sexual history?

   a. Making false assumptions regarding the sexual behavior and level of risk of clients

   b. Discomfort discussing sexuality or the inability to respond to issues that arise

   c. Homophobia, anti-gay bias, or heterosexism

   d. Lack of time

   e. All of the above

4. Providers can overcome most barriers to the taking of a proper sexual history can by planning ahead and educating themselves on their clients and how to take their sexual history.

   [ ] True [ ] False

5. Risk assessments should be integrated with each new client visit and updated regularly as the client's circumstances or behaviors change over time.

   [ ] True [ ] False

6. ________________________ is the cornerstone of all physician-client relationships, but gains special significance when assessing the health status of your gay and other MSM clients, especially those who have not come out or who are not open about their sexual behavior.

7. It is important to ask clients about sexual partner meeting venues, including bars or clubs, on the Internet, at circuit parties, at bathhouses, public venues, and about sex during travel.

   [ ] True [ ] False

8. With which group of men should providers ask about same-sex sexual behavior?

   a. Young men only

   b. Married men only

   c. Self-identified gay men only

   d. Gender non-conforming men only

   e. All male clients

9. The best charting system for all practices is to keep all client information in one centralized record because it is the easiest system to use and the only way to ensure client confidentiality.

   [ ] True [ ] False

10. Questions during sexual history taking should be limited to the topic of sexual behavior.

    [ ] True [ ] False

ADDITIONAL RESOURCES

Some important resources to consider in your training include:

- Patient Sexual Health History: What you need to know to help (online video, American Medical Association)
- Nussbaum MH, Hamilton CD. The Proactive Sexual Health History. Am Fam Physician. 66(9):1705-13. 2002.
- Centers for Disease Control and Prevention

  http://www.cdc.gov/std/treatment/SexualHistory.pdf

- Mountain Plains AIDS and Education Training Center and Seattle STD/HIV Prevention Training Center,
  https://medicine.utah.edu/internalmedicine/infectiousdiseases/uaetc/resources/std.pdf

For more on taking a sexual history or risk assessment questionnaires, please see:

- National LGBT Health Education Center. Fenway Health
- http://www.lgbthealtheducation.org/wp-content/uploads/13-013_SexualHistoryToolkit_v7.pdf
- National LGBT Health Education Center. Fenway Health
  http://www.lgbthealtheducation.org/wp-content/uploads/policy_brief_how_to_gather.pdf

- Project Explore
  http://caps.ucsf.edu/project-explore/

For more on motivational interviewing, please see:

- Motivational Interviewing, motivationalinterview.org
- Rosengren, D. B. Building Motivational Interviewing Skills: A Practitioner Workbook. New York: The Guilford Press. 2009.
- Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Health Care: Helping Clients Change Behavior. New York: The Guilford Press. 2008.

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2. Chakrapani V. Providing Quality Sexual Health Care to Men who have Sex with Men (MSM) and Hijras in India- Clinical Manual, 2005.
3. Ratelle S, Mayer K, Goldhammer H, Mimiaga M, Coury-Doniger P. Fenway MSM Toolkit; 2005.
4. Motivational Interviewing. http://www.motivation-alinterview.org/index.html (accessed Feb. 5 2014).
5. Miller WR, Rollnick S. Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: The Guilford Press; 1992.
6. Berg RC, Ross MW, Tikkanen R. The Effectiveness of MI4MSM: How Useful is Motivational Interviewing as an HIV Risk Prevention Program for Men who have Sex with Men? A Systematic Review. AIDS Education and Prevention 2011; 23(6): 533-49.

Supporting Gay Men and Other MSM Who Use Drugs and Alcohol

LEARNING OBJECTIVES

After completing this module, participants will be able to:

1. Describe the reasons for drug and alcohol use among gay men and other men who have sex with men (MSM).
2. Describe the known patterns of drug and alcohol use among gay men and other MSM.
3. Name the common drugs used by gay men and other MSM.
4. Discuss drug and alcohol use within the clinical setting with gay men and other MSM more comfortably.

INTRODUCTION

Research suggests that gay men and other MSM are more likely to use drugs and alcohol when compared with adults in the general population.[1] In this curriculum, "drugs" refers specifically to non-prescription drugs that are considered illegal or otherwise "recreational" in most countries. These higher rates of use can be a reaction to homophobia, discrimination, or violence that gay men and other MSM experience because of their sexuality.[2] In the clinical setting, candid discussions between healthcare providers and clients about the use of drugs and alcohol can be challenging and present with various barriers in nearly every context and when serving any given population. This is made more difficult because drug use and possession is not only highly stigmatized but also severely criminalized with harsh punishments in nearly every country.[3] For gay men and other MSM who use drugs, the added stigma they encounter when discussing their sexuality with providers makes it more difficult to talk candidly about drug and alcohol use.

This module aims to increase healthcare providers' knowledge of alcohol and drugs commonly used by gay men and other MSM. It also discusses the contexts in which drug or alcohol use occurs. It aims to increase healthcare providers' sense of comfort in discussing drug- and alcohol-related issues with clients in the clinical setting. This module does not aim to provide clinical guidance and training on how to implement specific harm reduction interventions like needle exchange programs nor does it provide training on how to diagnose or treat drug or alcohol dependence. Clients seeking or needing such higher-level interventions are best counseled according to nationally recognized guidelines around drug- and alcohol-related healthcare or referred to qualified allied health professionals.

MODULE OVERVIEW

1. Getting comfortable talking about drugs and alcohol
2. Do gay men and other MSM use drugs and alcohol more than others?
3. Why do gay men and other MSM use drugs and alcohol?
4. What are the known patterns of drug use among gay men and other MSM?
5. The link between drug use and HIV transmission
6. Drugs commonly used by MSM and their effects
7. Approaching drug use in the clinical setting
8. Drug and alcohol use screening tools
9. Interventions for decreasing drug and alcohol use
10. Potential signs of drug or alcohol abuse
11. Gay men and other MSM who do not report problematic drug or alcohol use

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 7 at:

http://www.pinknews.co.uk/2014/03/31/
london-study-chemsex-by-gay-men-is-often-to-mask-self-esteem-issues/

QUESTIONS FOR DISCUSSION

1. What relevance does the drug use scenario presented in the case study have for your country or local context?
2. Why do you think it is harder for gay men and other MSM to negotiate safer sex other than being under the influence of drugs?
3. What are strategies that you may recommend to encourage gay men and other MSM who uses drugs to connect with a healthcare provider?

GETTING COMFORTABLE TALKING ABOUT DRUGS AND ALCOHOL

It is important to recognize that an unknown proportion of people, regardless of socio-economic status or education level, use drugs and alcohol globally and do so for any number of reasons. Many of these individuals go through life using drugs and alcohol either regularly or occasionally without any disruption or negative impact on their social, professional, or physical lives. A proportion of them may even report positive benefits from their use of drugs or alcohol. It is also important to recognize that

for others, drug and alcohol use might be problematic each time they use drugs and alcohol or only under specific circumstances. For instance, drug and alcohol use may be problematic only when they use a particular drug or type of alcohol or only when they use an excessive amount. In these cases, they may report that their drug and alcohol use interferes, either at all times or under specific circumstances, with their personal health goals and/or with their goals for security, job, relationships, and family.[4]

GROUP ACTIVITY

Drug and Alcohol Use Awareness[28]

Objective: This activity is designed to allow participants to explore their believes and attitudes toward substance use. Participants will choose their placement along a continuum of true and false for a variety of statements relating to drug and alcohol use.

Main activity: Write or use a computer to print "True" on a large sheet of paper and tape it to a wall on one end of the training room. Write or print "False" on a second large sheet of paper and tape it to the opposite wall. Tell the group that you'll be standing in the middle of a line that runs the entire length of the room. One end of the room is the "True" area and the opposite end of the room the "False" area. In between represents a continuum of responses anywhere between "True" and "False."

Next, read the following statements aloud and ask the participants to move to the point on the line that best represents their views or beliefs. All of the statements are ambiguous. After everyone has moved, ask volunteers to support their points of view from the True, False, and Middle groups.

Statements:

» I use drugs.

» It's okay for young people to drink under their parents' guidance.

» It is important for people to be held responsible for things they do when they drink or get high.

» It's okay if my friends drink alcohol.

» It's okay if a friend uses illegal drugs.

» A drug user who works for your organization should be fired.

» Manufacturers of alcohol should be allowed to advertise their products on TV.

Questions for discussion: After you have completed the above statements, ask each of the questions below for discussion.

1. What did you learn as you participated in this activity?
2. Did anything surprise you? What?
3. Do you believe that some discussion of why persons selected their position on the continuum might have brought persons together? Why or why not?

Summarize key findings: Depending on how participants respond in this activity, what can you learn about the participants' awareness around drug and alcohol use and their view of drug and alcohol users? If participants appear judgmental or narrow in their views, you may transition the closing conversation about how that would apply to a clinical setting.

DO GAY MEN AND OTHER MSM USE DRUGS AND ALCOHOL MORE THAN OTHERS?

Research of drug and alcohol use among any population is difficult for many reasons. Some of these reasons are methodological and lead to challenges in comparing data across studies. Other reasons relate to the variation in drugs used, the quality of those drugs, and the patterns of drug and alcohol use. Patterns of drug and alcohol use can vary greatly across communities within the same country and even across the lifetime of one individual. Therefore, it is challenging to implement studies of drug and alcohol use prevalence among gay men and other MSM, who are themselves a hard-to-reach population because of criminalization and/or the stigma associated with same-sex behavior. Compounding this, the high levels of stigma associated with drug use prevent people from discussing drug use with researchers.

Additional research is needed, but several studies suggest higher rates of drug and alcohol use among severely marginalized populations, including gay men and other MSM. This suggests a clear link between drug and alcohol use and experiences of social discrimination such as criminalization, rejection, isolation, and the denial or abuse of human rights. Studies also indicate that some gay men and other MSM are less likely to abstain from drug and alcohol use and continue drinking heavily later in life to cope with experiences of marginalization.[2] For currently available prevalence data on drug use among gay men and other MSM across various world regions, refer to Adam Bourne's work on Drug Use Among Men Who Have Sex With Men.[4]

WHY DO GAY MEN AND OTHER MSM USE DRUGS AND ALCOHOL?

More research is needed to fully understand the reasons why gay men and other MSM use drugs and alcohol. Based on the existing literature, some of the reasons include:

1. To cope with anxiety, depression, isolation, and loneliness that result from stigma, homophobia, and social marginalization.
2. Because drugs and alcohol may be common or appear normalized in some social venues where gay men and other MSM socialize.
3. Drugs and alcohol help individuals relax, overcome social inhibitions, and increase confidence while seeking sexual partners.[5]
4. Drugs and alcohol can provide psychological enhancement of sexual experiences, the ability to engage in sex for extended periods of time, and lower sexual inhibitions.[6-8]
5. For gay men and other MSM living with HIV, drugs and alcohol may help them cope with a diagnosis of HIV and escape from the fear of rejection given their HIV-positive status.[9]

WHAT ARE THE KNOWN PATTERNS OF DRUG USE AMONG GAY MEN AND OTHER MSM?

We can draw several inferences based on our understanding of the limited data that exist concerning patterns of drug use among gay men and other MSM. Some of these include:[4]

1. Drug use among gay men and other MSM appears to be episodic, meaning that weekly or monthly use is more common than daily use. This suggests that gay men and other MSM are not usually drug-dependent but use drugs only in specific situations (such as when they are experiencing stress) or events (such as when they are partying or having sex).[10-12]
2. Patterns of drug use among gay men and other MSM are not uniform within all communities of gay men and other MSM. Minority of groups of MSM (such as ethnic minority gay men in the United States), younger gay men, and gay men living in urban areas report higher rates of drug use.[13-18]
3. Gay men and other MSM tend to use more than one drug during the same session or within a given time frame (known as polydrug use). For healthcare providers, this has implications for taking a comprehensive drug use history in a clinical encounter and for delivering accurate health information and resources as necessary.[19, 20]
4. Prevalence of injection drug use, especially heroin, has been low – rarely over 5% –compared to non-injection drug use. However, little or no attention has been given to understanding non-injection drug use among gay men and other MSM by researchers and public health officials.[21]

THE LINK BETWEEN DRUG USE AND HIV TRANSMISSION

Although the link between non-injection drug use and HIV is not fully understood and may be complex, some studies correlate drug use with higher incidence of HIV infection:

- Drug use may be linked to HIV risk, especially through the sharing of injection equipment and unprotected sex with a serodiscordant and viremic partner while under the influence of these drugs. The Centers for Disease Control and Prevention (CDC) report that injection drug users represent an estimated 12% of new HIV cases each year in the United States.[22]
- Drug use can lead to high-risk sexual behaviors because certain drugs lower sexual inhibition.[22]
- Use of some specific drugs such as cocaine or methamphetamines is associated with interruptions in anti-retroviral therapy (ART), which can increase chances of HIV transmission.[23]

» Among gay men and other MSM who are being treated for sexually transmitted infections (STIs), drug use is linked to a higher likelihood of HIV transmission.

DRUGS COMMONLY USED BY GAY MEN AND OTHER MSM AND THEIR EFFECTS

The following table summarizes drugs commonly used by gay men and other MSM worldwide with their corresponding street names/regional variations and established effects as reported in the literature.

List of Drugs	Street Name/Regional Variation	Effects
Alcohol	–	» Produces state of pseudo-relaxation and happiness. Continued consumption can lead to blurred vision, coordination problems and aggressive behavior. » Long-term use may affect vital organs, increased risk of cardiovascular disease, alcoholic liver disease, and cancer.
Amphetamine	» Speed » Uppers » Sulphate » Whizz	» Immediate effect: high-energy, feelings of confidence, invincibility, or impulsiveness » Continuous use: anxiety, depression, confusion, insomnia, psychosis, and suicidal ideation. » Long term use: loss of motor control or memory
Cannabis	» Marijuana » Mary Jane » Dope » Pot » Spliff » Hash(ish) » Weed » Puff » Grass » Herb » Draw » Wacky backy » Ganja » Hemp	» State of relaxation and happiness

Cocaine	» Coke » Charlie » C » Snow » Blow » A toot » Bolivian/ Peruvian/ Colombian marching powder	» Feelings of extreme happiness, confidence, and sexual arousal; usually followed by agitation, depression, anxiety, paranoia, and decreased appetite » Rare side and dosage-dependent effects include cardiac arrest or seizures, respiratory problems, insomnia, blurred vision, and vomiting.
Crack cocaine	» Rock » Base	
Crystal meth-amphetamine	» Crystal » Tina » Meth » Ice » Crank	(See above under amphetamines)
Ecstasy	» E » MDMA » X » XTC	» Feelings of extreme wellbeing and happiness » Large doses may lead to an increase in core body temperature, confusion, irrational behavior, palpitations, shaking, dehydration, collapse, and convulsions.
GHB/GBL	» Gina » G » Liquid ecstasy	» Sense of euphoria » Even an extra milliliter of GBL over a moderate dose can result in an overdose, the effects of which are often unconsciousness, coma, or death by respiratory depression.
Heroin	» Smack » Skag » Junk » Horse	» Produces initial pleasurable sensation, warmth, dry mouth, heaviness in arms and legs, possibly nausea, vomiting, and sever itching » Large doses may lead to nausea, vomiting, respiratory paralysis, heart attack, stroke, anaphylactic shock, coma, and death or psychiatric complications.
Poppers	» Amyl » Butyl » Isobutyl nitrate » Aromas » Liquid incense	» Inhalant that makes anal intercourse and other sexual behaviors more » Headaches, skin rashes, sinus pains and burns, but only if the liquid comes into contact with the skin.

TABLE 7.1 List of commonly used drugs and their effects[24-26]

APPROACHING DRUG USE IN THE CLINICAL SETTING

As mentioned earlier, drug and alcohol use is a difficult topic for both healthcare providers and their clients. It is therefore important for providers to be sensitive to their own anxiety in addition to that of their client when discussing drug use. Healthcare providers should use appropriate language when asking questions about drug use. Some principles to consider are:

- » Begin by building rapport and confidence with the client.
- » Remind clients that any information they share will be kept confidential. If information will be shared, providers must reveal to the client with whom it will be shared and under what circumstances. This is the same for information that the provider documents. Clients have a right to know if what they disclose will be documented and how that information will be used.
- » Remember to use a nonjudgmental and non-confrontational approach when discussing drug use with clients.

Other techniques to help when discussing drug use with clients are provided below. These techniques help providers sharpen their overall interviewing skills sensitively and sensibly. These techniques are not meant to serve as stand-alone tools for drug-related history taking:[27]

1. Normalizing
   "Many people find it difficult to talk about sex and drugs."
2. Transparency
   "I need to ask you some very specific questions about your drug use in order to better understand your health needs and provide the best possible care."
3. Asking permission
   "Would *it be alright if I asked you some questions about your alcohol use?"*
4. Option of now answering question:
   "If you're not comfortable answering any of these questions, you don't have to answer them."
5. Offering response choices:
   "How often do you mix drugs together? Never, Sometimes, Always, or Almost Always?"
6. Avoid asking for judgments or opinions:
   "How often do you drink in a week?" or *"how many drinks do you drink in one setting?"* is better than asking *"Do you get drunk?"* or *"Do you drink often?"*
7. Ask specific instead of general questions:
   "Have you ever used marijuana?" or *"Have you ever used cocaine?"* is better than *"Have you ever used street drugs?"*

FACILITATOR'S TIP

Ask the group to name all of the recreational they are familiar with and that are available in their country of residence. Depending on group dynamics and comfort levels, you may pose questions like:

- *How many of you have ever experimented with drugs?*
- *What about caffeine? Is it considered a drug? Why or why not?*
- *What about alcohol? Is it considered a drug? Why or why not?*
- *What about tobacco? Is it considered a drug? Why or why not?*
- *What about marijuana? Is it considered a drug? Why or why not?*

You may also decide to do this exercise in pairs so participants are more open and candid in talking about drugs. When you regroup, discuss how easy or difficult it was to talk about drugs and help the group reflect on why it may be difficult for gay men and other MSM to be open with their providers about drug and alcohol use.

DRUG AND ALCOHOL USE SCREENING TOOLS

A healthcare provider's role is to support a client in better understanding the role of drugs in their lives, providing accurate information and taking the necessary steps to reach client-directed goals.

This module does not replace current clinical guidance around management of clients' drug use or delivering harm reduction interventions like needle-exchange programs. It also does not provide clinical guidance around diagnosing abuse and/or dependence. It does, however, include helpful tips for healthcare providers who may be interested in supporting their gay and other MSM clients who use drugs and alcohol. It is ultimately the client's decision to stop drug use, modify it, or maintain it depending on their personal goals. The best method for assessing the way forward is:

1. Identify what the client's goals are in relationship to drug use.
2. Engage in an open discussion about whether or not the client's current use aligns with where they want to be. The role of the healthcare provider is to motivate the client to articulate their personal goals and come to a clear understanding of where they stand with their goals in relationship to their current drug and alcohol use.

Regardless of the outcome of such discussions, healthcare providers should aim to provide accurate information about drugs, including risks of death (e.g. from overdosing) and any relevant local information to help prioritize personal safety and security (e.g. taking possible measures to avoid a drug-related arrest or losing a job).

Providers can effectively screen for drug and alcohol use in a general history taking session when asking about lifestyle-related questions such as diet, exercise, or sleep.

A few tools for screening for drug use are:

» A single question test being used by healthcare professionals in primary care asks clients the following question:

  "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?"

  A response of at least 1 time is positive for drug use.
  More details regarding this tool can be found here: http://archinte.jamanetwork.com/article.aspx?articleid=225770

» A 3-step screening tool for alcohol can be found here: http://www.integration.samhsa.gov/images/res/tool_auditc.pdf

» A 4-question screening tool for drug and alcohol use can be found here: http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

» A 10-item drug use questionnaire can be found here: http://www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

» The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) Manual is a useful tool for use in primary care:

  http://whqlibdoc.who.int/publications/2010/9789241599382_eng.pdf?ua=1

INTERVENTIONS FOR DECREASING DRUG AND ALCOHOL USE

The distinction between use, abuse, and dependence is sometimes vague as this varies greatly from individual to individual. Healthcare providers must take into serious consideration whether or not clients are reporting their drug use as problematic. The following sections include tips for decreasing drug and alcohol use that include harm reduction approaches to alcohol or drugs and the use of safer injection practices.

Tips for Cutting Down on Alcohol Use[29]

1. Keep a drink diary so you can see your overall pattern of drinking. If you can remember your drinking from last week, you will have an idea of whether you are drinking too much. You should also be able to understand some of the situations in which you drink excessively.
2. Tell other people you are cutting down – it is easier to stick to decisions when others know what they are.
3. Choose a similar drink to your usual, but one that is weaker. For example, choose a regular strength lager rather than super strength.
4. Replace some of your alcoholic drinks with a low alcohol drink or non-alcoholic drink (a "spacer" rather than a "chaser").
5. Start drinking later in the day/evening.
6. Take a smaller amount of money out to a drinking session, so you cannot afford as many drinks.
7. Drink alcoholic beverages more slowly.
8. Take smaller sips.
9. Put your glass down between sips.
10. Try not to finish your drink before others finish theirs.
11. Make your first drink a non-alcoholic one, particularly if you are thirsty.
12. Have at least two alcohol-free days a week.
13. Avoid "rounds" when drinking in pubs/clubs.
14. Decide on a limit for any drinking occasion. For example, five units. Be realistic.
15. Keep a supply of non-alcoholic drinks at home.
16. Identify different ways of relaxing – these can include exercising.
17. If you are anticipating a heavy evening, avoid drinking on an empty stomach and do not drive.
18. You may find it difficult to reduce your intake of alcohol around certain people. Changing your drinking pattern may require you to steer clear of him/her for a short time, at least until you feel confident enough to cope with his or her demands of you to drink heavily.

SAFETY TIPS ON THE USE OF OTHER DRUGS

Cannabis/Marijuana

http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/cannabis/

GBL/GHB

http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/ghbgbl/

Crystal Meth

http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/crystal-meth/

Cocaine

http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/cocaine/

Safer injecting practices

http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/safer-injecting-practices/

POTENTIAL SIGNS OF DRUG OR ALCOHOL ABUSE

Many screening tools are available, but they may not be highly sensitive to the distinction between recreational use and dependence. Although clients are best informed about whether or not they have a drug abuse problem, some general signs of drug abuse may include:

- A tolerance to the drug
- Withdrawal symptoms
- Loss of control concerning the drug (or the inability to stop using the drug despite the desire to do so)
- Failed attempts to stop using the drug
- A preoccupation with the drug
- The continued use of the drug despite negative consequences

If a client identifies a problem with drug use, a useful technique for facilitating a client-centered conversation about the readiness to change is to ask questions about the client's perception of the importance of the issue and their confidence in making any kind of change. Treatment options exist along a continuum and include detoxification, treatment of comorbid conditions, maintenance of treatment, and prevention of relapse.

For those who do need assistance, healthcare providers should refer to an appropriate drug abuse counselor or organization for a specialty evaluation and treatment

GAY MEN AND OTHER MSM WHO DO NOT REPORT PROBLEMATIC DRUG OR ALCOHOL USE

For gay men and other MSM who do not report problematic drug use, providing health information related to drug use from credible sources in an honest and nonjudgmental manner may be adequate. If drug use is within the context of sex, then engaging in a conversation about sexual

health is also relevant. If a client reports problematic drug use such as drug use that prevents them from achieving their goals or enjoying their preferred quality of life, a nonjudgmental and respectful healthcare provider can offer support through client-directed goal-setting and decision-making. They also can collaboratively identify harm reduction strategies that work for the client and refer the client for additional help when necessary. Referrals are usually appropriate when the healthcare provider is not qualified or comfortable dealing with issues concerning drug use in a sensitive manner or when the client requests a referral.

CONCLUSION

In order to provide the highest possible quality of care to gay men and other MSM who use drugs, providers can take steps to be informed about drugs commonly used by gay men and other MSM and the positive and negative effects of these drugs. Providers should also understand the possible reasons for why some men might choose to use drugs and strategies to ensure that the related health needs, if any, of their clients who use drugs are addressed effectively. In doing so, healthcare providers must exercise compassion, confidentiality, and non-judgment while adopting harm reduction approaches that are aligned with public health science and ethical principles.

KEY POINTS FROM THE MODULE

- Research suggests that gay men and other MSM are more likely to use drugs and alcohol when compared with adults in the general population.
- The higher rates of use among gay men and other MSM can be a reaction to homophobia, discrimination, or violence experienced due to their sexual orientation.
- Like everyone else in the general population, a proportion of gay men and other MSM who use drugs and alcohol does so for pleasure and recreation, including in a sexual context or within social settings like dance clubs and bars.
- Drug use can lead to high-risk sexual behaviors through the loss of sexual inhibition while under the influence of certain drugs.
- A good way to handle alcohol and drug use in the clinical setting is to first identify what the client's goals are in relationship to alcohol and drugs and then engage in an open discussion about whether or not the client's current use aligns with where they want to be.
- Healthcare providers must exercise compassion, confidentiality, and non-judgment while adopting harm-reduction approaches that are aligned with public health science and ethical principles.

PRE-POST ASSESSMENT

1. Higher rates of drug use among gay men and other MSM can be a reaction to which of the following?

   a. Homophobia

   b. Discrimination

   c. Violence

   d. All of the above

2. A proportion of the population, including gay men and other MSM, uses drugs for recreation or pleasure.

   [ ] True [ ] False

3. Drugs and alcohol can provide psychological enhancement of sexual experiences.

   [ ] True [ ] False

4. The most common pattern of drug use among gay men and other MSM appears to be:

   a. Daily

   b. Weekly/monthly

   c. Annually

   d. Every two years

5. Younger gay men and ethnic minority gay men tend to report higher levels of drug use.

   [ ] True [ ] False

6. The most common form of drug use seen among gay men and other MSM is injection drug use using heroin.

   [ ] True [ ] False

7. Drug use can lead to high-risk sexual behaviors through the loss of sexual inhibition while under the influence of drugs.

   [ ] True [ ] False

8. ______________________ are inhalants that can make anal intercourse and other sexual behaviors more pleasurable.

9. Which of the following statements is best when discussing alcohol use in the clinical setting:

   a. Do you get drunk?

   b. How often do you get wasted?

   c. Do you drink often?

   d. How often do you drink in a week?

10. Development of tolerance to a given drug can be a sign of drug abuse.

    [ ] True [ ] False

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Interventions for HIV and STI Prevention

LEARNING OBJECTIVES:

After completing this module, participants will be able to:

1. Describe biomedical and behavioral HIV and sexually transmitted infection (STI) risk reduction options for gay men and other men who have sex with men (MSM).
2. Understand how to approach discussions around HIV and STI risk and risk reduction with clients.
3. Identify appropriate risk reduction strategies for clients.

INTRODUCTION

Promoting the health of gay men and other MSM requires a positive and respectful approach to sexuality and sexual relationships. It requires the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination, and violence.[1] Many organizations embrace a sexual health approach in their HIV services to gay men and other MSM. This approach takes the whole person into account, including the importance of pleasure and intimacy, mental and physical health, shame and guilt concerning sex, stigma, discrimination, and other social and structural factors.

This module presents established interventions for HIV and STI prevention. It discusses combination HIV prevention and World Health Organization (WHO) recommendations for HIV prevention, care, and treatment for gay men and other MSM. This includes correct and consistent condom use with condom-compatible lubricant. It then discusses several newer biomedical approaches to risk reduction: pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and medical male circumcision. This is followed by a discussion of sex without a condom and possible risk reduction strategies for those who practice sex without a condom. This module includes an in-depth discussion of HIV testing and counseling both for individuals and for couples before closing with the importance of HIV prevention with people living with HIV.

MODULE OVERVIEW

1. Combination HIV prevention
2. WHO recommendations for HIV prevention, care, and treatment for gay men and other MSM
3. Correct and consistent condom use
4. Lubricants

5. Pre-exposure prophylaxis
6. Post-exposure prophylaxis
7. Male circumcision
8. Risk reduction issues to consider
    - Sex without a condom
    - Strategic positioning
    - Oral sex
    - Viral load calculation
    - Serosorting
9. HIV testing and counseling
10. Couples' HIV testing and counseling
11. Motivating behavior change
    - Brief sexuality-related communication
    - Target behaviors
12. Single-session counseling
13. HIV prevention and people living with HIV
14. Key points from the module

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 8 at:

http://www.hivplusmag.com/sex-dating/2014/02/21/study-94-percent-gay-men-more-likely-bareback-someone-attractive

QUESTIONS FOR DISCUSSION

1. The University of Westminster study showed that 70% of gay men prefer sex without a condom, 80% have had condomless sex with someone they didn't know well, and that 94% said they would have sex without a condom with someone they found attractive. What do you think some of the other reasons gay men and other MSM might have for foregoing condom use?

2. Based on the statistics reported in the article, how would you counsel a gay man or other MSM who reported a history of sex without a condom? With what information would you provide them to assist them in reducing risk of acquiring HIV or other STIs?

3. Westminster students have started the "AIDS is Not Dead" campaign to raise awareness. Research has shown that new methods of raising awareness about HIV for gay men and other MSM are necessary. What are some new awareness-raising methods that might work in your community?

COMBINATION HIV PREVENTION

FACILITATOR'S TIP

Emphasize that there is no one way to reduce risk or address the HIV epidemic. Strategies must be tailored to the individual at risk and to the local context.

Currently, most HIV researchers and practitioners agree that to effectively address HIV prevalence and incidence among gay men and other MSM, a comprehensive approach, sustained over time and tailored to local needs, is necessary.[2] A combination approach involves combining and integrating biomedical, behavioral, community-level, and structural approaches to address HIV epidemics. One example is delivering behavioral interventions like risk reduction counseling with biomedical interventions like HIV treatment while also addressing barriers to access, thereby addressing numerous issues at once. The following table outlines contemporary approaches to HIV prevention among gay men and other MSM.

CONTEMPORARY APPROACHES TO HIV PREVENTION AMONG MSM	
Biomedical	» Early identification and treatment of HIV » PrEP » PEP
Behavioral	
Individual	» Risk reduction counseling » Drug and alcohol use counseling » Mental health counseling
Group	» Skills building (e.g., condom use, communication) workshops » Support groups
Partner and Couple	» Couples counseling » Disclosure » Serosorting
Family	» Family counseling
Networks	» Peer education » Diffusion of innovation » Network-based strategies
Institutional	» Workplace training » Sensitization of service providers
Community	» Mass media » Social marketing » Community mobilization
Structural	» Anti-discrimination laws and legal protections » Increased availability of condoms and condom-compatible lubricants

TABLE 8.1 Contemporary Approaches to HIV Prevention Among MSM.

Table adapted from MSMGF[2]

Focusing only on one factor, whether it be a structural-level factor, an individual-level factor, or something in between, does not sufficiently address HIV incidence at the population level. Similarly, addressing HIV with only one type of intervention is unlikely to result in significant long-term gains. This is why a combination approach is recommended. With biomedical approaches such as PrEP, for example, there inequities in access to basic health care. Gay men and other MSM cannot benefit from biomedical interventions if their access to these interventions is reduced because of cost, stigma, discrimination, or criminalization. The schematic below, showing linkages between homophobia and HIV risk, is one way to visualize the importance of taking a combination approach.

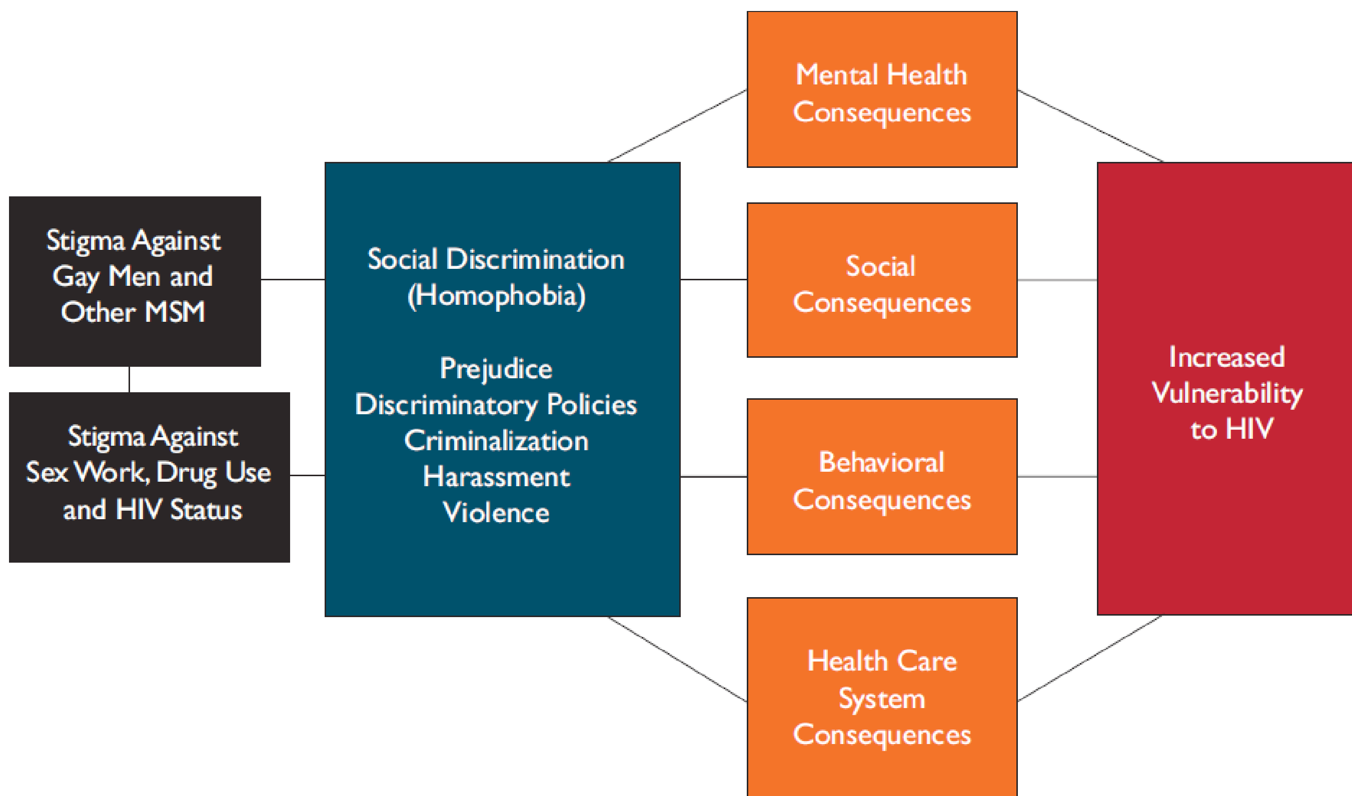

FIGURE 8.1 Linkages between homophobia and HIV risk[3]

WHO RECOMMENDATIONS FOR HIV PREVENTION, CARE, AND TREATMENT FOR GAY MEN AND OTHER MSM

The WHO suggests a combination approach as discussed in the previous section.[43] When developing these guidelines, the overarching principle was the respect for and protection of basic human rights. Consent and confidentiality must be ensured, protective laws must be established, and health services must be made inclusive of gay men and other MSM based on medical ethics and the right to health. Some of the WHO recommendations

for HIV prevention, care, and treatment for gay men and other MSM are below:[4]

1. Using condoms correctly and consistently during anal intercourse is strongly recommended over not using condoms.
2. Using condoms correctly and consistently is strongly recommended over serosorting for HIV-negative gay men and other MSM.
   » Serosorting is suggested over not using condoms as a harm reduction strategy under specific circumstances, such as where quality HIV testing and counseling (HTC) is available, HIV retesting rates are high, and the legal and social environment is supportive of HTC and serostatus disclosure.
3. Not offering adult male circumcision to gay men and other MSM for the prevention of HIV and STIs is suggested over offering it.
4. Offering HTC to gay men and other MSM is strongly recommended.
5. Offering community-based HTC linked to care and treatment for gay men and other MSM is strongly recommended in addition to provider-initiated HTC.
6. Implementing both individual-level and community-level behavioral interventions for the prevention of HIV and other STIs among gay men and other MSM is recommended.
7. Offering internet-based information, social marketing strategies, and sex venue-based outreach strategies to promote sexual well-being and increase uptake of HTC is recommended.
8. Those gay men and other MSM with alcohol or drug use issues should have access to psychosocial interventions for assessment, feedback, and advice.
9. Those gay men and other MSM who inject drugs should have access to needle and syringe programs and opioid substitution therapy.
10. Those gay men and other MSM living with HIV should have the same access to antiretroviral therapy (ART), including the management of opportunistic infections, co-morbidities, and treatment failure, as other populations.
11. Gay men and other MSM with STIs should be offered syndromic management and treatment.
12. Periodic testing for asymptomatic urethral and rectal *N. gonorrhoeae* and *C. trachomatis* infections using nucleic acid amplification tests (NAATs) are recommended. Similar testing using cultures is not recommended.
13. Periodic serological testing for asymptomatic syphilis infection for gay men and other MSM is strongly recommended.
14. Gay men and other MSM should be included in catch-up hepatitis B immunization strategies in settings where infant immunization has not reached full coverage.

FACILITATOR'S TIP

Demonstrate the proper use of condoms with an artificial penis or another object as you cover the following section.

CORRECT AND CONSISTENT CONDOM USE

Male condoms are sheaths of latex or another material used during anal, vaginal, or oral sexual intercourse. Condoms create a physical barrier between the genitals and sexual fluids of the partners engaging in sexual intercourse. When used correctly for all sex acts, condoms are 80-95% effective at preventing the transmission of HIV and other STIs.[5] However, many people do not use condoms correctly or consistently, increasing potential exposure to HIV and other STIs.[6] The following are instructions for correct use of male condoms, as presented by Brown, et al:[6]

1. Check the condom's expiration date and gently squeeze the package, checking for an air bubble, to ensure the package is not damaged.
2. Open the package by using the fingers to tear along the serrated edge. Avoid sharp objects like scissors or knives to avoid puncturing the condom.
3. Check that the condom is still lubricated. It should not be dry.
4. Ensure that the condom is the right way up. The lubricated side should be on the outside and it should roll down easily.
5. Pinch the tip of the condom to remove the air and create a pocket for ejaculate fluid.
6. While pinching the tip of the condom, unroll it to the base of the penis.
7. Add water-based or silicon-based lubricant. Do not use oil-based lubricants as they degrade condoms and increase risk of breakage.
8. After ejaculation, hold the condom at the base of the penis and pull the condom off before the penis softens.
9. Wrap the condom in a paper towel and dispose of it appropriately.
10. Use a new condom for each new act of intercourse.

Note: If the condom breaks or slips during intercourse, stop, remove it, and put on a new one.

Common errors in condom use:[6]

- Putting the condom on after sexual contact has already occurred.
- Removing the condom and resuming intercourse without one.
- Using a condom for the first round of sex, but not for subsequent rounds.
- Failing to pinch the tip to remove air when putting the condom on.
- Withdrawing after the penis has softened. This increases risk of the condom slipping off inside of the receptive partner.
- Failing to add water- or silicon-based lubricant, especially during anal intercourse.

- Using oil-based lubricants that damage latex.
- Failing to reapply lubricant during lengthy or vigorous sex as lubricant dries.
- Using two condoms at the same time. This increases friction and risk of breakage.

LUBRICANTS

Promoting condom use must be accompanied by emphasis on the use of appropriate lubricants. This is especially important for anal intercourse because the anus does not produce its own lubrication. Gay men and other MSM should be educated on the benefits of and need to use condom-compatible lubricants to ensure that condoms do not break. However, gay men and other MSM often report difficulty accessing condom-compatible lubricants. Providers should be prepared to advise their clients on what is and what is not appropriate to use as lubricant with latex condoms. Water-based lubricants are the most commonly available. Silicon-based lubricants are also suitable for use with condoms, but are less readily available. Saliva is not recommended as a lubricant because it dries quickly and therefore increases risk of damage to the rectal mucosal lining. Following are some common household items that may be used as lubricant if commercial condom-compatible lubricant is not available.

Appropriate for use with latex condoms:

- Low-fat, unflavored yogurt
- Fresh raw egg white (albumin)
- Any oils (cooking, baby, coconut, mineral, etc)
- Vaseline
- Body and hand lotions
- Margarine

PrEP is a promising intervention to reduce risk of HIV acquisition. However, few gay men and other MSM are aware of PrEP. Awareness-raising for PrEP is necessary.

PRE-EXPOSURE PROPHYLAXIS

Pre-exposure prophylaxis (PrEP) is an HIV prevention intervention whereby an HIV-negative individual takes antiretroviral medications (ARVs) regularly in order to reduce their risk of contracting HIV.[7] An example medication for PrEP is Truvada, an ARV containing tenofovir disoproxil fumarate and emtricitabine (TDF/FTC). Truvada was approved as PrEP by the United States Food and Drug Administration (USFDA) in 2012. Clinical trials have shown that PrEP is effective at preventing HIV acquisition both among gay men and other MSM and among heterosexual couples.[8] In these studies, PrEP reduced risk of HIV acquisition by 44% to 75%.[9]

PrEP is effective, but it is not a "silver bullet" and depends on strict adherence. The Centers for Disease Control and Prevention (CDC) recommend delivering PrEP as part of a comprehensive package of HIV prevention interventions that includes HTC, condom promotion and access,

management of STIs, and community-based outreach. Research shows that few gay men and other MSM know about the existence or availability of PrEP, meaning additional awareness-raising is necessary.[10]

POST-EXPOSURE PROPHYLAXIS

Post-exposure prophylaxis (PEP) is a biomedical HIV prevention intervention whereby an individual who is HIV-negative takes ARVs following a potential exposure to HIV. PEP involves taking ARVs immediately following exposure – usually within 72 hours – and continues for 28 days. PEP does not reduce risk of HIV acquisition to zero, but is highly effective. PEP has been used to reduce transmission from several exposure routes, including:[11]

- Occupational exposures (needle sticks, scalpel cuts, etc)
- Sexual exposures (sex without a condom, condom failure, sexual assault, etc)
- Percutaneous exposure from injection drug use
- Neonates exposed to HIV through breast milk or during birth

To best support their needs, clients who are receiving PEP should:[11]

- Receive HIV prevention counseling to reduce risk of future exposure.
- Be monitored to ensure medication adherence.
- Be monitored with laboratory safety evaluations such (liver enzymes, creatinine levels, etc).
- Be tested for HIV and other STIs, including hepatitis B and C.

Difficulties accessing PEP remain in many parts of the world, including the Caribbean, Africa, Central and South America, and the Middle East. Awareness is also a hurtle, as few gay men and other MSM are fully aware of PEP and it's benefits. Like with PrEP, additional awareness-raising is necessary for PEP.

MALE CIRCUMCISION

WHO guidelines state that adult male circumcision is not indicated for gay men and other MSM. Male circumcision has been shown to be effective at reducing the odds that a man will acquire HIV from a female partner who has HIV, but there is no strong evidence showing that male circumcision offers the same benefits during male-male intercourse. Among gay men and other MSM, studies have found no significant difference between those who were circumcised versus those who were uncircumcised for the odds of HIV acquisition during anal sex.[12] Additionally, like any surgical procedure, circumcision comes with risk of pain, bleeding, infections, and inflammation.

Additional research is necessary to understand the risks or potential benefits of circumcision for gay men and other MSM. When a provider is approached by a gay man interested in undergoing the procedure, they should explain the limitations and risks of circumcision to help their clients make the decision that's best for them.

RISK REDUCTION ISSUES TO CONSIDER

Correct and consistent condom use remains a highly effective way to prevent the spread of HIV and other STIs. However, correct and consistent condom use is not a feasible goal for all clients. Other methods of risk reduction may to be explored. This section discusses a variety of risk reduction methods that gay men and other MSM use. These may be viable harm-reduction options if they are unable to use condoms. Providers should inform clients engaging in each of the following practices of the possible benefits and limitations associated with each method. This allows clients to make informed decisions about their health, and to work with their healthcare provider to take steps to minimize exposure to or transmission of HIV or other STIs.

» Sex without a condom

Correct and consistent condom use remains one of the most effective methods for preventing the spread of HIV and other STIs, but many people forego condom use when they have sex. Research shows that even occasional condom use substantially reduces risk of acquiring HIV or another STI. Reasons for not using condoms are many and varied. Some reasons include:

- Discomfort
- Inconvenience
- Reduced sexual sensation
- Reduced intimacy with their partner
- Inability to discuss condom use
- Allergy to latex
- Inability to maintain and erection

Correct and consistent condom use remains one of the most effective methods to reduced risk of HIV and STI acquisition, but it is not a feasible goal for all men. Other methods of risk reduction may need to be explored.

Polyurethane condoms provide another option for people allergic to latex, but many individuals (with or without latex allergies) forego condom use during sex. The accepted HIV risk reduction model is an adaptation of harm reduction theory. This calls for using small manageable steps to reduce risk of HIV acquisition or transmission. For example, consistent condom use may not be a realistic goal for everyone, but there are other steps or methods that one can take in order to reduce risk. After exploring the client's reasons, methods, and practices for using or not using condoms or other methods of risk reduction, providers can work to gradually alter behaviors to minimize harm.

» **Strategic positioning**

Strategic positioning (also known as sero-positioning) is the act of choosing a sexual position or practice depending on the serostatus of one's partner, often for the purpose of sex without a condom.[13] Evidence shows that risk of HIV acquisition during sex without a condom is lower for the insertive partner than for the receptive partner.[14] One study even showed that risk of being the insertive partner without a condom was less likely to result in HIV acquisition than being the receptive partner while having sex with a condom.[15] Because of this, the partner with HIV typically take the receptive role and the HIV-negative partner takes the insertive role. However, strategic positioning may still lead to transmission of HIV. Individuals may also not know or accurately disclose their HIV status. Because of this, strategic positioning remains controversial.

» **Oral Sex**

Oral sex with an HIV-positive and viremic partner or partner of unknown HIV status is far less likely to lead to HIV transmission than either unprotected anal or vaginal sex with such a partner. This makes oral sex a potential risk reduction option both for gay men and other MSM and for heterosexual couples.[16] Studies suggest that oral sex can transmit HIV, but the exact risk of transmission is unknown.[15, 18] Experts maintain that it poses "low risk" or "extremely low risk," especially if the insertive partner does not ejaculate in the mouth of the receptive partner.[17] Transmission risk may increase in the presence of an STI, cuts or sores in the mouth, dry mouth, or an allergy in the receptive partner.[18] Overall, oral sex poses very little risk for transmission of HIV. It is important to remember, however, that other STIs may easily be spread through this route so care must be taken to avoid their transmission.

» **Viral Load Calculation**

Research suggests that HIV-positive people with higher viral loads are more infectious than people with lower viral loads.[19, 20] A Ugandan study that tracked seroconversion in 415 serodiscordant heterosexual couples identified viral load as the "chief predictor of the risk of heterosexual transmission of HIV."[21] During the course of the study, 90 HIV-negative individuals seroconverted, all of whose viral loads were significantly higher than the HIV-positive participants whose partners did not seroconvert. The researchers found that the risk of HIV transmission was significantly reduced if the HIV-positive partner's viral load was less than 1,500 copies per milliliter. This evidence supports the idea that lower viral load means a lower chance of HIV transmission. However, other variables make viral load calculation a difficult strategy to implement as a risk reduction strategy. Viral load varies by time of day, type of test done, and presence of STIs. Also, the level of virus in the blood, which tests measure, may be different than the concentration of the virus in other bodily fluids such as semen. Each of these compounding factors increases the difficulty of using viral

load calculation to successfully reduce risk.

» **Serosorting**

Serosorting, defined by the CDC as "a person choosing a sexual partner known to be of the same HIV serostatus, often to engage in unprotected sex, in order to reduce the risk of acquiring or transmitting HIV."[22] Most studies of serosorting have taken place in high-income countries, but serosorting has been shown to be a risk management technique used by gay men and other MSM. Studies in the United States, Europe, and Australia have found that 14%-44% of HIV-positive MSM and 25%-38% of HIV-negative MSM serosort.[23-26] Benefits of serosorting for those gay men or other MSM who are living with HIV include the possibility of reduced secondary HIV transmission and the ability to engage in sex without a condom. For HIV-negative people, if they are accurate – that is, if both partners truly do not have HIV at the time of the sexual encounter – serosorting does prevent HIV infection.

Despite the potential benefits of serosorting, risks remain. Commonly, people are unaware of their HIV status or incorrectly report their status to their partner. It is also possible for a newly-infected person to be in the window period for HIV testing where they receive a negative result, but are in fact HIV positive. Additionally, even when partners share the same serostatus, STIs may still be transmitted and unprotected sex between two HIV-positive partners may result in HIV superinfection. Serosorting is only feasible where HTC is available, testing rates are high, and the legal and social environment is supportive of testing and disclosure of HIV status. For these reasons, serosorting is not recommended as a risk reduction strategy.

HIV TESTING AND COUNSELING

HIV Testing and Counseling (HTC) refers to a public health intervention whereby an individual, a couple, or a family receives HIV testing as well as counseling on HIV prevention, treatment, care, and support.[27] There are a number of ways in which the approach may vary, but the core components generally consist of:

1. Pre-test counseling that outlines the testing process
2. A behavioral risk assessment
3. Informed consent of the participant
4. Administration of the HIV test
5. Post-test counseling which varies depending on the results of the test.

FACILITATOR'S TIP

Each provider will develop their own personal style for testing and counseling. For those who regularly perform HTC, have describe for you what an average session looks like. Have the other participants compare this style to their own styles.

HTC is a key entry point to care, treatment, and support for people living with HIV. Early detection enables linkage to care and support services that not only prolong the life of the individual, but also improve their quality of life, and prevent the spread of the disease through risk reduction and behavior change. Given that HTC is a key entry point to care, it should be offered in an accessible and affordable manner. There are several modalities of HTC, which range from facility-based to community-based, client-initiated to provider-initiated, and mobile clinics to door-to-door to name a few. Regardless of the modality used, several factors must be taken into consideration for HTC with gay men and other MSM:

» Many communities lack health providers who have cultural competency in working with gay men and other MSM.
» HIV stigma, homophobia, and hostile policies create environments in which gay men and other MSM are unable to safely access services.
» Many gay men and other MSM believe that health services are primarily geared toward heterosexual people.[28]

A true health system-level perspective is necessary to discuss how gay men and other MSM access HTC. Simply, many factors, ranging from policy to human resources to health system infrastructure and beyond, affect access to and use of services. Each factor interacts with the other factors in unique ways. However, to improve access to and uptake of HTC for gay men and other MSM, it is necessary to:

» Address HIV stigma, homophobia, criminalization, and other unsupportive policies.
» Improve health care infrastructure and training of health workers.
» Train and sensitize health workers on the needs of gay men and other MSM.

COUPLES HIV TESTING AND COUNSELING

One important modality of HTC is couples-based HIV testing and counseling (CHTC).[29] CHTC has been tested primarily in heterosexual couples, but is a strong intervention for gay men and other MSM as well. CHTC differs from standard HTC in that a couple receives pre- and post-test counseling – including the results of HIV tests – at the same time in the same room. CHTC is a way to interrupt HIV transmission in serodiscordant couples, help seronegative couples negotiate plans to remain negative, and link seropositive couples to care. It also facilitates communication and partner support. Advantages to testing couples together include:[30]

» CHTC provides a safe environment for couples to discuss risk concerns.
» Partners hear information together, enhancing likelihood of a shared understanding.
» The counselor can ease tension and diffuse blame.
» Counseling messages are based on the test results of both individuals rather than only one.

» An individual who receives a positive test result is not burdened with the need to disclose the result to their partner or persuade their partner to be tested.

» Counseling facilitates the communication and cooperation required for risk reduction.

» Treatment and care decisions can be made together.

» Couples can engage in decision-making for the future.

CHTC is an effective way to interrupt HIV transmission in serodiscordant couples, help HIV-negative couples remain negative, and link seropositive couples to care – all while facilitating communication and support.

CHTC is a voluntary, confidential interaction that respects the right of each client to make decisions. Each client must consent to the counselor sharing HIV test results with their partner or they will revert to individual HTC. Once consent is given, CHTC will assist couples to establish goals that fit their particular situation.

MOTIVATING BEHAVIOR CHANGE

Behavior change for HIV risk reduction is difficult, in part because behaviors that result in HIV transmission are deeply ingrained and highly pleasurable. However, facilitating behavior change is central to HIV prevention counseling. Clients must have the right information in order to change HIV risk behaviors, but knowledge alone is insufficient to produce lasting behavior change.[31, 32] Rather, several factors interact to cause a person to change and believe that they are able to do so.

» Brief Sexuality-related Communication

Brief Sexuality-related Communication (BSC) entails a healthcare provider using counseling skills opportunistically throughout an encounter with a client to address a client's psychological difficulties relating to sexuality and sexual wellbeing.[33] There is no assumption of provider continuity and these skills are applied within the timeframe of a typical primary care visit. BSC aims to support clients in exercising their sexuality with autonomy, satisfaction, and safety.[34] The key components of BSC include:[35, 36]

1. Attending: setting up the relationship with the client.
2. Responding: posing questions to open about sexual health.
3. Personalizing: conducting a basic evaluation of the medical, sexual, and social history of the client and interpreting the findings to identify sexual concerns or difficulties.
4. Initiating: relating to the client's personal goal of sexual health and wellbeing and the client's needs, including:
    » Provision of information.
    » Shared decision-making between the client and provider regarding steps to be taken.
5. Planned follow-up or referral when needed.

Through BSC, a client is supported in exploring and understanding issues relating to their sexuality and sexual health. The process also reformulates their emotions.[36] BSC is offered in a non-judgmental and non-stigmatizing manner and is age- and sex-appropriate for all. The conversation is individualized to the client's specific needs so that each client's needs are met to the best of the provider's ability. There are some common questions that providers can use to begin BSC, including:

"Do you have any questions or concerns about sexual matters?"[35]

"Are you satisfied with your sexual life?"[35]

"How do you feel about your sexual relationships with others?"[37]

In addition to these general questions, providers will then use questions targeted to the specific circumstances of each individual:

"Tell me about the difficulties you have in using condoms."[37]

"Have you been able to practice your sexuality in the way that you would like?"

"Some people who have had a particular problem (e.g., HIV treatment, cancer, hypertension - any issues that client is facing) tell me they have had sexual problems. How is it for you?"[37]

BSC uses a client-centered approach, which is likely to be effective in influencing behavior change.

» Target behaviors

A target behavior is any behavior that will reduce the risk of transmission of HIV or other STIs. This includes sexual, drug and alcohol use, and healthcare seeking behaviors. The standard target behaviors listed below are those that will result in the greatest reduction in risk, but the other behaviors listed are also important for a continuum of behavior change. Examples of target behaviors are listed below.

- Risk reduction target behaviors for sexual risk reduction for all clients:
  - Use a condom correctly and consistently for sexual intercourse
  - Delay or avoid sexual intercourse
  - Be in a mutually monogamous relationship with an uninfected partner
- Risk reduction target behaviors for clients who are not ready for the above:
  - Test for HIV/STIs regularly
  - Use condoms consistently with outside partners
  - Reduce the number of sexual partners

- Increase the frequency with which condoms are used for penetrative sex
- Use non-penetrative sexual practices
- Put a condom on right before ejaculation
- Any "first step" a client is willing to take

- Harm reduction target behaviors for clients who are not ready for the above:
  - Avoid sexual venues where drug use/high alcohol intake is prevalent
  - Avoid drugs that are likely to lead to high-risk behaviors
  - Reduce the frequency of drug use or quantity of drugs used
  - Do not have sex when high
  - For injection drug users, use in a less harmful way, i.e. snorting rather than shooting
  - Any "first step" a client is willing to take

SINGLE-SESSION COUNSELING

With the advent of rapid HIV tests, single-session HCT is replacing or has replaced standard two-step HCT in many areas of the world. Rapid testing is a one-step process, meaning it takes place in a single session. The first step of standard counseling is a risk assessment. If the client decides to be tested, the provider collects blood and sends it for testing. The client then returns in one to two weeks for the results. With single-session counseling, the provider verifies the client's desire to test, confirms informed consent, and collects a sample for the test, which takes 20 minutes or less to develop with a rapid test. Following are some frequently asked questions regarding single-session counseling.

» How does single-session counseling enhance standard HCT?

Single-session HCT provides two primary enhancements to standard HCT. First, the provider focuses on the most recent risk incident, explores it in detail, and helps the client see exactly what motivated the risk behavior. This helps create motivation to change the behavior next time. Second, single-session counseling focuses on helping the client make a realistic plan with incremental steps rather than grand long-term goals. This second enhancement is now used in both single-session and standard counseling.[38]

» How do clients feel about single-session counseling and testing?

Single-session counseling has been well-received. In a survey of 1,048 clients who accepted rapid testing in California, 95% said they would prefer a rapid test the next time they tested and 99.5% said they would recommend rapid testing to a friend.[38]

Risk Reduction Role Plays

Objective: This activity contains several role plays designed to make participants think about which risk reduction strategies they would suggest for their clients in a variety of situations.

Main activity: Divide the participants into pairs or small groups and assign each pair or group one of the case studies below. Instruct each pair or group to role play the case study with one participant playing acting as the counselor and one participant acting as the client. Instruct the participants to use risk-reduction counseling to find an appropriate risk reduction plan for the client in each case study.

Alternatively, the case studies below can be used as case studies for the large group spread throughout the module.

Give participants some time to work through each case study. For each case study, address the following questions:

What are the key risk behaviors of the client?

What strategies would you create to help each client reduce their risk?

How would you prevent the client from feeling judged?

What types of language would you use when speaking with the client?

Discussion: Ask each group to present their strategy for their case study. Allow other groups to pose questions. As the facilitator, you may also point out strategies you felt were particularly appropriate.

Summarize key findings: After all of the groups have presented, highlight important aspects of the strategies, especially highlighting that no single strategy is appropriate for all clients.

Case study 1
Zhao is a 24-year-old gay male from China. He is in a relationship with his boyfriend Xiong. When they have sex, Xiong only enjoys being the receptive partner, but Zhao enjoys both the insertive and receptive roles. They do not use condoms when they have sex with each other. Because Xiong does not enjoy taking the insertive role, the two have agreed that Zhao may find partners outside of their relationship to have sex with when he wants to bottom. Zhao does not have an emotional attachment to these third parties. He reports that he almost always uses condoms with his casual partners.

Case study 2
Eduardo is 27 years old and identifies as gay. He has come into your clinic for an HIV test, which he gets every six months. During the pre-counseling session, he tells you that he recently ended a serious relationship with his boyfriend. Following the break up, he fell into a deep depression and often visited bars and drank heavily. Many times, he found a man to have sex with. He tells you that he usually uses condoms, but that sometimes there were no condoms available, so he did not use them. He also has difficulty finding lubricants to use. Other times, he has been too intoxicated to remember.

Case study 3
Adam is an 45-year-old gay male who lives in an urban area of Brazil. Adam is also living with HIV. He has been in a long-term relationship with his HIV-negative partner Nikolas for many years. When they have sex, they often take turns being the penetrative and receptive partner. Because they know that Adam is living with HIV, they have always used condoms every time they have sex. Recently however, Nikolas has been pressuring Adam to forego condom use because he likes the added sense of intimacy associated with having sex without a condom. Adam continues to insist on using condoms when they have sex, but the issue has begun to cause problems for the relationship.

» How do providers feel about single-session counseling and testing?

Providers generally feel positively about single-session counseling, stating that it increases client perceptions of HIV risk and allows them to build better rapport with their clients. Though a few providers have mentioned seemingly higher anxiety in their clients, the primary concern was giving a preliminary positive result. All HIV-positive antibody tests must be confirmed by a different test, so a reactive result on a rapid test is considered "preliminary positive" until confirmed through laboratory testing.[38]

» How can a provider manage the complexity of disclosing a preliminary positive result?

The best way is for providers to prepare both the client and themselves for any test result. Discuss both the possibility that the test will be negative and the possibility that the test will be positive. Providers should remember that even an HIV-negative result may be surprising and challenging to disclose in some situations. However surprising and challenging a result might be though, the information is ultimately beneficial to the client. If a result is particularly difficult to give, providers may take some time alone or talk to a coworker after.[38]

» How can a provider help clients manage anxiety with the result only minutes away?

Providers should validate the client's feelings of anxiety, reassuring them that anxiety is a normal part of testing for HIV and waiting for the results. Providers can discuss what the client thinks might be the root of the anxiety, specifically the most recent risk incident. The client should tell the story of the incident and the provider should offer appropriate HIV information. The two should then discuss how the possible test result might impact the client's risk behavior.[38]

» What should a provider do when a client with a preliminary positive result will not submit a sample for confirmatory testing?

There are generally two reasons for which this might happen. Either the client already knew they were HIV-positive and came for re-testing to receive an incentive associated with it or it is because they would prefer to go to their own providers for confirmation and care. A provider cannot force a client to submit a second sample. If a client refuses, discuss what the results mean and their reasons for not wanting confirmation. Ask about the client's next step (such as seeking confirmation and care elsewhere). If they still refuse, document what happened and discuss it with a supervisor afterward.[38]

» What happens if a client's preliminary positive result is followed by a negative confirmatory result?

Discordant results like this are quite rare. It is possible that the rapid test returned a false positive or that the confirmatory test returned a negative result because the confirmatory test is less sensitive than the rapid test. According to the CDC, the majority of discordant results

are of this second kind and additional follow-up testing usually shows that the individual does have HIV. The client may be confused by this. The provider should validate and reflect on the client's reaction and let them know that, though this situation is rare, additional testing with be done to clarify the results.[38]

FACILITATOR'S TIP

When discussing prevention for people living with HIV, make sure to maintain a sex-positive approach and not to come across as judgmental or accusatory of those already living with HIV.

HIV PREVENTION AND PEOPLE LIVING WITH HIV

Many people with HIV are living longer, healthier, happier lives thanks to successful ART. Most of these people are sexually active in a healthy way and express and fulfill a responsibility to protect others from transmission of HIV.[39, 40] In response, HIV prevention approaches have begun to include people living with HIV and how these individuals can protect their partners rather than always focusing on HIV-negative people and how they can protect themselves.[41] These approaches recognize the risk of unsafe practices to HIV-positive individuals, such as STI co-infection and the possibility of HIV reinfection. The goal of interventions with people living with HIV is not only to reduce behaviors that may result in the transmission of HIV, but also to attend to other health and wellness needs. There are a variety of approaches that may be used, including barrier protection for sex, cleaning needles during needle sharing, reducing the number of sexual partners, and changing sexual or drug use behaviors to behaviors that are less likely to result in HIV transmission. Other interventions that focus on communication and negotiation skills by improving self-efficacy and self-esteem have also been successful. It may be beneficial to encourage an individual with HIV to disclose their serostatus to their sexual partners, though the literature on whether disclosure of serostatus leads to a reduction in risk behaviors is inconsistent.[42] In addition to these behavioral approaches, it remains necessary to address stigma and discrimination toward people living with HIV and to create environments that facilitate the empowerment of people living with HIV.

Involving HIV-positive people in the response to HIV is critical. It is necessary to address stigma and discrimination toward people living with HIV and to create environments that facilitate the empowerment of people living with HIV.

KEY POINTS FROM THE MODULE

- There is no "silver bullet" for the prevention of HIV for gay men and other MSM. A combination of methods is necessary tailored to each individual and each context.
- A combination approach using biomedical, behavioral, community-level, and structural approaches is necessary to produce lasting effects on the prevalence and incidence of HIV among gay men and other MSM.
- Correct and consistent condom use continues to be one of the most effective methods of HIV prevention, but there are other methods of HIV risk reduction that may assist those for which correct and consistent condom use is not a realistic goal.
- PrEP and PEP are two effective biomedical methods of HIV risk reduction for gay men and other MSM.

- HTC is a critical component of any HIV program and serves as an entry point to care, treatment, and support for people living with HIV.
- Rather than setting grand long-term goals for behavior change, it may be preferable to use smaller, realistic, incremental changes that result in behavior change.
- It is critical not only to include people living with HIV in any HIV prevention program, but also to address stigma and discrimination towards people living with HIV and to create environments that facilitate the empowerment of this group.

PRE-POST ASSESSMENT

1. ______________________ is defined as a person choosing a sexual partner known to be of the same HIV serostatus, often to engage in unprotected sex, in order to reduce the risk of acquiring or transmitting HIV.

2. Which of the following is the recommended approach to addressing HIV prevalence and incidence among gay men and other MSM?

    a. Biomedical approach

    b. Behavioral approach

    c. Structural approach

    d. Combination approach

3. Pre-exposure prophylaxis (PrEP) has been shown to be 100% effective at eliminating the risk of HIV acquisition in gay men and other MSM.

    [ ] True [ ] False

4. Setting small incremental goals is preferable over setting one large long-term goal to result in lasting behavior change.

    [ ] True [ ] False

5. It is unimportant to include people who already have HIV in an HIV-prevention program.

    [ ] True [ ] False

6. Which of the following is the most effective method for HIV risk reduction?

    a. Use non-penetrative sexual practices

    b. Put a condom on right before ejaculation

    c. Use a condom consistently for sexual intercourse

    d. Reduce the number of sexual partners

7. Male circumcision has been shown to be effective at reducing the risk of HIV acquisition for gay men and other MSM.

    [ ] True [ ] False

8. Viral load calculation is simple to employ as an HIV risk-reduction technique in the real world.

    [ ] True [ ] False

9. One benefit of couples HIV testing and counseling is that it provides a safe environment for couples to discuss risk concerns.

    [ ] True [ ] False

10. Gay men and other MSM do not have difficulties accessing PrEP or PEP in low- or middle-income countries.

    [ ] True [ ] False

ADDITIONAL RESOURCES

For more information about serosorting and strategic position, please see:

» Global Forum on Men Who Have Sex With Men and HIV (MSMGF). Serosorting and Strategic Position. Technical Bulletin Series. 2012.

http://www.msmgf.org/files/msmgf//documents/TechBulletins/EN/Sec5MSMGF_TechBulletins2012.pdf

For more information on guidelines and research from the WHO, please see:

» World Health Organization. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. 2014

http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

» World Health Organization. Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. 2011

http://apps.who.int/iris/bitstream/10665/44619/1/9789241501750_eng.pdf?ua=1

For more information on PrEP, please see:

» The Fenway Institute. Introducing the "PrEP Package" for Enhanced HIV Prevention. 2012

http://www.lgbthealtheducation.org/wp-content/uploads/12-1.125_PrEPdocuments_clinicians_v3.pdf

» Global Forum on Men Who Have Sex With Men and HIV (MSMGF). Systemic (Oral) Pre-Exposure Prophylaxis (PrEP).

http://www.msmgf.org/files/msmgf//documents/TechBulletins/EN/Sec2MSMGF_TechBulletins2012.1.pdf

For more information on PEP, please see:

» Global Forum on Men Who Have Sex With Men and HIV (MSMGF). Post-Exposure Prophylaxis. 2012

http://www.msmgf.org/files/msmgf//documents/TechBulletins/EN/Sec4MSMGF_TechBulletins2012.pdf

For more information on HIV Testing and Counseling, please see:

» World Health Organization. Service Delivery Approaches to HIV Testing and Counselling (HTC): A Strategic HTC Programme Framework. Geneva: World Health Organization. 2012.

For more information on Couples HIV Testing and Counseling, please see:

» Centers for Disease Control and Prevention. Couples HIV Counseling and Testing (CHCT) Trainer's Manual. Atlanta: Department of Health and Human Services, 2007; http://www.cdc.gov/globalaids/resources/prevention/docs/TM/TM-Module1-2009-060110.pdf.

» Cataldo M. Counseling and Testing for Couples. HIV Counselors Perspectives. Alliance Health Project. California: UCSF, 2012.

For more information about HIV prevention for people living with HIV, please see:

» International HIV/AIDS Alliance. Positive Prevention for People with HIV/AIDS: Strategies for People with HIV/AIDS. Emerging Practice Series.

http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/other/pdf/Positive_Prevention_IHA_Marked.pdf

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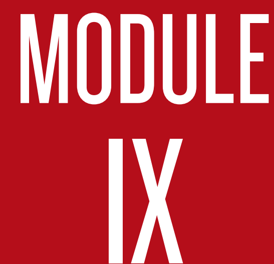

Clinical Care for HIV and Other STIs

LEARNING OBJECTIVES:

After completing this module, participants will:

1. List signs and symptoms of well-known sexually transmitted infections (STIs) and corresponding treatment recommendations as they are relevant to gay men and other men who have sex with men (MSM).
2. Increase familiarity with antiretroviral therapy (ART) initiation and treatment guidelines for HIV.
3. Understand the relationship between STIs and HIV infection, including HIV-related co-infection with tuberculosis (TB) and hepatitis.

INTRODUCTION

Gay men and other MSM have been under-served or ignored in the delivery of health information and care for quite some time.[1] Though gaps remain, the HIV epidemic has led epidemiological data on this group to become increasingly available. Gay men and other MSM have been shown to be, on average, more likely to be infected with HIV or some STIs than their non-MSM peers in nearly every nation where data are available.[2] In addition to HIV, STIs pose a serious public health concern for gay men and other MSM. This is in part because the presence of an STI increases an individual's susceptibility to HIV acquisition. Compounding this, STIs are difficult to detect, diagnose, and treat, especially in resource-limited settings.

This module provides an in-depth discussion of HIV and other STIs. It discusses STIs common in gay men and other MSM and the importance of testing for STIs in this population. Guidelines differ by country, but this module covers generally recommended steps for STI testing and treatment. It also focuses on HIV, where it introduces the virus before discussing HIV testing and treatment. It covers the benefits of early treatment, considerations for initiating ART, and treatment as prevention (TasP). The module closes with a discussion of HIV co-infection with two other serious infections: tuberculosis and hepatitis.

MODULE OVERVIEW

1. Sexually Transmitted Infections (STIs)
2. The Importance of Testing Gay Men and Other MSM for STIs
3. Human Immunodeficiency Virus (HIV)
4. Recommended Steps for STI Testing

5. HIV Testing
6. Treating STIs
7. HIV Treatment
8. Considerations in Initiating Antiretroviral Therapy (ART)
9. Benefits of Early Therapy
10. Treatment as Prevention
11. Treatment 2.0
12. Tuberculosis Co-infection and HIV
13. Viral Hepatitis Co-infection and HIV
14. Conclusion

PRE-READING ASSIGNMENT

Please find the pre-reading assignment for Module 9 at:

IRIN News. Uganda rejects HIV prevention tool on moral grounds. 2013. http://www.irinnews.org/report/98690/uganda-rejects-hiv-prevention-tool-on-moral-grounds%20-%20module%208 (accessed Feb. 11 2014).

QUESTIONS FOR DISCUSSION

1. What were some of the reasons for which the government of Uganda has refused to roll out PrEP? Are these reasons valid? Why or why not?
2. The article states that Uganda will continue to focus on ABC - Abstinence, Be faithful, and Correct and Consistent Condom use - as an HIV prevention strategy even in the face of evidence that HIV prevalence is rising and other scientifically-proven methods such as PrEP are effective in preventing HIV transmission. What implications does this decision have for HIV programming in Uganda, specifically for gay men and other MSM?
3. AVAC Executive Director Mitchell Warren says, "PrEP using tenofovir-based drugs is a niche product that cannot and will not replace other options that are part of combination prevention [a mix of biomedical, behavioural, and structural HIV prevention interventions]." He emphasized the importance of a comprehensive combination approach to prevention. Using your own knowledge and what you've learned in other modules, why do you think it is important to use a combination approach? What might a combination approach look like where you live?

FACILITATOR'S TIP

As this module is primarily clinical in nature, try to engage the participants as much as possible. Have them share their past experiences relating to HIV or STIs where appropriate throughout the module.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

When a pathogen infects a sex organ or the reproductive system and the infection is transmitted from one person to another primarily through sexual methods, it is termed a sexually transmitted infection.[3] Most STIs spread through bodily fluids such as semen, pre-ejaculate fluid, or blood, or through direct contact such as touching skin to sore. STIs vary widely with pathogens including viruses, bacteria, parasites, protozoa, and fungi. Many STIs may present either with or without symptoms. Because STIs are often asymptomatic, healthcare providers should test their clients for STIs regularly. Clients should also test when entering into a new sexual partnership both to ensure the client's health and to avoid transmitting an infection to their partner. The following table provides an overview of STIs common in gay men and other MSM. STI-related signs and symptoms commonly elicited or reported among women are included so healthcare providers can remain sensitive to the healthcare needs of their MSM clients as well as any of the client's female partners.

INFECTION	CAUSATIVE AGENT	SYMPTOMS
Chlamydia	**Chlamydia trachomatis**	» Often asymptomatic » Urethral infection may include discharge from penis; painful or frequent urination; pain and swelling of one or both testes (epididymitis). » Rectal infection may include discharge with bleeding (proctitis); pain and swelling. » Untreated infection can spread to the fallopian tubes in women, causing pelvic inflammatory disease (PID).
Gonorrhea	**Neisseria gonorrhoeae**	» Often asymptomatic » Urethral infection may include whitish, yellowish, or green discharge from penis; painful or frequent urination. In women, a painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods; PID (For a clinical picture of penile discharge, refer to Figure 9.1) » Rectal infection in both men and women may include discharge, anal itching, soreness, bleeding, or painful bowel movements » Pharyngeal infections may cause a sore throat

Syphilis	**Treponema pallidum**	» Primary phase: Marked by the appearance of a single sore (chancre), but multiple sores may be present; sores occur mainly on the external genitals, or in the vagina, anus, or rectum, but possibly on the lips or mouth. (For a clinical picture of a perianal chancre, refer to Figure 9.2) » Secondary phase: Skin rashes and/or sores in the mouth, vagina, or anus (also called mucous membrane lesions); fever; swollen lymph glands; sore throat; hair loss; headaches; weight loss; muscle aches; fatigue. » Latent phase: Begins when primary and secondary symptoms disappear; may last for many years (10–30 years). » Tertiary phase: Difficulty coordinating muscle movement; paralysis; numbness; blindness; dementia; damage to internal organs; death.
Hepatitis A	**Hepatitis A virus (HAV)**	» Loss of appetite » Malaise » Fatigue » Nausea and vomiting » Abdominal pain » Enlarged liver » Dark urine » Jaundice » Rash » Arthritis
Hepatitis B	**Hepatitis B virus (HBV)**	» Loss of appetite » Malaise » Fatigue » Nausea and vomiting » Abdominal pain » Enlarged liver » Dark urine » Jaundice » Rash » Arthritis » May result in liver cancer
Hepatitis C	**Hepatitis C virus (HCV)**	» Often asymptomatic » Loss of appetite » Malaise » Fatigue » Nausea and vomiting » Abdominal pain » Enlarged liver » Dark urine » Jaundice » Chronic cases include cirrhosis, liver diseases, and possibly death

Herpes	Herpes simplex virus: HSV-I (usually oral herpes) and HSV-2 (usually genital herpes)	» Tingling » Itching » Pimples or blisters that will crust over and scab like a cut » Symptoms may recur every few weeks, months, or years (For a clinical picture of multiple genital ulcers occurring in genital herpes, refer to Figure 9.3)
Human Papillomavirus infection	Human Papilloma virus (HPV)	» Often asymptomatic » Genital and/or anal warts in males and females. » Rarely, warts in the throat (known as recurrent respiratory papillomatosis) (For a clinical picture of genital warts, refer to Figure 9.4)
Human immuno-deficiency virus infections	Human immuno-deficiency virus (HIV)	Symptoms of acute infection are often flu-like and include: » Headache » Swollen glands » Sore throat » Rash » Fatigue » Muscle and joint aches and pains » Diarrhea » Dry cough » Rapid weight loss » Recurring fever » Night sweats » Later, pneumonia, associated infections, and some non-communicable diseases such as cancer.
Lymphogranuloma Venereum (LGV)	Chlamydia trachomatis, serovar L2	» Painless sore on the male genitals or in the female genital tract » Blood or pus from the rectum » Painful bowel movements » Groin swelling and redness » Drainage from inguinal lymph nodes » Rarely, diarrhea and lower abdominal pain

TABLE 9.1 STIs common in gay men and other MSM[3]

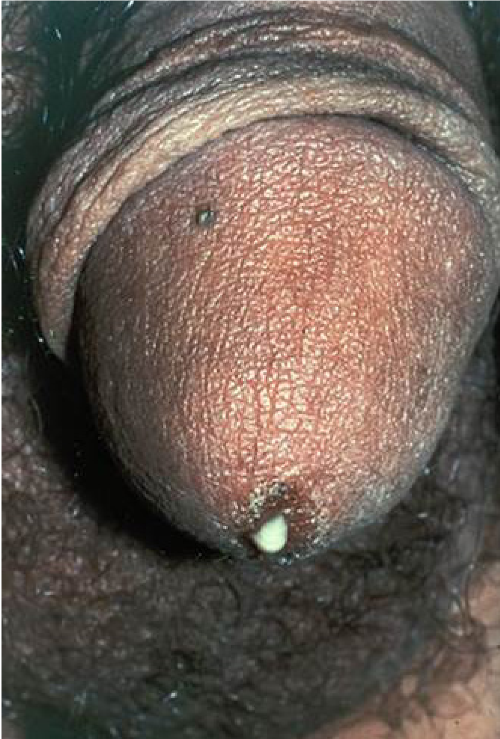

FIGURE 9.1 Purulent discharge from the penis (gonorrhea)[4]

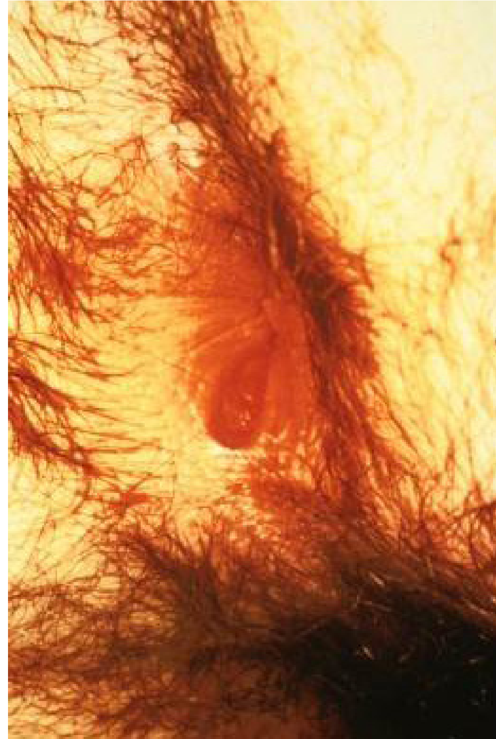

FIGURE 9.2 Perianal chancre (syphilis)[4]

FIGURE 9.3 Multiple ulcers (genital herpes/HSV-2)[5]

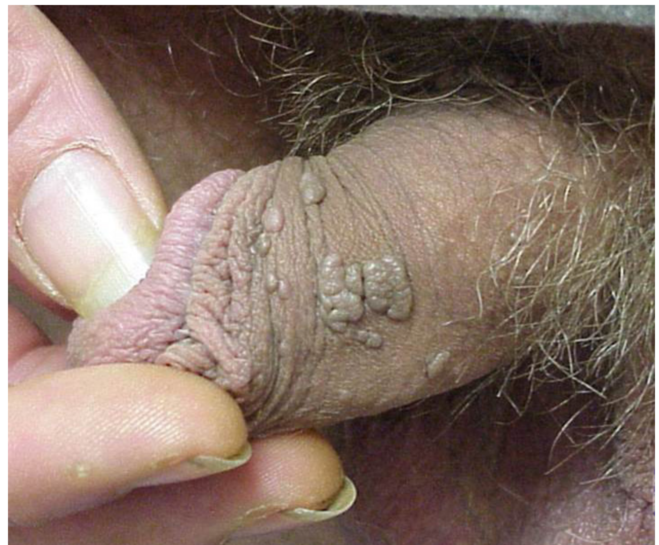

FIGURE 9.4 Penile warts (HPV)

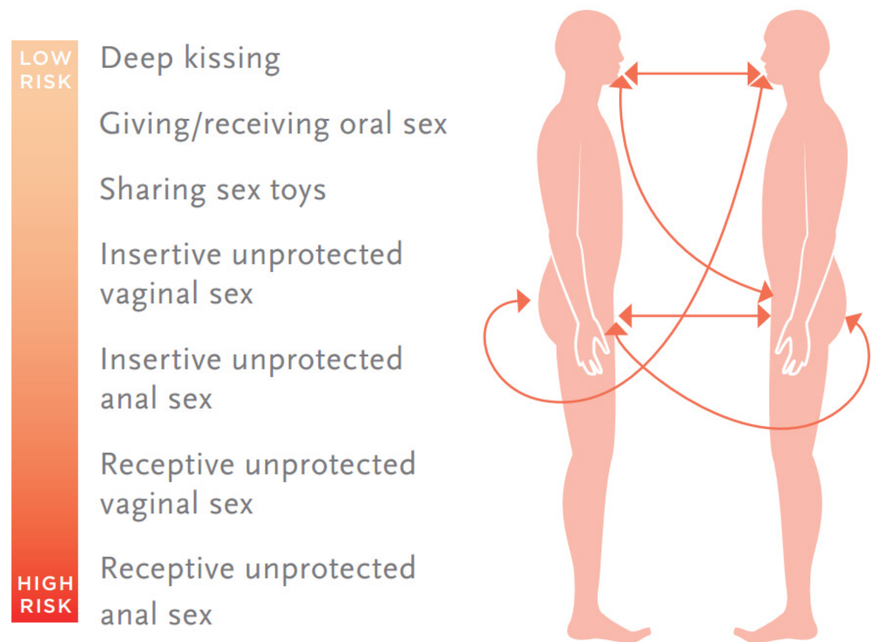

FIGURE 9.5 Hierarchy of STI transmission risk[6]

THE IMPORTANCE OF TESTING GAY MEN AND OTHER MSM FOR STIS

Compared to rates in the general population, incidence of certain STIs is elevated among gay men and other MSM because of the variety of factors that have been discussed. STIs because of the variety of factors that have been discussed.[6] Additionally, some STIs, such as gonococcal infections, are often asymptomatic or have symptoms that are easily missed, such as the chancre of syphilis. Also, the presence of an STI is associated with increased risk of HIV acquisition. There are several biological reasons for this:[7]

- STIs disrupt mucosal barriers, making HIV acquisition easier.
- STIs cause localized inflammation, facilitating HIV infection of mucosal cells.
- STIs cause generalized inflammation within the body, increasing the rate of HIV replication and progression to AIDS in clients who are infected with HIV.

Because prevalence rates of HIV and certain other STIs among gay men and other MSM is already elevated, regular STI screening is particularly important for this population. By screening clients regularly as part of routine care, healthcare providers have the opportunity to make a significant impact on STI and HIV prevention efforts both locally and nationally.[8]

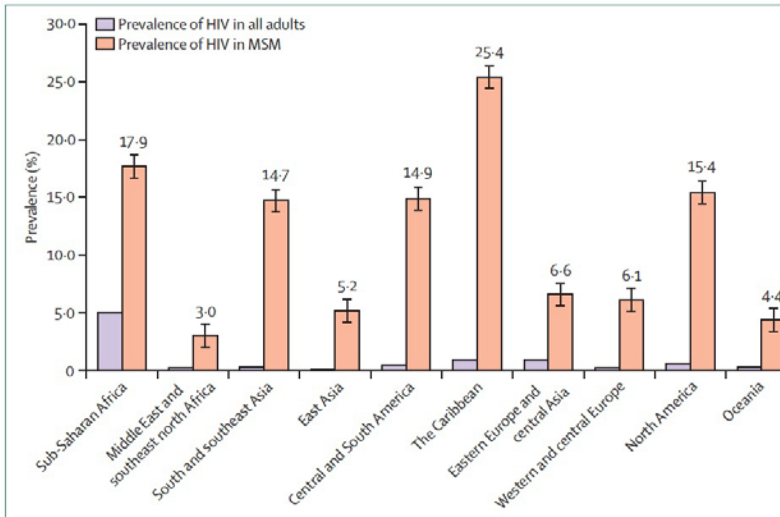

FIGURE 9.6 HIV prevalence rates among MSM compared to all adults by region[10]

The human immunodeficiency virus (HIV) is a retrovirus that attacks essential cells in the human immune system, including T cells (specifically CD4+ T cells), macrophages, and dendritic cells. Over time, HIV destroys CD4+ T cells, depriving the body of cell-mediated immunity. The body becomes progressively more susceptible to opportunistic infections, leading to the development of acquired immune deficiency syndrome (AIDS). More than 35 million people worldwide are living with HIV and more than two-thirds live in Sub-Saharan Africa.[9] Additionally, HIV prevalence has been found to be higher in gay men and other MSM than in the general population in nearly every setting where it has been studied (Figure 9.6).[10-12]

During the initial acute infection, viral load is high and CD4+ cell count decreases as HIV attacks these cells. The symptoms during this phase are often flu-like and include fever, swollen glands, sore throat, rash, muscle and joint aches or pains, fatigue, and headache, among others.[13] Viral load is particularly high during acute infection. As such, individuals with HIV are more likely to transmit the virus during this time when they have sexual intercourse or share needles.[14]

The immune system then begins to fight the virus. Viral load decreases and CD4+ cell count increases, but not to levels held before infection. The person enters the clinical latency phase, when the virus is still replicating, but at lower rates than during acute infection.[14] Many people are asymptomatic during this phase and may take years to develop AIDS. Progression to AIDS occurs when the immune system weakens to a level where CD4+ cell counts are less than 200 cells per TB, chest infections, skin rashes, sores in the mouth, diarrheal illnesses, and some types of cancer occur.[14]

A visual representation of the course of an HIV infection is shown in Figure 9.7.

HIV is not spread through saliva. Kissing or sharing food or utensils with an HIV-positive individual will not transmit HIV unless there is also blood present.

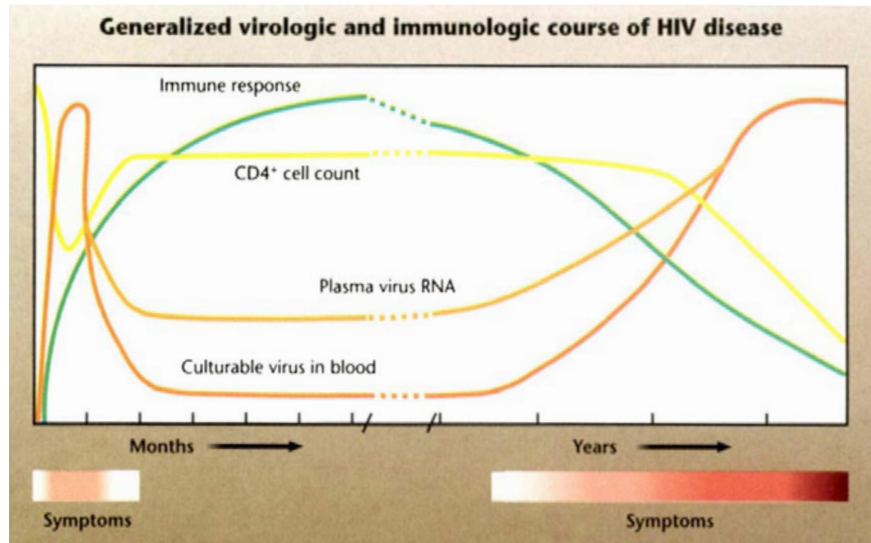

FIGURE 9.7 Schematic of the natural course of an HIV infection[52]

Bodily fluids such as blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk of infected individuals may transmit HIV. It is not transmitted through saliva. HIV may only be transmitted from an HIV-positive and viremic individual. Otherwise, there is no risk. Some modes of HIV transmission include:[15]

1. Unprotected anal intercourse with an HIV-positive and viremic partner or partner of unknown HIV status
2. Unprotected vaginal intercourse with an HIV-positive and viremic partner or partner of unknown HIV status
3. Sharing of unsterilized needles, syringes, or other equipment
4. Vertically during pregnancy, birth, or breastfeeding
5. Blood transfusions, blood products donation
6. Organ/tissue transplants from infected individuals

RECOMMENDED STEPS FOR STI TESTING

Healthcare providers should assess the STI risk of all male clients. Fenway Health presents the following as recommended steps for STI screening:[8]

1. Interview the client and conduct a culturally sensitive sexual history to:
   - Identify sexually active gay men and other MSM.
   - Identify risk of STI exposure.
   - Assess alcohol use history and drug use and assess if it is relevant to client's sexual health.
   - Assess underlying social and psychological challenges.

GROUP ACTIVITY

Transmission of STIs and HIV

Objective: To ensure that participants understand the major means of transmission of STIs and HIV

Main Activity: Ask participants to identify all of the sexual acts between two men that can lead to HIV and STI transmission. In addition to the exchange of body fluids, ensure that the group includes different types of direct contact with the skin, sore, or parasite. Then facilitate a discussion about the level of risk associated with each sexual act. Include which sexual partner is at greater risk for infection.

Discussion: Invite questions for clarifications. Facilitate a discussion around the following questions: How big is the gap between the reality of risk and people's perceptions of risk? Where do we get our information from? How can we improve access to accurate, appropriate and timely sexual health information? What factors affect the level of risk? What can we learn from this about the factors that might increase vulnerability?

Summarize key findings: Finish by summarizing the basic facts about transmission of HIV and STIs.

2. Ask the client if they are experiencing any STI symptoms and ask about specific symptoms consistent with the presence of an STI. Keep in mind that the client may be asymptomatic.
   - » Common symptoms include dysuria, urethral discharge, pain, skin rash, and anorectal pruritis.

3. Consistently provide the following recommended clinical STI prevention services:
   - » Testing (at least annually) for:
     - STI signs (visual inspection of the skin, mouth, genital, and anal area).
     - HIV infection if HIV negative or not tested within the previous year.
     - Syphilis with a confirmatory test to establish whether it is incident untreated syphilis, partially treated syphilis, or whether the client is manifesting a slow serologic response to appropriate prior therapy.
     - Urethral *N. gonorrhoeae* and *C. trachomatis* in men who have had insertive intercourse.[3]
     - Rectal *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive anal intercourse.[3]
     - Pharyngeal *N. gonorrhoeae* and *C. trachomatis* in men who have had receptive oral sex.
   - » Vaccination against HAV and HBV for all gay men and other MSM in whom a previous infection or vaccination cannot be documented.[3]
   - » Circumcision assessment and removal of foreskin.

FACILITATOR'S TIP

Before discussing STI treatment, familiarize yourself with local treatment recommendations. If they differ from the recommendations presented here, present local guidelines instead.

HIV antibody tests may not detect HIV immediately upon infection. Seroconversion usually occurs 2-12 weeks after infection.

4. Consider screening for other STIs:
   - Lymphogranuloma venereum (LGV): consider LGV in diagnosis of compatible syndromes (proctitis and proctocolitis) and perform tests to diagnose chlamydia.
   - Herpes simplex virus (HSV)
   - Human papillomavirus (HPV)

Screen all sexually active gay men and other MSM at least annually regardless of the client's history of consistent condom use. Clients at higher risk (such as those with multiple partners or those who engage in anal intercourse without a condom with anonymous partners) should be screened every three to six months.

HIV TESTING

HIV testing was covered in-depth previously. Here, reiterate that HIV testing and counseling (HTC) is a key entry point to care, treatment, and support for people living with HIV. Early detection enables care and support not only to prolong life, but also to improve quality of life and prevent the spread of HIV through risk reduction and behavior change. Seroconversion, the point at which HIV antibodies are detectable in sera, usually occurs 2-12 weeks after initial infection. Rapid tests use blood from a vein or finger prick to test for the presence of HIV antibodies. An enzyme immunoassay (EIA) or enzyme-linked immunoassay (ELISA) is used to look for the antibodies. Before seroconversion, an individual will continue to test negative for HIV even though the virus is present. Confirmatory testing is usually done with a Western blot. Gay men and other MSM should be tested for HIV at least annually, but possibly every 3-6 months for those with higher risk of HIV exposure (such as serodiscordant couples, commercial sex workers, and those who have unprotected sex with multiple partners).

TREATING STIS

Though guidelines differ in each country and specific treatment regimens vary, the following table presents STI treatment guidelines for adults and adolescents recommended by the United States Centers for Disease Control and Prevention (CDC).

STI	RECOMMENDED REGIMENS
Chlamydia	Azithromycin 1 g orally in a single dose **OR** Doxycycline 100 mg orally twice daily for 7 days
Gonorrhea	Ceftriaxone 250 mg in a single intramuscular (IM) dose **PLUS** Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days* If ceftriaxone is unavailable (urethral, rectal, cervical infection): Cefixime 400 mg in a single oral dose **PLUS** Azithromycin 1 g orally in a single dose or doxycycline 100 mg orally twice daily for 7 days* **PLUS** Test-of-cure in one week
Syphilis (primary and secondary)	Benzathine penicillin G 2.4 million units IM in a single dose
Syphilis (tertiary)	Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at one-week intervals.
Syphilis (latent)	Early latent syphilis: Benzathine penicillin G 2.4 million units IM in a single dose. Late latent syphilis or latent syphilis of unknown duration: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals.
Hepatitis A (HAV)	Usually requires only supportive care with rest, abstaining from alcohol, and coping with nausea until the body eliminates the virus. Hospitalization might be necessary for clients who become dehydrated because of nausea and vomiting and is critical for clients with signs or symptoms of acute liver failure. Medications that might cause liver damage or are metabolized by the liver should be used with caution among persons with HAV.
Hepatitis B (HBV)	No specific therapy is available for persons with acute HBV; treatment is supportive. Persons with chronic HBV infection should be referred for evaluation to a physician experienced in the management of chronic liver disease. Certain therapeutic agents for the treatment of chronic hepatitis B can achieve sustained suppression of HBV replication and remission of liver disease in some persons.
Hepatitis C (HCV)	Persons determined to have HCV should be evaluated for the presence of active infection, presence or development of chronic liver disease, and possible treatment. Combination therapy with pegylated interferon and ribavirin is the treatment of choice for people with chronic HCV. Healthcare providers should consult with specialists knowledgeable about management of HCV infection.

Herpes	Acyclovir 400 mg orally three times daily for 7-10 days **OR** Acyclovir 200 mg orally five times daily for 7-10 days **OR** Famcyclovir 250 mg orally three times daily for 7-10 days **OR** Valacyclovir 1 g orally twice daily for 7-10 days
Human Papillomavirus (HPV)	Treatment is directed to the macroscopic or pathologic lesions caused by infection. Subclinical genital HPV infection typically clears spontaneously and antiviral therapy is not recommended. In the absence of lesions, treatment is not recommended for subclinical genital HPV.
Lymphogranuloma Venereum (LGV)	Doxycycline 100 mg orally twice daily for 21 days Alternative recommendation: Erythromycin base 500 mg orally four times daily for 21 days.

TABLE 9.2 CDC STI treatment guidelines for adults and adolescents

*Because of the high prevalence of tetracycline resistance among Gonococcal Isolate Surveillance Project isolates, particularly those with elevated minimum inhibitory concentrations to cefixime, the use of azithromycin as the second antimicrobial is preferred.

FACILITATOR'S TIP

Before discussing HIV testing, familiarize yourself with local HIV testing procedures. If they differ from what is presented here, present local testing procedures instead.

HIV TREATMENT

ART is the core biomedical component of the management of HIV infection and has significantly reduced morbidity and mortality from HIV since its introduction. ART functions biologically similarly in all people, regardless of sexual or gender identity. Therefore, ART recommendations for gay men and other MSM are the same as for non-MSM populations. Following are the core aspects of the World Health Organization (WHO) recommendations for MSM and transgender adults:

» All clients should have access to CD4+ cell-count testing to optimize pre-ART care and ART management.

» *First-line therapy*

A non-nucleoside reverse transcriptase inhibitor (NNRTI)
PLUS
Two nucleoside reverse transcriptase inhibitors (NRTIs), one of which should be zidovudine (AZT) or tenofovir (TDF).[16]

Note: tenofovir disoproxil fumarate (TDF) + lamivudine (3TC) or emtricitabine (FTC) + efavirenz (EFV) as a fixed-dose combination is recommended as the preferred option to initiate ART.[17]

» *Second-line therapy*

A ritonavir-boosted protease inhibitor (PI)
PLUS
Two NRTIs, one of which should be AZT or TDF, based on what was used in first-line therapy.[16]

CONSIDERATIONS IN INITIATING ANTIRETROVIRAL THERAPY

Initiating a gay man or other MSM on ART follows the same WHO guidelines as for other adults or adolescents with HIV.[17, 53] Studies have shown a reduction in the community viral load among gay men and other MSM where ART coverage was high, but the evidence is insufficient to modify recommendations.[18, 19] In general, the WHO recommends starting an otherwise healthy adult or adolescent on ART when CD4+ cell count reaches or drops below 500 cells/mm^3. Those with a CD4+ cell count of 350 cells/mm^3 or less should have greater priority. The WHO recommends initiating ART in clients in the following instances regardless of clinical stage or CD4+ cell count:

» Active TB disease
» Those with HBV co-infection with severe chronic liver disease
» HIV-positive individuals in a serodiscordant partnership (for HIV transmission risk reduction)
» Pregnant and breastfeeding women with HIV

Other populations that differ from the general recommendation of initiating below 500 cells/mm^3 include infants, children under 5 years old, and children between 5 and 10 years old with severe/advanced HIV disease (WHO clinical stage 3 or 4). These populations should be initiated on ART regardless of CD4+ count. The following table summarizes the WHO recommendations for ART initiation.

POPULATION	RECOMMENDATION
Adults and adolescents (▸10 years)	» Initiate ART if CD4+ cell count ≤500 cells/mm^3. » As a priority, initiate ART in all individuals with severe/advanced HIV disease (WHO clinical stage 3 or 4) or CD4+ count ≤350 cells/mm^3.
	» Initiate ART regardless of WHO clinical stage or CD4+ cell count: • Those with active TB disease • Those with HBV co-infection with severe chronic liver disease • HIV-positive individual in a serodiscordant partnership (to reduce HIV transmission risk) • Pregnant and breastfeeding women with HIV
Children ▸5 years old	» Initiate ART if CD4+ cell count ≤500 cells/mm^3 » As a priority, initiate ART in all children with severe/advanced HIV disease or CD4+ count ≤350 cells/mm^3.
	» Initiate ART regardless of CD4+ cell count: • Individuals with severe/advanced HIV disease (WHO clinical stage 3 or 4) • Those with active TB disease

Children 1-5 years old*	» Initiate ART in all regardless of WHO clinical stage or CD4+ cell count » As a priority, initiate ART in all HIV-infected children: • Who are 1-2 years old • With severe/advanced HIV disease • Whose CD4+ count ≤750 cells/mm^3 or <25%, whichever is lower
Infants <1 year old*	» Initiate ART in all infants regardless of WHO clinical stage or CD4+ cell count.

TABLE 9.3 Summary of WHO recommendations on ART initiation[17]

*Initiate ART in all HIV-exposed children below 18 months of age with presumptive clinical diagnosis of HIV infection.

There are several other factors beyond the WHO recommendations that must be considered when choosing an HIV treatment regimen. The choice of HIV medications to include depends on the client's individual needs. People living with HIV and their healthcare providers must consider the following factors as well:[20]

1. Other diseases or conditions that the person living with HIV may have.
2. Possible side effects of HIV medications.
3. Potential interactions between HIV medications or between HIV medications and other medications that the person living with HIV is taking.
4. Results of drug-resistance testing and other tests. Data suggest that 10-17% of ARV-naïve individuals in Australia, Japan, the United States, and Europe are infected with HIV resistant to at least one ARV drug. Other data suggest that these rates are lower (5.1-8.3%) in low- and middle-income countries, though rates of resistance are rising.[21]
5. Convenience of the regimen. For example, a regimen that includes two or more HIV medications combined in a single pill is more convenient to follow than a regimen with several pills.
6. Any personal issues that might affect adherence to medication. ART is to be considered a lifelong therapy. Interruption of ART is not recommended except for in cases of serious toxicities or inability to take oral medications. Interruptions usually cause rapid virologic rebound with CD4+ cell count decline.[22]

Healthcare providers should work with their clients to agree on the best HIV treatment plan for that particular individual.

BENEFITS OF EARLY THERAPY

WHO guidelines generally recommend initiating ART for other-wise-healthy adults and adolescents when their CD4+ cell count drops below 500 cells/mm^3. However, early initiation of ART has several clinical and prevention benefits.[23, 24] The reduction in HIV incidence associated with lower viral load has prevention benefits at the individual level, but also impacts HIV transmission at the community level.[27, 28] There are several other benefits to early ART. These include:

1. Maintenance of higher CD4+ cell counts and reduced viral reservoir, which can prevent irreversible immune system damage.[25]
2. Prevention of HIV-associated complications such as TB, non-Hodgkin lymphoma, Kaposi's sarcoma, peripheral neuropathy, HPV-associated malignancies, and HIV-associated cognitive impairment.[26]
3. Prevention of non-opportunistic conditions and non-AIDS-associated conditions such as cardiovascular, renal, and liver disease; malignancies; and infections.[26]

TREATMENT AS PREVENTION

Treatment as prevention (TasP) refers to treating an HIV-positive person with antiretroviral drugs to reduce the risk of transmitting HIV to an HIV-negative partner.[27] Because ART reduces viral load and people with lower viral loads are less likely to transmit HIV to their HIV-negative partners, ART may also act as a prevention intervention.[28] However, this is only a secondary benefit, as ART's primary purposes are to treat HIV disease, improve health, and prolong life.[27] The HPTN 052 study showed that early initiation of ART reduced sexual transmission of HIV among serodiscordant heterosexual couples by up to 96%.[29] Concerning gay men and other MSM, the San Francisco Men's Health Study found a link between ART and decreased incidence of HIV infection within gay serodiscordant couples. This was true even though not all of the men in the study adhered to their treatment regimen.[30] Outside of this San Francisco study, however, there is limited evidence that TasP provides the same prevention benefits to gay men and other MSM as it does to the serodiscordant heterosexual couples in HPTN 052.[31] Additional studies are being conducted with promising results anticipated.

Challenges remain to scaling up TasP globally, including:

- High cost of ART
- Dependence on access to and utilization of HIV services
- Dependence on knowledge of HIV status
- Increased drug resistance
- Adverse events
- Toxicity

Still, homophobia and HIV stigma impede access to HIV services by gay men and other MSM. Many gay men and other MSM report that ART is difficult to access or not accessible at all.[32] As such, TasP remains a promising intervention for this population if it results in increased access to and uptake of ART. Furthermore, few gay men and other MSM are fully aware of currently available prevention and treatment options.

For TasP to be successful requires:[33]

- Increased advocacy for TasP as part of a combination prevention package for gay men and other MSM.
- Capacity-building and mobilization of local gay or other MSM advocates and community-based organizations.
- Improved linkages to care and treatment for gay men and other MSM.
- Additional training and sensitization of healthcare workers.

TREATMENT 2.0

Treatment 2.0 refers to a 10-year initiative developed by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the WHO that aims to improve access to and maximize the prevention benefits of ART globally.[34] It stresses the need for a coordinated plan of action between multilateral, bilateral, and country-level agencies to simplify and scale up efforts toward universal access to HIV care and treatment.[35] The overall targets by 2015 include:

- Elimination of new HIV infections in children.[34-36]
- Reduction of TB deaths among people living with HIV by 50%.[34-36]
- 15 million people on ART.[34-36]

It is estimated that Treatment 2.0 could prevent 12.2 million new infections, 7.4 million AIDS deaths, and result in a gain of 20.4 million life-years.[34-36] There are five pillars that guide progress toward achieving the goals of Treatment 2.0, as shown in Figure 9.8. These are:

- Creating a better pill and diagnostics
- Treatment as prevention
- Stopping cost being an obstacle to ART
- Improving uptake of HIV testing and linkage to care
- Strengthening community mobilization

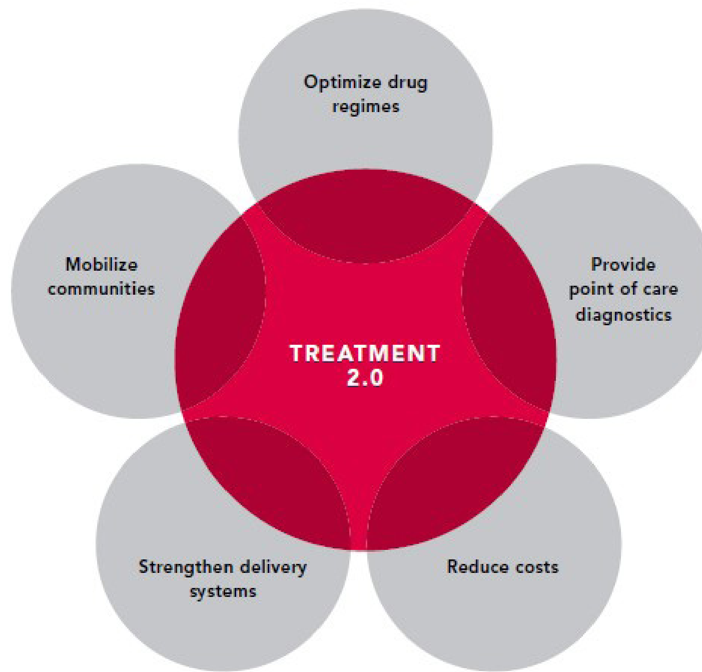

Figure 9.8 Guiding Principles of Treatment 2.0

Treatment 2.0 promotes expansion of services to gay men and other MSM, protection of their human rights, and efforts to mitigate stigma and homophobia.[34] Treatment 2.0 has enormous potential to positively impact the global HIV/AIDS epidemic and expand care to gay men and other MSM.

TUBERCULOSIS AND CO-INFECTION WITH HIV

Co-infection with TB occurs when an individual is living with both HIV and either a latent or active TB infection at the same time. Globally, almost one in four deaths among people living with HIV is due to TB, making it the leading cause of death among this population.[37] Latent TB infection can usually be treated with one type of medication, whereas an active TB infection might require several concurrently.[38] Some common first-line TB treatment medications include isoniazid, rifampin, ethambutol, and pyrazinamide.[39] In the case of multi-drug resistant TB (MDR-TB) or extremely drug resistant TB (XDR-TB), second-line medications, such as streptomycin, kanamycin, clarithromycin, amikacin, capreomycin, or other antibiotics, are necessary. These drugs are more expensive, more toxic, less effective, and require a longer course of treatment than first-line drugs.[38] The WHO has established guidelines for the treatment of TB in people living with HIV. These include:

» Antiretroviral Therapy

  ART can restore some immune system function, which can mitigate the impact of TB and HIV. All people living with HIV with an active TB infection should be placed on ART immediately.[40]

» Intensified TB Case Finding

All people living with HIV should be screened regularly for TB. Research on TB case finding shows that the presence of one or more of the following 3 symptoms - persistent cough, fever, or night sweats - detects the vast majority of active TB cases.[41, 42]

» Isoniazid Preventive Therapy

People living with HIV who test positive for a latent TB infection should be put on isoniazid preventive therapy (IPT) for up to 36 months.[40]

» Infection Control for TB

This includes rapid detection of people who are infectious, precautions to reduce airborne transmission in healthcare settings, and treatment of those either suspected or confirmed to have active TB.[40]

There are two key challenges for TB treatment in people living with HIV. The first is MDR-TB. The likelihood of dying from MDR-TB is high, especially for people living with HIV, unless treatment with appropriately tailored therapy can begin very quickly after infection. Ensuring that clients complete TB treatment with methods such as directly observed therapy short course (DOTS) is, to date, the most effective way to avoid the spread of MDR-TB. Second, clinical management of HIV/TB co-infection is difficult because of the many treatment interactions between medications for HIV and TB. These interactions can cause many negative health effects such as liver-related illnesses.[43] Because gay men and other MSM are disproportionately affected by HIV and experience greater difficultly in accessing the health system, it is particularly important that efforts be made to integrate TB screening and case finding into the minimum service package for this population.

VIRAL HEPATITIS CO-INFECTION WITH HIV

Hepatitis refers to swelling and inflammation of the liver, often due to a viral infection. It can interfere with critical liver functions such as processing of nutrients, filtering toxins and waste from blood, and supporting immunity.[44] The three major types of viral hepatitis are hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV). Types D and E are also important but less common.[45] Symptoms of hepatitis are often flu-like and include fever, nausea, fatigue, vomiting, loss of appetite, and joint pain. Symptoms may also include dark-colored urine, grey-colored stool, and jaundice.[46] Gay men and other MSM are disproportionally affected by HAV, HBV and HCV. In the United States, for example, an estimated 10% of new HAV infections and 20% of new HBV infections are in gay men and other MSM.[47]

Worldwide, 2 to 4 million people living with HIV also have chronic HBV co-infection, while 4 to 5 million people living with HIV are co-infected with HCV.[48, 49] The effects of HIV make it more difficult for the body to clear the hepatitis virus.[47] People living with HIV with HAV co-infection may experience more severe symptoms and require longer recovery times.[49] People living with HIV co-infected with HBV or HCV are also at increased risk of cirrhosis or liver disease and progress to these conditions more quickly. The following table provides an overview of treatment for HAV, HBV, and HCV.

VIRUS TYPE	VACCINE AVAILABLE	TREATMENT AVAILABLE
Hepatitis A (HAV)	Yes	» No specific treatment exists for HAV.[50] » Recovery requires rest, abstaining from alcohol, and coping with nausea until the body eliminates the virus.
Hepatitis B (HBV)	Yes	» Standard of care is treatment using antiviral medications.[46] » HBV can require lifelong management if it becomes chronic.[46]
Hepatitis C (HCV)	No	» Medications are available and can cure those living with HCV. 46 » Relapse and re-infection is possible.[46] » Many HCV medications are prohibitively expensive.

TABLE 9.4 Overview of Hepatitis Treatment

Globally, guidelines for viral hepatitis in gay men and other MSM are not widely available. When they are available, programs differ greatly by country depending on the available resources.[44] If possible, all gay men and other MSM be vaccinated against HAV and HBV and should be screened for chronic HBV annually.[46] HCV testing is recommended for those gay men and other MSM who engage in higher-risk sexual activities or who are living with HIV.[46] Globally, it is necessary to improve awareness of and vaccinate against hepatitis as part of a minimum package of services for HIV prevention and treatment. Efforts must also be made to improve healthcare provider education regarding hepatitis and to improve access to healthcare for gay men and other MSM.

CONCLUSION

The HIV epidemics among gay men and other MSM are fundamentally different from those in other groups at risk. Biological, social, network, and structural factors combine to spread HIV efficiently and rapidly in this group. Individual risk behaviors contribute only modestly to these dynamics.[51] Therefore, new and more effective HIV prevention programs for gay men and other MSM are necessary to reduce infectiousness. This requires expanding testing, expanding treatment for positive men, and reducing risk of HIV acquisition for HIV-negative men. Currently available tools are able to reduce the incidence of HIV infection substantially, but more and better tools will be necessary to achieve an AIDS-free generation for

gay men and other MSM. Similarly, stigma, discrimination, and homophobia both inside and outside of the healthcare system continue to limit access to basic HIV services and prevention methods for gay men and other MSM. If we are to make a substantial impact on the HIV epidemics among gay men and other MSM, we must focus our efforts on the delivery of effective interventions that address each gap in the testing and treatment cascade. We must also ensure that safe and affirming spaces for gay men and other MSM are available for prevention, treatment, and care.[51]

KEY POINTS FROM THE MODULE

- Gay men and other MSM are more vulnerable to HIV infections and other STIs.
- Presence of STIs increase risk for HIV acquisition.
- Gay men and other MSM should be screened at least annually for HIV and other STIs depending on their sexual health needs.
- Treatment as prevention is a promising risk reduction intervention for gay men and other MSM.
- Gay men and other MSM often have difficulty accessing HIV services.
- A large number of factors, personal and otherwise, must be taken into account when initiating ART.
- Early treatment is important not only for improving the health of an HIV-positive individual but also as an HIV prevention tool.
- Tuberculosis and hepatitis co-infections are particularly dangerous for people living with HIV. Services for these infections must be integrated into a standard package of services for gay men and other MSM.

PRE-POST ASSESSMENT

1. Which is NOT likely to be an early symptom of HIV infection?

   a. Fever

   b. Rash

   c. Genital warts

   d. Sore throat

2. Over the natural course of an HIV infection, viral load starts low and follows a smooth curve upward until progression to AIDS.

   [ ] True [ ] False

3. ____________________ infection is usually marked by the appearance of a single sore called a chancre.

4. Gay men and other MSM should be vaccinated against which type(s) of hepatitis?

   a. HAV

   b. HBV

   c. HCB

   d. All of the above

   e. HAV and HBV

5. The same types of HIV treatment regimens work for all individuals.

   [ ] True [ ] False

6. It is important to screen gay men and other MSM for rectal and pharyngeal STIs in addition to urethral.

   [ ] True [ ] False

7. The WHO recommends initiating ART for anyone with a CD4+ count of __________________ or less.

8. Globally, ____________________ is the leading cause of death among people living with HIV.

9. HIV antibody tests are capable of detecting an HIV infection as soon as a person acquires the virus.

   [ ] True [ ] False

10. HIV is efficiently transmitted through saliva.

    [ ] True [ ] False

ADDITIONAL RESOURCES

For more on specific treatment guidelines for HIV and other STIs, please see:

» World Health Organization. Guidelines for the Management of Sexually Transmitted Infections.

http://apps.who.int/iris/bitstream/10665/42782/1/9241546263_eng.pdf

» Centers for Disease Control and Prevention. 2010 STD Treatment Guidelines

http://www.cdc.gov/std/treatment/2010/default.htm

» CDC also has a new treatment guidelines app which can be downloaded here

http://www.cdc.gov/std/STD-Tx-app.htm

For more on treatment as prevention, please see:

» MSMGF. Treatment as Prevention.

http://www.msmgf.org/files/msmgf//documents/TechBulletins/EN/Sec8MSMGF_TechBulletins2012.1.pdf

» World Health Organization. Guidance on Couples HIV Testing and Counselling Including Antiretroviral Therapy for Treatment and Prevention in Serodiscordant Couples.

http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf?ua=1

For more on HIV treatment and ART initiation, please see:

» World Health Organization. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. 2014http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1

» World Health Organization. Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach, 2013

http://apps.who.int/iris/bitstream/10665/85321/1/9789241505727_eng.pdf?ua=1

» World Health Organization. Prevention and Treatment of HIV and Other Sexually Transmitted Infections Among Men Who Have Sex With Men and Transgender People: Recommendations for a Public Health Approach, 2011

http://apps.who.int/iris/bitstream/10665/44619/1/9789241501750_eng.pdf?ua=1

» AIDSinfo Education Materials. What to Start: Selecting a First HIV Regimen. 2013

http://aidsinfo.nih.gov/education-materials/fact-sheets/21/53/what-to-start--selecting-a-first-hiv-regimen

For more on HIV drug resistance, please see:

- World Health Organization. HIV Drug Resistance Report, 2012.

  http://apps.who.int/iris/bitstream/10665/75183/1/9789241503938_eng.pdf

For more on tuberculosis and HIV, please see:

- World Health Organization. Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings.

  http://whqlibdoc.who.int/publications/2011/9789241500708_eng.pdf?ua=1

- Centers for Disease Control and Prevention. Tuberculosis an HIV.

  http://www.cdc.gov/tb/publications/guidelines/HIV_AIDS.htm

For more on hepatitis and HIV, please see:

- Centers for Disease Control and Prevention. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents.

  http://www.aidsinfo.nih.gov/contentfiles/Adult_OI.pdf

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The Global Forum on MSM & HIV (MSMGF) is a coalition of advocates working to ensure an effective response to HIV among MSM. Our coalition includes a wide range of people, including HIV-positive and HIV-negative gay men directly affected by the HIV epidemic, and other experts in health, human rights, research, and policy work. What we share is our willingness to step forward and act to address the lack of HIV responses targeted to MSM, end AIDS, and promote health and rights for all. We also share a particular concern for the health and rights of gay men/ MSM who: are living with HIV; are young; are from low and middle income countries; are poor; are migrant; belong to racial/ethnic minority or indigenous communities; engage in sex work; use drugs; and/or identify as transgender.

Promoting the Health of Men Who Have Sex With Men Worldwide

A TRAINING CURRICULUM FOR PROVIDERS

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