

men who have **sex with** men

An Introductory Guide for Health Workers in Africa

Revised Edition 2011



DESMOND TUTU
HIV FOUNDATION

Men who have Sex with Men:
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Health Care Workers in Africa

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Editors

Benjamin Brown, Zoe Duby,
Andrew Scheibe, Eduard Sanders

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It is requested that the manual be referenced appropriately when used
for training purposes.



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HIV FOUNDATION

Men who have Sex with Men: An Introductory Guide for Health Care Workers in Africa

Revised edition 2011

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Dedication

To all the Africans who have been persecuted on the basis of their sexuality or their sexual behaviour and to those who have been denied the services and help that they need.

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Introduction

Men who have sex with men (MSM) are just like everybody else and have the right to enjoy fulfilled lives. MSM exist in all cultures and in every part of the world. As a result of discrimination and homophobia, however, many MSM are unable to reach their full potential and are faced with several barriers to accessing health care and justice services. Many health care providers face barriers to providing services to MSM where the law prohibits it. A culture of acceptance, understanding and non-discrimination should be cultivated in Africa – and the health care environments are critical areas in which to start this revolution.

High rates of HIV infection occur among MSM in low- and middle-income countries. This appears to be partly driven by persistent stigma and discrimination. The lack of specific and appropriate prevention strategies has failed to make a positive impact on curbing the spread of HIV among MSM. In many African countries there is little recognition by policymakers of this risk group.

In some countries, laws banning male-to-male sexual contact exist and are enforced. Poor advocacy, the lack of research and poor programming for MSM communities continues.

Currently no counsellor or health care provider training material addresses the specific health care needs of MSM, the risks of HIV infection or the anal acquisition of sexually transmitted infections (STIs) in sub-Saharan Africa.

The recent attacks, arrests and murder of MSM, MSM advocates and MSM service providers in Uganda, Malawi, Kenya, Senegal and across Africa highlight the need for an end to discrimination based on sexual orientation and sexual practices. The basic human rights of freedom from discrimination and the ethical principle of equal access to health care should guide governments to providing health care services for all, including MSM. Work done by SAFAIDS and other organisations in Africa have highlighted the existence of high levels of stigma and homophobia in the health care sector around MSM and lesbian gay bisexual transgender intersex (LGBTI) issues. Health care workers have a

duty to provide services to all people, and their personal views should not affect their ability to provide these in a non-discriminatory way.

The guide also aims to empower health care workers to discuss anal sex with men and women in addition to being sensitive to MSM behaviour. There is no way to determine whether a man is an MSM by looking at him, and the skills and understanding harnessed are applicable to all users of health care services and their providers.

The organisers

Two groups, the Desmond Tutu HIV Foundation based in Cape Town, South Africa, and KEMRI based in Kilifi, Kenya, have extensive experience in working with MSM in their respective countries. These organisations have combined experiences and expertise to develop a manual aimed at improving STI/HIV risk-reduction counselling and testing services for MSM in Africa.

The Desmond Tutu HIV Foundation was established in 2004 as a research action organisation that envisions a brighter future where HIV is manageable and its presence is diminished. The Foundation has been actively involved in research and service provision among Cape Town's MSM community since its founding. Current MSM activities focus on HIV biomedical prevention research; MSM HIV prevalence studies; the dissemination of research findings among local and broader scientific and MSM communities; and the establishment of MSM-friendly HIV testing services at its various clinic sites in and around Cape Town.

The KEMRI-Wellcome Trust Research Programme started MSM research in coastal Kenya in 2005 and has since counselled, tested and screened over 1 000 MSM. Of these, both HIV-positive and -negative MSM have regularly attended a drop-in centre and a research clinic. Over 3 000 visits have been made.

The project is supported by a community advisory board comprised of members from the local communities. This board and the experience gained from several community initiatives (e.g. legal support for volunteers who were taken into custody, food tickets for HIV-positive volunteers, etc.) have informed our understanding of MSM in Kenya. The research is conducted in collaboration with the universities of Washington (USA) and Oxford (UK).



Limitations

The guide was developed by researchers, service providers and advocates from non-governmental organisations from South and East Africa, and received expert opinion from across Africa, yet its implementation in government services may yet be limited. The guide should be viewed as providing suggestions for good practice. There is a need to obtain more input from MSM community members and from governmental service providers. An earlier version of this guide is available online at <http://www.marps-africa.org>.

The guide's adaptation and translation into formats relevant to Francophone, Arab, Lusophone and Portuguese Africa still need to be addressed. Many of the resources provided are from the WHO, North America and South Africa, and may not be completely applicable across Africa; however, we are committed to including more African tools as they are developed in the future.

Finally, we wish to acknowledge that the interpretation of sexuality across the complex cultural and social landscape of Africa has not been adequately achieved. As more social research develops, future editions of the manual will make an effort to address the complex social, spiritual and cultural dimensions that shape sexuality and to provide more African-developed resources.

We encourage the adaptation of the content and exercises to suit different contexts. Please feel free to share this resource widely.



Overview

Learning outcomes

After completing the programme individuals should be able to:

- Discuss the vulnerabilities of MSM
- Describe homophobia and the impact that stigma and discrimination have on MSM
- Understand the difference between sexuality identity, sexual behaviour and sexual orientation, and understand how these relate to MSM
- Describe common sexual practices of MSM and understand the importance of asking all clients about anal sex practices
- Explain how HIV- and STI-related health issues specifically impact MSM
- Discuss various ways to make risk-reduction counselling, testing and other health care services more sensitive to the needs of MSM.

Aims of the MSM counsellor and health care provider training course

This manual and training programme aims to educate health care workers with the necessary skills and knowledge to provide the sensitive services that support and adequately cater for MSM and their unique needs within African health care settings.

Target audience

This programme is aimed at HIV counsellors and other health care workers who operate in Africa and have varying degrees of experience with MSM. It has been designed specifically for individuals who already have a basic understanding of and experience in the HIV sector.

Information in this manual, including findings from African-based research and first-hand experiences of African organisations has been presented in such a way as to be accessible to all individuals.

Use of study groups

For the best outcome, the information in this manual should be supplemented and reviewed within the context of a structured training programme. For advice in developing such a programme, please contact the manual editors. The manual content should be covered in its entirety before individuals attend training sessions. It is suggested that a facilitator experienced in counselling or working with MSM lead all trainings but where this is not possible an experienced HIV counsellor or health care worker would be able to facilitate the programme. Case studies and interactive exercises are provided in order to practise the study material within a group but this manual can also be used by individuals who are not able to attend group sessions.

Format of the MSM health care worker guide

This guide is divided into eight modules. These should be completed sequentially but may be reviewed individually.

A pre- and post-course assessment has been included to measure levels of experience, knowledge and attitudes before and after completing the course. A post-course commitment is included at the end of the programme in order to encourage participants to commit to applying the lessons learnt in the field.

Module structure

Each module begins with a statement of learning outcomes that help identify key knowledge and important skills that the trainee should have acquired and/or feel comfortable doing after completing each module. A brief summary is also included that reviews basic information, important facts and skills covered in the module.

Many modules include exercises and reflection tasks in order to provide an opportunity for personal reflection and assessment of knowledge, attitudes and beliefs. Furthermore, practical case studies are presented in story form throughout the course. The case studies are based on real experiences, and provide an opportunity for participants to practise newly learned skills and knowledge. At the end of each module the learning objectives are revisited and important facts and lessons are reinforced.



Certification

Successful completion of the training programme implies that counsellors are familiar with core knowledge and feel comfortable to counsel MSM in an enlightened manner.

The importance of an open mind and attitude

Participants taking part in this course may have developed certain perceptions and opinions about MSM based on personal beliefs and ideals. Both positive and negative assumptions about MSM can impact the ability to effectively counsel MSM clients. It is of vital importance that counsellors provide a service to all clients that is free from judgement. The interests of the client should be the priority of each and every counselling session. Respect should be shown to all clients, and confidentiality of all sessions is of the utmost importance. This programme will also attempt to assist counsellors to overcome personal barriers that may affect their ability to address the specific needs of MSM in Africa.



Where to next?

The development of tools for African health care workers is an ongoing process. This guide builds on the pioneering work of the first guide, published in 2009, and has been broadened to include the input from a diverse range of reviewers. Hard copies of this manual will be circulated to health care workers across Africa.

The content of this edition will be used to update the information on the online version (<http://www.marps-africa.org>). The manual will be posted as an electronic document on websites of many partners, including the Global Forum on MSM and HIV (<http://www.msmsgf.org>); the International Rectal Microbicide Advocates (<http://www.rectalmicrobicides.org>), and will be circulated electronically on several listservs across Africa and internationally. Partners have been identified in West Africa and in Mozambique to adapt and translate the second edition into French and Portuguese. Relationships with North African and Arab partners will also be established in order to explore further expansion and adaptation of the manual. As additional research and programmes are implemented, the lessons learnt and tools developed will be incorporated so that this manual will be representative of Africa's diversity and adaptable to a variety of contexts.

Several health care worker training initiatives which utilise this guide as a knowledge framework are under way in South Africa and eastern Africa. These interventions have also been used to critically evaluate the guide's effectiveness at addressing stigma and building capacity of health care workers to engage MSM and their clients around anal sexual practices. The lessons learnt will be shared with the greater community.

We encourage users of this manual and other stakeholders to provide input and suggestions in order to improve on the current work. Comments can be sent to the email address on the Editor's page of the guide.

Preface

Same-sex behaviour is a part of the great diversity of human sexuality. Love, intimacy and sex between people of the same gender occur in every community, in every culture and on every continent. These behaviours, and the individuals and couples who engage in them, are sometimes tolerated, sometimes celebrated, but are all too often hidden, denied and stigmatised. And those of us in the health care community must admit that stigma and discrimination against sexual minorities in health care settings are real. And that they are wrong. No one should be discriminated against in health care based on sexual orientation, gender identity or sexual behaviour. This is particularly relevant for men who have sex with men (MSM) since we know they are at risk for HIV and other sexually transmitted infections, and that they are also at risk for exclusion from HIV prevention, treatment and care. To address the health needs of these men, their families and their communities, we each must do better. And all of us in health care settings need to be much more familiar with the concerns of MSM and their health needs, and the best practices for how to provide the services they require.

It is for this reason that this manual, *Men who have Sex with Men: An Introductory Guide for Health Care Workers in Africa*, produced by the Desmond Tutu HIV Foundation of South Africa and KEMRI in Kenya, is so welcome and so important. Health care workers really are at the forefront of responding to HIV across Africa. They are key to the success or failure of HIV prevention, AIDS treatment and care for the affected. We have known for a long time that a gender perspective is essential in HIV programmes. And we have developed tools and training materials on gender sensitivity and on understanding the differing needs and concerns of women and girls, men and boys. We now know the same is true for sexual minorities. Health care workers need practical and non-judgemental tools to improve their capacity in responding to the needs and concerns of MSM, and in this MSM manual this is just what we now have. Here the health care worker will find clear and evidence-based information on counselling for MSM, on safer sexual practices, and on the emotional and social needs of these men. Culturally competent and tailored to the African context, this is a clinic-based guide which should be available wherever HIV services are provided in Africa.

Providing these services will not be easy, and nor is dealing with our own prejudices, and our discomfort with those whose sexuality or sexual behaviour differs from our own. Nevertheless, ethical and scientific imperatives are at stake. As health care providers, we are ethically obliged to provide services without discrimination. Patients are not worthy or unworthy, and no one should be excluded from our compassion and our care. The medical and scientific imperatives are clear too: for those at high risk for HIV infection the denial of appropriate services can be literally life threatening. When we speak of universal access, we must take those words seriously and to heart. Universal does not mean 'everyone deserves care except those I find undeserving'. Universal means universal – and it includes MSM.

So please read this important manual. Please use it. For those who are leaders, train your staff in its use and encourage your health care setting to become a leader in the provision of quality and non-discriminatory care for MSM. It is the right thing to do, the ethical thing to do, and part of the next vital stage of the HIV response.

Finally, let me congratulate the Desmond Tutu and KEMRI teams on this wonderful work. They have done a real service for HIV programmes in Africa.

Chris Beyrer MD, MPH

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Contributors

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Zoe Duby is currently at the Desmond Tutu HIV Foundation, running the MSM Sensitivity Training for Health Care Workers, and building a qualitative research base at the Men's Division. She is also working towards her PhD at the School of Public Health at the University of Cape Town, focusing on heterosexual anal sex and HIV in sub-Saharan Africa. Zoe gained a BA in Social Anthropology at the University of Sussex (UK) and an MPhil in the Sociology of HIV at the University of Cape Town.

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Andrew Scheibe is a medical doctor and one of the programme's managers for the Men's Health Division at the Desmond Tutu HIV Foundation. His interests lie in HIV prevention among MSM in South Africa and the economics of health systems.

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Kevin Stoloff is a psychiatrist and honorary lecturer at the University of Cape Town with special interests in 'mental health in HIV', psychopharmacology and the mental health of MSM, for whom he provides outpatient services. His post is funded by PEPFAR via the ANOVA Health Institute.



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The dedication and hard work of all team members have resulted in a manual that will benefit health care workers and MSM in Africa. This version builds and improves on the previous manual, and provides a larger glossary and resource section. This manual is complemented by an online version, which can be accessed at <http://www.marps-africa.org>.

Our appreciation goes to the Desmond Tutu HIV Foundation for allowing us to use the Adult HIV Training Programme as a guideline for the development. Initial learning activities and tools were adapted from materials developed by the International HIV/AIDS Alliance and the NAZ Foundation (India) Trust.

Input from our expert contributors has resulted in an up-to-date manual that is relevant and accessible to African health care workers. Special mention goes to Benjamin Brown, Zoe DUBY, Eduard Sanders and Andrew Scheibe for driving the development and editing processes. We are honoured by the preface provided by Chris Beyrer and for the comments provided by our peer reviewers, who included Kevin Rebe (ANOVA Health Institute, South Africa); Oliver Anene (Male Attitude Network, Nigeria); Paul Semugoma (LGBTI and HIV adviser, Uganda); Chivuli Ukwimi (IGLHRC, South Africa); Lundu Mazoka (Friends of RAINKA, Zambia); Gift Trapence (CEDEP, Malawi); He-Jin Kim (Gender Dynamix, South Africa); MacDarling Cobbinah (Ghana); Cheikh Traore (UNDP, USA); Joseph Rath (SOLIDER, Seychelles); Carlos Toledo, Gail Andrews & Marina Rifkin (CDC, South Africa); Stefan Baral (Johns Hopkins University, USA); Wanja Muguongo (UHAI, Kenya); Andy Seale (Global Fund, Switzerland); Kent Klindera (amFAR, USA); Mark Canavera (West African MSM specialist); Angus Parkinson (USA); James Robertson (India HIV/AIDS Alliance); and Michel Maietta (Sidaction, France).

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Facilitator guidelines

The following guidelines have been provided for use by facilitators who will use this manual to conduct group training.

Introduction

1. Briefly welcome the participants, and introduce yourself.
2. Provide a concise overview of the MSM course and its objectives.
3. Ask participants to introduce themselves by stating the name they wish to be known by during the sessions and to briefly describe how they feel about being at the MSM training.
4. Attend to any necessary housekeeping arrangements: breaks, toilet location, etc.
5. Explain that the issue of MSM is potentially sensitive, and that in order to contribute to discussions people will need to feel safe enough to express their thoughts and feelings, and secure in the knowledge that their confidentiality will be respected.
6. Begin with a process of setting ground rules, acknowledging that the discussions of sexual behaviour (especially stigmatised/criminalised) can be difficult, and that people are under no expectation to speak from personal experience on these issues. There may be health care workers who are MSM in the training and who want to do better when working with other MSM.

Suggested ground rules

(Ask participants to suggest ground rules, add any that are missing.)

- We will value difference (of opinion and experience).
- We will keep everything shared within this workshop confidential.
- We will arrive on time to show respect to other people in the group.
- We will seek to practise active listening.
- We will switch off mobile phones and laptops during sessions.

Any others...?

What we will achieve in this course

- Many people have values, religious beliefs and prejudices that hinder their capacity to provide services that are grounded in public health and human rights principles. We will explore our own attitudes and feelings about working with MSM.
- We will make our services and professional behaviour more MSM friendly.
- We will increase understanding of specific needs of MSM within the context of the HIV epidemic.

Facilitation skills

- Review what you will do before you start facilitating. This gives you confidence in what you are doing.
- Arrive at the venue earlier than everyone so you can set up the seating arrangement.
- Prepare in advance what you will need for the duration of your session.
- Remember to pay attention to all participants. Do not interrupt while people are talking and always check group participation.
- A facilitator is not a teacher, which means that in a lot of situations there is no wrong or right answer. A facilitator 'facilitates' or helps others to discover what they know and to find their own solutions.
- Facilitators are not teachers, but must empower the participants and give them the skills to think about their own feelings and to cope with them.
- Use summarising and reflecting to make sure that all participants understand what is being discussed.
- Remember that it is fine to say: 'I don't know' to a question.
- Remember cooperation, patience and leadership skills while working with fellow facilitators and the group.

Make participants feel welcome

Greet participants when they arrive, and be mindful throughout the session of using both a tone of voice and gestures that will create a safe environment.

Be sensitive to people of varying levels of knowledge and backgrounds

Participants may differ in terms of culture, religion, values, age, gender, working conditions and educational backgrounds. Encourage mutual respect among and between participants.



Respect everyone's opinions

It is important that each individual feels free to express their views and opinions in the sessions. However, be aware that some people may express opinions that are offensive to others. Encourage all the participants to respect each other's views and feelings. *Encourage constructive debate.* If participants disagree with each other, or with you, it is important to facilitate an open discussion.

Stay focused and on time

Encourage participants to discuss and share experiences, but try to keep group discussions focused on the topics you are covering and within the time you have for each activity.

Be flexible but efficient

There is a lot of material to cover in the curriculum, so you will have to find a balance between giving space to the participants to express their feelings and views, and making sure that all the sections are addressed. Be flexible enough to adapt the content and time allowances for each section according to how the participants respond in each session.

Be prepared

Plan your session carefully and know exactly what you are going to cover. To do this you will need to read the reference material carefully with objectivity.

Allow space in the discussion for people to share their experiences

Participants who are comfortable sharing their experiences, either in a personal or professional capacity, may be able to help others grow and enrich the group's learning.

Encourage broad and active participation

Notice who is quiet and who responds the most frequently; try to encourage input from everyone.



Build an honest relationship with participants

Share your views and ideas. If you don't know something, say so. Ask if someone else in the room can give input. This will encourage participants to talk freely and express their own ideas and opinions.

Always take the time to:

- remind the group about important points
- emphasise your main ideas throughout the session
- summarise the discussion and link relevant ideas.

Talking about MSM

It is important that you present the information contained in the session in a non-judgemental and professional way. It can, however, be difficult sometimes to cope with your own experiences and beliefs about MSM, sexuality and personal choices, as well as those of others.

Dealing with hostility

MSM and same-sex behaviour are very emotional and sensitive issues. Because of this, some participants may not want to talk about them, and may not like the way you present them. It is often hard for people to confront their own attitudes and behaviour. Remember that people find change difficult and it is natural for them to resist it. To deal with resistance and hostility, you will have to be open about your expectations of the course. Not everyone will change his or her mind within one session. Do not get drawn into arguments, but instead encourage participants to debate the issues with each other within a context of acceptable guidelines and respect for the facts.

A good facilitator should:

- remain neutral and resist reacting strongly to participants' opinions
- be an active listener
- ask questions instead of making demands
- encourage open communication
- keep the group focused on the issue.



Dealing with emotional aspects of the course

MSM and same-sex behaviour can be emotional and difficult for people to discuss. One way of dealing with this is to lay down *ground rules* at the beginning of the course to help shape discussion. (See ground rules section.)

Following are some useful tips to help you cope if people express negative emotions during the course:

- Remind the group that discussions about MSM and related topics can bring up strong feelings of anger, disgust and embarrassment. These are normal.
- Decide how the group can show support: allow them to share feelings, take a break and/or give them time to talk to you or someone else privately. Make sure that you are able to refer participants to counselling if anyone feels the need to talk to someone after the course.

Support for you, the facilitator

It is not only the course participants who will be examining and re-examining personal values, beliefs and choices during the course. As a facilitator, your job can be the most taxing because you are immersed in the same course content as the participants, but need to remain neutral and guide the group through the material by maintaining a learning-appropriate tone. This does not mean you are not allowed to have feelings; just that you will have to deal with them outside of the classroom.

Try to find ways to get the support you need. Take time to relax. Talk to someone you trust, or see a professional counsellor if you feel you need an unconditional listening ear. Remember that if you are presented with problems that you are unable to deal with, refer the participants to the appropriate services and people.

Glossary

Alcohol	This includes beer, wine and spirits. These substances act as a central nervous system depressant. Alcohol is usually ingested orally as a drink
Anal sex	Sex which usually involves the insertion of the penis into the anus (penile-anal penetrative sex)
Antiretrovirals (ARVs)	Medication used to kill HIV. In combination it can be used to treat and prevent HIV infection
Anus	The region of the bowels which opens onto the skin
Anxiety	Feeling of nervousness, which may be an emotion, as well as symptoms felt in the body
Bechet's disease	An auto-immune disease affecting joints, eyes, mouth and gut
Bisexual	Having sexual partners of both the same and the opposite sex
Bisexuality	The sexual orientation in which an individual has romantic and/or sexual feelings towards both males and females
Chancroid	STI caused by the bacterium <i>Haemophilis ducreyi</i> , resulting in ulceration and swollen lymph nodes
Chlamydia	A group of sexually transmitted bacteria commonly responsible for 'the drop'/urethritis/proctitis
Cocaine/crack cocaine	Substances derived from the coca plant which act as a central nervous system stimulant, which can be snorted, injected or smoked
Coming out	The process of coming to terms with one's own sexuality (sexual orientation and sexual identity)
Concurrent partners	Having more than one sexual partner at the same time
Depression	A bad feeling that is present for a few weeks in which mood is low, and sleep and appetite may be affected
Discharge	Fluid oozing from an area of inflammation, which includes cells aimed at fighting infection and the infectious agent. Discharge may be seen coming from the penis, anus, vagina or throat as a result of selected sexually transmitted infections

Dual diagnosis	This is given when an individual presents with signs and symptoms for two co-occurring conditions, each requiring treatment and management
Ecstasy	This belongs to the class of drugs known as amphetamines, which act as a central nervous system stimulant. They are usually ingested orally, but can also be snorted, smoked, injected or inserted anally
Ejaculation fluid (cum)	Fluid released from the penis during ejaculation ('cumming'). Many viruses and bacteria which are responsible for sexually transmitted infections can be present in this fluid
Female condom	Loose-fitting polyurethane sheath with an inner ring at the closed end, and an outer ring at the open end, inserted inside the vagina or anus, for protection against pregnancy and/or HIV and STIs
Fingering	Using one or more fingers to stimulate the genitals, including the insertion of the fingers into the anus or vagina
Flashback	The feeling of experiencing or witnessing a situation again (usually a traumatic one)
Frottage	Rubbing penises together for sexual stimulation
Gay man	A man who has romantic, sexual and/or intimate feelings for other men. 'Gay' is generally a more commonly used term for homosexual. The term <i>men who have sex with men</i> (MSM) should be used unless individuals or groups self-identify as gay
Gender/biological sex	The term <i>biological sex</i> refers to biologically determined differences, whereas <i>gender</i> refers to differences in social roles and relations. Gender roles are learned through socialisation, and vary widely within and between cultures
Gender identity	A person's sense of self as male or female. While most people's gender matches their biological sex, someone may be born biologically male, yet have a female gender identity
Genital Gonorrhoea	Relating to sexual organs A sexually transmitted infection caused by the bacteria <i>Neisseria gonorrhoea</i> , commonly affecting the penis, anus and vagina, and less commonly the throat

Granuloma inguinale	An STI caused by the bacterium <i>Calymmatobacterium granulomatis</i> , resulting in many painless ulcers and abscesses in the groin
Heroin	This substance belongs to the class of drugs known as opiates, which act as a central nervous system depressant and analgesic. It is usually taken intravenously (injected)
Hepatitis	Inflammation of the liver, which may be caused by a virus, drugs or, rarely, diseases of the immune system
Herpes	A group of viruses which are spread through direct contact. Herpes simplex type 1 is responsible for 'cold sores' – superficial ulcers around the mouth and nose. Herpes simplex type 2 causes most cases of painful sores found around the penis, anus or vagina (genital herpes)
Heterosexuality	The sexual orientation in which an individual has romantic or sexual feelings towards members of the opposite sex
Homophobia	Discrimination, stigma, fear or hatred based on homosexuality, directed at gays, lesbians, bisexuals and transgender people
Homosexuality	The sexual orientation in which an individual has romantic or sexual feelings towards members of the same sex
Human papilloma virus (HPV)	The virus responsible for genital warts. Different subtypes exist, some of which are associated with the development of anal, penile and cervical cancer
Incidence	The number of new people who develop a condition during a particular period of time. This measurement is different to prevalence.
Insertive partner ('top')	In anal sex, the partner who is inserting his penis into the other partner's anus
Intersexed people	Previously referred to as 'hermaphrodites', this refers to individuals who are born with a combination of both male and female reproductive organs, chromosomes, and/or hormones that are either fully or partially developed

Khat/cat	This substance belongs to the class of drugs known as methcathinone which acts as a central nervous system stimulant. It is usually snorted, but can also be taken orally or intravenously, or smoked
Lesbian	A woman who has romantic, sexual and/or intimate feelings for other women. The term <i>women who have sex with women</i> (WSW) should be used unless individuals or groups self-identify as lesbians
LGBTI	Abbreviation for 'lesbian, gay, bisexual, transgender, intersex'
Lubricant	Substance which reduces friction during sexual intercourse. Lubricants can be water based (e.g. K-Y Jelly®) or oil-based (e.g. Vaseline®, body cream, cooking oil). Latex male condoms should only be used with water-based lubricants, as oil-based ones weaken latex.
Lymph nodes	Glands which form part of the immune system and are involved in fighting infection. Major groups of glands exist in the inner thigh, in the armpits and in the neck
Male condom	A sheath placed over the erect penis before sexual intercourse. which prevents pregnancy and HIV/STIs by blocking the exchange of sexual fluids
Mandrax	This substance belongs to the class of drugs known as methaqualone. It acts as a central nervous system depressant, and is usually ingested orally, but can also be smoked
Marijuana/dagga	This substance acts as a central nervous system depressant and hallucinogen and is usually inhaled by smoking it, but can also be ingested orally
Methamphetamine	This includes speed, crystal meth/tik, which act as a central nervous system stimulant and can be snorted, ingested orally, injected or smoked
MSM	Men who have sex with men. This term includes not only men who self-identify as gay or homosexual and have sex only with other men but also bisexual men as well as men who self-identify as heterosexual but have sex with other men



Multiple stigma	Stigmatising because of two or more perceived differences, e.g. sexual orientation, HIV-positive status and race
nPEP	Non-occupational post-exposure prophylaxis – the use of post-exposure prophylaxis after exposure to an infectious agent which is not a result of work practices or exposure
Oral sex	Contact between the mouth and tongue and genitals (penis, testicles, anus, vagina), which includes licking, sucking, kissing
Oro-anal sex	Contact between mouth, tongue and anus, including licking (rimming) and kissing the area around the anus and rectum
Penetrative penile-anal sex	Sex act describing the positioning or role of the ‘active’ partner or ‘top’ whose penis is being inserted into the anus of his sexual partner
Post-exposure prophylaxis (PEP)	The use of medication to prevent infection after exposure to an infectious agent – preventive treatment (antiretroviral drugs typically taken for four weeks) started immediately (within 72 hours) after exposure to the HIV virus in order to prevent the virus from developing inside the body
Phobia	Excessive anxiety or fear about a specific object or situation
Physiological	Relating to the physical body
Prevalence	The number of people who currently have a particular condition within a particular period of time. This measurement is different to incidence
Prostate	A large internal gland which surrounds the urethra at the base of the bladder which produces some of the liquid and substances found in ejaculation fluid
Proctitis	Inflammation of the rectum, commonly due to a sexually transmitted infection in the rectum
Prostatitis	Inflammation of the prostate commonly due to an infection. This may occur as a complication of urethritis
Receptive anal sex	Sex act describing the positioning or role of the ‘passive’, ‘receptive’, ‘bottom’ whose anus is being entered



Receptive partner ('bottom')	In anal sex, refers to the partner whose anus is being penetrated by the other partner's penis
Rectum	The lower region of the bowels linking the descending colon to the anus – also referred to as the rectal passage
Reiter's syndrome	A collection of urethritis, joint disease and eye symptoms
Rimming	Licking/kissing the anus with the tongue/mouth (see oro-anal sex)
Sero-conversion	The time when an infectious agent is present in the body
Sero-discordant relationship	A romantic or sexual relationship between two people of differing HIV status
Serosorting	The process of selecting a sexual partner based on his or her HIV status. For example, an HIV-positive man may 'serosort' and seek out only other HIV-positive men as sexual partners
Sexual behaviour	The manner in which people express their sexuality. Examples of this behaviour can include physical or emotional intimacy and sexual contact
Sexual orientation	The term used to describe the set of emotional, physical and romantic feelings an individual has towards others. These feelings and behaviours are usually directed towards men or women, or both men and women
Sexually transmitted infection (STI)	Infection transmitted and acquired through sexual contact
Stereotype	To perceive all members of some group as if they all were all identical, e.g. to see all MSM as being effeminate
Stigma	Shame or disgrace attached to something regarded as socially unacceptable
Stigmatise	The action of treating someone differently or unfairly because of some perceived difference (e.g. sexual behaviour, gender)
Substance abuse	A pattern of repeated substance use despite the negative consequences (not to be confused with substance dependence)

Substance dependence	A pattern of habitual substance use that involves physical dependence (with increased tolerance and withdrawal), psychological dependence, and behavioural dependence
Symptom	Feeling or problem as experienced by a client, participant or individual
Syphilis	A sexually transmitted infection caused by <i>Treponema pallidum</i> , one of the 'genital ulcer diseases'
Thigh sex	The act of rubbing the penis between the partner's thighs
Transactional sex	The process of exchanging sex for goods, money, shelter, food or other items or services
Transgender	A person who has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as 'he' or 'she' according to their gender identity, i.e. the gender that they are presenting, not their sex at birth
Transphobia	The fear, rejection or aversion, often in the form of stigmatising attitudes or discriminatory behaviour, towards transsexuals, transgender people and transvestites
Transvestite	A person who wears clothes associated with the opposite gender in order to enjoy the temporary experience of membership of the opposite gender. A transvestite does not necessarily desire a permanent sex change or other surgical reassignment
Transsexual	A person is in the process of or has undertaken surgery and/or hormonal treatment in order to make his or her body more congruent with his or her preferred gender
Ulcer	A sore which involves a break in the protective covering provided by skin
Unprotected anal intercourse	Anal sex, penis in anus, which occurs without the protection provided by a condom
Urethritis	Inflammation of the urethra, the pipe linking the bladder to the outside, along which urine passes. Commonly caused by the bacteria gonorrhoea and chlamydia

Vaginal sex	Sex which usually involves the insertion of the penis into the vagina (penile-vaginal penetrative sex)
Warts	Growths on the skin, caused by the human papilloma virus which is responsible for warts in the genital area
WSW	Abbreviation for women who have sex with women. This term includes not only women who self-identify as lesbian or homosexual and have sex only with other women but also bisexual women as well as women who self-identify as heterosexual but have sex with other women



MSM pre-course questionnaire

Thank you for your interest in this health care worker MSM training programme. Please complete the questionnaire and assessment before starting the programme.

Previous MSM counselling experience

- 1. In the past three months how often have you asked your male clients about MSM behaviour?**
 - a. Never
 - b. Sometimes
 - c. Often
 - d. Every time
- 2. In the past three months how many clients who are MSM have you counselled about safer sexual practices?**
 - a. None
 - b. 1–5
 - c. 5–10
 - d. More than 10
- 3. Have you ever discussed anal sexual practices with any of your clients, male or female?**
 - a. Yes
 - b. No
- 4. Have you ever asked male clients about sexual acts with other men?**
 - a. Yes
 - b. No
- 5. Have you received any training on how to counsel about anal sex?**
 - a. Yes
 - b. No
- 6. Have you received any previous training on how to counsel clients who are MSM?**
 - a. Yes
 - b. No

7. Have you received any previous training on how to address specific health needs for clients who are MSM?

- a. Yes
- b. No

Pre-course assessment

1. How many countries in Africa provide protective legislation for MSM?

- a. None
- b. One
- c. Five
- d. Ten
- e. All

2. On average _____ of African people consider that homosexuality should not be accepted by society.

- a. 25–40%
- b. 40–55%
- c. 55–70%
- d. 70–85%
- e. 85–99%

3. The risk of a man acquiring an HIV infection during unprotected receptive anal sex is _____ unprotected insertive anal sex (with a man or a woman).

- a. about a tenth higher than
- b. about a fifth higher than
- c. about the same as
- d. about five times higher than
- e. about 10 times higher than

4. A health care worker can be stigmatised for counselling and treating HIV-positive clients who are MSM.

[] True [] False

5. Moral judgement is a form of internal stigma.

[] True [] False

6. Social withdrawal is a form of external stigma.

[] True [] False

7. Being lesbian, gay or bisexual had often been described as an 'illness' by the medical profession before 1973.

[] True [] False



- 8. Research shows that _____ of every community is homosexual.**
- between 20 and 30%
 - around 5%
 - less than 2%
 - between 10 and 15%
- 9. A person who feels pressure to change his or her sexual orientation may experience low self-esteem, poor self-confidence and depression.**
[] True [] False
- 10. Most risk-reduction sessions following HIV testing assume sexual intercourse to be penile-vaginal.**
[] True [] False
- 11. Only homosexual men practice anal sex.**
[] True [] False
- 12. When a man reports anal sex with a man during counselling you should ask if he takes the insertive or receptive role.**
[] True [] False
- 13. Anal warts will not cause anal cancer.**
[] True [] False
- 14. Genital warts are caused by:**
- HIV
 - HPV
 - Chlamydia
 - Syphilis
- 15. Which is NOT likely to be an early symptom of HIV infection?**
- Fever
 - Rash
 - Genital warts
 - Sore throat
- 16. When people experience a sudden overwhelming fear during which they may feel they are 'going crazy' or 'going to die', it is called _____**
- post-traumatic stress syndrome
 - panic attack
 - phobia
 - depression

- 17. Which substance, after long-term use, is most likely to cause violent and potentially homicidal or suicidal behaviour?**
- Alcohol
 - Marijuana
 - Methamphetamines
 - Crack cocaine
- 18. When anxiety becomes excessive and distressing, and affects the way we function in our everyday lives it becomes _____**
- addictive
 - depression
 - stigmatised
 - a disorder
- 19. Condoms are 80–95% effective at preventing HIV and STIs.**
[] True [] False
- 20. If a client who is an MSM complains that condoms always seem to break when he uses them, which would be the best response for a counsellor to give?**
- Tell the client to use commercial condoms instead of the free ones.
 - Provide a condom demonstration to the client then ask him to repeat the demonstration.
 - Hand a few condoms to the client to replace the broken ones.
 - Suggest he adds some Vaseline® (an oil-based lubricant) to reduce friction.
- 21. When putting on a male condom, it is necessary to ensure that there is air at the tip to allow room for semen.**
[] True [] False
- 22. Asking key questions about an MSM's sexual behaviour will _____**
- cause the client to feel bad about himself
 - provide an assessment of the client's sexual risk taking
 - make the counsellor appear judgemental
 - reinforce the client's behaviour



- 23. Defining specific, achievable and measurable _____ that take into consideration the influences and motivations of the client can help with risk reduction.**
- a. risks
 - b. costs
 - C. counselling
 - D. goals
- 24. When counselling an at-risk MSM, the counsellor's opinions and judgements should not affect his or her behaviour towards the client.**
- [] True [] False



Men who have sex with men and HIV in sub-Saharan Africa

Learning outcomes

By the end of this module, you should be able to:

- define MSM
- summarise what is known of HIV risks for MSM in sub-Saharan Africa
- explain why sex between men carries a high risk of HIV transmission
- explain why MSM in Africa are more vulnerable to HIV infection
- discuss the barriers that MSM may encounter in seeking HIV services.

Introduction

In this module you will provide an overview of men who have sex with men (MSM) in sub-Saharan Africa. Specifically, this will be focused in a health-related context by reviewing their risks of HIV infection, their vulnerabilities, and possible ways to address their health needs.

Core knowledge section

Who are MSM?

'Men who have sex with men' or MSM describes those males who have sex with other males. 'Sex between men' includes anal sex, oral sex, masturbation or any combination of these practices. MSM include men who only have sex with other men, as well as men who have sex with both men and women. MSM may identify themselves as 'homosexual', 'gay' or 'bisexual', but may also see themselves as 'heterosexual' or 'straight' (Murray & Roscoe, 2001). MSM also include men who have sex with other men because of their situation rather than their sexual preference. For example, men may have sex with other men

because their circumstances prohibit or preclude sex with women, such as in prisons, boarding schools or military barracks (Gear, 2005).

MSM in sub-Saharan Africa

MSM are part of every culture and society around the world, although the level of public acknowledgement of their existence can vary from place to place.

In sub-Saharan Africa MSM have only recently been recognised in the context of HIV/AIDS, yet there is plenty of evidence that dates back before the 19th century to show that same-sex practices and MSM have always been present in African countries, and are often well integrated into local culture. This explains why there are words for types of same-sex behaviours and MSM in many native African languages.

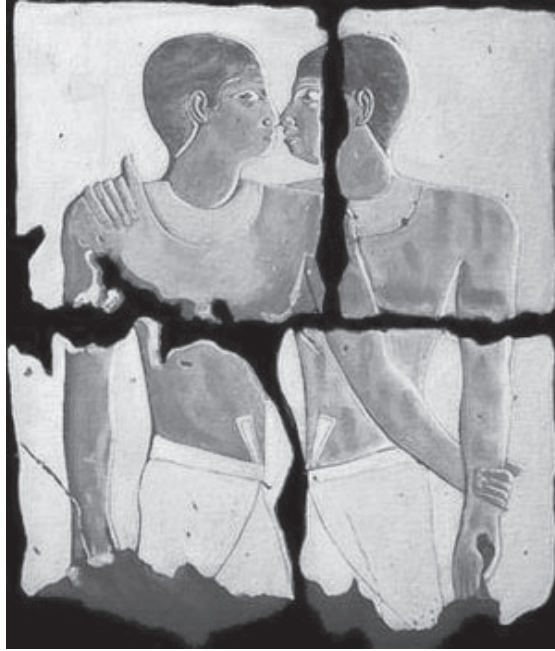
Anthropologists, the people who study societies and culture, have reported examples of partnerships of men with older and younger men; of men taking on different gender roles (where one partner takes either a masculine or feminine role); and of men who appear more on a par with each other (Wilson, 1951). Same-sex behaviours have been reported in situations where men are unable to have sex with women for periods of time, such as in prisons, and same-sex sexual experimentation before marriage or in adolescence has been reported (Murray & Roscoe, 2001). In some areas, male-to-male sex is a necessary component of certain traditional practices (Weiss, Quigley & Hayes, 2000).

Much of what we are now learning about African MSM arises through direct contact made between these men and various support, advocacy and research projects. Such groups have been identified in Senegal, Guinea Bissau, Mali, Cote D'Ivoire, Nigeria, Burkina Faso, Sudan, Cameroon, Ghana, Uganda, Kenya, Tanzania, Malawi, Namibia, Botswana and South Africa (Wilson & Halperin, 2008). In many other countries, grass-roots organisations representing MSM are also well known.

It is difficult to know how many MSM there are in Africa because very few of the routine surveys about sexual behaviours have included questions on same-sex practices in Africa. Stigmatisation of same-sex behaviour also makes doing research difficult, as MSM may be afraid to reveal their behaviour. In Asia, Europe and Latin America, where such surveys routinely include these



questions, between three and 20% of all men have had sex with other men at least once in their lives. Stigma will be discussed in module 2.



MSM and HIV/AIDS

The first reports of AIDS were among MSM in the US in the early 1980s. Since then, MSM in many parts of the world have remained the group at highest risk of HIV infection, and a principal target for HIV prevention efforts (AVERT, n.d.).

HIV epidemics in Africa

Most adults newly infected with HIV in sub-Saharan Africa acquire the infection through 'heterosexual' sex, in other words through penetrative sex with a partner of the opposite sex. Personal risk of HIV infection can be increased by having more sexual partners; older sexual partners; not using condoms; having sexually transmitted infections; and, specifically for men, being uncircumcised (Kenya National AIDS Control Council, 2008). To date, most national HIV/AIDS control programmes in Africa have concentrated upon reducing heterosexual

HIV transmission, and transmission between mother and child (Baral, Sifakis, Cleghorn & Beyrer, 2007).

In recent years it has been recognised that HIV epidemics in African countries are more complicated than this. High-risk groups (such as sex workers, intravenous drug users and MSM) are more affected than the general population, but often have no access to HIV prevention or care. Furthermore, high-risk groups may also play a role in enabling transmission more generally (Global Forum on MSM and HIV, 2010).

MSM and HIV in Africa

Unfortunately, there are still many African countries that have yet to collect any information about HIV among MSM populations. Where there is information, it shows that in most African countries, MSM have a much higher rate of HIV infection than other men in their communities (Figure 1).

Overall, the rate of HIV infection among MSM in sub-Saharan Africa is estimated to be four to five times higher than the rate for other men, and in some countries could even be more than 20 times higher (Baral, Sifakis, Cleghorn & Beyrer, 2007; Varghese, Maher, Peterman, Branson & Steketee, 2002).

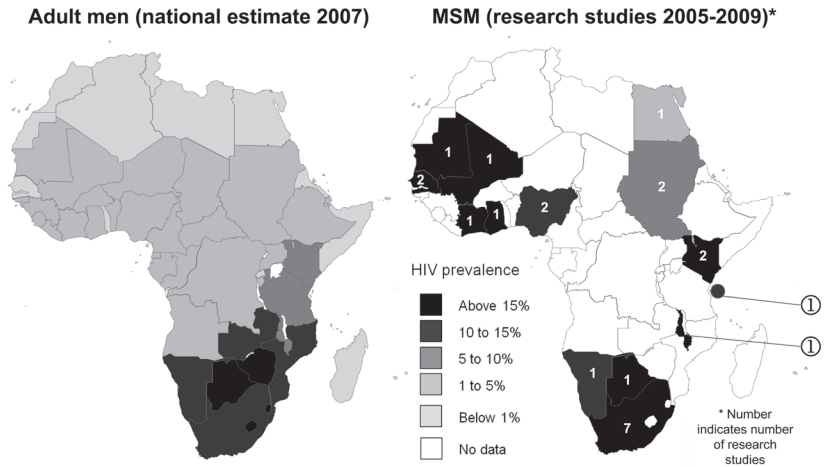


Figure 1: Percentage of African MSM living with HIV



Exercise: Brainstorming (20 minutes)

Consider the following question and if possible discuss in a group.

'Why do so many countries in Africa not acknowledge HIV in their MSM community?'

Why does HIV affect MSM more than other communities?

To understand why MSM in Africa have a high rate of HIV, it is useful to think about the specific behaviours that put them at personal **risk** of HIV infection, as well as the **vulnerabilities** that limit MSM's ability to avoid these risks.

A. Risk

Risk is defined as the chance that a person may acquire HIV infection. High-risk behaviours are those that offer more opportunities for the HIV virus to be transmitted from one person to another. Examples of high-risk behaviours include unprotected sex with a partner whose HIV status is unknown or positive; multiple unprotected sexual partnerships; and using contaminated needles and syringes to inject drugs.

Risks among African MSM*Unprotected anal sex*

The main explanation for the higher risks of HIV among MSM is that HIV is very easily transmitted during unprotected anal sex. Penetrative anal sex between men involves one man (the **insertive** partner) inserting his penis into the anus of his partner (the **receptive** partner).

Studies in Africa confirm that unprotected receptive anal sex is the strongest risk factor for HIV among MSM. Official figures suggest that African MSM frequently do not use condoms for anal sex, and where they do they frequently do not use safe, water-based lubricants. The use of condoms and lubricants will be discussed further in module 6.

Sex between men need not always involve penetrative anal sex, and some MSM never have anal sex. Oral sex, masturbation and thigh sex carry a much lower risk of HIV transmission, and men may chose to avoid anal sex for their



own, or their partner's, protection. For men that do have anal sex, the correct use of condoms and water-based lubricants for anal sex considerably reduces the risk of HIV transmission. Anal sex and other common sexual practices will be discussed further in module 4.

Drug and alcohol use

Some African MSM, in certain contexts, may also report a higher use of recreational and illegal drugs than other members of the population. This practice may add to the risk of HIV if injecting materials are shared with others (Dahoma et al., 2009). In most African settings, however, MSM are no more likely to use injecting drugs than other men. In contrast, consumption of alcohol commonly takes place where MSM socialise and meet sexual partners. Some research suggests that alcohol use with sex reduces inhibitions and increases MSM risk-taking behaviours. You will learn more about drug use among MSM in module 7.

Multiple partners

For some MSM in sub-Saharan Africa, sex is often **transactional sex**, and sex with casual partners is commonplace. (Fipaza, Wiemer, Karlyn & Mbizvo, 2010; Sanders, Graham, Mwangome, Githua & Mutimba, 2007). One explanation for this behaviour may be because MSM in many African countries may face hostility that could make it more difficult to establish a steady, faithful relationship with one partner. Also, it is not clear whether African MSM have more sexual partners than other African men, but they may have very different networks of friends and sexual partners than other African men.

In many African countries, most MSM also have female sexual partners and are often in marital relationships with women (Smith, Tapsoba, Peshu, Sanders & Jaffe, 2009). Research suggests that where MSM have both male and female partners, they may be less likely to adhere to safe sex methods with their female partners than their male partners. This emphasises the need for professionals counselling MSM to consider all potential aspects of HIV risk and prevention needs.

Other sexually transmitted infections

A high proportion of MSM in surveys report recent symptoms of sexually transmitted infections. The risk of HIV transmission is increased when an



individual has a genital or rectal sexually transmitted infection. You will learn more about sexually transmitted infections among MSM in module 5.

B. Vulnerability

A community's vulnerability to HIV refers to conditions adversely affecting the community's ability to avoid, prevent or cope with the threat of HIV/AIDS. MSM communities in Africa are very vulnerable to HIV infection. This is due to a combination of many factors that reduce their ability to avoid HIV infection effectively. These factors may include:

- **Personal factors** such as the lack of knowledge and skills required to protect oneself and others
- Factors pertaining to the **quality and coverage of services**, such as inaccessibility of services due to distance, cost and other factors
- Societal factors such as **social and cultural norms, practices, beliefs and laws** that stigmatise and disempower certain populations, and act as barriers to essential HIV prevention messages (Cáceres, Konda, Segura & Lyerla, 2008).

Personal factors that may increase HIV vulnerability

Knowledge of risks of MSM sexual practices

Many MSM wrongly assume that anal sex is a safe alternative to vaginal sex. This may arise from a preconception that men are less likely to be HIV positive than women, or from the lack of sexual health information and education highlighting the risks of anal sex. Some studies indicate that there are men and women who are unaware of the potential benefit of condom use in protecting themselves during anal sex, even in communities where anal sex is considered a risky behaviour for HIV infection.

Safe sex skills

The effective use of condoms (including female condoms) and lubrication for anal sex can reduce the risk of HIV transmission. This protection depends upon the skills of MSM to select and apply lubrication properly, their ability to negotiate the need to use condoms with their sexual partner, and their ability to access affordable supplies of condoms and water-based lubricants (Dahoma et al., 2011). Unfortunately, many African MSM use oil-based lubricants, which



may damage latex condoms. Condom usage and lubrication is covered in more detail in module 6.

Testing and knowledge of HIV status

Most MSM live unaware of their own HIV status, due in part to ignorance of the risks of their own sexual behaviours and/or a reluctance to use HIV testing services (Sandfort, Nel, Rich, Reddy & Yi, 2008). Most African countries that collect information on MSM HIV testing report that less than 40% of MSM have tested within the previous 12 months.

From the perspective of MSM, confirming HIV status can offer benefits regardless of whether the test result is positive or negative:

- A negative result can reinforce existing good prevention practices (such as condom use) or indicate the need to adopt them.
- A positive result allows the individual to access early HIV treatment as well as adopt practices to reduce the risk of infecting future sexual partners (positive prevention).
- Knowledge and disclosure of personal HIV status can strongly influence partner choices. For example, MSM who know that they are HIV positive may decide to have sex only with other HIV-positive men (called serosorting). By contrast, knowledge of discordant HIV status in an ongoing relationship between men (in other words a relationship where one partner tests HIV positive, the other partner tests HIV negative) can reinforce the need to adopt safe sexual practices and can motivate men to test together.

Coverage and quality of services

At the present time, very few African countries include MSM in their national plans for HIV control, and almost none allocate HIV-control resources to provide services for MSM specifically. In official figures in 2008, 46 African countries reported that no services were available for MSM (American Foundation for AIDS Research, 2008). This is in direct opposition to recommendations from the World Health Organization (WHO) who state that (Dahoma et al., 2011) 'the minimum set of interventions for MSM should include safe access to information and education about HIV and other STIs, condoms, water-based lubricants, HIV testing and counselling, and STI services', and that

'[i]nterventions should be delivered within a framework of sexual health, which includes discussions of relationships, self-esteem, body image, sexual behaviours and practices, spirituality, sexual satisfaction and pleasure, sexual functioning and dysfunction, stigma, discrimination, and alcohol and drug use.'

Exercise: Health care service accessibility (40–60 minutes)

As a group, discuss the following quotes from MSM in turn:

[S]ome of them don't treat us with respect. Sometimes, if you were having sex without a condom and maybe you get an STD, 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.

I once went to the clinic and there were two gay men at the clinic, apparently one of them had an STD, then a nurse said to them she expected that, she wasn't expecting them to have flu but an STD, because they sleep around and God is punishing them.

1. What aspects of a health care service encourage MSM to come forward?
2. What aspects of a health care service discourage MSM from coming forward?
3. How could services in your country be improved to reach MSM?

Buzz-group exercise: Is my service MSM friendly?

In small groups, each participant describes the environment where individuals seeking HIV care or testing are seen. If possible, relate this to examples of MSM accessing the service. Other group members ask questions about the accessibility of the service to MSM, based on issues raised in the previous discussions, and identify things that could be changed to make these services MSM friendly.

Feed these ideas back to the whole group.

While many HIV prevention and treatment services do exist to serve the general public, they may be ill prepared to deal with the specific sexual health needs of MSM for the following reasons:

- Lack of MSM-appropriate sexual health materials (information, water-based lubricants, condoms)
- Lack of experience with MSM among health care workers/counsellors
- Lack of specific knowledge upon which to deliver accurate risk-reduction counselling appropriate to MSM behaviours or diagnose health problems (e.g. rectal STIs)
- Judgemental or abusive reactions to MSM from health care workers/counsellors
- Judgemental or abusive reactions to MSM from other facility users (lack of safe space).

Even when MSM do access existing services, they may be refused access by staff or advised to go elsewhere. In some contexts, MSM may have access to other sources of information, advice and even clinical service (e.g. via word of mouth, NGO organisations or 'MSM-friendly' private clinics). For many others there is no alternative affordable service.

Societal factors that may increase HIV vulnerability

Law and politics

At present, male same-sex behaviour is illegal in most sub-Saharan African countries (Figure 2), four of which may impose the death penalty on transgressors (parts of Nigeria, Somalia, Sudan and Mauritania). Protective legislation for MSM only exists in South Africa. Recent legal reforms in some East African countries have aimed to strengthen anti-homosexual legislation, rather than make the law more inclusive. It has been observed that countries that have decriminalised MSM behaviour and offered legal protections to MSM see as a benefit more MSM coming forward for prevention, testing and treatment.

Although countries differ in the extent to which same-sex laws are formally prosecuted, many African MSM report harassment from state authorities, including police and public officials, in relation to their sexual orientation or on minor charges. In southern Africa, studies have shown blackmail to be related to HIV risk.

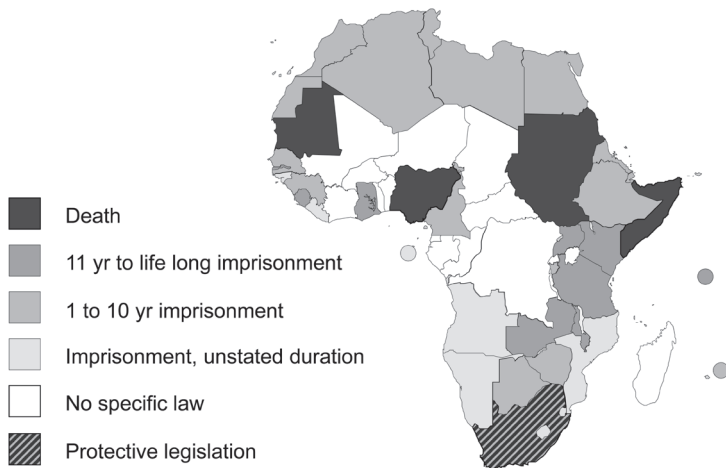


Figure 2: Laws regarding same-sex behaviour (2009)

Public opinion

Irrespective of the law, public opinion toward homosexuality in African countries may be extremely hostile. Compared to other countries, African public opinion ranks as the most homophobic in the world in international opinions surveys – on average 85–99% of African people consider that homosexuality should not be accepted by society (Ottosson, 2009).

The roots of hostile public opinion are not well understood, but may include:

- the opinion that homosexuality is ‘un-African’
- the misconception that homosexuality is a behaviour introduced to Africa by foreigners
- the tendency of organised religion to brand homosexuality as immoral
- family/cultural expectations that men have partnerships that bear children.

Covertness

MSM may be fearful to disclose sexual behaviours with other men or same-sex orientation to members of their family or to health care staff. The consequence is that most MSM feel unable or fearful of coming forward to ask for help. This

often prevents them from accessing the knowledge, skills and services that would help meet their HIV prevention and treatment needs.

Self-esteem

The consequences of homophobic stigma from society, communities, religious groups, family and friends have a direct impact on an individual's sense of personal worth. In other parts of the world, lack of self-esteem arising from stigma has been shown to reduce a person's motivation to protect themselves or others from high-risk behaviours.

Consequences of multiple vulnerabilities

Lack of knowledge and personal skills, the inaccessibility and unavailability of prevention and treatment services, and the hostile and stigmatising societal environment combine to make MSM individually and collectively more vulnerable to HIV risks. Each of the individual factors listed above could increase the HIV risk of an individual or community. MSM are particularly vulnerable precisely because they experience, both as individuals and as a community, the collective impact of many of these factors. Together these factors add up to make MSM at high risk for HIV infection and extremely vulnerable.

Summary

- MSM exist in Africa, as they do in every culture and society, although their existence has long been overlooked and denied by authorities.
- MSM may practise anal sex, oral sex, masturbation and combinations of these practices, and many MSM also have sex with women.
- MSM in Africa have a considerably higher rate of HIV infection than other African men.
- MSM experience multiple simultaneous factors that make them vulnerable to HIV infection.
- Unprotected receptive anal sex is the most risky sexual behaviour for the transmission of the HIV virus and is often practised among African MSM.
- Few African countries include MSM in their national plans for HIV control, and almost none allocate HIV control resources, despite WHO recommendations.

- ➔ More research about MSM in Africa needs to be done to inform the development of clinical and public health HIV prevention, treatment and care.

Optional exercise

Group role play exercise: Discussing MSM behaviours

Scenario

Counsellor/health care worker:

A man has come to you to request an HIV test, for which you are providing pre-test counselling.

Man:

You are a 30-year-old married man with two children, and you are now trying for a third baby. You and your wife tested HIV negative during her last pregnancy. In the last year, you have also started a sexual relationship with a man. You have kept this relationship hidden as it is frowned upon in your community.

In groups, discuss the following (10 minutes):

- ➔ How did you come to discuss the relationship with another man? Was this information volunteered by the man or prompted by questions from the counsellor?
- ➔ From the man's perspective, what did the counsellor do or say that made you feel comfortable to discuss your relationship with another man? What did the counsellor do or say that made it uncomfortable to discuss this relationship?
- ➔ From the counsellor's perspective, what aspects (if any) of this discussion did you find difficult and why? What would have made this easier? Did you find out what you needed to know to offer the right professional advice to this man?

Small groups feedback to whole class (facilitator).

Group exercise (30 minutes): Picture gallery

Begin by collecting pictures of the following: an MSM sex worker in a bar, a businessman using a mobile phone, a young MSM being chased out of a village, an MSM couple at a parade, an MSM being pointed at in a VCT (voluntary counselling and testing) clinic, a middle-aged man at home with wife and children.

Then label all pictures with the following:

'This man had sex with a man last night. Was it safe?'

In groups, choose one picture. Agree whether or not this man had safe sex or not. Discuss and justify why you conclude this. Put all pictures up next to each other, to which each group discusses their conclusion.

Facilitator groups themes of discussion.

Homophobia: Stigma and its effects

Learning outcomes

At the end of this module, participants should be able to:

- define *stigma*
- define the differences between external and internal stigmas
- relate stigmas to their own experience of being treated differently
- list the ways in which a person can be stigmatised for being MSM
- list the effects of stigmas on MSM
- describe homophobia
- explain the double stigma that MSM who are HIV positive may experience
- define stereotyping of MSM
- describe how to support an MSM client who is stigmatised.

Introduction

In this module you will learn about stigmas and what they mean. (You may already have heard about the stigma that is attached to people living with HIV, which is very similar to that of MSM.) You will explore its multiple impacts on MSM. We will discuss homophobia, a form of prejudice directed specifically at men suspected of being MSM, especially towards those who appear to be more effeminate. Stigmas may cause many forms of reaction, including violence. MSM who are HIV positive may experience the burden of double stigma, firstly because of their sexual behaviour and secondly because of their HIV status. You will find out how stigmas affect MSM in a wide range of ways, from how they feel about themselves to how they live their lives, and whether or not they access health care services or HIV counselling and testing. Finally you will learn how to support a client who experiences stigmatisation.

Core knowledge: Stigma

A *stigma* can be defined as:

...an attribute or quality that shames an individual or group of people in the eyes of another individual or group. This means that people may look at an individual and have a negative attitude towards that person because of a certain characteristic or quality, e.g. if the person is HIV positive or even just suspected of being positive, or if they are an MSM or a foreigner (Engender Health, 2004).

Because of stigmas, certain people often come to be treated differently from others. This is what we mean by discrimination. Discrimination is a form of behaviour which results in unequal or unfair treatment. Stigmatising attitudes do not always end up in discrimination, but the effect of a negative attitude is still hurtful for MSM.

There are two main types of stigma – external and internal:

- **External stigmas** cause certain people to be treated unfairly and differently to everyone else. For example, a person who is an MSM may be refused treatment by health care workers, or be made to sit in a separate waiting area from other patients.
- **Internal stigmas** cause a stigmatised person to feel a certain way about themselves because of external stigmas. For example, an MSM's confidence may suffer, and he may feel sad and depressed (Hamilton, 2006).

Exercise

Think back to a time in the past when you were in any way treated differently by other people. For example, it may have been a time when you moved into a new area and attended a new school, and the learners there teased you for being new to the area. It may have been when you lived in an area where you were from a different group to other people around you. It could have been when you were taken care of by a distant family relative who was not your mother or father, and who treated you with less love and affection than they did their own children.

Try to remember such an experience and remember what happened. How were you treated differently? Then answer the following questions:





1. In what way were you treated differently by others around you?
2. How did this make you feel?
3. How do you think this experience affected you in the long term?
4. What did you learn from this experience?

Core knowledge: Homophobia

Homophobia is the fear or hatred of MSM, and of lesbians, gay men and bisexuals. Homophobia often arises from prejudice and misunderstanding, and can be expressed in many forms, including contempt, discrimination and even violence. In the case of transgender people this is known as transphobia, although transgender people may also experience homophobia.

MSM who appear to be more feminine or who cross-dress are more likely to experience homophobia, because they violate traditional expectations about what it is like to be male. In contrast, MSM who appear to be more masculine can often ‘pass’ for heterosexual (i.e. be seen by others as heterosexual) and so may experience less victimisation (Hamilton, 2006).

Exercise

Draw an empty table on a piece of paper with the headings ‘Causes’, ‘Effects’ and ‘Examples’. Think of the causes, effects and examples of stigma that MSM may face, then look at the table below and see if you have missed out any important ones.

Causes	Effects	Examples
<ul style="list-style-type: none"> ➤ Lack of knowledge or understanding ➤ Lack of information ➤ Intolerance 	<ul style="list-style-type: none"> ➤ Withdrawal ➤ Depression ➤ Loneliness ➤ Isolation ➤ Sadness ➤ Anger 	<ul style="list-style-type: none"> ➤ Name calling ➤ Labelling ➤ Gossiping ➤ Making assumptions about MSM ➤ Judging and criticising



→

Causes	Effects	Examples
<ul style="list-style-type: none"> ➤ Religious beliefs ➤ Cultural beliefs ➤ Society's norms and expectations ➤ Perceived difference ➤ Fear ➤ Competition over resources (e.g. health care or jobs) 	<ul style="list-style-type: none"> ➤ Feelings of hopelessness ➤ Low self-worth ➤ Substance abuse ➤ Self-destructive behaviour (e.g. not looking after health) ➤ Lack of access to services such as health care 	<ul style="list-style-type: none"> ➤ Rejecting ➤ Excluding ➤ Denying services to individual MSM ➤ Discriminating against MSM ➤ Prejudice ➤ Physically attacking the individual ➤ Chasing MSM away ➤ Killing MSM

Core knowledge: External and internal stigma

Signs of **external stigma** are:

- **Avoidance:** people avoiding MSM or not wanting to sit near them.
- **Rejection:** people rejecting MSM. This could be family members or friends no longer being willing to associate with the MSM or it could be that a society or group of people do not welcome MSM.
- **Moral judgement:** people blaming MSM for their behaviour or seeing them as immoral.
- **Stigma by association:** people who associate with MSM are stigmatised because of their association.
- **Gossip:** talking about MSM in a negative way to other people.
- **Unwillingness to invest in MSM:** MSM may be marginalised within an organisation because of their behaviour, and so denied training or promotion.
- **Discrimination:** opportunities denied to MSM, e.g. being denied employment, proper medical care or access to medical aid schemes, and

service providers denying services to MSM, e.g. membership of employee benefit schemes, or being denied insurance and home loans.

- **Abuse:** MSM being physically or verbally abused (being shouted at, called names).
- **Victimisation:** MSM being blamed, for example, by politicians for problems in a country.
- **Abuse of human rights:** for example, denying MSM their basic human rights, such as breaching of confidentiality in HIV testing.
- **Violence:** attacks on and in some cases even murder of MSM for their sexual orientation.

Internal stigma (felt or imagined stigma) is MSM's feelings about themselves, e.g. shame, fear of rejection and discrimination, and depression, because of the experience of external stigma, and how they respond to these feelings.

Signs of **internal stigma** are:

- **Self-exclusion from services or opportunities:** MSM not wanting to access services or not applying for work because they are afraid of being exposed as MSM.
- **Perceptions of self:** MSM having low self-esteem.
- **Social withdrawal:** MSM withdrawing from social contact with friends, family or work colleagues.
- **Overcompensation:** MSM believing that they have to contribute more than other people, or feeling indebted if people are kind to them.
- **Avoiding being open about their sexual orientation:** MSM being unwilling to disclose their sexual orientation because they are afraid of the consequences.
- **Not seeking health care:** MSM avoiding health care facilities because of fear of being treated badly because they are MSM.
- **Mental health issues:** MSM becoming depressed or developing other mental health problems.
- **Substance abuse:** MSM drinking and using drugs to cope with stigma.
- **Suicide:** in some circumstances MSM, especially those who are HIV positive, may resort to trying to kill themselves to escape the pain of stigma (Kidd & Clay, 2003).

Exercise

Draw two columns on a piece of paper, labelled 'Stigma experienced by MSM' and 'Stigma experienced by people living with HIV'. Try to list as many forms of stigma under each column as possible.

Then compare the two columns. You will probably find that the kinds of stigma suffered by the two groups are very similar.

In fact, MSM who are also HIV positive may experience double stigma from others. They are stigmatised for being MSM and also stigmatised for being HIV positive. This may be an even heavier burden than for someone who is either MSM or HIV positive. Without support, this may result in isolation, severe depression and even suicide.

Stereotyping and making assumptions

Briefly define the word *stereotype*. What does it mean?

To stereotype means to perceive all members of some group as if they all were all identical, e.g. to see all MSM as being effeminate or having HIV. This may lead to stigmatising behaviour.

Exercise

1. Imagine a stereotypical soccer/football supporter. Describe what he looks like and how he might behave.
2. Do all soccer supporters look and behave like this?
No, probably not. The assumptions we make about people are often wrong. We may judge a group of people on the basis of what society tells us to believe, or based only on limited exposure to the group.
3. Now imagine a stereotypical MSM. Describe what he looks like and how he might behave.
4. Do all MSM look and behave like this? No, you can probably find evidence for many different kinds of MSM (e.g. some are effeminate, and some can 'pass' for heterosexual; some have anal sex, others do not; some are young, others are old.)
5. We can conclude that the assumptions we make about people like MSM are often wrong, and we need to be careful not to stereotype them.

Addressing stigma

How could we tackle stigma directed at MSM? Brainstorm a list of options, then look at the list below.

How to deal with stigma directed at MSM

1. Treat all MSM with complete respect. 'Treat others as you would like to be treated.'
2. Be careful to avoid using language that is stigmatising towards MSM, both in their presence and with other community members. Words like 'queer' and 'moffie' are usually stigmatising.
3. Challenge other counsellors or health care workers who show stigmatising attitudes to MSM by providing correct information.
4. Challenge stigmatising attitudes towards MSM among your family and friends.
5. Become more knowledgeable about MSM. Knowledge reduces ignorance, which in turn reduces stigma.
6. Provide the same quality of service to all clients regardless of their sexual orientation or sexual behaviour.
7. Talk to community members about MSM and their health care needs.
8. Get to know MSM individuals to break down stereotypes you may have.

Exercise: Stigma

Read the case studies below. If you have a partner, role play a counselling session with one person playing the MSM and the other the counsellor.

After you have finished the role play, or if you are doing the case studies on your own, answer the following questions:

1. What types and forms of stigma are present in each case?
2. How do you provide appropriate support for these clients?



**Role plays***Role play scenario A*

Jalil is a young MSM who lives in Nairobi, the capital of Kenya. Jalil is 19 years old, and has been living on the streets since his parents threw him out of their home when they found out he was gay. Jalil then engaged in sex work to survive, but was not aware of the risks of HIV, so he did not ask clients to use a condom when he allowed them to penetrate him anally. Jalil then became HIV positive. Since then Jalil has lost weight and so his previous clients have left him. He has since resorted to scavenging in the refuse dump for food. Jalil sleeps in the street, where he is at risk of being assaulted.

Role play scenario B

Karl is a 42-year-old MSM who lives in Namibia. He studied hotel management but found it difficult to get a job. He used to be the manager of a bar where most of the customers were MSM. His family never accepted his job, and he was rejected and isolated by them. Three years ago, Karl met a girl with whom he has had two children. He keeps wondering and worrying about his health and whether he should visit a clinic for a check-up. Karl's biggest fear is that if he is ill, he will need to tell the clinic staff about his sexual behaviour. If word gets out about this, his children may be teased and humiliated in the community.

Role play scenario C

Tsepho is a very effeminate 27-year-old man who lives in Daveyton, a township in Gauteng, South Africa. He has engaged in sexual activity with men for the last 10 years. Recently, he went for a health check-up to the local clinic, which included an HIV test. The nurse who tested him shouted at him when she met him and called him a 'sissy girl'. She accused him of immoral behaviour and of disobeying the teachings of his church. Tsepho is afraid now of seeking health care or testing again for HIV.





Role play scenario D

Ahmed is a young married man and the father of two children. He lives in Dakar (Senegal), where he teaches English. He has a good relationship with his friends and neighbours. Although he is married, Ahmed sometimes has sex with men. His family does not know about his sexual orientation; however, some people in the neighbourhood have had their suspicions. One day, his family heard a rumour that Ahmed was seen with a group of MSM. Since then, he has faced rejection and threats in the neighbourhood and at school. He finally left his house when he could no longer cope with the situation.

Summary

- A stigma is defined as an attribute or quality that shames an individual or group of people in the eyes of another individual or group.
- Stigma is a common experience for MSM and has multiple impacts on them.
- The stigma experienced by MSM is also known as homophobia. It is fuelled by certain religious and cultural beliefs, and is often more harsh for effeminate MSM.
- MSM who are HIV positive may experience the burden of double stigma because of both their sexual orientation and their HIV-positive status.
- External stigma refers to how MSM are treated negatively by others. Examples include gossip, being ignored, avoidant behaviour, judgement, abuse and violence.
- Internal stigma refers to how MSM feel and act because of external stigma. Examples include low self-esteem, depression, not seeking medical assistance, withdrawal from contact with people, and suicide.
- Stigma affects the health and wellbeing of everyone who is stigmatised and needs to be addressed.
- Appropriate support and counselling can minimise the effects of stigma and assist MSM in their wellbeing.

Sexual identity and coming out

Learning objectives

By the end of this module, you should be able to:

- explain the term *sexual identity* and the factors that influence it
- explain the difference between sexual orientation and gender identity
- explain the difference between sexual identity and sexual behaviour
- explain the coming-out process, and what makes this process so difficult for many MSM
- offer support in a role play situation to someone who is coming out
- engage with common stereotypes regarding sexual orientation.

Introduction

In this module you will learn more about the difference between sexual identity and sexual behaviour. This module will also introduce you to the complex process of *coming out*, during which an individual attempts to come to terms with having a sexual orientation that differs from the norm of being 'heterosexual'. You will learn that just because they differ from the social norm, MSM do not have an illness or a disease, and do not have a choice about their sexual orientation. Finally, this module will offer guidelines on how to support someone who is coming out, and addresses the impact of the coming-out process on the family.

SECTION 1: SEXUAL IDENTITY

What is sexual identity?

Many people believe that all people can be grouped according to whether they are male or female, and whether they are homosexual (gay) or heterosexual

(straight). This simplistic view does not allow for the reality of each and every person having a unique **sexual identity** in the same manner that every person has a unique face. Our sexual identity is determined according to three independent levels that include a spectrum of individual difference:

Level 1: The most basic **biological level** determines our physical sex, male or female, according to our genitals and other physical features. However, a very small number of people are born *intersex*, either with ambiguous or inconclusive genitals or with internal tissue secreting hormones of the opposite sex. It is a myth that MSM are intersex.

Level 2: This **psychological level** relates to our sexual orientation – the extent to which we are sexually, emotionally and romantically attracted to either the opposite sex, the same sex or to both sexes. Heterosexual people will be primarily attracted to people of the opposite sex, while homosexual people are primarily attracted to people of the same sex. Many people are *bisexual*, being aware that they are attracted to both men and women. Importantly, an individual's sexual orientation can shift or develop over time. Note that no one, whether they are heterosexual, bisexual or homosexual, chooses their sexual orientation.

Level 3: The **social level** of sexual identity relates to how we interact with society's expectations regarding *gender* (what constitutes appropriate behaviour for men and women, or masculinity versus femininity). Each individual experiences in a different way what it is to be a man or a woman, and they may express this through their clothing, mannerisms and speech, interests or career choice.

MSM and sexual identity

While the vast majority of MSM are biologically male (as opposed to intersex), there is considerable variation regarding their **sexual orientation**. Most MSM **do not** identify as being either *gay* or homosexual, and may not consider themselves to be bisexual. In terms of their identity, most MSM regard themselves as being heterosexual men, and most MSM present with a masculine gender identity. It is very possible that they may have a wife and children and are regarded as being heterosexual and masculine by their family, friends and colleagues. They are unlikely to be recognised as being MSM by health care workers unless they present with a feminine gender identity.

MSM who present with a feminine gender identity, for example by partly or fully dressing as a woman, often experience higher levels of prejudice and discrimination than MSM who have a more masculine identity (Joint Working Group, 2005).

What is sexual behaviour?

Many people find it difficult to talk about sex and may have different ideas of what the term *sex* actually means. For example, some people only consider **penile-vaginal penetration** to be sexual behaviour, while others may include oral stimulation or mutual masturbation in the definition of 'sex'. MSM can interact sexually with other men in many different ways. It is a myth that all MSM engage in penile-anal sex, and it is a fact that anal sex also occurs between men and women (World Association of Sexology, 2000).

Many MSM have sex with both men and women. Some MSM only have sex with men, irrespective of whether they identify as being gay or not. The term *gay* is not used universally and in some communities 'homosexual' men may use other terms to identify themselves.

Unlike a sexual interaction between a man and a woman, where sexual roles are primarily defined according to biological and gender-based roles, sex between men can include a more complex range of behaviours because the sexual roles are not as clearly defined. A man can choose to be either penetrative or receptive during oral or anal intercourse, or may enjoy both roles. There are many variations and preferences in sexual activity (Makadon, Mayer, Potter & Goldhammer, 2008).

Situational MSM

Some circumstances that men find themselves in could lead to male-to-male sex. Often referred to as **situational homosexuality**, such circumstances could include being in prison, in a military situation or in a male-only hostel or dormitory. Economic circumstances, such as poverty, can be conducive to some men exchanging sex for money, accommodation or food. Not all male-to-male sex is voluntary. Men can also be raped.

MSM and gay men

Not all MSM identify as being *gay* in spite of their having sex with other men. This is because sexual identity and sexual behaviour are not necessarily linked, and because the concept of being gay is often seen as unacceptable. Identifying as 'gay' implies that the individual has accepted a 'gay' identity, which some people regard as being too open and visible about their sexual orientation. Many people in Africa think that sexuality should not be discussed openly and might only tolerate male-to-male sexual interactions as long as they are not publicly acknowledged. Some consider being gay as 'Eurocentric', 'Western', un-African, un-Christian or un-Islamic and as foreign to their culture or religious beliefs. This often results in some MSM choosing to hide their true sexuality, for example by pretending to have sex only with women. It is important to remember that gay men neither chose their sexual orientation, nor are they able to change it.

Exercise**Definitions**

Sexual identity = who you are sexually (e.g. 'gay' or 'straight'), what you think of yourself as.

Discuss all the different aspects of a person that make up their IDENTITY – for example: gender, race, appearance, religion, marital status, occupation, hobbies and interests, etc.

Sexual orientation = who you are sexually attracted to (e.g. heterosexual, homosexual, bisexual)

Discuss the origin of these words:

- *hetero* = different
- *homo* = same
- *bi* = two

Sexual behaviour = what sex you have, what you DO sexually (e.g. anal sex, oral sex, etc.)





MSM falls under SEXUAL BEHAVIOUR

Discuss why *men WHO HAVE SEX with men* is **what they do** and not **who they are**.

The *anal taboo* refers to the general social avoidance of any reference to the anus because of complex factors that associate that body part with shame, guilt and dirt.

Analphobia refers to an irrational fear of anything to do with that part of the body.

The social environment of MSM identities and behaviours

As stated above, many MSM are exposed to varying degrees of stigma, prejudice and discrimination due to cultural norms, religious views and other complex social factors. This is reflected in the fact that homosexual behaviour is outlawed in 38 African countries (Smith, Tapsoba, Peshu, Sanders & Jaffe, 2009).

Cultural norms regarding homosexuality differ around the world in the same manner that the rights of women differ in various countries. In some countries, for example, women are not allowed to show their face in public or to drive a car. Religion is often used to express negative attitudes towards MSM. Some Christians or Muslims, for example, quote selective Biblical or Koranic texts to justify prejudice against MSM.

Many people associate homosexuality with men having anal intercourse, a notion that awakens the **anal taboo** and **analphobia**. These phenomena play a significant role in some people's discomfort with homosexual identities and behaviours, and contribute to homophobia and discrimination against MSM.

As stated previously, however, not all MSM engage in anal sexual activity and many heterosexual couples enjoy anal intercourse. In some countries where premarital sex is forbidden, young women choose to engage in receptive anal sex in order to preserve their 'virginity'.

Hostile attitudes towards homosexual identities and behaviours are conveyed to children by their parents, at school, by religious institutions and through the media portraying only heterosexual relationships as being acceptable. Most children are raised in an environment that automatically assumes they will be heterosexual, and that disapproves of homosexuality.

Some people become increasingly aware of their homosexual desires during their childhood, adolescence or later in life, and need to come to terms with the conflict they experience between their own desires and what society expects them to be. This complex process is called **the coming-out process**.

Exercise: Agree/Disagree

Facilitator tips

1. Make sure there is enough space for participants to walk freely from one end of the room to the other.
 2. Place a large piece of paper headed 'Agree' and another with 'Disagree' on the wall at each end of the room.
 3. Tell participants that you will read out a statement and they should then go to the end of the room that best represents their response. If they are not sure, they should stand in the middle of the room, or in the direction of the answer that most describes their response.
- 'Gay and *MSM* mean the same thing.'
 - 'Homosexuality is a sickness that can be treated.'
 - 'The term *MSM* describes a sexual orientation.'
 - 'I would be devastated if my own son told me he was gay.'
 - 'There are some men who identify as being straight/heterosexual who have sex with other men.'

SECTION 2: THE COMING-OUT PROCESS

What is the coming-out process?

Coming out is a term that refers to an individual becoming increasingly aware of his or her non-heterosexual sexual orientation, and coming out of 'hiding' by disclosing this to others.

The process of coming out is different for every individual; some are comfortable with their experiences, while others experience a crisis period. Some people become very depressed and may even become suicidal. The way individuals experience the coming-out process is often influenced by their social surroundings, especially their family's attitudes towards diversity. For example, children raised in a warm, accepting family that values their uniqueness and fosters their individuality, as opposed to enforcing social expectations on them, may experience the process more comfortably. Likewise, a family that conforms strictly to traditional social norms and are intolerant of individuality may create a more hostile environment for their child's developing sexuality.

The process can commence at any age, but most often happens during adolescence, which is already a challenging period of physical, emotional and social change. The coming-out process typically involves a period of confusion and ends in the formation of a sexual identity that the individual feels comfortable with, and finally with the disclosure of the sexual orientation to others (Makadon, Mayer, Potter & Goldhammer, 2008).

Following is an example of one model of a male that includes six stages in the coming-out process, which could last for a very brief time to many years and may occur in any sequence. During all six stages the individual is coming to terms with his own sexual identity, while stages 4–6 also involve disclosing this to others.

Stage 1: Identity confusion

The individual sees himself as 'heterosexual' but starts becoming conscious that he may be somehow different due to his inner thoughts, feelings and impulses. These are confusing and he begins to experience a degree of anxiety, and possibly feels ashamed. He attempts to conform to heterosexual social expectations.

Stage 2: Identity comparison

The individual becomes increasingly aware that he is different from the heterosexual social norm and may feel isolated and alone, with increased anxiety about feeling more attracted to males as opposed to females. Anxiety levels can increase, and the individual fears being rejected.

Stage 3: Identity tolerance

The individual still feels confused, anxious and isolated but experiences an encounter with someone or something that makes it clearer to him that he may be homosexual. This could include meeting another gay person or seeing a gay person depicted on television that the individual can relate to. He begins to accept that he may be homosexual.

Stage 4: Identity acceptance

The individual begins to explore the concept of possibly being homosexual within a heterosexual environment and begins to experience less conflict about his identity. He may attempt to seek out other homosexual people and to gain information on homosexuality. He experiences anxiety about disclosing his sexual orientation to someone else but does manage to do so.

Stage 5: Identity pride

The individual reinforces his new sexual identity by separating himself from heterosexual norms and feels confident to disclose his sexual orientation to others. Being homosexual becomes a very important aspect of the person's identity.

Stage 6: Identity synthesis

The sense of being homosexual is integrated into other aspects of the individual's identity and lifestyle, and while he may be known to be homosexual to those around him he is able to focus on other aspects of his life.

As with all such models, the above merely provides a theoretical framework for understanding this complex process which will be experienced differently by every individual. For many individuals, coming out is a continuous and lifelong process.

No one is entirely sure what causes some people to be heterosexual and others to be bisexual or homosexual. Most agree that it is a combination of genetic and environmental factors.

Supporting someone who is 'coming out'

An individual who is going through the complex coming-out process often feels confused, anxious, fearful of being rejected, depressed, alone and

isolated. Following are a few suggestions you could make to someone who is coming out:

- Find an appropriate and safe space and time to talk to him.
- Assure him that you will always accept him and will not judge him, no matter what happens, and that you are there to support him.
- Assure him of his privacy and that you will honour his right to confidentiality.
- Encourage him to talk to you – and listen to him. He may want to talk about other matters before he tells you what is really going on. Acknowledge his feelings.
- Assure him that he is normal. Homosexuality is not a disease or an illness, and there is nothing wrong with him. He is simply a bit different from most people, in the same way that left-handed people are different from right-handed ones.
- He needs to know that he is not alone. It is estimated that between 3% and 10% of the world's population is homosexual, and the confusion and anxiety he is experiencing are both understandable and normal.
- He may be very anxious of disclosing his sexual orientation to his family. Suggest that he does this only when he feels confident enough and at a time and place that suit him. There should be no pressure on him to disclose his sexual orientation to others.
- Explore whether he has a brother or sister that he is particularly close to with whom he could disclose his sexual orientation before he discloses to his parents, so that the sibling could support him if necessary.
- Suggest that he does not need to disclose to both parents at the same time. If he is anxious about his father's reaction, for example, he could come out to his mother and ask her how best to disclose to his father.
- Remind him that his sexual orientation is a very private matter and that he needs to discuss confidentiality with anyone he comes out to. No one has the right to disclose his sexual orientation to others.
- If he is at school he may want to discuss his situation with a teacher he trusts and respects, or the school counsellor if there is one. Colleges and universities usually provide student counselling services.
- Encourage him to get further information on what it means to be homosexual. He could use the Internet to do this, or if he lives in a large

city you could help him find a gay organisation that could give him information and support.

- Encourage him to meet and talk with other men who have experienced the coming-out process. This will allow him to feel less isolated and to learn from their experiences.
- If he is anxious about the sexual aspects of being homosexual, inform him that he should not engage in any sexual activity until he feels ready for this. No one should make him perform or engage in any sexual activity he is not comfortable with. He may be wary of the notion that all male-to-male sex includes anal sex; assure him that this is not true. Encourage him to make sure he is aware of what 'safer sex' means for male-to-male sex before he has sex with another man.
- If he is a mature man who is coming to terms with his homosexuality, encourage him to meet other men to whom he can talk about this. If he has the means to do so he may want to talk to a social worker or a psychologist to help him through this process.
- If he has a wife and perhaps children as well, it is likely that he will be experiencing high levels of anxiety, guilt and shame. He might fear the loss of his family and the scorn of his friends and family. Assure him that many men only become conscious of, or come to terms with, their true sexuality later in life. Some homosexual men feel compelled to marry a woman due to social and family pressures, and may even hope that having a wife will allow them to suppress their homosexual desires. Feeling as if he is leading a double life could impact on all areas of his life. Acknowledge that his sexual orientation does not in any way negate his love for his wife and family and that he is fearful of causing them emotional distress. He may feel trapped and unable to alter his circumstances, but encourage him to consider the value of honesty, and the fact that it may be in both his own and his wife's interests for him to resolve the situation by having an honest conversation with her. Acknowledge the fact that he will need to proceed at his own pace, and that he could benefit from professional support. Encourage him to ensure he is fully informed of safer sex behaviours, and that he practises responsible sex at all times. This becomes more important if he is sexually active with men as well as with his wife, and feels unable to introduce condoms into the marital bed in order to protect his wife from HIV and other STIs.

You cannot assume responsibility for anyone who is going through the coming-out process, as he will need to proceed according to his own comfort levels, but you can be there to offer support when he needs it.

Remember that if someone does confide in you that he is homosexual or gay, or that he engages in MSM behaviour, you may not disclose this to anyone else without his consent. It is also important to remember that in many homophobic countries coming out may lead to physical harm and violence. This is something that should be considered carefully before encouraging anyone to come out. Nobody should ever be forced to disclose their sexuality but as a health care worker you can still offer support and guidance.

Guidance to ensure confidentiality of health care workers providing services to MSM is provided in Appendix 1 at the end of the manual.

Coming out and the family

While the above stages reflect the individual's experience of coming to accept having a different sexual orientation to most people, his family may experience a similar process. Sometimes parents may suspect that their son is somehow different from other boys based on his mannerisms or interests, and may deny this to themselves.

Many parents develop a long-term fantasy for their children, which often includes marriage and producing grandchildren for them. When confronted with the reality of a homosexual son, many parents react angrily, or they may choose to believe that it is only a phase he is going through and that he will change if he meets the right girl. Parents often wonder what caused their son to be homosexual and may blame each other. Some parents refuse to accept a son's homosexuality and may banish him from the home or react violently towards him.

It is sometimes advisable for a son to not disclose his sexual orientation to either one or both parents, especially in instances where the family culture is clearly homophobic or homophobic, or in instances where he may be placing himself at risk.

Ideally, parents will attempt to gather more information on homosexuality in order to understand their son's situation better. By so doing they will learn that neither of them caused him to be homosexual; that his sexual orientation is

not a disease or an illness, and that it cannot be changed or 'cured'; and that he did not choose it. This is a time when a son would certainly benefit from the parents' support as it is possible that he may be teased or bullied at school on the grounds of his sexual identity. If parents are unsure of how to respond they should be advised to seek professional help from a psychologist or social worker in order to ensure that they react in their child's best interests.

Difference between coming out and disclosure

Disclosure simply means telling others something that has been hidden or secret.

'Coming out' refers particularly to coming to terms with one's own sexual orientation and sexual identity. Coming out can involve telling others, but can also mean just coming to terms with oneself.

MSM who are HIV positive may face the challenge of coming out and of disclosing their status.

Exercise: Disclosure

What are the benefits and disadvantages of disclosing one's HIV-positive status to others?

Ask participants to list the risks and benefits of disclosure. These should include the following:

Benefits of disclosure

- Relieves the burden of keeping one's HIV status secret
- Releases stress
- Reduces worries about people finding out
- Helps the person living with HIV to deal with feelings of guilt
- Reduces feelings of loneliness
- Allows the person living with HIV to get support from others
- Enables the person living with HIV to access medical care and to plan for treatment
- Peace of mind
- Acceptance by others and oneself.





Risks of disclosure

There are real reasons why disclosing is difficult. Reasons for not disclosing include:

- fear of being treated differently because of being HIV positive
- fear of rejection
- fear of being pushed out of the family or the family home
- loss of employment
- just being seen as a person with AIDS (not as a person who has AIDS but is also many other things too)
- accusations of being promiscuous
- victimisation: violence and abuse.

How to support the process of disclosure or coming out:

- referrals to support groups and services
- offering guidance and advice
- listening
- providing information
- helping the individual identify to whom to disclose to and how, and preparing for possible negative reactions
- building confidence and self-esteem.

Exercise: Disclosure case study

Read the following case study involving disclosure. As a counsellor, think of what you would do in this situation. If possible, use this scenario as a role play with a partner or a group.

Boniface is a 28-year-old MSM who is unemployed. He lives with his parents, a brother and two sisters in a shack settlement outside Abuja. His family are unaware that Boniface has sex with men, and often pressure him to marry.





Recently, he noticed that he was losing weight. He attended the local clinic and consented to have an HIV test. Boniface subsequently discovered that he was HIV positive. He was initially very shocked about this news, as he did not believe that HIV infection could occur through sex between men. However, with the support of a patient and understanding counsellor, Boniface came to terms with his diagnosis. It is now three months since his first diagnosis. You as the counsellor decide to bring up again the issue of disclosure, as you believe Boniface will benefit from social support.

Summary

- Not all MSM identify as gay; in fact, many MSM do so with women as well.
- Sexual identity, sexual orientation and sexual behaviour are unique for every person and may not always be in line with societal expectations.
- Coming out is a complex and lifelong process that involves many stages.

Anal sex and common sexual practices

Learning objectives

By the end of this module you should be able to:

- understand that anal sex is practised by men with women, and men with men
- recognise different roles during anal sex (insertive/receptive)
- discuss anal sex with your clients
- explain various sexual behaviours that are practised by MSM
- explain different levels of risk associated with MSM sexual practices.

Overview

Around the world, discussing anal sex can be challenging because it is often surrounded by stigma and taboo, both from a health care provider's as well as a client's point of view.

In this module you will learn, though, that anal sex is practised by 'heterosexual' men and women, and by MSM. For a woman, anal sex is always 'receptive' (she can only receive the penis in her anus). For a man, anal sex can be both 'insertive' (he can insert his penis into the anus of a woman or a man) or 'receptive' (he can receive the penis in his anus).

As a health care worker you will provide services to men who report sexual intercourse with men and women (bisexual), with men only (homosexual), and with women (heterosexual).

You will also learn to ask what role a man takes when he reports practising anal sex and why this is important.

In this module you will also learn more about anal sex between men and women (penile-anal penetrative sex).

We will start this module with reviewing some literature on anal sex between heterosexual men and women. Then we will focus on anal sex and role taking of MSM.

Introduction: What is anal sex?

Anal sex is a sexual act that involves the insertion of the penis into the anus. This is a common sexual behaviour among MSM but it is also practised between men and women.

When a man engages in anal sex he can engage in either:

- **insertive anal sex** – which occurs when a man uses his penis to penetrate his partner. This is also called topping, fucking, being the active role, etc.
- **receptive anal sex** – which occurs when he is penetrated by his partner's penis. This is also called bottoming, being the passive partner.

MSM who engage in anal sex may prefer to engage in only one type of anal sex, insertive or receptive, or to engage in both roles (World Association of Sexology, 2000).

Anal sex practice among heterosexual men and women

Anal intercourse has been one of the most stigmatised of heterosexual sexual behaviours, perhaps because of its association with male homosexuality (Duby, 2009).

In Africa, very little is known about how common anal sex is among heterosexual men and women. A study in South Africa in 2003 of almost 12 000 men and women aged 15–24 years found that anal sex was practised by 4% of heterosexual men and women (Lane, Pettifor, Pascoe, Fiamma & Rees, 2006). A more recent study of almost 2 600 men and over 1 800 women sampled from townships in South Africa found that 360 (14%) men and 172 (10%) women reported practising anal sex in the three months before the study (Kalichman et al., 2009).

Surveys conducted in the US and European countries reveal higher reports of anal sex practised by heterosexual men and women; 30% of women and 34% of men aged 15 to 44 years had practised it (Leichliter, Chandra & Liddon et al., 2007).

While questions about anal sex in the general population are rarely asked, anal sex practice among female sex workers (FSWs) in Africa has been assessed in some surveys. To illustrate this, among 147 Kenyan FSWs who were chosen by chance from a larger cohort of self-identified sex workers, 41% reported having ever practised anal intercourse; and half of the women who ever practised it did so once or more than once a month (Schwandt, Morris, Ferguson, Ngugi & Moses, 2006). Almost all women said that their client asked for anal sex and that they charged more for it.

Thus anal sex is not exclusively practised by MSM. MSM exist in Africa as anywhere else, and they have among the highest risk of contracting HIV and are also unaware that HIV can be transmitted anally. It seems probable that heterosexual men and women also know equally little about anal sex and the risk of STD and HIV transmission during this activity – this is simply because health care providers do not ask them about it. Evidence shows that condom use for anal sex by ‘heterosexuals’ is lower than condom use by ‘homosexual men’ (Chetwynd, Chambers & Hughes, 1992; McGowan, 2008; Misegades, Page-Shafer, Halperin & McFarland, 2001).

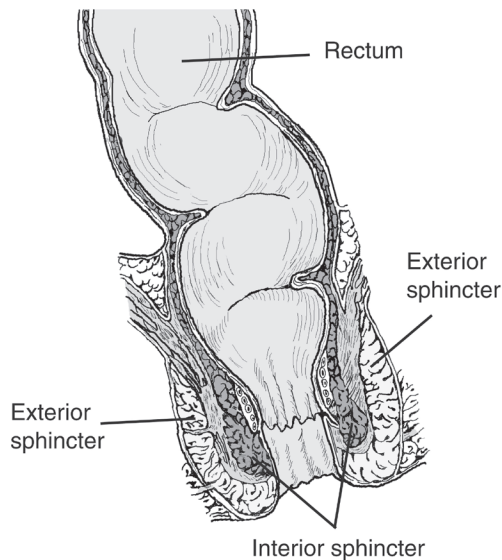


Figure 3: The anorectum

The difference in risk of HIV infection through anal sex as opposed to vaginal sex has to do with differences between the anus and the vagina. The anus continues to the rectum and has many specialised muscles (Figure 3). The lining of the anus and rectum is thinner than that of the vagina – making it easier for bleeding and damage to occur during sex (Figure 4).

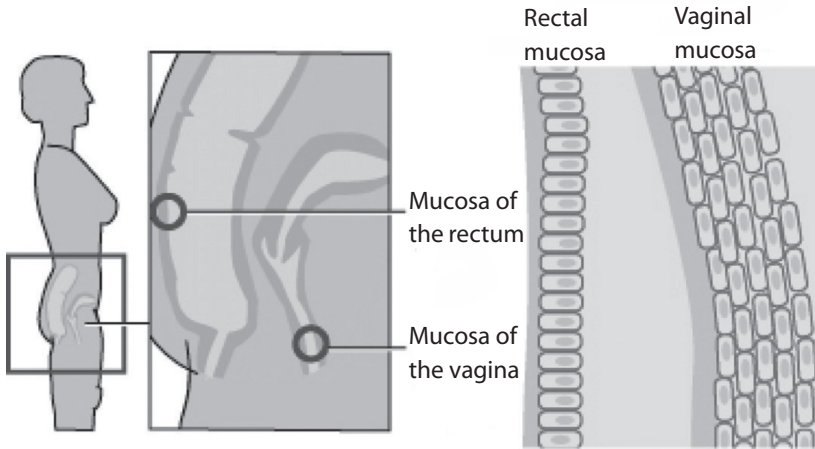


Figure 4: Female vaginal and anal mucosa

Table 1 helps to show the differences between penile-anal and penile-vaginal sex.

Table 1: Differences between penile-anal and penile-vaginal sex

Penile-anal sex	Penile-vaginal sex
No natural lubrication in anus	Vagina produces natural lubrication when sexually aroused
Anus has limited elasticity	Vagina has elasticity and stretches
Colon and rectum only a single layer of epithelial cells (one cell thick)	Vagina much thicker epithelial layer (approximately 40 cells thick)
Tears easily with no lubrication	Vagina doesn't tear as easily, and is more robust →

→	Penile-anal sex	Penile-vaginal sex
	Presence of faecal matter possible (containing bacteria)	No faecal matter present
	Many inflammatory cells (CD4 receptors) under surface in rectum	Fewer CD4 receptor cells in vagina than rectum

Different sex acts carry different risk for HIV infection. In men, unprotected receptive anal sex is 10 times more risky than engaging in unprotected vaginal sex (Figure 5). For a woman, engaging in unprotected (receptive) anal sex is five times more risky than engaging in unprotected vaginal sex (Figure 6).

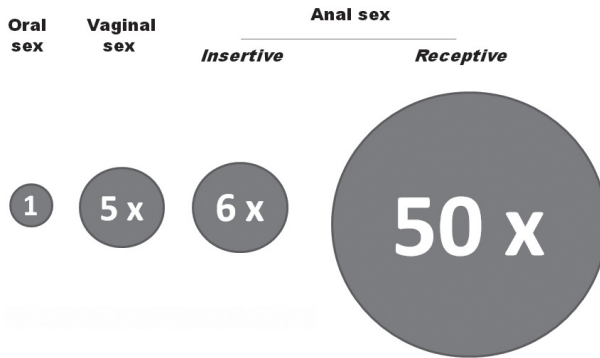


Figure 5: Male risk for HIV during different sex acts

Source: Smith et al. (2005)

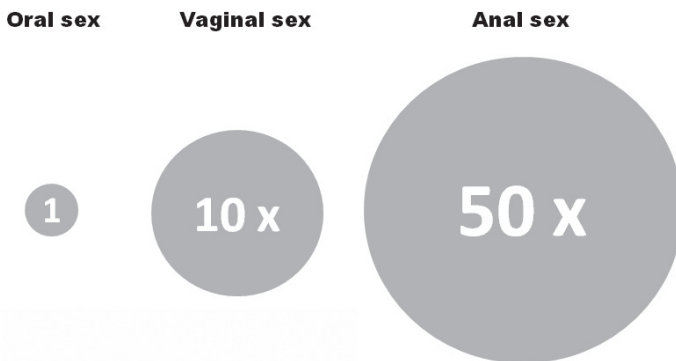


Figure 6: Female risk for HIV during different sex acts

Source: Smith et al. (2005)

Before we reflect upon our own attitude towards anal sex practice, let us read the case studies.

Case study 1

Fatima is 19 years old. She has come to you in a VCT clinic. She says that her reason to go for VCT is the arranged marriage that will happen in a few weeks' time. She is a bit nervous for the test and says that she is a virgin. She wants you to do the test 'for information' and, upon further prompting, because 'she is not certain about her future husband, who is 29 years older'.

You are in doubt. You wonder if you should ask her to come back with her husband-to-be, or if she has another concerns. Is she sexually active already? How you can introduce the topic of anal sex without 'losing contact with her', and find out more about the real reason of her visit?

This case study illustrates that some women have avoided pregnancy or loss of virginal status through engaging in anal intercourse, a common practice in a number of societies.

Young girls in Christian, Islamic and traditional societies throughout Africa practice anal sex in order to protect their vaginal or 'technical' virginity (Duby, 2009).

In many regions of African the traditional coming-of-age ritual of some 'virginity testing' is practised; young girls are examined before marriage to ensure that their hymen is intact. Discovery of a ruptured hymen brings shame to a girl and her family, and can jeopardise her eligibility for marriage. As a result of the high value placed on virginity and hymen maintenance (a falsity as the hymen can be ruptured in non-sexual activity such as tampon use or physical exercise) young people choose to have oral and anal sex instead.

Discuss the definition of 'virginity'

Is virginity defined by the female hymen being intact? (What about situations where the hymen breaks due to exercise or when a girl is born without a hymen?)

How can male virginity be defined?

We must be careful how we use and define the word *virginity*, especially when working with youth. 'Sexual debut' is now commonly used.

Case study 2

Jean is a 19-year-old male sex worker who works mostly around bars in the city centre. He is not very proud of his work but feels he has no choice as he did not go to secondary school and has no training or professional skill. Tonight he is hungry and has only enough money for his fare home. Jean is quite small and not very physically strong.

Festus is 42, married with three children and a successful businessman. He occasionally comes into the city at night to pay for sex with men and sometimes street boys. He does not consider himself to be gay. He enjoys sex with men because he can 'be rough'. Festus knows about HIV and STIs but assumes that anal sex is safe. Tonight he wants rough sex and approaches Jean.

In both the above case studies Fatima, Jean and Festus may have anal sex for the following reasons: preserving virginity, avoiding pregnancy, earning some extra money, and enjoying some rougher insertive anal sex.

Homosexuality was not mentioned in these cases. It may be possible that if you asked Jean or Festus if they would have homosexual contact, they would answer in the negative.

Do you think about anal sex as an act that is practised among homosexuals only?

Asking questions about anal sex of a man or a woman is as important as asking an MSM about anal sex. However, when a man reports anal sex you need to ask if he does it with women or men, or with both. If he has sex with men, you need to ask about sexual role taking.

Exercise: Agree/Disagree**Facilitator tips**

1. Make sure there is enough space for participants to walk freely from one end of the room to the other.
2. Place a large piece of paper headed 'Agree' and another with 'Disagree' on the wall at each end of the room.





3. Tell participants that you will read out a statement and they should then go to the end of the room that best represents their response. If they are not sure, they should stand in the middle of the room, or in the direction of the answer that most describes their response.
4. After you have called out the first statement and participants have placed themselves accordingly, ask, in turn, for a volunteer from each end of the room to explain to the group why they are standing where they are. Ask others to share their response before moving on to the next statement.
5. Allow debate – without arguments arising – and write down key words and comments that come up to be discussed/explained after the activity.
6. Afterwards, ask participants:
 - a. What did you learn from the activity?
 - b. What did you learn about yourself?

Do you agree or disagree with the following statements?

1. **Anal sex is a natural behaviour.**
2. **There should be no laws against anal sex.**
3. **Anal sex goes against my religion.**
4. **Anal sex was brought to Africa from the West.**
5. **It is not possible for a woman to enjoy anal sex.**

Discussing anal sex with your client

During the HIV testing session, a client will be asked about the number of sex partners he has had in a certain period. For instance: 'In the past month, how many partners have you had?' With that one question and the answer to it, however, a counsellor will not know what 'exposure' took place (what kind of sex?), and counselling on possible risk behaviours will not be sufficiently tailored to the behaviour of that client, therefore other questions are required to gain more information. For example: Was there oral, anal or vaginal sex?

Was there penetrative sex with the regular partner and oral sex with the one-off partner? Which sex act was protected? Were condoms used the first round and not in the second round?

Health care workers are trained to ask these questions of clients but they may not be trained to ask the same questions about anal sex because of the stigma surrounding it and the misconception that it is practised by MSM only. Many health care workers and counsellors feel very uncomfortable and embarrassed to ask about anal sex. By gaining more information about anal sex and about the risks that it poses for HIV transmission, health care workers can grow to understand the importance of discussing it with their clients. Anal sex can be practised in different positions (by men) and thus counsellors must ask clear questions in order to gain understanding of their clients' behaviour and risk taking.

Below are helpful questions that can be asked by a counsellor or clinician to gain a deeper understanding of their clients' behaviour:

- Have you ever practised anal sex?
- Have you practised anal sex during the last year (or shorter period)?
- Did you practise anal sex with a woman, a man, or with both?
- When you practised anal sex were you the receptive partner, the insertive partner, or both?
- The last time you had insertive anal sex, did you use a condom?
- The last time you had receptive anal sex, did you use a condom?
- Was lubrication used during anal sex? If so, what kind?

These questions can be asked along with other standard sexual behaviour questions. Sometimes, clients will understand your question better when you use language that is less formal, for instance: Are you usually 'top', 'bottom', or 'both'?

Anal sex and HIV testing

At first enquiry, clients very commonly deny engaging in anal intercourse, and usually it is only at the second or third clinical visit that they acknowledge and discuss this aspect of their sexuality (Halperin, 1999).

Unfortunately, there is still little health care worker training that focuses on supporting discussing anal sex practices with clients even though unprotected receptive anal sex is the most efficient method of the sexual transmission of HIV.

Health care workers have an opportunity to exchange such information when they first contact the client before offering an HIV test.

Central to counselling training is the understanding that HIV can be transmitted between adults when contact is made between the penis and the vagina. Hence, HIV prevention programmes and the messages that only focus on 'abstaining from sex', 'being faithful to one partner', and 'using condoms each time you have sex' miss out on an important and very risky route of HIV transmission, i.e. anal sex.

Exercise: HIV testing and anal sex questioning

Recall the last time that you conducted an HIV testing and counselling session for an adult. This could have been a voluntary test (offered to a walk-in volunteer at a VCT clinic), a diagnostic test (offered as part of clinical care), or a research-initiated test (purposefully offered in view of participation in a research protocol).

Reflect on the moment when you approached the topic of HIV transmission and HIV prevention. You will have said something like: 'I am going to ask some questions about your sexual partners, and about your understanding of HIV transmission'. Now reflect on the last time you tested and counselled an adult for HIV.

Did you ask about anal sex practice?

- **If you did:** recall your question(s) and what the client's response was.
- **If you did not:** try to recall the reason why you did not.

Other sexual behaviours of MSM

Exercise: Body mapping of sexual practices

Facilitator tips

1. Give participants a sheet of paper and a marker, and ask each of them to draw a naked man, including the genitals.
2. Ask them to draw a star next to the parts of body that can be used for sexual pleasure.
3. Ask them to write down the different names/terms for these parts
4. Next to the starred body parts, ask them to write down all the ways in which that part can be sexually stimulated or used for sexual stimulation and all the names for that sexual behaviour.
5. Identify the different levels of HIV transmission risk of each – between low, medium and high – by writing an 'L', 'M' or 'H' next to each sexual behaviour.

Are there any behaviours that can only be done by a woman?

When we think of MSM, we often think only of anal sex. The above shows that there are many ways in which two men can sexually stimulate each other, not just by engaging in anal sex.

There is often a heavy focus directed toward anal sex when discussing the sexual behaviour of MSM because it is well known that HIV can be transmitted effectively through unprotected anal intercourse. However, not all MSM engage in anal sex, therefore it is necessary as a counsellor working with MSM to be familiar with these other behaviours. Some of these include the following:

- **Kissing.** This is the act of using one's lips to touch another person or object. Kissing is used to express emotions like love and affection. While kissing traditionally occurs between two people's lips, a person can use their lips to kiss anywhere on someone else's body.
- **Dry sex, dry humping, rubbing, frottage.** All these describe a sexual activity in which two people rub their bodies (or body parts) together using similar movements as penetrative sex but without penetration.
- **Mutual masturbation.** This is a sexual act in which two or more people stimulate themselves sexually using their hands.

- **Oral-penile sex ('blow job', 'sucking off', 'giving head')**. This is the sexual act that involves stimulating a person's genitalia using the mouth and tongue.
- **Using sex toys**. A sex toy is any object that can be used to sexually arouse or stimulate a person. There are countless varieties of sex toys but the most familiar, like the dildo for example, are shaped to resemble the penis.
- **Fingering**. This is a sexual act in which a finger or fingers are used to penetrate and stimulate a partner's genitalia.
- **Oro-anal (rimming, anilingus, 'ass licking')**. A sexual activity that involves the mouth and tongue to sexually stimulate another person's anus.

Summary

- Anal sexual practices occur in Africa between men and women, and between men.
- Counselling sessions are opportunities to enquire about and provide information about the risks of anal sex.
- Asking about, and counselling on, anal sexual behaviours is an important part of HIV and STI prevention.
- Counsellors and clinicians should know the risks associated with different sexual behaviours and advise clients on how to reduce their risk of becoming infected with HIV and other STIs, or transmitting HIV and STIs
- MSM may take both receptive and insertive anal sex roles.

HIV and sexually transmitted infections (STIs)

Learning outcomes

By the end of this module, you should be able to:

- list the common STIs which affect MSM
- list the common symptoms of STIs
- describe how to ask clients about symptoms of STIs
- explain how STIs are spread
- explain what to do if a client has or may have an STI
- explain the link between HIV infection and STIs
- inform clients about pre- and post-exposure prophylaxis (PrEP & PEP) for HIV
- list the common symptoms of acute HIV infection and the reasons why early access to HIV care is needed.

Introduction

Sexually transmitted infections (STIs) are a group of diseases which can be passed between individuals during sexual activity. Health care workers may find it hard to provide care because of homophobia or fear of providing services to MSM. Governments and health care workers have an obligation to provide health care to all, and should not deny care because of discrimination or fear.

MSM in Africa have a high burden of sexually transmitted infections. Studies done among men in South Africa, Senegal and Kenya found that about four out of every 10 men were infected with an STI (Ghebremichael & Paintsil, 2009; Wade et al., 2005).

Currently, existing STI treatment guidelines in Africa are insufficient for MSM as they do not take into consideration receptive anal intercourse and do not suggest treatment for certain diseases that may especially affect MSM. Often, health care workers like counsellors or nurses are the first point of contact for many MSM in the health care setting. They possess a rich opportunity to assist in referring clients with a potential STI to a health care professional, therefore it is crucial for all health care workers to know about the STIs which are common in men.

This module will focus on the basic facts of common STIs that may be encountered when working with MSM. While this knowledge will not replace that of a trained medical professional it can assist in encouraging participants to seek out this type of medical assessment. Details on where to obtain treatment guidelines are included in Appendix 2 at the end of the manual.

Core knowledge section

What is an STI?

STIs are diseases which may be caused by bacteria or viruses. Most are spread through bodily fluids (semen, ejaculate fluid/pre-cum, blood) and others by direct contact (touching skin to a sore). Among MSM these diseases can be spread through oral, penile-anal and oro-anal sex.

What are common symptoms of an STI?

The following can be potential signs of an STI. Should a client report any of these symptoms, they should be referred for a medical follow-up:

- Sores on the penis, testicles, anus and surrounding area
- Burning urine
- White discharge (pus) from the penis or anus
- Painful testicles (balls)
- Swollen glands on the inside of the leg
- Growth on the penis, testicles, anus and surrounding area
- Pain or bleeding with defecation (bowel movements)
- New-onset painful receptive anal intercourse
- Itchy genital area, penis or anus (International HIV/AIDS Alliance, 2003; Wilson et al., 1951).

How are STIs spread?

STIs are spread through the exchange of bodily fluids (blood, semen, etc.) or from direct contact during oral, anal or oro-anal sex. Unprotected receptive anal sex carries the highest risk for STIs. Unprotected penetrative anal sex is also high risk for infections which can occur in the penis or the anus (CDC, 2010b). During oral sex, infection can be spread between the penis of the insertive partner and the throat of the receptive partner. During oro-anal sex, infections can be spread between the anus of the receptive partner and the mouth of the man giving oro-anal sex. Lastly, infection can also be spread by directly touching open sores (ulcers) (WHO, 2003).

Is there a link between HIV and STIs?

People who are HIV infected and also have an STI spread the virus more easily to other people and people with STIs can contract HIV more easily. This is because STIs cause swelling and increased blood flow to infected areas, and infections which cause sores (or ulcers) breaking the skin's surface. The increased blood flow and broken skin make it easier for HIV to enter/leave the body (Wilson et al., 1951).

What STIs are common among MSM?

The following STIs can be common in MSM: HIV, syphilis, gonorrhoea, chlamydia, herpes, viral hepatitis and warts (caused by a virus called the human papilloma virus or HPV).

Human immunodeficiency virus (HIV)

HIV is a virus that is spread through bodily fluids, affects the human immune system and causes AIDS. Receptive unprotected anal sex carries the highest risk of becoming infected with HIV. Unprotected penetrative penile-anal sex also carries a high risk of contracting HIV. Oral-penile sex and oro-anal sex also carry some risk of HIV infection, but this risk is much lower. The chance of getting HIV is higher if there are cuts or sores in the mouth or around the penis and anus.

In HIV-positive men, ejaculation fluid (semen, cum) and blood carry the highest number of viruses. However, pre-ejaculate (pre-cum) may also contain HIV. Removing the penis before ejaculation during oral or anal sex still carries a risk of HIV transmission.

The course of HIV infection among MSM is no different from other men. A few weeks after infection, a flu-like illness may be experienced. Fever, skin rash, sore throat, muscle pain and tiredness may be present. During this time HIV is very easily spread to others.

Years without any obvious symptoms may follow until the immune system (the body's army which fights sickness) weakens. Infected people may then develop tuberculosis (TB); chest infections; skin rashes; sores in the mouth; diarrhoeal illnesses; and some types of cancer. They may also lose weight.

HIV is a manageable infection. Regular medical follow-up is needed to prepare individuals to start antiretroviral therapy (ART). Once started, antiretrovirals need to be taken daily for life. The decision on when to start is based on clinical and laboratory criteria, which are often country specific due to variable resources and patient readiness. Treatment usually consists of at least three different types of drugs. Links to the latest WHO HIV treatment guidelines are included in Appendix 2.

All sexually active individuals should be offered HIV testing every six months to a year. For people who have many risky exposures (unprotected anal intercourse, multiple sexual partners, concurrent partners, transactional sex) HIV testing should be done more regularly every three to six months. Individuals who presents with flu-like symptoms (fever, tiredness, skin rash, muscle pain, joint pain, sore throat) two to 10 days following risky sexual exposure should have HIV tests repeated six weeks and three months after the event to pick up possible early HIV infection. The spread of HIV can be greatly reduced if HIV diagnosis is made early, since most infections are spread from individuals who are in the early stages of infection and are often not aware that they are spreading it to their sexual partners (Makadon, Mayer, Potter & Goldhammer, 2008; Wilson et al., 1951).

The use of antiretrovirals to prevent HIV

Antiretrovirals have been shown to provide some protection against HIV infection among HIV-negative people. Antiretrovirals should be given **ONLY** by a qualified health care worker. Their use for HIV prevention before and after exposure is linked to possible risks of viral resistance. At present, access to these prevention methods is limited, but may increase as drug prices decrease and research results become available.



**Post-exposure prophylaxis (PEP)**

Post-exposure prophylaxis (PEP) generally refers to a set of services that is provided to manage specific aspects of exposure to blood-borne pathogens. Non-occupational post-exposure prophylaxis (nPEP) is an emergency medical response where antiretroviral drugs are given to HIV-negative people following high-risk exposure sexually or through injection drug use. The aim is to give a person's immune system a chance to develop protection against the HI virus and to prevent HIV from becoming established in the body. In order to give PEP the best chance of working, the medication must be taken as soon as possible within two to 24 hours, and definitely within 72 hours of exposure to HIV. Left any longer, the effectiveness of the treatment is severely diminished. MSM may be exposed to HIV infection if they are sexually assaulted, if the condom bursts or during consensual unprotected sex. Hepatitis B and other STIs can also be transmitted at the same time as the HIV.

Rationale for using PEP

Although HIV PEP has not been proven to be 100% effective against HIV infection, it has been shown to work in health care workers who have been pricked with an infected needle and were treated with AZT. The medications that are given to prevent transmission of HIV from an HIV-infected mother to her baby are another form of PEP that have been shown to work (CDC, 1995; Otten, Smith, Adams & AI, 2000; Smith, Grohskopf, Black & AI, 2005).

The post-exposure prophylaxis regimen

Post-exposure prophylaxis (PEP) after anal sex consists of 28 days of three different types of the antiretroviral drug (e.g. zidovudine, lamivudine and lopinavir-ritonavir) that are also prescribed as treatment for people with HIV.





As with most antiretrovirals, these can cause side effects such as diarrhoea, headaches, nausea/vomiting and fatigue. Some of these can be quite severe and it is estimated that one in five people gives up the treatment before completion (Smith, Grohskopf, Black & Al, 2005).

Does availability of PEP lead to increased risky behaviour?

Some believe that increasing the availability of PEP will lead to behavioural changes such as not using condoms and seeking to use PEP repeatedly. However, various studies have indicated that increasing awareness and availability of PEP leads to the reverse. As shown by a study in the US, 'people reduced their risk behaviour after using PEP, rather than increasing it' (Donnell, Mimiaga & Mayer, 2010).

Counselling and management of a client that requires HIV PEP

It is important for health care workers prescribing PEP to counsel their patients on the importance of drug adherence and on managing minor side effects of the medication but to refer serious side effects for specialist care. Common side effects are temporary and can be relieved with standard medications against pain, fever and nausea (e.g. paracetamol and anti-emetics). Completion of the 28-day course is necessary for maximum efficacy of PEP medication. Testing for and giving hepatitis B vaccination and treatment of STI should be part of the management.

Gay men often do not voluntarily disclose their sexual orientation to health care providers. However, a confidential and respectful relationship between providers and their patients including open communication about sexual behaviour is essential when conducting a useful and proper risk assessment.





Point-of-care service provision needs to be as comprehensive as possible to avoid patients being seen by many providers and repeatedly having to disclose intimate information. Counselling should include information on risk reduction and the need for follow up HIV testing at six weeks, three months and six months post exposure.

Pre-exposure prophylaxis (PrEP)

PrEP is an approach currently under development which aims to use HIV medications to prevent HIV among individuals who are not yet infected with the virus. The Global IPrEX study, an international study conducted in the US, South America, Thailand and South Africa, has shown the first evidence that this approach may be effective among MSM. The study was conducted among almost 2 500 high-risk MSM receiving a comprehensive package of HIV prevention services (condoms, lubrication, HIV testing, risk-reduction counselling and STI screening and testing) and showed fewer incidents of HIV infection among those who received the daily study drug (enofovir/Emtricitabine) compared to those who were taking a daily placebo (a tablet with no active ingredient). No major safety concerns were raised, but a few cases of drug-resistant HIV were detected and there was some weight gain among those taking the study drug. The idea is that PrEP prevents HIV from replicating in the body and will prevent HIV infection (Grant et al., 2010). Only HIV-negative individuals would be able to use PrEP under the care of an experienced medical practitioner, and would need to continue to use condoms, lubrication, responsible sexual behaviours, laboratory work-up and regular HIV testing to maximise protection against HIV infection. Studies looking at how well PrEP would work in the 'real world' and the cost implication of its widespread use still need to be completed before it becomes part of standard HIV prevention among MSM. (See Appendix 1 at end of the manual for additional information and contacts about the use of PrEP.)

STIs***Urethritis (urethral discharge syndrome, drop)***

Neisseria gonorrhoea and *Chlamydia trachomatis* are the bacteria or germs which commonly cause most infections in the urethra of the penis (the pipe joining the bladder to the outside). These germs can also infect the testicles, anus and mouth. Infection of the urethra may cause white or clear fluid to leak from the penis. Clients may report that fluid from their penis is wetting their underwear, and commonly report an itchy or burning sensation in their penis when urinating. Symptoms usually develop from about three to five days after exposure, but may take longer. Infection can also occur without any symptoms, and individuals may not know that they are infected (International HIV/AIDS Alliance, 2003).

Urethritis is spread through contact with the penis, anus, mouth or vagina. Scarring of the urethra and spread of the infection to the testicles and prostate can occur if the infection is not treated. Infection with gonorrhoea and chlamydia may spread beyond the genital tract and may cause painful glands, painful joints and muscles, and skin rash.

The tests used to identify the exact germ causing the infection are expensive and not normally needed. These tests are commonly done on urine or from a sample of the fluid on the inner lining of the penis. Infection with both germs at the same time is common, and the WHO recommends treatment of both germs with a combination of antibiotics in resource-limited settings. Men may be infected again and need to be retreated whenever symptoms are present (CDC, 2010b).

Genital ulcers

Genital ulcers, or sores, may be either painful or painless. The former are most commonly caused by the herpes virus and the latter most often by syphilis. Other causes of genital sores include *lymphogranuloma venereum*, chancroid, primary HIV infection, *granuloma inguinale*, trauma, cancer, drugs, Behcet's disease and Reiter's syndrome (Wilson et al., 1951).

Genital herpes

Herpes is the most common STI in Africa (WHO, 2007). A recent study among high-risk MSM in South Africa found 15% of participants (about one in every

six) to be infected with genital herpes (Grant et al., 2010). Infection is for life and no cure exists. Herpes simplex type 1 is responsible for 'cold sores' – superficial ulcers around the mouth and nose which usually heal by themselves. Herpes simplex type 2 most commonly causes a few painful sores around, on or near the penis, anus or vagina (genital herpes) surrounded by a red area. The virus is spread through direct contact. By touching open sores with a body part (hand to penis; penis to anus; mouth to penis, etc.) the virus can be passed to other people. The virus may also be spread from person to person even if there are no open sores and the skin is intact (CDC, 2010b). Treatment is expensive and not freely available, and works to control the sores if it is started early. Treatment is needed for severe sores or for those which do not heal.

Syphilis

Syphilis is caused by bacteria and can first appear as a painless sore (ulcer) on the penis, anus or surrounding area. This sore heals, and individuals may then develop a rash, swollen glands, and muscle and joint pains. These symptoms then disappear and the person may be symptom free for many years. The bacteria continue to live in the body and may spread to cause disease in the testicles, heart and brain. Often, syphilis is only diagnosed in a blood test. Penicillin, given as three injections over three weeks, is effective for treating most cases of syphilis (International HIV/AIDS Alliance, 2003; Wilson et al., 1951).

Viral hepatitis

Viral hepatitis may be caused by one of a group of viruses which directly affect the liver, most of which can be spread in the same way as other STIs. Hepatitis A and B are important illnesses among MSM in Africa. Hepatitis C is more of a problem among intravenous-drug users, but has been shown to be spread between MSM in other parts of the world.

Hepatitis A

In Africa many people become infected during childhood. Lifelong protection can be obtained from natural infection or through immunisation. Among MSM it may be spread through oral-anal sex. In adults the disease is usually short lived – causing nausea, vomiting, yellowing of the skin (jaundice), abdominal pain, swollen glands and joint pain. For those not previously infected, there is

an effective immunisation available for hepatitis A (Makadon, Mayer, Potter & Goldhammer, 2008).

Hepatitis B

Hepatitis B is spread through bodily fluids, similarly to HIV, but unlike HIV, hepatitis B can be prevented by vaccination. Hepatitis B infection is common in Africa. Most individuals are able to recover fully from hepatitis infection; however, between about one in four and one in 20 have long-term infection, depending on whether it started in childhood or adulthood. Some of these people develop scarring of the liver (cirrhosis), which may cause the development of liver cancer (Wilson et al., 1951).

Individuals who are infected with HIV and hepatitis B need special attention due to the medications used to treat the infections and the possibilities of liver problems. Treatment for hepatitis B is very expensive, not very effective and only available in areas with extensive resources. Hepatitis B vaccination is recommended for all people who practice riskier sex, such as sex workers and MSM (CDC, 2010a).

Genital warts

Another virus, HPV (the human papilloma virus) causes warts in the genital area. These appear as growths around the penis and the anus. Sometimes they are itchy and they may bleed if scratched. Warts often heal without treatment. Large warts need treatment with medication or may need to be surgically removed. Warts may be numerous, and become very large in HIV-positive individuals. The presence of warts around the genitals or anus is a sign of unprotected sex (WHO, 2003). Occasionally infection with HPV may lead to anal cancer, which is 17 times more likely to occur in MSM than in non-MSM (NY1.com, 2009). A vaccine (Gardasil®) is now available for the prevention of HPV infection and for anal cancer, and has been approved for use in males between nine and 26 in several countries. Owing to the cost of this vaccine access is currently limited.

Other STIs and rectal STIs

Lymphogranuloma venereum (LGV) is another infection caused by a type of chlamydia bacteria. It may cause a sore in the genital area and swelling of the

glands in the groin, and result in abscesses. Antibiotics are needed to treat this infection (NCBI, 2009).

Many of the bacteria mentioned above may cause infection in other parts of the body. *Neisseria gonorrhoea* and chlamydia may also infect the anus and mouth. Infection in the anus may cause painful bowel movements and painful receptive anal sex, and there may be a white or bloody discharge from the anus (proctitis). Diagnosis may be made by direct observation using a proctoscope – an instrument inserted into the anus that allows a health care professional a better view of the lining of the anus. Laboratory tests on a sample from the anus can also be used to make the diagnosis. Treatment is by means of antibiotics to cover the most likely bacteria (WHO, 2003).

Infection in the mouth may cause a painful, swollen throat and mouth. White fluid may also form on the back of the mouth. Genital herpes may also infect the mouth and cause cold sores (Makadon et al., 2008).

Clients with symptoms should not wait for them to go away, but should be seen by a health care professional. Infestation with parasites like lice and scabies is common, which is a possible cause of itchiness in the genital area. Hepatitis A and C are other viruses which can be spread through sexual contact among MSM.

How can you ask about STI symptoms?

Asking about STIs should be standard practice during HIV counselling and testing sessions, and during medical history taking. Speaking with a client about STIs and the symptoms associated with them can sometimes be difficult because the client may be embarrassed to speak openly about them. This challenging barrier can often be overcome by explaining to the client that STIs are very common in African men and that many are easily treatable. Below are a number of questions that are non-specific but may help to identify an STI. MSM with any of these symptoms or other symptoms associated with the penis, anus and genital area should be referred to a health care professional for management.

- Have you noticed any sores on your private parts (penis, anus and surrounding area)?
- Do you find it uncomfortable to pass urine?
- Do you have any burning sensations when urinating?

- ➔ Have you noticed clear or white fluid on the tip of your penis which is not semen?
- ➔ Are you experiencing any pain in your testicles which is new?
- ➔ Is receptive anal sex more painful or uncomfortable than before?
- ➔ Have you noticed any blood when having a bowel movement?
- ➔ Have you noticed any white fluid or pus leaking from you anus?
- ➔ Do you have any irritation or itchiness in your private parts which is new?

What should health care workers do if they suspect a client may have an STI?

Any client with symptoms of an STI should be offered HIV testing, and needs to be referred for medical evaluation. Clients who report symptoms of an STI should be made aware of the problems and risks caused by them. Sexual partners also need to be referred for medical review, even if they do not have any symptoms (WHO, 2003)

Additional resources for information on STIs and HIV are listed in Appendix 1 at the end of the manual.

Group exercise 1

Referring to the body maps exercise from Module 4, go through all the sexual activities written on the body maps, marking each with an 'L' (low risk), 'M' (medium risk) or 'H' (high risk) for spreading HIV and STIs. Referring to the body maps, discuss which STIs could be spread through each activity.

Group exercise 2

Instructions (30 minutes)

Hand out copies of the case studies below. Ask the participants to discuss them in pairs. Allow each person 10 minutes to act as the client and 10 minutes as the counsellor for one of them. Allow 10 minutes to discuss difficult issues, and answer questions in a group.

Case study 1

Abdul, a 40-year-old father of two, comes to the clinic for an HIV test. He tells you that for the last three days he has had a burning sensation while urinating, and noticed white fluid on the tip of his penis when he woke up that morning. He tells you that he had unprotected anal sex with a male sex worker a week ago.

Explain to Abdul what could be causing the burning urine and the white fluid on the tip of his penis.

Counsel Abdul on what he should do. Include advice about referral, treatment, prevention and risk of HIV infection.

Case study 2

Tshepo is a 20-year-old male who lives with his parents in Harare. At a party two weeks ago, he consumed a great deal of alcohol and woke up the next morning in the bed of another man. He remembers having had sex with the man, but does not remember if they used a condom. His HIV test was negative six months ago. He says that today he noticed some painful sores on his penis.

Explain to Tshepo what you think could be the cause of the sores on his penis.

Counsel Tshepo about what it means to have an STI and what he should do. Include advice about referral, treatment and the need for HIV testing.

Summary

- STIs, including HIV, are common among MSM.
- Early identification and treatment of STIs can minimise the spread and effects of STIs.
- HIV is transmitted more easily when one/both partners have an STI, open sores or wounds, or broken skin.
- PEP should be offered to HIV-negative individuals within 72 hours of exposure to HIV or sexual assault, under the guidance of a medical practitioner, if available.

- PrEP as a concept has been shown to provide some protection against HIV among HIV-negative MSM, but more studies are needed before it can be widely recommended.
- As a counsellor you are able to inform men about the risks associated with different sexual behaviours.
- All suspected or confirmed symptoms of an STI should be assessed by a health care professional.
- Screening for common STIs should be included in all HIV counselling sessions.

Condom and lubricant use

Learning outcomes

By the end of this module, you should be able to:

- highlight the role of condoms for preventing HIV and STIs
- explain the main differences between male and female condoms
- discuss the difference between oil-based and water-based lubricants
- tailor condom promotion messages to take into account the range of sexual behaviours of MSM clients.

Introduction

In this module, you will learn about male and female condoms, and understand their key role in preventing HIV and STIs. This module equips you with the necessary knowledge and skills to incorporate practical advice on correct condom and lubricant use, identify common errors in condom use, and tailor your prevention messages to the sexual behaviours of MSM clients.

Core knowledge

Male and female condoms

A condom is a protective sheath used during anal, vaginal or oral sexual intercourse. It creates a physical 'barrier' between the genitals and sexual fluids of two partners engaging in intercourse. It can be used for contraception, and/or HIV and STI prevention. There are two main types of condoms – 'male' condoms and 'female' condoms.

Male condoms are usually made out of latex (rubber). Female condoms are usually made out of polyurethane (a thin strong plastic). Male condoms

made out of polyurethane also exist (but are not widely available) – these are useful for avoiding latex allergies.

Currently, the female condom is approved for vaginal use only – that is why it is called the ‘female condom’. However, ‘female condoms’ can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection (Gross et al., 1999).

Table 2 compares the male condom with the female condom.

Table 2: Similarities and differences between male and female condoms

Male condom	Female condom
Latex (rubber)	Polyurethane (plastic)
Water-based lubricants only e.g. K-Y Jelly®	Any lubricant, preferably water-based (although oil-based lubricants, such as Vaseline®, body cream or oil are also suitable)
Can break if not used correctly	Does not break easily
Some men find it too tight/ restrictive	Not tight on penis
Must be put on/taken off the erect penis immediately before/after penetration	Can be inserted before penetration and left in for longer
Does not conduct heat	Warms up to body temperature
Must be worn on the penis (insertive partner)	Can be inserted into anus (receptive partner) or used over the penis (insertive partner)

How well do condoms work?

When used correctly and for all sex acts, condoms are 80–95% effective at preventing HIV and STIs. These estimates are based on research among heterosexual couples engaging in regular sexual intercourse using condoms consistently (Steiner & Cates, 2006; Pinkerton, 1997; Weller & Davis, 2003). Often, however, individuals do not use condoms correctly or consistently (Steiner, Cates & Warner, 1999), resulting in potential exposure to HIV/STIs.

Male and female condoms are manufactured according to strict quality standards and are tested for strength, leakage, lubrication, proper packaging and labelling.

Instructions for correct male condom use

1. Store condoms in a place away from heat and humidity. Check the expiration date on the package. Check that the package is not damaged and has no holes by feeling the air in it.
2. Do not rip or puncture the condom when opening the package. Open it with the fingers, NOT with teeth, scissors, a knife or anything sharp.
3. Check that the condom is not dry.
4. Make sure the tip of the condom is the right way round – the lubricated side should be on the outside, and the condom should roll down easily.
5. Pinch the tip (teat) of the condom with one hand. This removes the air and makes space to hold the semen.
6. Place the condom on the erect penis and unroll it to the base of the penis with the other hand, while still pinching the tip of the condom. If uncircumcised, pull back the foreskin before putting on the condom. After it has been put on, push the foreskin forward again (towards the tip) to let the foreskin move without breaking the condom.
7. Smooth out any air bubbles.
8. Add a water-based lubricant (e.g. K-Y Jelly®) to the outside of the condom if necessary. Do NOT use oil-based lubricants.
9. After ejaculation, hold the condom at the base of the penis and pull it off before the penis softens.
10. Remove the condom, taking care not to spill any semen.
11. Wipe any ejaculate off the penis.
12. Make a knot in the condom and dispose of it appropriately out of the reach of children.
13. Use a new condom for each new act of intercourse.

If the condom breaks or slips during intercourse, STOP, remove it and put on a new one.

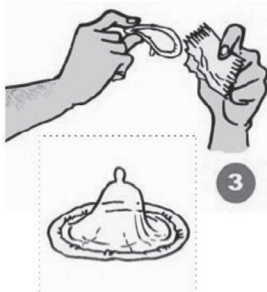
Diagrams for the correct use of condoms for anal sex are given on the following page (Figure 7).



1. Check that the package does not have a hole in it (it has a hole in it if there is no air in it or if it is oily)



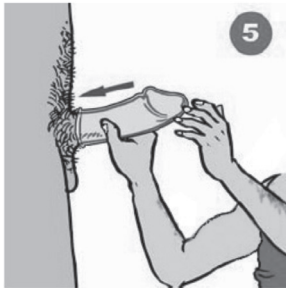
2. Open the condom packaging with your fingers using the serrated edge (it is easier to open) or the V sign



3. Carefully take the condom out and find out which way to unroll it (touch the end: if it is oily, it is the right side, otherwise turn it around)



4. Pinch the end of the condom between two fingers of one hand (to squeeze out the air) and place it on the erect penis (the penis must be hard)



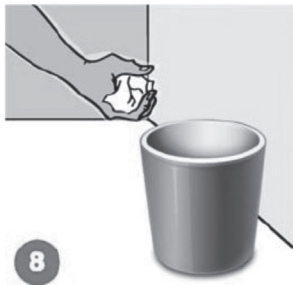
5. Unroll the condom, using two fingers from your other hand, right to the base of the penis while still pinching the end of the condom



6. Take the condom off after ejaculation (when he has ejaculated), and before the penis becomes soft



7. Carefully remove the condom with a disposable tissue or toilet paper



8. Wrap the condom in the tissue and throw it away in the bin out of reach of children

Figure 7: Diagrams for the correct use of the male condom for anal sex

Common errors

- Putting on the condom halfway through sex, i.e. 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 the second or third round
- Failing to pinch the tip of the condom (to remove the air) when putting it on
- Withdrawing *after* the penis has softened
- Failure to add lubricant, especially during anal sex
- Use of oil-based lubricants (e.g. lotion, vegetable oil, Vaseline®) that can damage the latex
- Lengthy or vigorous sex
- Engaging in sexual positions that may increase the likelihood of slippage
- Putting on two male condoms at the same time

Instructions for correct female condom use

Method 1: Use by receptive partner

1. Check the expiry date.
2. Find the arrow on the packaging and tear downwards.
3. Insert the female condom into the vagina or anus.
4. Either keep or remove the inner ring, depending on preference. The inner ring can be used to insert the female condom, and then be removed thereafter.
5. Leave the outer ring on the outside of the body.
6. Add lubricant to the inside of the female condom or on the penis if needed.
7. Guide the penis inside the outer ring into the female condom. If the penis enters to the side of the female condom or pushes one of the sides of the outer ring inside the vagina or anus, STOP, adjust the outer ring, and start again.
8. To take out the female condom, twist the outer ring and gently remove.
9. Tie a knot and dispose of it in the trash.

Method 2: Use by insertive partner

1. Remove the inner ring. The ring can be placed on the OUTSIDE of the condom, as this can provide additional stimulation to the receptive partner.
2. Place the condom over the erect penis like a sock.
3. Add lubricant to the condom and/or to the partner's anus.
4. Holding both rings in place at the base of the penis, insert the penis into the anus or vagina.

Challenges of using the female condom include difficulty inserting and keeping it in place, irritation, unpleasant texture and noise of the condom (Gibson, McFarland, Wohlfeiler, Scheer & Katz, 1999; Gross et al., 1999).

As with the male condom, it is recommended to use the female condom only once, and to use a new one for each sex act. However, guidelines may vary depending on the setting. In cases where female condoms are in short supply, they may be re-used up to five times IF they are disinfected, washed, stored and re-lubricated adequately. Re-use of female condoms may differ by region, and local guidelines and recommendations should be used. The recommended steps for safely washing and storing female condoms are outlined in Appendix 3 (WHO, 2002).

Advantages of female condoms are that they allow for more sensation by the 'top' (penetrating partner), and their material and texture mean that the 'bottom' (receiving partner) cannot feel the condom. Female condoms are a more satisfactory option for men who do not enjoy using male condoms.

Lubricants

Lubricants (or 'lubes') are substances that reduce friction between the penis, vagina or anus during sex. Lubrication helps prevent condom *breakage*, and *decreases* the risk of slippage during anal sex (Smith, Jolley, Hocking, Benton & Gerofi, 1998). For MSM especially, lubrication is very important during anal sex in order to prevent anal/rectal trauma.

Water-based and oil-based lubricants

There are two main types of lubricant: water-based and oil-based.

Water-based lubricants can be used with male latex condoms as they do not damage the latex. Examples include K-Y Jelly® and Assegai®. Most male

and female condoms already have water-based lubricant on them; however, adding lubricant is especially important for anal sex as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing.

Oil-based lubricants must NOT be used with the male condom as they damage the latex and may *increase* the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil and petroleum jelly (e.g. Vaseline®).

Research in Kenya has shown that most MSM report using lubrication during anal sex but that not all of them use water-based ones (Onyango-Ouma, Birungi & Geibel, 2005).

In many communities throughout Africa, water-based lubrication is not freely available and may be too expensive for most individuals to buy. In these cases, many individuals use other substances that provide lubrication during sex. It is critical when counselling clients about alternative types of lubrication to emphasise that only water-based products be used. It is important to also educate a client that alternatives to lubrication that are oil-based, such as butter or fat, are just as dangerous to use with a condom as oil-based lubricants.

Giving advice on lubricant use to clients

- Ask the client whether he usually uses lubricant during sex.
- If he does not use lubricant, ask whether he ever experiences pain or discomfort during sex.
- Explain what a lubricant is and inform him of the importance of ensuring smooth intercourse in order to minimise pain and the risk of tearing/bleeding.
- Explain that a lubricant can be used during intercourse regardless of whether a condom is used.
- Explain that condom use is the safest way to prevent HIV infection during sex, and that you recommend using a lubricant to ensure smooth intercourse as the anus does not produce natural lubrication.
- If possible, demonstrate correct lubricant use and give out water-based lubricants during the counselling session.
- Explain to clients that water-based lubricants (e.g. K-Y Jelly®) can be bought at most pharmacies.

As a counsellor it is important to be able to explain to clients what lubricants are and the difference between water-based and oil-based lubricants, and to recommend water-based lubricants.

Condom use among MSM

Despite high levels of awareness of HIV, condom use among MSM is not yet systematic or consistent (Onyang-Ouma, Birungi & Geibel, 2005; Sanders et al., 2007; Smith et al., 2009).

Many factors influence when and how an individual uses a condom. Decisions are often made based on individuals' perceptions of their partner, e.g. whether he or she looks healthy, whether he or she has had many partners, whether they have been together for a long time, and whether or not money is exchanged.

As relationships progress over time, condom use often declines as partners think that condoms are no longer needed as they trust each other. Partners should emphasise the pleasurable aspect of condom use (Philpott, Knerr & Boydell, 2006), in order to ensure long-term use in the context of stable partnerships.

Given the high number of sexual partners that some MSM often have, systematic condom use is essential (Smith et al., 2009).

Given the difficulties of knowing the correct status of one's partner(s), the safest option is always to use a condom, and to use one with all types of partners, including one-night stands, clients who pay for sex, casual partners and long-term stable partners.

Barriers to condom use

There are many reasons why individuals may feel unable or unwilling to use condoms:

- They may believe that HIV cannot be transmitted during anal sex.
- They may have a negative attitude and misconceptions about condoms.
- They may believe condoms are not effective at preventing HIV and STIs.
- They may find it difficult to insist on condom use with their partner because they are afraid that:
 - ❖ their partner might think they have been unfaithful
 - ❖ their partner or client might think they are HIV positive
 - ❖ their partner might think they do not trust them.

- They may lack knowledge and skills for correct condom use.
- They may think that sex is more pleasurable without condoms.
- MSM sex workers may earn less money or lose clients if they request sex with a condom.
- They may lack the power to suggest condom use, especially if they are in an imbalanced relationship, e.g. with differences in age and/or economic status.
- They may have impaired judgement due to the use of drugs or alcohol.
- They may be short on condom supplies, e.g. if engaging in several rounds of sex.
- They may not have easy access to condoms (e.g. if living in rural areas).
- They may forget to carry condoms when going out.

Health care workers should be aware of the range of reasons for which MSM clients do not use condoms. Health care workers should try to understand the main factors preventing their clients from using condoms on a case-by-case basis, and identify possible areas for offering support.

Negotiation skills

A useful approach to suggest condom use to one's partner(s) is to emphasise the positive role of condoms in enhancing pleasure and sexual wellbeing. Highlighting the importance of condoms in terms of physical as well as emotional wellbeing may help promote condom use in short- and long-term partnerships.

Condom negotiation tips include a range of options, which may include the following:

- Use the clear stance of 'no condom – no sex'.
- Emphasise that condom use makes it easier to feel relaxed and enjoy the sexual act more.
- Bring a leaflet on condom use from the counselling session and use it to help introduce the topic to the partner.
- Make a packet of condoms easily available (e.g. on the bed, in a pocket, etc.).
- Make condom use an activity for both partners, and offer to put it on the partner (using the mouth or hands).

- Make the experience sexy and exciting by using flavoured, coloured or ribbed condoms. Perceiving the condom as a 'sex toy' may help persuade the partner to use it.
- Suggest the use of a water-based lubricant (e.g. K-Y Jelly®) to increase sensitivity.
- Offer to engage in a range of non-penetrative sexual activities (touching, fingering, mutual masturbation, rimming and oral sex) instead of penetrative sex.
- Suggest using the female condom instead of the male condom. Female condoms can be a good way to flatter the partner by saying he has a big penis and needs to use the big condom.

Summary

- When used correctly and consistently, condoms are 80–95% effective at preventing HIV transmission.
- Female condoms offer an added option in cases where male condoms cannot be used.
- Water-based lubricants, such as K-Y Jelly®, decrease the risk of slippage and breakage during anal intercourse.
- Condoms can be promoted as an added way of enhancing pleasure when negotiating condom use with a partner.

Practical exercise

Model penises or bananas are needed in this exercise. If these are not available, use two fingers put together.

If in a training group, the following is a training participant activity:

Working in pairs, one participant uses a penis model (or banana) to demonstrate correct condom use to their partner, who should pay attention for any mistakes and test the demonstrator's knowledge by asking additional questions. Then they switch roles. Once both participants have given the demonstration, the facilitators share with the group those elements of the condom demonstration which were omitted, but which should have been included.

Case studies

Please read each of the following case studies and, drawing on the knowledge from this module, consider each discussion point. Feel free to draw on your personal experiences as well where appropriate. In each case study, describe what the counsellor/clinician could have done better, and how he or she could have incorporated some of the key information and messages from this module.

Case study 1

During a counselling session, an MSM tells the counsellor that he is tired of using condoms because they always seem to break. The counsellor answers by saying that he is probably not using the condoms correctly, and that he should be more careful. He then hands over a few condoms to the client, and suggests that he keeps on trying.

Discussion points

- What could the counsellor have done better in answering the client's comment?
- What are the key components of correct condom use which the counsellor could have explained?
- Could the counsellor have done anything else in addition to giving out *a few* condoms?
- How would you have dealt with this situation?

Case study 2

During a counselling session, an MSM asks the counsellor about female condoms. The client says he has never seen one and was wondering what they looked like and how they were used. The counsellor tells him that the female condom is for women only and that he should therefore not worry about it.



*Discussion points*

- Is the counsellor right in stating that the female condom is for women only? In what situations could the female condom be useful to a client who has sex with men?
- What are the steps associated with correct female condom use?
- Is there more than one method for using the female condom for anal sex?
- How would you have dealt with this situation?

Case study 3

During a counselling session, an MSM explains that he would like to start using condoms with his long-term male partner, but does not see how he can persuade him to start using condoms; the partner would probably be angry and offended at the suggestion, and accuse him of lack of trust. The counsellor encourages the client to end the relationship, since continuing to have unprotected sex would put him at risk of HIV and STIs.

Discussion points

- Could the counsellor have helped the client by providing any other advice?
- What factors does he fail to take into account when he suggests that they end the relationship?
- Could the counsellor/clinician have used this as an opportunity to discuss the range of possible negotiation strategies for condom use? What strategies could the counsellor have suggested?
- Would couple testing be a useful approach? What are the strengths and limitations of couple testing in situations where partners may have more than one partner?
- How would you have dealt with this situation?





Case study 4

During a counselling session, an MSM says that he and his partner – who is HIV positive, is on ARVs and is healthy – always use condoms. However, while his partner was engaging in insertive anal sex with him, the condom broke. This occurred three days previously, and he is worried that he may have acquired HIV. The counsellor shows concern and explains that if the partner is on treatment and has a low viral load, his client's risk of being infected with HIV is reduced. He then recommends that the client returns after the window period three months later for an HIV test.

Discussion points

- What are the strengths and weaknesses of the approach used by the counsellor?
- Could the counsellor have recommended anything else to help prevent HIV?
- Should the counsellor have informed the client about PEP? Can you explain what PEP is and when it should be administered?
- Should PEP have been administered?
- How would you have dealt with this situation?

Mental health: Anxiety, depression and substance abuse

Learning objectives

By the end of this module, you should be able to:

- define anxiety
- explain the difference between 'normal' anxiety and excessive anxiety
- explain the difference between 'a bad mood' and depression
- list the symptoms and signs of anxiety
- list the symptoms and signs of depression
- explain why MSM may be more prone to depression and/or anxiety
- explain why people who are HIV positive may be more prone to depression and/or anxiety
- describe what to do when a client is depressed or anxious
- list the substances commonly abused by MSM and their effects
- explain how substance abuse increases the risk of contracting HIV among MSM.

Overview

Anxiety, depression and substance dependence are common forms of mental instability in the general population. However, the rates of these illnesses are even higher among MSM (Cochran, Sullivan & Mays, 2003). Despite increasing publicity and programmes aimed at improving awareness about mental health, these disorders remain poorly diagnosed and ineffectively treated. Anxiety, depression and substance dependence impact negatively on a person's ability to function at work, within families and socially, and can have a profound effect on physical health. For these reasons, it is important that counsellors know

how to recognise these disorders, and refer patients exhibiting symptoms of mental instability for appropriate care.

SECTION 1: ANXIETY AND DEPRESSION

Core knowledge

Anxiety: What is anxiety and when is it excessive?

Anxiety is a normal emotion in everyday life and is closely related to fear. It has been around as long as we humans have had to defend ourselves from wild animals. Figure 8 helps to show how this reaction can prepare us for *fight* (if we have to protect ourselves) or *flight* (if we have to run away).

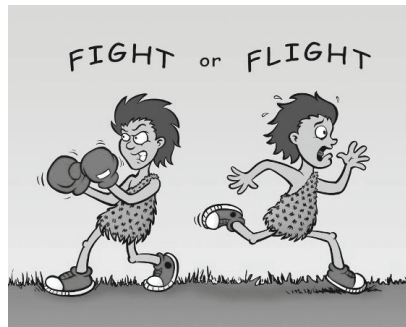


Figure 8: Anxiety and the flight reaction

Anxiety prepares the body by involving other organs, like blood, lungs and muscles, which then enable the *fight* or *flight* response. In our everyday lives, anxiety in small amounts helps us perform better, for example in exams (Cochran, Sullivan & Mays, 2003).

However, when anxiety becomes excessive, is difficult to control and affects the way we function in our everyday lives, it becomes a disorder.

When people feel anxious they may exhibit mental (in the mind) and physiological (in the body) signs and symptoms (Cochran, Sullivan & Mays, 2003).

Signs and symptoms of anxiety

Mental aspects include:

- fear
- uneasiness
- worry.

Physiological aspects include:

- sweating
- shaking
- heart racing
- nausea
- pins and needles
- dizziness
- shortness of breath
- feeling of choking
- chills or hot flushes.

People who are anxious may experience some or all of these feelings. Some may only feel slightly uneasy, or if the anxiety is severe, panicky or terrified.

What are the different types of anxiety?

Panic disorder

People may have periods of overwhelming fear which come 'out of the blue' during which they may feel they are 'going crazy', or 'going to die'. They usually also feel it in their bodies (the physiological symptoms mentioned above). This would be a panic attack and when these happen repeatedly, we call this *panic disorder*.

Generalised anxiety disorder

In generalised anxiety disorder people are in a state of constant worry and nervousness about many things in their lives. They are often tense and are unable to control their worry. They may have some of the physical symptoms mentioned earlier.

Phobias

Some people have an extreme and often irrational fear of a certain thing or object (e.g. spiders) or of a situation (e.g. heights) or of social situations. When this fear is so severe that it causes them to avoid these things or situations, we call it a *phobia*.

Post-traumatic stress disorder

People who have been traumatised, e.g. hijacked, raped, beaten up or involved in an accident, may experience disturbing dreams, and what we call 'flashbacks' for some time afterwards. They may find it difficult to relax, struggle to sleep, and feel nervous much of the time. They cope by avoiding situations which remind them of the event.

MSM and anxiety

It is believed that one of the main reasons why MSM are more vulnerable to mental health problems like anxiety is that they often have to conceal their sexual orientation out of shame and guilt. They may also fear that they will be stigmatised, ostracised, fired from their jobs, or even physically attacked (Pachankis & Goldfried, 2006; United States Department of Justice, 2001). In addition, MSM are more likely to abuse alcohol and drugs, which may cause, or worsen, anxiety (Cochran, Keenan, Schober & Mays, 2000).

Studies have shown that MSM often have lower self-esteem than straight men, and are more worried about what people might think of them in social situations. This increases anxiety in these situations (Cochran, 2001).

Anxiety and people living with HIV/AIDS

In addition to the risks of anxiety that MSM face, being HIV positive can further increase anxiety because of the following:

- The illnesses that the virus can cause, or the virus itself, can cause anxiety because of direct effects on the brain.
- The treatments for HIV can cause anxiety (Cohen, Batista & Gorma, 2008).

What should you do if you identify an anxious patient?

1. Screen for depression and substance abuse.
2. Ask questions which will give you an idea about the severity of the anxiety, and distress caused, and/or if their lives are negatively affected by it:
 - a. Do you feel worried or anxious most of the time?
 - b. Do you have spells when suddenly you feel very frightened, anxious or uneasy in situations when most people would not be nervous (panic attacks)?

- c. Have you ever witnessed or experienced a traumatic event that involved you or someone else getting hurt? If you have, do you get troubled by flashbacks, nightmares or thoughts of the trauma?

If the MSM client answers 'yes' to any of these questions they will need referral to a nurse or doctor at the clinic or to a mental health care professional, who will be able to make decisions about the need for counselling, psychotherapy or medication.

Case study (10 minutes)

Review the following case study. Identify the symptoms and signs of anxiety and try to come to a conclusion about the anxiety disorder illustrated here.

Oliver, a 23-year-old man from Lusaka, was waiting for a taxi late one Saturday evening after a night out when he noticed three men getting out of a car which had been driving behind the taxi. One of the men shouted abuse at him as the men ran up to him and threw him to the ground. One person held him down while the other two people punched him in the face and kicked him in his stomach. The three men ran off and Oliver was left bleeding by the side of the road. It is several months after the accident, and Oliver constantly feels nervous and that his heart is racing all the time. He sweats excessively, especially when he is in a taxi, and has difficulty talking about what happened or going anywhere near where the attack took place. He sleeps poorly and his nights are often disturbed by bad dreams.

Depression: What is depression?

It is usual for most people to have 'ups and downs'. We may feel miserable on a Monday morning, but very happy on payday, or our birthday, for example.

When we talk about depression, however, we refer usually to a 'down' that is normally longer and more intense than just a 'bad mood'.

We define depression as a feeling state that has the following symptoms or signs:

- feeling sad
- being unable to enjoy things that would usually be pleasurable
- feeling apathetic and lacking motivation to act
- feeling hopeless
- feeling lonely and cut off from other people
- feeling tired and having no energy
- feeling worthless, guilty or bad about oneself
- sleeping badly – either sleeping too much or too little
- a change in eating habits – either eating too much or too little
- contemplating or planning suicide
- difficulty in concentrating.

People may have just a few of these symptoms, or many/all of them. Even a few, if severe, can lead to difficulties in day-to-day functioning.

MSM and depression

Why are MSM more prone to depression?

MSM are prone to depression for similar reasons that they are prone to anxiety and substance abuse.

Studies have shown that low levels of chronic guilt and chronic shame, as well as healthy approaches to coming out, are linked to good mental health (Makadon, Mayer, Potter & Goldhammer, 2008). Unfortunately in many communities, people see sex between men as unacceptable; for example, in many African countries it is a crime. As a result, MSM may grow up believing that their attraction to men is wrong or sinful. Depression (as well as anxiety) may result as one of the consequences of feeling stigmatised, excluded from mainstream society, and the need to conceal their behaviour. In addition, research has shown that people who feel badly about themselves are more likely to suffer depression (Croucamp, 2009; Sheehy, 2004).

Depression and people living with HIV/AIDS

People who are living with HIV are also more prone to depression. One of the main reasons for this is that being HIV positive further increases stigma. This may then lead HIV-positive people to hide their status and feel that they have done something wrong or sinful, which in turn may cause feelings of isolation and loneliness, and lead to depression (Harding et al., 2007).

As with anxiety, being HIV positive makes a person vulnerable to certain infections in the brain, which themselves can cause depression. Furthermore, the effects of the virus itself can cause depression.

Lastly, there are treatments for HIV which can negatively affect a person's mood.

What to do when a client is depressed

When identifying symptoms of depression, it is important to try to differentiate between mild-to-moderate and severe depression. The figure below provides some tips on how to tell the difference.

Desperation may be:



Mild – moderate	Severe
A few symptoms	Many symptoms
Brief	Longer-lasting
Effect on activities is small	Struggles to do things
	May be thinking about dying
	May hear voices
	May stop eating or drinking

Figure 9: The differences between mild-to-moderate and severe depression

- If there are a few symptoms with little effect on day-day functioning, then a 'problem-solving' approach by a lay counsellor would be appropriate. The counsellor would probe to identify specific problems that may be causing/contributing to the depression, and work with the patient

on practical, creative ways to find solutions. However, it is important that the lay counsellor attends supervision sessions with someone who has more knowledge of mental health issues, and reports regularly on the counselling sessions.

- If a client has several symptoms of depression, then he needs to be referred to a clinic to see a nurse, a doctor or a social worker for assessment. That person could then decide whether the person could be managed in a primary health care setting or if there is a need for referral to specialised mental health services, if these are available in that community.

Suicide

Every year, many people who feel sad or hopeless about their life will attempt suicide.

Those people who are depressed and have previously tried to harm themselves or are having suicidal thoughts are most at risk. Substance abuse, unemployment and physical illness further increase risk. It is, however, difficult to predict as people may be impulsive and act without having planned their actions.

What to do if you have a patient who is suicidal

It is important to take **every threat of suicide seriously** and therefore **not to try to assess risk yourself**.

- Refer the person as discussed above when someone has depression.
- If at all possible, try to have a colleague or family member stay with the person, if you need to leave to seek help.
- **Do not leave a suicidal person alone.**

Case studies (30 minutes)

Review the following case studies in pairs or individually and decide in each case whether there is risk of depression or suicide. In each case, decide what appropriate action to take.



**Case study 1**

Victor is a 17-year-old MSM. He learned two weeks ago that he is HIV positive. He comes into the clinic crying, he has lost weight and he cannot sleep at night.

Case study 2

Ahmed is 32 years old and is married to a woman. Recently a health care worker disclosed to his family that he has sex with men, and he was then thrown out of the family home. Ahmed tells you he has nothing left to live for, and that he wants to kill himself. He says he is going to lie down on the railway line between Mombasa and Nairobi when a train is approaching.

Case study 3

Juma comes to see you at the clinic. He is a 20-year-old MSM who lives on the street. He seems very quiet in the counselling session and looks sad and hopeless. However, he has put on weight since the last time you saw him, and is better dressed than before.

SECTION 2: SUBSTANCE USE AMONG MSM***MSM and substance use***

Not all MSM use or abuse alcohol and drugs, but like most groups in society there are members in the MSM community that do. The precise degree of substance use and abuse among MSM is difficult to determine, but many studies report that the level of drug use among MSM is higher among those who identify as being heterosexual (Cochran, Keenan, Schober & Mays, 2000; Stall & Wiley, 1988).

Why do many MSM abuse substances?

People abuse drugs and alcohol for many reasons. For MSM specifically, one of the reasons may be as a form of escaping the stress that they experience as a result of discrimination by society (Reback, Kamien & Amass, 2007). For some MSM, drug use provides a sense of social acceptance and community while bonding at gay clubs and circuit parties (Halkitis et al., 2008).

How does substance use increase the risk of contracting HIV?

Abusing drugs and alcohol can make individuals more vulnerable to contracting HIV because it may cause them to engage in riskier sexual behaviour. This behaviour could include:

- not using condoms
- having sex with a stranger
- having an increased number of sexual partners
- engaging in prolonged sex sessions
- having unsafe sex to acquire drugs.

MSM who inject drugs, either into their veins or into their muscles, may be directly at risk for acquiring HIV through the needle. Sexual partners of HIV-infected intravenous drug users (IDUs) may be at risk for contracting HIV through sexual transmission (Lane, Shade, McIntyre & Morin, 2008; Reback, Kamien & Amass, 2007; Stall & Wiley, 1988).

How do I identify substance abuse?

According to the *Diagnostic Statistical Manual (DSM)*, substance abuse is characterised and diagnosed by:

- a **tolerance** to the substance – a person increases the amount used and experiences a reduced effect of the substance
- **withdrawal** symptoms (that may be physical or psychological) upon stopping the substance
- **loss of control** around use of a substance, i.e. the substance is taken in larger amounts and over a longer time than intended
- a desire to stop or **failed attempts** at reducing or stopping substance use
- a **preoccupation** – an increased amount of time spent using the substance so that the amount of time spent in other activities (e.g. work, recreation, relationships) is decreased
- the **continued use of a substance despite negative consequences** (e.g. loss of job, breakdown of relationships, poor physical health) (DSMM, 1994).

As the period of abuse increases, emotional and behavioural problems are evident. You may recognise changes and effects on their lifestyle in the following areas:

1. **Behaviour** – they are unreliable, deceptive and restless, and find it difficult to concentrate.
2. **Finances** – they experience financial problems with cash flow, and incur debt.
3. **Career** – they change jobs or are unemployed frequently.
4. **Relationships** – these are negatively impacted by instability and betrayal, and multiple partners and prostitution may occur.
5. **Appearance** – they show lack of self-care and personal hygiene, i.e. dirty clothing, unwashed hair.
6. **Emotions** – they are irritable, depressed or aggressive (American Psychiatric Association, 2000).

What are the common substances that MSM use and what are their effects?

Facilitator tips

1. Ask participants to think of substances that they know of that are used in their communities. Write these up on the flip chart.
2. Explain which substances are 'uppers' and which are 'downers', and briefly describe the effects of each substance and how it is usually taken.

- **Alcohol** generally produces a state of pseudo relaxation and happiness. Continued consumption can lead to blurred vision, coordination problems and aggressive behaviour. The long-term use of alcohol may affect vital organs in the body. Regularly consuming alcohol is correlated with an increased risk of developing cardiovascular disease, alcoholic liver disease and cancer (Stoppard, 2000). Alcohol consumption is associated with high-risk sexual behaviour. It is readily available and legal (to those over 18), and helps people become less inhibited.
- **Marijuana/dagga** produces feelings of relaxation, causes slow and uncoordinated movement, and increases appetite. Large doses may result in paranoia, hallucinations and psychosis. Short-term effects include learning problems, loss of coordination and memory, limited problem solving and irrational thinking. Physical consequences include increased heart rate and reduced blood pressure, anxiety, fear, distrust or panic (Livingston & Morkel, 2009).

- **Methamphetamine** (tik, speed, crystal meth) produces a rapid pleasurable feeling, which is followed by feelings of depression and irritability when the drug wears off. It is known to heighten sexual arousal and has a strong association with high-risk sexual behaviour. Use often occurs in the context of sexual encounters with anonymous partners of undisclosed HIV status (Halkitis et al., 2008). Long-term use can result in violent or psychotic behaviour, mood disturbances, and homicidal or suicidal thoughts. Methamphetamine use is particularly problematic because it is generally cheap, easily obtainable and highly addictive. Particularly with tik, the drug may include a variety of ingredients (e.g. rat poison, drain cleaner, paint thinners, etc.) and the effects experienced may vary considerably. The possible long-term effects of tik use, depending on the specific ingredients used, may lead to respiratory problems, decreased appetite, severe itchiness, dental problems, insomnia, cognitive impairment (concentration and memory), and psychiatric complications (depression, anxiety, obsessive-compulsive, aggression, sexual dysfunction, psychosis, etc.) (Livingston & Morkel, 2009).
- **Cocaine and crack cocaine** (a cheap and impure form of cocaine) cause a feeling of extreme happiness, confidence and sexual arousal. This is usually followed by agitation, depression, anxiety, paranoia and decreased appetite. Crack is highly addictive and is a potent and dangerous drug. Side effects include possible cardiac arrest or seizures, respiratory problems, insomnia, blurred vision and vomiting.
- **Ecstasy** induces feelings of extreme wellbeing and happiness. Large doses can lead to an increase in core body temperature, confusion, irrational behaviour, palpitations, shaking, dehydration, collapse and convulsions. The long-term effect of ecstasy use can lead to cognitive impairment (concentration and memory), sleep disturbance, psychiatric complications (depression, anxiety, psychosis) and an increase in impulsivity.
- **Heroin** generally produces an initial pleasurable sensation, warmth, dry mouth, heaviness in the arms and legs, and possibly nausea, vomiting and severe itching. This may be followed by drowsiness, a slow and irregular heart rate, shallow breathing, delayed reaction time and a loss in concentration. Large doses can lead to nausea, vomiting, respiratory paralysis, heart attack, stroke, anaphylactic shock, coma and death. The long-term effect of heroin use may lead to skin infections, fatigue, respiratory problems, collapsed veins (if injecting), cognitive impairments

(concentration and memory), psychiatric complications (depression, anxiety, sexual dysfunction, psychosis), increased risk of intentional injury, and extreme withdrawal when not using. (Stoppard, 2000).

- **Khat/cat** generally produces a state of euphoria, and increased confidence and energy, heart rate, core body temperature, alertness and impulsivity. Large doses can lead to insomnia, shaking, muscle twitching, irregular heart rate, profuse sweating, dehydration, headaches, anxiety, delusions, depression, convulsions, stroke and even death. The long-term use of khat/cat may lead to excessive weight loss, skin infections, blueness in the hands and feet, distinct personality changes, cognitive impairments (concentration and memory) and psychiatric complications (depression, anxiety, psychosis).
- **Mandrax** generally produces initial feelings of euphoria, followed by feelings of relaxation and drowsiness, slowed breathing, reduced heart rate, reduced sensitivity to pain, impaired judgement, slurred speech, slowed reaction time, and brief loss of consciousness. Large doses can result in seizures, coma and death. Mandrax can be lethal when used in combination with alcohol or heroin. Long-term use of mandrax can lead to anaemia, impaired liver functioning, severe weight loss, impaired vision and slurred speech, cognitive impairments (concentration and memory), poor muscle control, dental problems, psychiatric complications (anxiety, depression, psychosis), and increased risk of intentional or accidental injury.

How do I help my MSM clients who are abusing substances?

The best thing to do is to refer them for professional specialised help. Find out where the best place to refer them is in your area.

What is dual diagnosis?

Dual diagnosis refers to the situation in which a client suffers simultaneously from substance abuse and a mental illness. This is a very common occurrence, and studies have shown that roughly 60% of people who are diagnosed with substance abuse have a co-occurring mental disorder. This means they will need to be treated both psychiatrically and medically. The most common mental health problems associated with addiction include depression, bipolar mood disorder, and antisocial and borderline personality disorders. There is also the

possibility of developing substance-induced psychosis – a temporary psychotic episode that may last for several days or weeks (see the earlier section on anxiety and depression) (Nocon, Berge, Astals, Martin-Santos & Torrens, 2007).

Case study

Hakim comes to you for his pre-HIV-test counselling. He looks very nervous and distracted, he has dark rings under his eyes and he gives off the odour of being unwashed. While you are trying to counsel him he keeps looking behind him and biting his fingernails. Hakim speaks very quickly, telling you that he sometimes sells sex to make ends meet, and sometimes forgets to use a condom because he has a bad memory.

- What do you think is the cause of Hakim's behaviour?
- What support do you think Hakim needs?

Summary

- Stigma and rejection from others may cause mental health problems among MSM.
- The most common mental health issues which counsellors are likely to come across are depression and anxiety.
- Excessive anxiety is abnormal and has a negative affect on a person's ability to function.
- Depression and anxiety can be treated with counselling, medication or a combination of both.
- Counsellors also need to be aware of the signs of suicide, and know what action to take to prevent an MSM who is suicidal from killing himself.
- Substance abuse is common among MSM and may lead to increased risk-taking behaviour.
- Substance abuse should be managed by a health care professional.

Risk-reduction counselling with MSM

Learning objectives

At the end of this module you should be able to:

- explain how risk-reduction counselling can be adapted for MSM
- describe key areas that should be addressed in a risk-reduction counselling session with MSM
- describe how inappropriate language, personal bias and stigma can be overcome when counselling MSM
- list different tips for improving health care services for MSM
- describe different ways for engaging MSM in sexual-health services.

Introduction

This module will explore methods to better adapt behavioural interventions such as risk-reduction counselling and HIV testing services to meet the needs of clients identified as MSM. It will explore how personal bias, language and misinformation can negatively impact the health and wellbeing of MSM, as well as how these barriers can be overcome. You will learn tips and strategies that could improve your ability to effectively counsel MSM in addition to various ways of reaching out to MSM within your community.

What is risk-reduction counselling?

Risk-reduction counselling is a behavioural intervention that attempts to decrease an individual's chances for acquiring HIV or other STIs. This is achieved by helping people identify and change specific behaviours that may put them at risk for becoming infected and by reinforcing healthy behaviours that can keep them well.

It has been recommended around the world to include risk-reduction counselling in standard HIV testing procedures, particularly for individuals with high-risk behaviours (Philpott, Knerr & Boydell, 2006). Additionally, risk-reduction counselling has been shown to be effective in increasing condom usage and in decreasing the risk of future STIs (Kamb et al., 1998; Simbayi et al., 2004).

The main objective of risk-reduction counselling is for clients to set a realistic goal for behaviour change that could reduce their chances of contracting HIV (Poljak, Smit & Ross, 2008). As a prevention tool, risk-reduction counselling is the most effective when it is patient centred, meaning that the counselling session focuses on the specific risks, needs and thoughts of the client.

Engaging any individual about his or her sexual practices is not easy but particularly when working with MSM this process can be made more difficult because of social stigma, discrimination and misinformation about the common sexual practices of MSM.

Please refer to Appendix 4 for a review of standard risk-reduction counselling methods.

Is risk-reduction counselling conducted differently with MSM?

Risk-reduction counselling can be conducted with MSM just like any other client as long as it takes into account their specific needs, background and challenges (CDC, 2001). Therefore, each risk-reduction session, no matter the background of the client, will be unique and require different strategies and techniques (Kamb et al., 1998). While there is no standardised risk-reduction model specifically for MSM, there are a number of factors that can influence a counselling session with MSM which need to be taken into consideration.

Understanding the effect of personal beliefs and knowledge

The most significant influence in a counselling session is the counsellors themselves, and the knowledge, opinions and beliefs they bring with them. Unfortunately, many counsellors share the beliefs of some communities and cultures that have misconceptions or negative perceptions about MSM.

Counsellors with negative perceptions of MSM must take measures to ensure that their personal beliefs are not affecting the service the client is receiving.

Understandably, this can be a difficult process for any counsellor or health care worker. Many service providers, clinics and hospitals believe in providing care to people regardless of their circumstances or status in life. This can be an important standard to remember for any counsellor who may be struggling with personal views or beliefs about MSM.

When health care workers let their own values and beliefs affect the services they provide, they can easily be preventing the assistance of those individuals who need their help the most. Ultimately, although some counsellors may not approve of a man having anal sex with another man, they have a responsibility and a duty to help their clients protect themselves and to engage in safe sexual behaviours, whatever those behaviours may be.

The effect of closeted clients

Studies in South Africa (which has more legal protection for sexual minorities than any other African country) have shown that some MSM may not feel comfortable enough to disclose their personal sexual practices to a health care worker or doctor. One explanation for this may be because of the social stigma and discrimination many MSM face in their communities. As a risk-reduction counsellor, this can be a significant challenge to successfully helping a client. After all, if clients are unwilling to explain their true sexual practices, how can effective risk-reduction counselling take place?

One possible solution is to treat each and every client equally. If clients feel too uncomfortable to disclose their sexual orientation, a counsellor may ask the wrong questions. For example, if counsellors only ask questions about having sex with women, clients may not openly disclose that they are also having sex with men. Therefore, to prevent these possible oversights, a counsellor can standardise the questions they use and keep them the same for each client. For example, when asking clients about their number of sexual partners, counsellors could ask them, even those who openly identify as MSM, how many men *and* women they have engaged with sexually.

The significance of confidentiality

All risk-reduction counselling sessions, regardless of the client, must remain completely private between the client and the counsellor (CDC, 2001). For MSM in particular, ensuring confidentiality is critical. MSM, particularly those

who have not come out, could face a number of negative effects should knowledge of their sexual behaviour be made public. If MSM begin the session with this fear or concern, they may be less likely to engage productively in the counselling, therefore it must be a priority in each session to express to the clients the ways in which their privacy will be respected.

What sexual behaviour of MSM should be addressed in a risk-reduction session?

In many risk-reduction sessions, sexual behaviour is generally discussed with the client based on the types of sexual activities they are engaging in. The types of behaviours discussed will therefore be unique for each and every person, including MSM. Keep in mind that all MSM, like everyone else, do not engage in every sexual act possible. For example, some MSM choose not to engage in any type of anal sex. Therefore, when discussing sexual behaviour with MSM during a risk-reduction session, it is important to focus on the behaviours specific to each individual client.

It is important for a counsellor to be familiar with various sexual activities and their risks, and possible alternatives to those activities, in order to provide the best options for behaviour change to a client. For more information on anal sex and common sexual practices of MSM, please refer to module 4.

Below is a brief review of some risk behaviours, influences on behaviour and possible behaviour changes for MSM that may be discussed during a risk-reduction session.

Sexual risk behaviour

- Unprotected receptive anal sex
- Unprotected penetrative anal sex
- Having a high number of sex partners
- High use of alcohol or other substances before or while having sex
- Having an STI while being sexually active
- Being unaware of their own HIV as well as the HIV status of their sexual partner(s)
- Selling sex in exchange for food, money, drugs, shelter, etc.

Potential influences on behaviour

- Personal beliefs about HIV and sex
- Social ideas, laws and culture
- Alcohol and drug use that can impair judgement and lead to unsafe sex
- Knowledge of HIV status
- Access to sex
- Stigma and discrimination
- Access to treatment and prevention services like clinics or free condoms.

Methods of changing behaviour

- Using a latex condom with water-based lubrication when engaging in penetrative or receptive anal or vaginal sex
- Lowering the number of sexual partners
- Decreasing alcohol and drug intake
- Not visiting venues that lead to one-off or anonymous sex
- Getting tested for HIV/STIs regularly
- Having treatable STIs treated regularly.

Exercise 1

Below are a series of case studies, each of which describes an MSM. For each example, use the six steps of risk-reduction counselling provided in Appendix 4. If you have a study partner, role play each case study in a counselling session, with one person acting as the client and the other as the counsellor.

Case study 1

Simphiwe is a 31-year-old man who is married to a woman and has three children. On Saturday nights he likes to go to a local tavern across town that is known for being frequented by gay men. On these nights, he often drinks heavily at the bar and waits to be approached by one of the men. Frequently, he will offer to drive one of them home in exchange for penetrative anal sex. He says he does not like to use condoms because they do not fit well and he does not carry them because he does not want his wife to suspect him.





Case study 2

Lindiwe is 20 years old and was born male but lives her life as a female. She wears women's clothes and many would consider her extremely effeminate. Lindiwe's father kicked her out of her house when she was 14 because he did not like her behaviour and did not want a 'gay' son. Because of the way in which she acts and dresses, it is difficult for Lindiwe to find steady work and so often she engages in casual sex work to make ends meet. Many times the men who pay her for sex will pay more if they do not have to use a condom.

Case study 3

Mandisi is a 34-year-old male who defines himself as straight. He lives with his wife and children in a rural community but spends many months of the year working at a mine hundreds of kilometres away. When at home, Mandisi is sexually active with his wife but while at the mine, he spends all his time with other men and does not have any way of having sex with a woman. Therefore, he has met other male mine workers who he will have sex with in order to relieve his sexual tension. Mandisi and his male sexual partners do not consider themselves to be gay and only have sex with each other because women do not live or work at the mine. Because there are only male workers at the camp, the mine owners do not provide condoms or lubricants to any of the employees.

Improving communication during risk-reduction counselling with MSM

Using the appropriate language and terminology with MSM is a key component to creating an environment in which they feel comfortable to engage with a counsellor and discuss their sexual behaviour. Following are a few useful tips that help guide the use of language during a session with MSM:

Use the types of words the client is using

As long as the counsellor remains comfortable, using the same language a client uses to describe his sexual practices can create a sense of understanding. For example the terms *passive* and *bottom* both refer to acting as the receptive

partner during anal sex but a client may use the terminology that is applicable for his social network or community.

Do not automatically label clients or assume details about their behaviour

Culturally, it may be common to assume things about MSM because of the way they dress or act. For example, you might assume that an effeminate client who dresses in women's clothing acts only as the receptive partner during anal sex, but in fact outward appearance cannot be linked to sexual practices. Making these types of assumptions could not only offend clients but also influence the type of questions that are asked and the types of responses they are able to provide.

Do not include value judgements or personal beliefs

It is not the job of counsellors to judge their clients because this will not provide a client with any helpful service. For example, if a man is married to a woman but having sex with other men, a counsellor should not encourage him to stop having sex with men because he is 'cheating on his wife'. Instead the counsellor could encourage the man to remain faithful to his wife because decreasing his number of partners could protect him from HIV.

Repeat statements about behaviour or identity in order to clarify their meaning

There are many ways people identify themselves, their sexual orientation and their sexual behaviours. Given the many definitions and possible behavioural implications of each, it can be beneficial, when clients label themselves in a specific way, for the counsellor to ask them for a deeper explanation of what that label means. This will allow the counsellor to fully understand the behaviours and practices of clients.

Create a safe space

This can be achieved by making your clients feel comfortable by reminding them of their ensured confidentiality, and asking questions to show you are open minded, knowledgeable and non-judgemental. Making informal but affirming references to the MSM community that your clients can identify with can be a passive method of informing them that you are someone who is supportive of their community.

Exercise 2***Risk-reduction counselling practice***

Following are two case studies involving MSM and their sexual practices. For each case study address the following questions:

- What are the key risk behaviours 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?

If possible, identify a partner to practise these case studies with. One individual should be the client and the other the health care worker.

Case study 1

Femi is 18 years old and identifies himself as gay. He has come into your clinic for an HIV test, which he gets every six months. During the pre-counselling session he told you that in the last six months he has had 30 male sexual partners. On most weekends Femi likes to visit shebeens with his friends where they drink until heavily intoxicated. Often on these outings, Femi finds a man to have sex with. Femi says he likes to be penetrated but that he always uses condoms. He admits that when he is drunk, he sometimes does not remember all of the details.

Case study 2

Sandile is 42 years old and has been married to a woman for many years. He has come to your clinic for an HIV test and during the counselling session tells you that his wife wants to have a baby so when they have sex, they do not use condoms. Sandile also likes to have sex with other men sometimes. He is afraid of his wife finding out and so does not go to the bars that gay men frequent. Instead, he often will find a male sex worker and pay him to have sex in private. Sandile says he only has sex with a man about once a month and that because he does not like the way condoms feel he does not use them.

How can I and/or my organisation engage MSM for HIV testing and risk-reduction counselling?

Because of discrimination and stigma within their communities, MSM may be forced to lead secret lives and not have their identity openly known. This can make both individual MSM difficult to find and entire MSM communities hard to reach. Given the history of lack of service provision, it can be problematic to help MSM access vital services like HIV testing.

Additionally, many service providers work within communities where they themselves would face stigma, discrimination or violence for advertising any MSM-friendly services they may offer. Therefore, individualised methods need to be developed that not only reach the MSM community but also protect service providers. Following are a few key strategies which have proven to be useful at a site in Cape Town, South Africa.

Establishing a key informant

Often MSM operate within close social networks. Depending on the level of discrimination or stigma in the community where they are based, these networks can either be closed and highly private, or more open and easily accessible. For either situation, identifying and building a relationship with a key member of an MSM social network can be highly valuable. This key informant can give insight into the behaviours of MSM in their network, such as where and how they socialise. They can also act as a promoter for your services within their social networks.

Creating a trusting relationship

Establishing a trusting mutual relationship with MSM in the community is absolutely critical for creating a sustained relationship. This process can begin with a key informant who may then be able to spread this information to other MSM. Whether on behalf of an organisation or individually, being upfront and clear in your intentions is necessary in establishing strong community ties.

Educating the community

Once a trusting relationship has been built with an MSM or with a group, attempts can then be made to educate them about the services or activities that are available for their participation. This would also be an excellent opportunity to address any concerns they may have about confidentiality by



explaining the ways in which this is guaranteed by your service or organisation. Promoting MSM-friendly services using other MSM as face-to-face promoters can effectively spread information about your service to MSM while protecting it from more public criticism.

Exercise 3

Individually, in groups or in pairs brainstorm different ways you could engage MSM in your community on an individual, organisational and community level. Think of reasons why it might be difficult to contact or interact with MSM in your community and how you might overcome those challenges. Afterwards, share these ideas with your group or co-workers.

Summary

- Risk-reduction counselling is an effective behavioural intervention that can help reduce an individual's risk for STIs and HIV.
- Appropriate and socially relevant language should be used with MSM to make them feel comfortable.
- Personal bias or stigma should be addressed before working with an MSM so as not to affect the client negatively.
- The use of health care services by MSM can be improved by:
 - ❖ Establishing key informants
 - ❖ Creating trusting relationships
 - ❖ Educating the community.

MSM post-course evaluation

There are no right or wrong answers in the course evaluation. Thank you for completing it and helping to improve this training.

- 1. I believe that it is important for counsellors and health care workers to be sensitive to the needs of sexual minorities like MSM.**
 - a. Yes
 - b. No
 - c. Don't know
- 2. I would have difficulty discussing issues relating to MSM behaviour and anal sex with men due to my own values or beliefs.**
 - a. Yes
 - b. No
 - c. Don't know
- 3. I believe that it is not necessary to ask married male clients about having sex with other men.**
 - a. Yes
 - b. No
 - c. Don't know
- 4. I feel comfortable asking my clients about anal sex practices.**
 - a. Yes
 - b. No
 - c. Don't know
- 5. I am aware of common sexual activities which MSM may engage in and the risks associated with these behaviours.**
 - a. Yes
 - b. No
 - c. Don't know

Post-course assessment

Thank you for your interest in this counsellor MSM sensitivity training programme. Please complete the assessment before starting the programme.

- 1. How many countries in Africa provide protective legislation for MSM?**
 - a. None
 - b. One
 - c. Five
 - d. Ten
 - e. All
- 2. On average _____ of African people consider that homosexuality should not be accepted by society.**
 - a. 25–40%
 - b. 40–55%
 - c. 55–70%
 - d. 70–85%
 - e. 85–99%
- 3. The risk of a man acquiring an HIV infection during unprotected receptive anal sex is _____ unprotected insertive anal sex (with a man or a woman)**
 - a. about a tenth higher than
 - b. about a fifth higher than
 - c. about the same as
 - d. about five times higher than
 - e. about 10 times higher than
- 4. A health care worker can be stigmatised for counselling and treating HIV-positive MSM clients.**
[] True [] False
- 5. Moral judgement is a form of internal stigma.**
[] True [] False
- 6. Social withdrawal is a form of external stigma.**
[] True [] False
- 7. Being lesbian, gay or bisexual had often been described as an 'illness' by the medical profession before 1973.**
[] True [] False

- 8. Research shows that ____ of every community is homosexual.**
- a. between 20% and 30%
 - b. around 5%
 - c. less than 2%
 - d. between 10% and 15%
- 9. A person who feels pressure to change his sexual orientation may experience low self-esteem, poor self-confidence and depression.**
 True False
- 10. Most risk-reduction sessions following HIV testing assume sexual intercourse to be penile-vaginal.**
 True False
- 11. Only homosexual men practice anal sex.**
 True False
- 12. When a man reports anal sex with a man during counselling you should ask if he takes the insertive or receptive role.**
 True False
- 13. Anal warts will not lead to anal cancer.**
 True False
- 14. Genital warts are caused by _____**
- a. HIV
 - b. HPV
 - c. chlamydia
 - d. syphilis
- 15. Which is NOT likely to be an early symptom of HIV infection?**
- a. Fever
 - b. Rash
 - c. Genital warts
 - d. Sore throat
- 16. When people experience a sudden overwhelming fear during which they may feel they are 'going crazy' or 'going to die', it is called _____**
- a. post-traumatic stress disorder
 - b. a panic attack
 - c. phobia
 - d. depression

- 17. Which substance, after long-term use, is most likely to cause violent and potentially homicidal or suicidal behaviour?**
- Alcohol
 - Marijuana
 - Methamphetamines
 - Crack cocaine
- 18. When anxiety becomes excessive and distressing, and affects the way we function in our everyday lives it becomes _____**
- addictive
 - depression
 - stigmatised
 - a disorder
- 19. Condoms are 80–95% effective at preventing HIV and STIs.**
[] True [] False
- 20. If an MSM complains that condoms always seem to break when he uses them, which would be the best response for a counsellor to give?**
- Tell the client to use commercial condoms instead of the free ones.
 - Provide a condom demonstration to the client, then ask him to repeat it.
 - Hand a few condoms to the client to replace the broken ones.
 - Suggest he adds an oil-based lubricant to reduce friction.
- 21. When putting on a male condom, it is necessary to ensure that there is air at the tip to allow room for semen.**
[] True [] False
- 22. Asking key questions about an MSM's sexual behaviour will _____**
- cause the client to feel bad about himself
 - provide an assessment of the client's sexual risk taking
 - make the counsellor appear judgemental
 - reinforce the client's behaviour
- 23. Defining specific, achievable and measurable _____ that take into consideration the influences and motivations of the client can help with risk reduction.**
- risks
 - costs
 - counselling
 - goals

24. When counselling an at-risk MSM, the counsellor's opinions and judgements should not affect his/her behaviour towards the client.

True False

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Pre- and post-course assessment solutions

A health care worker can be stigmatised for counselling and treating HIV-positive MSM clients.	True X	False
Moral judgement is a form of internal stigma.	True	False X
Social withdrawal is a form of external stigma.	True	False X
Being lesbian, gay or bisexual had often been described as an 'illness' by the medical profession before 1973.	True X	False
A person who feels pressure to change his sexual orientation may experience low self-esteem, poor self-confidence and depression.	True X	False
Most risk-reduction sessions following HIV testing assume sexual intercourse to be penile-vaginal.	True X	False
Only homosexual men practice anal sex.	True	False X
When a man reports anal sex with a man during counselling you should ask if he takes the insertive or receptive role.	True X	False
Anal warts will not lead to anal cancer.	True X	False
Condoms are 80– 95% effective at preventing HIV and STIs.	True X	False
When putting on a male condom, it is necessary to ensure that there is air at the tip to allow room for semen.	True	False X
When counselling an at-risk MSM, the counsellor's opinions and judgements should not affect the client's behaviours.	True X	False

Post-programme commitment

I have completed the MSM sensitivity training course. We covered topics about sexual practices affecting MSM in Africa. Topics included stigma, anal sex, STIs, mental health issues, substance abuse and condom usage.

Focus was placed on how to explore sexual practices among MSM and how to approach risk reduction. I am committed to using this new knowledge and these new skills in my daily work. I am committed to being more aware of MSM and the issues affecting their health.

Signed _____ Date _____

In order to assess the effectiveness of this course we would like to contact health care workers three months after course completion.

May we contact you to complete a short questionnaire after completion of the course? (Please circle one)

Yes No

Please provide your work contact details:

Name and surname _____

Facility name & address _____

Email address _____

Contact number _____

Alternate contact number _____

Appendix 1: STI and HIV resources

Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health
Massachusetts Department of Public Health, The Fenway Institute.
Prevention and management of sexually transmitted diseases in men who have sex with men: a toolkit for clinicians, 2004 http://www.aidsetc.org/pdf/p02-et/et-17-00/msm_toolkit.pdf

HIV treatment guidelines:

World Health Organization:
<http://www.who.int/hiv/pub/arv/adult2010/en/index.html>

The Body:

The Complete HIV/AIDS Resource: <http://www.thebody.com>
Safer sex guidelines and resources: <http://www.thebody.com/safesex/safer.html>

Centres for Disease Control and Prevention:

Sexually transmitted infections, including treatment guidelines:
<http://www.cdc.gov/std>
<http://www.cdc.gov/std/treatment/2010/>
GayHealth.com: <http://www.gayhealth.com>
STI information: <http://www.com/templates/sex/std/index.html>
Project inform: <http://www.projectinform.org>

HIV biomedical prevention information

<http://www.globaliprex.com>
<http://www.avac.org>

Responding to HIV-related needs of MSM

International HIV/AIDS Alliance: Workshop Guide on Responding to the HIV-related Needs of MSM in Africa. <http://www.aidsalliance.org/publicationsdetails.aspx?id=416>

Appendix 2: PEP

Consent form and checklist for post-exposure prophylaxis (PEP)

Name

Record number

I understand that I have had an exposure incident that may be a risk for HIV transmission, hepatitis B and other sexually transmitted infections.

I have been given the following information relating to the use of post-exposure prophylaxis:

- The risk of HIV transmission with and without taking PEP
- The benefits and risks of taking PEP
- The importance of being tested for HIV to check my current status
- The risks of taking PEP if I already have HIV before this exposure
- PEP is not guaranteed to prevent HIV transmission
- The possible side effects of the PEP medicine
- The risk if I do not complete the 28 days of the PEP course
- The importance of taking the correct dose of the medicine at the right time
- The benefits of HIV testing: now and again at six weeks, and at three and six months
- Other recommended blood tests
- The importance of taking precautions to prevent HIV transmission (such as using condoms with the correct lubricant, and not sharing needles)
- Not to donate blood, semen or body tissue for the next six months.

I have understood this information and have been given the opportunity to ask questions and have received satisfactory answers.

I voluntarily consent to post-exposure prophylaxis.

I decline post-exposure prophylaxis.

Name Signature

Date

MEN WHO HAVE SEX WITH MEN

I confirm that I have provided information about PEP as listed above.

Name

Signature

Position Date



Appendix 3: Condoms and lubricants

Guidelines for re-use of the female condom

In situations where access to female condoms is limited, **female condoms may be used up to five times, provided they are washed, stored and lubricated adequately** [21]. The WHO recommends the following steps:

- **Disinfection:** As soon as possible after use, soak the female condom for two to five minutes in a solution of water and household bleach using a ratio of 1:20 (i.e. one unit of bleach for 20 units of water).
Note: Do not try to remove the ejaculate prior to putting the condom in the bleach/water solution. Do not soak the condom overnight as extended exposure to bleach/water may damage it. Do not try to disinfect the condom by boiling it or applying high temperatures.
- **Washing:** Remove the female condom from the solution and wash it with soap and water, then rinse it with water to remove the soap. Dry both sides using a clean cloth, or air dry.
- **Visual inspection:** Hold the condom up to the light to check for holes. If there are none, replace the inner ring. If holes are observed, throw the condom away.
- **Storage:** Store the cleaned, dry, unlubricated condom in a clean, dry place away from heat and sharp objects.
- **Relubrication:** Relubricate the condom just prior to re-use. This makes it easier to insert, and makes intercourse more comfortable. The best lubricants are water-based ones, such as K-Y Jelly® which can be obtained at a local pharmacy. Oil-based lubricants (e.g. Vaseline®/petroleum jelly) may also be used since they do not damage polyurethane. Avoid using substances which may cause allergies or inflammation, such as hand or body lotions.

Appendix 4: Risk-reduction counselling session overview

Following is an outline for one particular method of risk-reduction counselling.

Step 1: Assess the behaviours of clients

In order to assist clients in developing risk-reduction goals, it is firstly important to gain a better understanding of their sexual practices, including both safe and risky behaviours. Particular focus can be placed on behaviour from the previous three months, as this may impact their need for further HIV testing. This basic assessment can be achieved by asking them key questions regarding the number and type of sexual partners they have, the types of sexual acts they have engaged in, and their use of alcohol or other substances.

Step 2: Assist clients in identifying a risk behaviour to address

Clients should select a behaviour that they are motivated to change. Generally, this will be one that is causing them some type of physical or emotional distress or other negative side effects. It is important that clients be significantly involved in choosing which behaviour to address. When they are actively involved in the identification process, they will be more motivated to follow through on the risk-reduction goals or strategies than if the counsellor selects the behaviour.

Step 3: Discuss the 'cost and benefits' of this behaviour

Once a behaviour has been selected it can be helpful to assist clients in exploring and understanding the reasons why they engage in this behaviour. This will involve discussing their motivators or 'benefits' for doing so. Additionally, it is critical also to explore and discuss the consequences of this behaviour, in other words, the 'costs' the participant will pay for engaging in it. For example, when discussing the 'cost and benefits' of engaging in unprotected anal sex, a participant may list such 'benefits' as 'it feels good', 'it is more intimate', or 'it is cheaper than buying condoms', while some 'costs' might be the danger of becoming infected with an STI or HIV, or the fear and emotional stress associated with not knowing their HIV status. The counsellor should use

the 'cost and benefits' listed by their clients to assist them in understanding why they engage in the risk behaviour and why they should consider altering that behaviour.

Step 4: Set goals

Once clients have a deeper understanding of why they engage in the risk behaviour and motivators that influence them, they should create a personalised goal to change this behaviour in some way to become safer. This goal should be specific, achievable and measurable. Goals that are less detailed can be difficult to achieve or follow through with. Most importantly, a behaviour-change goal should be realistic for clients and based on their specific circumstances. Setting a behaviour-change goal that is impossible for them to achieve right away may lead them to becoming demotivated or disappointed in themselves. For example, it may be unrealistic for a client who very regularly has a large number of sexual partners to set a behaviour-change goal of becoming monogamous. Instead, a smaller but achievable goal might be for such clients to reduce their sexual partners to a smaller number of people, which may also be something that they can sustain over time.

Step 5: Discuss barriers

It can also be helpful to discuss with clients any potential barriers that may prevent them from achieving their goal and to help them to develop strategies to overcome them. Barriers could include things like pressure from friends or an addiction to a drug. Predicting potential barriers that could make behaviour difficult for the client is particularly helpful if you have infrequent contact with clients or will only see them once.

Step 6: Reinforcement

Ultimately, changing behaviour can be a difficult process, therefore it can be helpful to make clients feel proud and motivated when they conclude their session, and to remind them that with a new goal comes a new opportunity to improve their behaviour. Furthermore, it needs to be stressed and emphasised that not all MSM engage in risky behaviour. Clients may easily be engaging in a number of safe behaviours that they enjoy, and reinforcing these behaviours is a great way to encourage their self-esteem and support behaviours that are protecting their health.

Appendix 5:

MSM resources in Africa

CAMEROON

Alternatives-Cameroun

Email. alternatives.cameroun@gmail.com

Tel. +237 99 20 03 29

- ➔ Outreach to gay men and other MSM in cruising places (bars, night clubs) of Douala, Yaoundé, and Buea. Door-to-door actions are also carried out to reach the most hard to reach.
- ➔ Voluntary counselling and testing and follow-up of HIV infection, hepatitis and other STIs at the Access centre, a HIV clinic and dropping centre in the city of Douala.
- ➔ Follow-up includes medical consultations, psychological and social support, adherence to ART, diet courses, and donations of drugs to cure opportunistic infections.
- ➔ All services are free.

GHANA

Centre for Popular Education and Human Rights

Tel. +233 (0) 277 754247, +233 (0) 244808280

- ➔ Address socio-economic issues facing young people and the gay, lesbian, bisexual, and transsexual communities
- ➔ Create HIV/AIDS and human rights awareness among Ghanaian youth and the Lesbian, Gay, Bisexual, and Transgender (LGBT) communities
- ➔ Fight for the rights of young people and the LGBT community based on the principle of equal rights and justice
- ➔ Drop-in centre services for MSM
- ➔ Peer education outreach activities
- ➔ Condom and water-base lubricants distribution
- ➔ HIV Counselling and Testing services
- ➔ STI Referrals services for MSM
- ➔ Human rights education and advocacy

- Uses interactive theatre for Empowering the LGBTI community
- Provides dental dams to lesbian women.

KENYA

ISHTAR MSM, Nairobi

Email. info@ishtarmsm.org

Tel. +254 713 797157; +254 20 2497228

<http://www.ishtarmsm.org>

- Policy & Advocacy on prevention for STI/HIV
- Facilitating and mobilization of CT services to MSM
- Distribution of Condom and lubricants to MSM
- Equal access of healthcare for MSM by identifying and developing referral systems for MSM health needs.
- Safe Sex Workshops and Open Forum Discussions
- Peer Education and Counselling
- Post Test Clubs
- Outdoor Activities.

KEMRI-Wellcome Trust Research Programme, Mtwapa and Kilifi

Tel. 041 7522063; 041 7522535; 041 7525044

- Research on HIV and STI infections in Most at Risk Populations (MARPs)
- HIV counselling & testing of general population and MARPs and referral to care

Kibera Community Empowerment Organisation (KCEO), Nairobi

Email. kceo2008@gmail.com

- Health education to men having sex with men as well as female sex workers in Kibera slum.
- Mobilise, refer for STI/HIV services, educate and advocate for LGBTI rights.

LVCT (Liverpool VCT, Care & Treatment), Nairobi

Email. ldias@liverpoolvct.org

Tel. +254 20 2714590/2715308

www.liverpoolvct.org

- Innovative and integrated HIV counseling & testing service provision
- Condoms and water-based lubricant distribution

- IEC development and distribution
- Referral and follow-up to HIV/SRH and other related services
- Clinical and laboratory monitoring, opportunistic infection management and ART
- Targeted Support Groups and Post Test Clubs
- Sensitivity training for health workers
- Capacity Building
- Policy Advocacy
- Formative and action research.

PEMA Kenya, Mombasa

Email. Cliffordduncan2@gmail.com; pemakenya@gmail.com; ejabizo@yahoo.com

Tel.+254 713 681 341; + 254 724 922 592; +254 721 924 147

- Provide training and services to LGBTI and MSM on health related human rights
- Train health service providers to reduce stigma and give the same attention to MSM and LGBTIs
- Training members on security management
- Peer education sessions/ in reaches
- Intense condom and lubricants promotion
- Media sensitization
- Intense STI screening and treatment
- Health workshops
- Small and large social events to disseminate information on HIV/AIDS, condom and lubricants distribution and HTC services
- 24 hr referral centre
- Sensitization of Religious leaders on LGBTIs issues.

UHAI - the East African Sexual Health and Rights Initiative, Nairobi

Tel: +254(020)2330050/ 8127535

Email. wanja@uhai-eashri.org

www.uhai-eashri.org

- Grant-making initiative that provides grants and capacity support to sexual minority rights organisations in the 5 East African countries – Burundi, Kenya, Rwanda, Tanzania and Uganda

- Actively supports LGBTI and sex worker organizing in the East African region by providing flexible and accessible resources to these organizations and support activism around sexual minority health and rights.

MALAWI

College of Medicine-University of Malawi, Blantyre

Email. jkumwenda@jhu.medcol.mw

- There are no services at present that are provided to MSM in Malawi.

NIGERIA

MALE ATTITUDE NETWORK (MAN), Calabar, Cross River State

Email. contactus@maleattitudenetwork.com; [oanene@maleattitudenetwork.com](mailto: oanene@maleattitudenetwork.com);

Tel. +234 704 292 6723

www.imh-initiative.org/welcome

- Provides psychosocial care and support for young gay and bisexual men in rural Nigeria
- Carries out HIV prevention programming, care and support for people living with HIV, and community-focused advocacy and capacity building activities in Kaduna, Calabar and the FCT in Nigeria
- Provides 24hrs phone and online counselling and referral services across Nigeria.

The Men's Health Network, Nigeria (MHNN), Population Council, Abuja

Email. Sylvia Adebajo; sadebajo@popcouncil.org

Tel. +234 806 887 9584

- Targeted HIV programming for male MARPs in Nigeria
- MHNN utilizes a social franchise model to increase the supply of quality medical care through both public and private sector service providers
- Identifies and trains private practice clinicians to provide non-discriminatory sexual health care for MSM and their male and female partners
- Services include HCT, sexually transmitted infection (STI) syndromic management, condom and lubricant distribution, and referrals
- Peer education
- Community outreach.

SOUTH AFRICA

Desmond Tutu HIV Foundation Men's Division, Cape Town

Tel. +27 21 650-6969

Email. ben.brown@hiv-research.org.za

www.desmondtutihivcentre.org.za

- HIV research, community engagement, capacity building, MSM resource centre, advocacy and training among MSM in South Africa.

Durban Lesbian & Gay Community & Health Centre, Durban

Tel. +27 31 301-2145

Email. info@gaycentre.org.za

www.gaycentre.org.za

Part of the KZN Coalition for Gay & Lesbian Equality. Offers a safe and secure space for the lesbian, gay, bisexual, transgender and intersex communities of Durban and KwaZulu-Natal.

Projects and Services offered by the Community Centre

- Personal Counselling & Support Groups
- HIV/AIDS Education & Support
- Legal Advice Centre
- Reading and Resource Centre
- Religious Project
- Tourist Advice Project
- Other Projects & Activities.

Gay and Lesbian Network, Pietermaritzburg

Email. a_maharaj@ananzi.co.za

Tel. +27 33 342 6165

- Ensure optimum commitment and services for the upliftment and recognition of the LGBTI community through creative programmes that foster Equality, Tolerance, Respect and Acceptance
- Developing safe spaces
- Direct psychosocial support.
- Personal development and ongoing skills development work
- Practical skills dissemination
- Providing HIV&AIDS services, HIV support groups and workshops

- Advocating for an enabling environment – introducing positive changes to the environment in which LGBTI people, live, work and play
- Sensitize general society by creating awareness and educating society about sexual orientation.

Health4Men ANOVA HEALTH INSTITUTE

www.anovahealth.co.za

Free and confidential services aimed at men in underserved populations, including MSM and unemployed men. The project has operations running in the Western Cape, Gauteng and North West provinces.

The free services offered by the Health4Men clinics include:

1. Training of medical staff and providing technical support on MSM sexual health
2. Free sexual health checkups
3. HIV-related counselling, screening, monitoring and treatment
4. Free CD4 and viral load testing
5. Consultations and treatment for STIs
6. Vaccinations against viral STIs
7. Supplying of condoms and free water-based lubrication
8. Individual and same-sex couple counselling
9. A range of support groups, including groups for men living with HIV
10. Seminars and talks related to men's sexual and psychosocial health
11. Production of specialised messaging targeting men's health needs
12. Responsible sex campaigns.

Health4Men Treatment sites:

- CAPE TOWN: Ivan Toms Center for Men's Health, Woodstock Tel. +27 (0)21 447 2844
- SOWETO: Simon Nkoli Centre for Men's Health, Soweto Tel. +27 (0)11 989 9756/9865

OUT Well-being, Tshwane, Gauteng

Tel. 012-430-3272

Helpline. 0860 OUT OUT (0860 688 688)

www.out.org.za

- Direct Services (including full-time clinic, face-to-face and telephonic counselling, and range of psychosocial support groups)
- Outreach Activities (including Play Safe Campaign, One2One Peer Education Programme, and Barrier Method Distribution Service)
- Training and Development (including mainstreaming of service providers).

Sexual HIV Prevention Programme (SHIPP), Futures Group

Tel. +27-12-362-0584

- Capacitate and enable the deliverers of services, so organizations can get capacitation and resources (through the small grants programme under SHIPP)
- Technical assistance
- Training and coordination at the local level.

Triangle Project, Cape Town

Email. info@triangle.org.za

Tel. +27 21-4483812

www.triangle.org.za

- Advocating for the human rights, wellbeing and empowerment of the Lesbian, Gay, Bisexual, Transgender & Intersex (LGBTI) community
- Offers defined services holistically to LGBTI persons, their families and those who support them and work towards gender equality;
- Challenging harmful stereotypes, disempowering forms of patriarchy and masculinity within hetero-normative gender roles and identities.

UGANDA

Frank & Candy, Kampala

Email. FrankCandy.Uganda@gmail.com

Tel. +256 772 444 826

- Informing and empowering Queer Ugandans to deal with their needs in HIV and STI Prevention and care, Sexual Health education and wholesome care of the individual and community
- Informational Sexual Health Newsletter
- Virtual Social Networking Safe Space
- Informational Listserve linking professionals and activists interested in LGBTI Health in Africa.

INTERNATIONAL***amfar, The Foundation for AIDS Research, New York, USA***

Email. kent.klindera@amfar.org

Tel. +1.212.806.1600

www.amfar.org/msm

- Provides financial and technical support to MSM/LGBT-led community-based organizations implementing innovative strategies to reduce the spread and impact of HIV among MSM in low-and-middle income countries.

Center for Public Health and Human Rights, Johns Hopkins School of Public Health, Baltimore, MD, USA

Email. sbaral@jhsph.edu

- HIV Epidemiology and Prevention Research for MSM in Africa.

International HIV/AIDS Alliance, Brighton, United Kingdom

Tel. +44-1273-718900

Email. mail@aidsalliance.org

<http://www.aidsalliance.org>

- Technical expertise, policy and advocacy work, and funding
- Expertise in addressing the needs of marginalized populations, including MSM and transgender communities.

United Nations Development Programme, New York, USA

Email. cheikh.traore@undp.org

Tel. (1) 212 906 6573

- Addresses HIV and sexual diversity through attention to legal and policy environment
- Partnering with municipal governments to strengthen their understanding and response to men who have sex with men, sex workers and transgender people
- UNDP co-convenes with UNFPA the working group on "Men who have sex with men, sex workers and transgender people"
- Strengthening the evidence base related to HIV and sexual diversity
- Catalyzing and supporting municipal action on HIV and sexual diversity
- Human rights and access to justice initiatives for marginalized populations.

SIDACTION - Homosexuality and HIV in Africa Program, Paris, FRANCE

Email. m.maietta@sidaction.org)

Tel : +33 (0)1 53 26 45 66

<http://www.sidaction.org>

- Mobilize funds to develop and maintain high-quality HIV programs, including scientific research
- Grant-making initiative, jointly managed with AIDES, that provides grants and capacity support to NGOs in francophone Africa to develop access to care and prevention for men who have sex with men and living with HIV.

Men Who Have Sex With Men: An Introductory Guide for Health Workers in Africa

This second edition of the MSM guide was developed to make HIV counsellors and health care workers mindful of MSM practices in Africa. Building on the evaluation and comments of peer reviews and individuals trained, this guide presents practical suggestions to improve MSM counselling in an accessible manner, with case studies and best-practice exercises serving as the example.

The aim of this guide is to provide workers with the skills they need to properly counsel on MSM behaviours in the African context.

The Manual is comprised of 8 modules:

Men Who Have Sex with Men & HIV in sub-Saharan African

Stigma

Sexual Identity & Coming Out

Anal Sex & Common Sexual Practices

HIV & Sexually Transmitted Infections (STIs)

Condom & Lubricant Use

Mental Health: Anxiety, Depression & Substance Abuse

Risk Reduction Counselling with MSM

Additional contents include:

Glossary

Resource List

Facilitation tips

Pre & Post Course Assessments

The Desmond Tutu HIV Foundation (DTHF) is a registered non-profit organisation focused on the pursuit of excellence in research, treatment, training and prevention of HIV and related infections. The DTHF operates community sites throughout greater Cape Town, South Africa, providing treatment, testing, and outreach services to at-risk communities like MSM.

In developing this resource, the DTHF is honoured to have partnered with Dr. Eduard Sanders of KEMRI-Kilifi, and received contributions from a variety of UK, US, and African based experts.



DESMOND TUTU
HIV FOUNDATION

