

Two large male symbols (a circle with an arrow) are positioned behind the title. The first is pink and the second is blue. They overlap each other and the text.

Men who have sex with Men

An Introductory Guide for
Health Workers in Africa



MSM: An Introductory Guide For Health Workers In Africa

Developed by the Desmond Tutu HIV Foundation

Editors

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MSM: An introductory guide for Health Workers in South Africa
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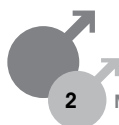
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This guide is dedicated to those men who live in countries in Africa that not only do not accept, but actively persecute MSM.

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Introduction

Background

Male-to-male sexual contact has been consistently shown to be an important contributing factor to the HIV epidemic. High rates of HIV infections 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 there are limited counsellor or health provider training materials which address MSM specific health needs; the risks for HIV infection or the anal acquisition of STIs in sub-Saharan Africa.

The Organisers

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 clinical sites in and around Cape Town.

Aims of the MSM counsellor and health provider training course

It is hoped that this manual will provide counsellors and health care providers with the insight and skills necessary to illicit MSM behaviours among their clients and provide counselling services that adequately cater for their unique needs in an African context.

Target audience

The programme is aimed at HIV counsellors and other health workers

who work in Africa and have varying degrees of experience with MSM. Findings from African research and experience has been presented in a way that is accessible to individuals taking part in the programme.

A basic understanding and limited experience of working in the HIV sector is required before completing this programme. The manual highlights issues that are specific to MSM and provides additional training relevant to this population group.

Use of study groups

For the best outcome, the manual content should be covered by counsellors before individuals attend training sessions. It is suggested that a facilitator experienced in counselling or working with MSM leads the programme. 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 provide an opportunity for practising skills.

This manual can also be used by individuals who are not able to attend group sessions.

Learning outcomes

After completing the programme individuals should be able to:

1. Discuss the relationship between stigma and sexuality.
2. Explain how they will overcome personal stigma in the workplace.
3. Explain why it is important to ask about MSM behaviour among all men attending counselling sessions.
4. Explain how to ask about MSM behaviours in men whose sexual orientation they are unsure of.
5. Explain what sexual health & other relevant issues should be addressed once MSM behaviour has been identified.
6. Discuss how they will counsel on identified behaviours or issues.

FORMAT OF THE MSM HEALTH WORKER GUIDE

This guide is divided into various modules. Modules may be completed individually or completed together in an intensive workshop course.

A pre- and post-course assessment is 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 will take between 2 and 2.5 hours to complete.

Each module begins with a brief summary of what is covered in the module. Basic information, important facts and skills are mentioned.

Learning outcomes are stated at the beginning of each module.

These outcomes help identify key knowledge and important skills that the trainee should have acquired and/ or feel comfortable doing after completing each module.

The core knowledge presented in the various sections is relevant for counsellors working with MSM in Africa.

Exercises and reflection tasks are included to provide an opportunity for personal reflection and assesses the counsellor's knowledge, attitudes and beliefs. These are important to explore because these issues may affect the quality counselling provided.

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. Prompts will assist in ensuring important aspects are dealt with.

At the end of each module the learning objectives are revisited and important facts and lessons are re-enforced.

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.

Plans for expansion

Plans exist to translate the programme into several African languages and to develop a web-based version in order to improve access to the programme.

Glossary

Homosexuality – refers to the sexual orientation in which an individual has romantic or sexual feelings towards members of the same sex.

Heterosexuality – refers to the sexual orientation in which an individual has romantic or sexual feelings towards members of the opposite sex.

Bisexuality – refers to the sexual orientation in which an individual has romantic and/or sexual feelings towards both males and females.

Coming out – is a figure of speech which refers to the process of revealing one's sexual orientation to others.

PHLA – is a person living with HIV/AIDS. Individuals known to be infected with HIV. This includes individuals with early infection and end stage disease (AIDS).

Sexual orientation – is 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, women or both men and women.

Sexual behaviour – is the manner in which people express their sexuality. Examples of this behaviour can include physical or emotional intimacy and sexual contact.

Serosorting – is the process of selecting a sexual partner based on their HIV status. For example, an HIV positive man may 'serosort' and seek out only other HIV positive men as sexual partners.

Serodiscordant relationship – refers to a romantic or sexual relationship between two people of differing HIV statuses.

Gay man – is a man who has romantic, sexual, and/or intimate feelings for other men. Gay is generally a more commonly used term for homosexual.

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.

Gender identity – refers to 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.

Pre-course assessment

Thank you for your interest in this counsellor MSM sensitivity training programme. Please complete the questionnaire and assessment before starting the programme. We suggest that photocopied versions of the questionnaire and assessment are used.

Previous MSM counselling experience

Make a circle or a cross on your response.

1. In the past three months how many MSM clients have you counselled about safer sexual practices?
 - a. None
 - b. 1 – 5
 - c. 5 – 10
 - d. More than 10
2. Have you ever discussed anal sexual practices with any of your clients, male or female?
 - a. Yes
 - b. No
3. Have you ever asked male clients about sexual acts with other men?
 - a. Yes
 - b. No
4. In the past three months how often have you asked your male clients about MSM behaviour?
 - a. Never
 - b. Sometimes
 - c. Often
 - d. Everytime
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 MSM clients on relevant health issues?
 - a. Yes
 - b. No

Pre-course assessment

STIs, including HIV, are major health problems among African men	True	False
Research done in Africa has shown that sexual behaviour between men does occur	True	False
Many countries in Sub-Saharan Africa still have laws that criminalise homosexuality	True	False
Stigma against MSM places them at high risk of acquiring HIV	True	False
'Coming out' means letting others know about a person's sexual orientation	True	False
Anal sex is only practised by MSM	True	False
Unprotected receptive anal sex carries the highest risk of getting HIV	True	False
HIV, Herpes, Chlamydia, Gonorrhoea, Hepatitis B and Genital Warts are all sexually transmitted infections (STIs) which affect MSM	True	False
Excessive feelings of fear, or anxiety, can cause mental illnesses, and are common among MSM	True	False
Some symptoms of depression include: feelings of sadness, changes in appetite, feeling tired all the time & thoughts of death	True	False
Alcohol and drug use is common among MSM	True	False
Alcohol and drug use has been associated with an increased risk of contracting HIV	True	False
MSM with substance abuse problems should be referred to a health professional if possible	True	False
If used correctly, and consistently, condoms prevent most STIs	True	False
Oil based lubrication, like Vaseline ®, can safely be used with latex condoms	True	False

Module 1

MSM AND HIV IN SUB-SAHARAN AFRICA

OVERVIEW

In this module you will be introduced to what is known about men who have sex with men (MSM) in sub-Saharan Africa and their risks of HIV infection, and begin to consider why MSM are at high risk of HIV and how this might be addressed.

LEARNING OUTCOMES

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

- I. Define MSM.
- II. Summarise what is known of MSM and their HIV risks in sub-saharan Africa.
- III. Explain why sex between men carries a high risk of HIV transmission.
- IV. Explain why men who have sex with men in Africa are more vulnerable to HIV infection.
- V. Discuss the barriers that MSM may encounter in seeking HIV services.

Core knowledge

Who are MSM?

Men who have sex with men (MSM) describes those males who have sex with other males. 'Sex between men' includes anal sex, oral sex, masturbation and combinations of these practises. MSM include men who have sex only with other men, as well as men who have sex with both men and women. MSM include men who identify with a personal or social identity associated with their behaviour, such as 'homosexual', 'gay' or 'bisexual', as well as men who do not identify with such an identity (many African MSM identify their sexual orientation as 'heterosexual').

A thorough overview of MSM identity will be covered in module 3.

MSM IN SUB-SAHARAN AFRICA

Men who have sex with men have only recently begun to be widely recognised in sub-Saharan Africa. Sex between men occurs in every culture and society, though its extent and public acknowledgement vary from place to place.

Reports of same sex practices and men who have sex with men have come from most African countries and date back before the 19th century. Also, there are references to homosexuality present in many native African languages.

Anthropologists have described 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 equal to each other.² Also, same-sex sexual experimentation before marriage or in adolescence has been reported³ and in some areas male-to-male sex is a necessary component of certain traditional practices.⁴

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.⁵ In many other countries, grass-roots organisations representing MSM are also well-known.

It is difficult to know how many African men have sex with other men because none of the routine surveys about sexual behaviours have included questions on same sex practices in Africa. 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.

MSM AND HIV INFECTION

The first reports of AIDS were among men who have sex with men in the United States in the early 1980s. Since then, men who have sex with men in many parts of the world have remained at highest risk of HIV infection, and a principal target for HIV prevention efforts.

HIV EPIDEMICS IN AFRICA

Most adults newly infected with HIV in sub-Saharan Africa acquire the infection through 'heterosexual' sex, in other words through sex between a man and woman. Personal risk of HIV infection can be increased by having more sexual partners, older sexual partners, not using condoms, having sexually transmitted infections and, being uncircumcised.⁶

To date, most national HIV/AIDS control programmes have concentrated on reducing heterosexual HIV transmission and transmission between mother and child.⁷

In recent years it has been recognised that HIV epidemics in African countries are complicated. High risk groups (such as sex workers, intravenous drug users and MSM) are more affected than the general population. Furthermore, they can play a role in enabling transmission more generally (in Kenya, for example, 10-15% of new HIV infections in the country are thought to be caused by MSM).¹

MSM AND HIV IN AFRICA

Research on African MSM to date show that, in most countries, MSM have a considerably higher rate of HIV infection than other men in the same setting (figure 2). Most African countries have yet to collect any information about HIV among their MSM populations. Overall the rate of infection among MSM in sub-Saharan Africa is estimated to be 4 to 5 times the rate in other men, although the rate may be more than 20 times higher in some countries.^{7, 8}

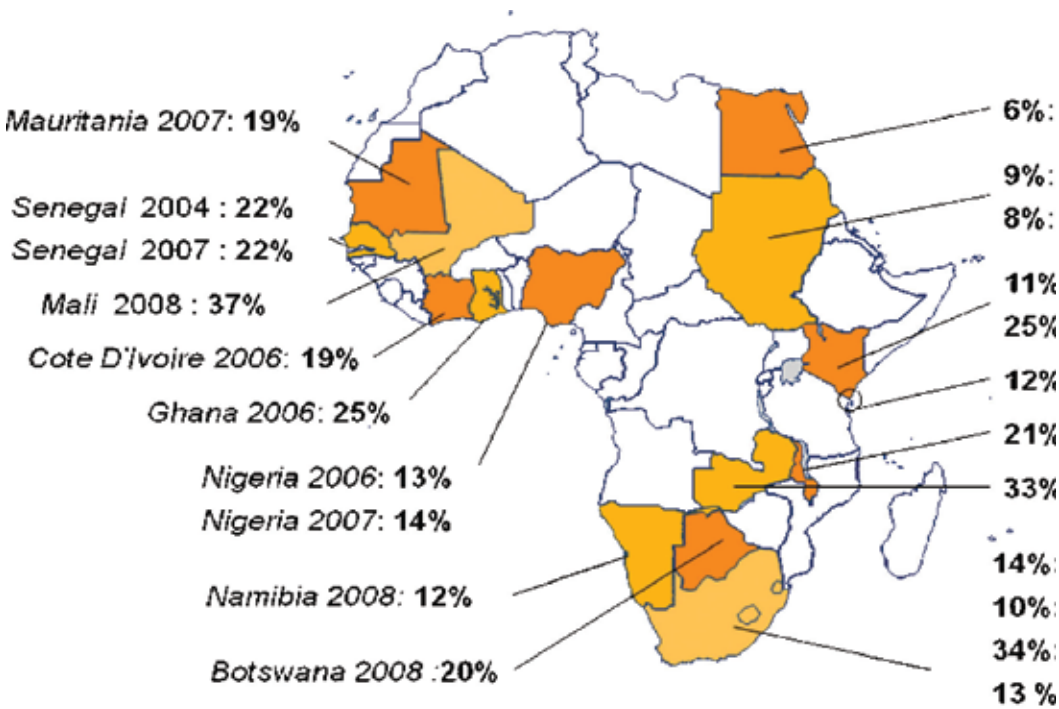


Figure 1: Percentage of African MSM living with HIV

EXERCISE (20 MINUTES)

Brainstorming (15 minutes) – Consider the following question and if possible discuss in a group.

Why have the HIV needs of MSM only recently been described in sub-Saharan Africa?

Why do MSM have more HIV infection?

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

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 injecting drug use with contaminated needles and syringes.

RISKS AMONG AFRICAN MSM

Unprotected anal sex

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

Regarding sex with an HIV positive partner:

- The risk of a man acquiring an HIV infection during unprotected receptive anal sex is **10** times higher than during unprotected insertive anal sex (with a man or woman) or unprotected vaginal sex with a woman.⁵
- The risk of a man (or woman) acquiring an HIV infection during unprotected receptive anal sex is **5** times higher than for a woman engaging in unprotected vaginal sex.

The high risk of HIV transmission in receptive anal sex is because:

- Anal sex is more traumatic than vaginal sex, sometimes resulting in abrasions and cuts that reduce the body's barrier to HIV infection.
- Unlike the vagina, the anus and rectum have no natural lubrication. Lack or misuse of inappropriate lubricants (e.g. Vaseline, oil) may worsen trauma or damage condoms.

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 don't use safe, water-based lubricants. The use of condoms and lubricant will be discussed further in module 7.

Sex between men need not always involve penetrative anal sex: oral sex, masturbation and thigh sex carry a much lower risk of HIV transmission, and men may choose to avoid anal sex for their (or their partners') protection.

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. Some research suggests that alcohol use with sex increases MSM risk taking behaviours. You will learn more about drug use among MSM in module 6.

Multiple partners

It is not clear yet whether African MSM have a greater number of sexual partners than other African men, however, MSM involved in sex work may have many sexual partners. Studies across Africa suggest that most of the male partners of African MSM are also African in origin, and that in addition to male partners, most MSM also have female partners, including wives, casual girlfriends and sometimes women who pay MSM for sex .⁹

Other sexually transmitted infections (STIs)

The coexistence of genital or rectal sexually transmitted diseases, other than HIV, are known to increase the risk of HIV transmission. A high proportion of MSM in surveys report recent symptoms of STIs.

You will learn more about sexually transmitted infections among MSM in module 5.

VULNERABILITIES OF MSM

Vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These 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, practises, beliefs and laws** that stigmatise and disempower certain populations, and act as barriers to essential HIV prevention messages.

These factors, alone or in combination, may create or increase an individual's vulnerability and, as a result, the community's vulnerability to HIV infection.

Personal factors

Knowledge of risks of MSM sexual practices

Many MSM assume that anal sex is a safe alternative to heterosexual 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 even where anal sex is considered a risky behaviour, that some MSM are not aware of the potential benefit of condom use.

Safe sex skills

The effective use of condoms (including female condoms) and lubrication for anal sex can be an effective measure to reduce the risk of HIV transmission. Most African MSM use oil-based lubricants that may damage latex condoms. Effective use depends upon the skills of MSM to select and apply these properly, their ability to negotiate the need to use condoms with their sexual partner, as well as having access to affordable supplies of condoms and water-based lubricants.¹⁰ Condom usage and lubrication is covered in more detail in module 7.

Knowledge about HIV status

Most MSM live unaware of their HIV status, due in part to ignorance of the risks of their own sexual behaviours and/or a reluctance to use HIV testing services.

Most African countries collecting 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 practises (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 practises to reduce the risk of infecting future sexual partners (positive prevention).

Elsewhere in the world, knowledge and disclosure of personal HIV status can strongly influence partner choices. For example men who know themselves to be 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.

GROUP EXERCISE

Is my service MSM-friendly?

Each participant discusses the environment where you see individuals seeking care or HIV testing. If possible relate this to examples of MSM accessing the service. Other group members question as follows:

- What aspects of your service encourage men who have sex with men to come forward?
- What aspects of your service discourage MSM from coming forward?
- How could your service be improved to reach MSM?

Discuss in small groups. Small groups then feed back to whole group.

Alternative focus for whole group discussion: real quotes as follows:

I. “(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.”

II. "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."

The World Health Organisation (WHO) recommend that: ¹⁰

'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

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

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 providing services from MSM specifically. In official figures in 2008, 46/52 African countries reported no services were available for MSM. ¹¹

While many HIV prevention and treatment services do exist, 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, female 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

Law and politics

At present, male same-sex behaviour is illegal in most sub-Saharan African countries (figure 1), four of which may impose the death penalty. Protective legislation for MSM exists only 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 consequence more MSM coming forward for prevention, testing and treatment.

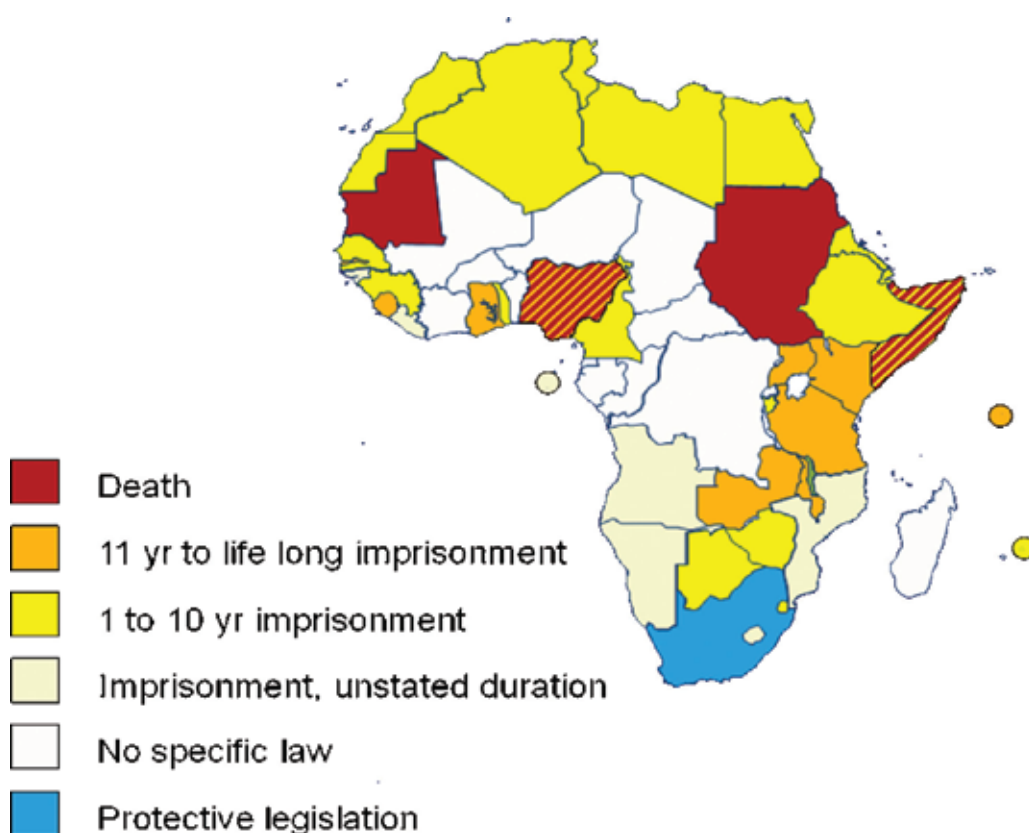


Figure 2: Laws regarding same-sex behaviour (2009)

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.

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 to 99% of African people consider that homosexuality should not be accepted by society.

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 expectations that men have partnerships that bear children.

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.

Covertiness

First and foremost, MSM may quite understandably be fearful to disclose sexual behaviours with other men, or same-sex orientation, to members of their family, to health care staff and to those who might be able to share knowledge, skills and services to help MSM meet their HIV prevention and treatment needs. The consequence in nearly every context is that most MSM are thought not to be able to come forward for help.

Self-esteem and self-efficacy

The consequences of homophobic stigma from society, communities, churches, family and friends have direct impacts 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.

SUMMARY

- 'Sex between men' includes anal sex, oral sex, masturbation and combinations of these practices and occurs in every culture and society.
- MSM in Africa have a considerably higher rate of HIV infection than other African men.
- More research about MSM in Africa needs to be done to ensure access to health services.
- Few African countries include MSM in their national plans for HIV control, and almost none allocate HIV control resources, despite WHO recommendations.
- Unprotected receptive anal sex is the most risky sexual behaviour for the transmission of HIV and is often practised among African MSM.

Module 2

STIGMA

OVERVIEW

In this module you will learn about stigma and what it means. You will explore its multiple impacts. You will see that 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 that such stigma affects MSM in a range of ways, from how they feel about themselves, to whether or not they access testing, care and treatment.

Learning outcomes

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

- I. Define stigma.
- II. Relate stigma to their own experience of being treated differently.
- III. List the ways in which a person can be stigmatised.
- IV. Explain the double stigma that men who have sex with men and who are HIV positive may experience.
- V. Describe how to support a client who is stigmatised.

EXERCISE

Think back to a time when you were treated in any way differently by other people. For example, it may have been a time when you moved into a new area and attended a new school. 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. Try to remember such an experience and what happened. This should take about 8 minutes. Answer the following questions:

1. What exactly happened to you that you were treated differently?
2. How were you treated differently by others around you? Think of all the ways in which they treated you differently.
3. How did this make you feel?
4. How do you think this experience affected you?
5. What did you learn from this experience?

It would be beneficial to share these experiences with other members of a group, if possible.

Group discussion. Individuals may relate their experiences of stigma to the group. Try linking individual stories to the definitions of stigma given below. Additional input may be obtained from the core knowledge section.

Stigma

Stigma has been defined as any attribute or quality that shames a person in the eyes of others. This means that other people look at that individual and have a negative attitude towards that person because of that quality or characteristic. For example, that person is a foreigner or they are HIV positive.

Stigma allows people to then treat that person differently to other people. This is what we call discrimination. Discrimination is a form of behaviour that results in unequal or unjustifiable treatment.

There are two main kinds of stigma:

- **External stigma:** relates to how a person who is stigmatised is treated by everyone else. For example, the person who is HIV positive can be refused treatment at a clinic or hospital by health-care workers, or can be made to sit separately from the other patients.
- **Internal stigma:** refers to the way that the stigmatised person begins to feel about themselves as a result of external stigma. For example, the person's confidence may suffer, and they may feel sad and depressed.¹²⁻¹⁵

EXERCISE (30 MINUTES)

Begin by dividing a sheet of paper into two columns. In one column write a list of ways that MSM are stigmatised simply because they are MSM. In the second column, make a list of how MSM who are HIV positive are stigmatised because of their HIV status.

In both cases, list all the ways in which the stigma may be experienced. This may include attitudes, what is said, actions, exclusion and how the experience of stigma then impacts on MSM.

Remember to think of both external and internal stigma.

When you have exhausted all of your ideas, take note of both lists. Are they similar? Are they different? Is there any overlap? Note that MSM who are HIV positive (or even just suspected of being HIV positive) may suffer double stigma, because of both their sexual behaviour and their status. This is a heavy burden to bear, and may have particular consequences in terms of mental health (such as depression and abuse of substances to cope with the stigma).

EXAMPLES OF STIGMA

External stigma may take many forms. Here are some of the more common ones:

1. **Avoidance:** avoiding MSM because of their sexual orientation or because they are suspected of being HIV positive.
2. **Rejection:** family members, friends, community members or health care workers may reject MSM because of their sexual behaviour or because of their HIV status.
3. **Moral judgement:** people may make judgements of MSM as being immoral or blame them for their behaviour or status. Similarly, people living with HIV/AIDS (PLHA) may be judged or blamed.
4. **Discrimination:** denying opportunities to MSM or PLHA, such as jobs, access to health care, or a place to live.
5. **Not being willing to invest in the stigmatised person:** treating someone in employment differently to others because they are an MSM or they are HIV positive.
6. **Abuse:** physical or verbal abuse (shouting, calling names) of MSM or of PLHA.
7. **Gossip:** talking about MSM (and especially MSM who are HIV positive) in a negative way to others.
8. **Abuse of human rights:** denying MSM their basic human rights, such as the right to confidentiality in HIV testing, the right to care and treatment, the right to be treated with dignity. Similar treatment is given to PLHA.
9. **Violence:** in extreme cases, MSM and PLHA have faced physical attack and have even been murdered in some circumstances.
10. **Stigma by association:** people who associate with MSM (or PLHA) may in turn be stigmatised.

Internal stigma may also take a range of forms:

1. **Self-esteem:** MSM and PLHA may have poor self-esteem as a result of stigma.
2. **Social withdrawal:** MSM and PLHA may avoid family, work colleagues and community members.
3. **Avoiding disclosure:** MSM may keep their sexual behaviour secret. MSM who are HIV positive may avoid disclosing their HIV status to others because of fear of stigma.
4. **Avoiding services or opportunities:** MSM may avoid accessing health or social services because they are afraid of being treated badly. The same is true of PLHA.
5. **Not seeking treatment:** MSM who are HIV positive may not come forward for testing, or when they have tested HIV positive, may not seek care and treatment because of fear of being treated badly.
6. **Mental health:** MSM may become depressed, may abuse substances and may develop other mental health problems as a result of stigma.
7. **Suicide:** in extreme circumstances, MSM who have experienced high levels of stigma, either for being MSM or for being HIV positive, or both, may resort to attempting to kill themselves, in order to escape the pain of stigma. ¹²⁻¹⁵

GROUP EXERCISE

Read the case studies below. If working alone, answer the following questions: what types and forms of stigma are present in these cases? How do you provide appropriate support for these clients? If you have access to a partner, each take turns role playing a scenerio.

Case study A

John is a young MSM who lives in Nairobi, the capital of Kenya. John is 25 years old, and has been living on the streets since his parents threw him out of the house. They had found out he was gay after he was discovered in a back room having sex with a classmate from school.

John then engaged in sex work to survive, but was not aware of the risks of HIV, so he did not use condoms when he allowed other men to penetrate him anally. John then became HIV positive.

Since then John has lost weight, and so his previous clients have left him. He has since resorted to scavenging in the refuse dump for food. John sleeps in the street, where he is at risk of being assaulted.

Case study B

Tsepho is a married man of 47 years, who lives in Daveyton, a township in Gauteng, South Africa. He has engaged in sexual activity with men outside his marriage for the past 10 years. Recently, when he went for a health check-up at the local clinic, Tsepho discovered that he was HIV positive. He reported that he had sex with a man for a couple of years and with his wife. The nurse who tested him shouted at him when she gave him the test result, and accused him of immoral behaviour and of wanting to kill his wife through contracting HIV and infecting her. Tsepho is afraid now of seeking health care. He is also scared that he will infect his wife, and of his family discovering his secret sexual life.

SUMMARY

- Stigma is common and has multiple impacts.
- MSM who are HIV positive may experience the burden of double stigma, because of both sexual behaviour and their HIV-positive status.
- External and internal stigma affects the health and well being everyone and needs to be addressed.
- Appropriate support and counselling can minimise the effects of stigma and assist clients in their well being.

Module 3

SEXUAL IDENTITY, COMING OUT & DISCLOSURE

OVERVIEW

All human beings have a sexual orientation, a sexual identity, and are capable of engaging in sexual behaviour. Most people are familiar with heterosexuality, which is a sexual orientation that describes a person who has romantic or sexual feelings to other people from the opposite sex. For example, a man who is sexually attracted only to women is a heterosexual.

Since heterosexuality describes the majority of people and is often the focus of most cultures and communities, there is little opportunity to learn about other sexual orientations. In fact, many people may even be unaware that other sexual orientations exist.

This module will focus on sexual orientation, sexual identity, and sexual behaviour as it relates to MSM. This information will help to serve counsellors who are unfamiliar with these concepts but who are working with MSM.

Furthermore, this module will equip counsellors with information that can assist their MSM clients with experiences they may go through, such as coming out and disclosure.

Learning Objectives

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

- I. Define sexual orientation.
- II. Define sexual behaviour.
- III. Explain the development of a sexual identity.
- IV. Understand and be able to explain the coming out process.
- V. Engage with stereotypes and stigma that lead to prejudice.
- VI. Engage with the psycho-social issues that confront MSM which result in risky behaviour.
- VII. Be able to deal and converse with frequently asked questions about sexual identity and coming out.

SEXUAL ORIENTATION

A person's sexual orientation refers to the set of emotional, physical and romantic feelings they have towards other individuals. These feelings and behaviours can be directed towards men, women, or both men and women. It is often thought that sexual orientation pertains only to people who identify with a homosexual identity. In fact, everyone has a sexual orientation and for the majority of people, they have no control over how their sexual orientation is expressed.

WHAT IS SEXUAL BEHAVIOUR

Sexual behaviour refers to the way in which people express their sexual orientation. This behaviour includes the ways people interact emotionally, physically and sexually with others. It can also include the ways in which people find and attract their partners. Individuals express their sexual behaviour differently. Some may choose for this aspect of their lives to remain private while others may want to make it public.

SEXUAL IDENTITY

Sexual identity describes the way in which an individual identifies their sexuality. There are many ways in which people identify, or label, their sexuality and not all of them relate to their sexual orientation. For example, a man who is married to a woman but has sex with men on the side may describe himself as straight or heterosexual, even though his sexual orientation may better be described as bisexual. Many factors can influence the way a person develops their sexual identity, including the societal norms of their communities, culture, and religion.

DIFFERENCES BETWEEN HOMOSEXUALITY AND HETROSEXUALITY

Homosexuality is used to describe a person's sexual orientation when they have emotional, sexual, or intimate feelings towards members of the same sex, whereas heterosexuality refers to a person's sexual orientation when they have emotional, sexual, or intimate feelings towards individuals of the opposite sex. For example, if a man was sexually attracted to another man his orientation would be homosexual.

CAUSES OF HOMOSEXUALITY

Many people wonder what causes a person's sexual orientation to be homosexual or gay. Most people believe that sexual orientation is either

caused by a person's genetics (something they are born with) or that it is a reflection of their behaviour (something that they learn).

The fact is, however, that it is not known what causes sexual orientation, whether it is heterosexual, homosexual, or bisexual. Some studies suggest there are genetic influences, but not all researchers or experts agree with these research findings. Ultimately though, most researchers agree that sexual orientation is determined by biological (genetic) and social (environment, family, community) factors.

MSM AND RELIGION

This is a very common question and one that is difficult to answer since religion is a complex institution made of many different people, beliefs, and practises. Some religions do made negative references to men engaging in sexual practises with each other. These same religions also make similar negative references to many of the practises that people engage in today and many society supports. For example, divorce may be looked negatively upon by a religion and yet many people get divorces today. Furthermore, there is also great variability within each religion with each group believing in different aspects and practises. Ultimately, the decision of whether or not a specific religion supports men who have sex with men is left up to the individual to decide based on how they choose to interpret their religious views.

'CURING' MSM

This question suggests that men who have sex with men are sick, which is untrue. In the past some psychiatrists and doctors tried to show that homosexuality was a mental illness, but they have since been proven wrong. From 1973, being lesbian, gay or bisexual is no longer described as an 'illness' by the medical profession. However, some people still wrongly send their gay sons or lesbian daughters to clinics, psychologists or sangomas to be 'cured'. Attempts to change a person's sexual orientation can have negative consequences on self esteem, mental health and personality. Depression, suicide, low self esteem and poor self confidence can result from efforts to change another person's sexual orientation. Homosexuality is a normal sexual behaviour and does not need a 'cure'.

IS MSM UN-AFRICAN?

Many years of research have shown that between 5% and 10% of people in every community are homosexual. Yet, sometimes people believe

that homosexuals live only in Europe or America. They think lesbian and gay people do not exist in Africa. This is not true. Being homosexual has nothing to do with being African. In Africa, lesbian, gay and bisexual people live in every community, whether they are 'black', 'coloured', 'white' or 'Indian'.

The laws and constitutions of some countries protect citizens against discrimination based on race and sexual orientation. In Africa many countries have not changed laws to protect citizens from discrimination based on sexual orientation. Religious intolerance and negative attitudes force many people to hide their sexuality. As a result, many homosexuals do not disclose or openly show who they really are in public.

MSM AND GENDER INDENTITY

Some people think a man must be or should be a woman to love another man. This comes from the thinking that only men and women can be together. If one thinks like this then it seems logical that a man who loves another man must wish to change his sex. But this is not true.

There is a big difference between being a man who has sex with other men and being a man who wants to be a woman. Therefore, men can have sex with other men and not necessarily want to become women.

MSM AND SEXUAL CHILD ABUSE

Child sexual abuse is deviant and criminal behaviour. It is not restricted to any specific group of people. Studies have shown that the 'average' child sex offender is a heterosexual male who is known to the child. The adult male who does sexually abuse boys is often a man who is attracted to children regardless of their sex. Child sexual abuse has nothing to do with men who have sex with other men.

COMING OUT

What is coming out?

Coming out is short for 'coming out of the closet' and refers to a time when an individual expresses to someone that they are gay. Coming out is not a one time event but is a process that involves coming out many times to each new person that an individual encounters. This process generally starts when the individual acknowledges their sexual orientation to themselves.

At what age do most MSM 'come out'?

There is no specific age for coming out. Research shows that the general age for coming out for boys is 19. But some people come out much younger, while others wait until they are much older, even sometimes after having been married to a woman. Also, some MSM choose to never come out at all.

For the most part, MSM realise their sexual orientation as teenagers. When asked, some MSM will state having felt 'different' since they were little, but being unable to understand or explain it.

It is often when friends or schoolmates start having their first sexual encounters that young MSM begin to discover and learn to express their sexual orientation.

How does someone come out?

The coming out process can be a unique experience for everyone. Sometimes there are similarities that can be broken down into internal and external stages.

Internal stages:

- Often begins with a vague idea of being 'different'. This can happen at quite a young age, but more likely at the beginning of puberty (adolescence).
- The person considers the notion they are gay, but initially they often deny this to themselves.
- They then begin to think about it, read about it and slowly come to accept it. For many young people, this is a lonely and depressing time.

External stages:

- This stage begins when the person chooses to tell someone else for the first time.
- Includes outward signs of this person engaging in activities to explore their sexual orientation, like meeting new friends or engaging in new social events.

Only in the external stages does coming out become visible to the outside world. This may take many years to happen.

Each person comes out in different ways under unique circumstances. Some people move faster than others through the stages, others never get to the point at which they can tell others or feel they can lead a lesbian or gay lifestyle.

The level of self acceptance and support in the social environment affects the ways, the speed and the extent to which individuals 'come out'.

Disclosure

Disclosure is very similar to coming out since it is the process through which people make known to others their HIV status. People usually need to disclose their status when they are HIV positive. Disclosure may need to occur to friends, partners, family, and medical professionals.

Particularly for MSM, disclosure can be a difficult process because of the additional discrimination, stress, or stigma they may face because of their sexual orientation.

As a counsellor who may be working with MSM, it is useful to have skills that can assist clients in disclosing. This is because MSM clients may also need to disclose their HIV status and because disclosure skills may also assist with coming out.

Confidentiality

If a client discloses that they are HIV positive it is critical that, just as when an MSM comes out, that this information be kept strictly private and confidential.

The reason for this is that if the person is revealed to others to be HIV positive, he or she may experience stigmatisation from others in various forms, including rejection. The person who has just received his HIV diagnosis may be in a state of shock, and does not need to have the additional burden of coping with other people's emotional responses to his diagnosis.

The benefits and risks of disclosure

Once a person has been diagnosed HIV positive they become a Person Living with HIV/AIDS (PLHA). After they have accepted their status, they may feel the need to disclose their status to others, chosen carefully, in order to obtain social support. ^{12 – 15}

EXERCISE

Begin to think about both the benefits and disadvantages of disclosing HIV status to others. As a group or individual, make two columns on a piece of flipchart paper, 'Benefits of disclosure' and 'Risks of disclosure'. Fill in each column with your ideas. Once you have finished compare your thoughts to the lists below. Were your ideas similar or different? Where there certain risks or benefits that you were surprised to learn?

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.
- Takes away feelings of loneliness.
- Allows the person living with HIV to get support from others.
- Enables the person living with HIV to get medical care and to plan for treatment.

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.
- Fear of losing employment.
- Fear of just being seen as a person with AIDS (not as a person who has AIDS but is also many other things too).^{12 - 15}

HELPING A PLHA TO DISCLOSE THEIR STATUS

Disclosure, like coming out, does not just happen once and is then over. A PLHA may choose to disclose to one person today, to another tomorrow and to someone else next year. The process is never over. Every time the PLHA meets someone new, they must decide whether or not to disclose.

Before starting to disclose the PLHA needs to feel strong in themselves and to accept his or her status. Only the individual can decide when they are ready for disclosure as this is a personal decision that has significant impact on their lives.

Important points that can help an individual with disclosure

- The PLHA should disclose first to the person he feels most comfortable with and trusts the most. Disclosing to people who are less accepting should come later.
- The PLHA can prepare by thinking of the best time and best place in which to disclose.
- The PLHA can also practise what to say first with someone who already knows his status, such as his counsellor.
- The PLHA should think of how to respond if the person he discloses to reacts positively. He should also think of what to say or do if the reaction is negative.
- Often people react negatively to disclosure but later become more accepting.
- The more the PLHA can disclose, the less worry he will have about people finding out accidentally.
- With time and practise, disclosing becomes easier.

Ways a counsellor can assist someone who needs to disclose

- Accept the PLHA for who he is. Accepting builds up the PLHA's confidence and helps him to feel stronger. This in turn gives the person confidence to disclose.
- Respect the PLHA's right to confidentiality and having his status kept from others.
- Talk to the PLHA about his fears of disclosure.
- Talk about the various benefits of disclosure.
- Offer positive examples of disclosure.
- Ask the PLHA about his thoughts about disclosing.
- Ask if the PLHA wants to practise the words to use to disclose. They can role-play with the counsellor how to disclose.
- Accept the PLHA's own pace about disclosure. The PLHA needs to make his or her own decisions.
- Encourage the PLHA to talk to other PLHAs.
- Encourage the PLHA to join a support group, where disclosure is talked about.
- Offer continual encouragement to disclose by talking about the issue in every counselling session where there is contact with the PLHA. 12 - 15

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.

Tebogo is a 28-year-old MSM who is unemployed. He lives with his parents, brother and two sisters in a shack settlement outside Cape Town. His family are unaware that Tebogo 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. Tebogo 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, Tebogo 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 Tebogo will benefit from social support.

SUMMARY

- Homosexuality is a type of sexual orientation and is not an illness and does not need a cure.
- Sexual orientation, identity and behaviour differ between individuals.
- Some MSM make the decision to come out while others do not as it is an individual choice.
- MSM who are HIV positive may face the challenge of coming out and of disclosing their status.
- There are both risks and benefits to coming out and for disclosing.

Module 4

ANAL SEX AND COMMON SEXUAL PRACTISES

OVERVIEW

Around the world, discussing anal sex is found to be challenging and surrounded by stigma, both from a health provider point of view as well as from a client point of view. In Africa especially, discussing anal sex has become a considerable taboo.

This has led HIV counselling training to focus mostly on penile-vaginal contact and exclude discussions about anal sex and same sex behaviour among men.

Given that anal sex practice is diffuse through various communities, it is beneficial for counsellors to possess the ability to discuss anal sex and other common sexual behaviours easily and in an educated manner.

Learning Objectives

- I. Define anal sex.
- II. Describe various sexual practices in which MSM engage.
- III. Explain the different levels of risk associated with MSM sexual practices.
- IV. Explain various methods for discussing anal sex with your client.

Core knowledge

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. When a person engages in anal sex they can engage in either:

- **Insertive anal sex** – 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** – occurs when a man is penetrated by his partner's penis. This is also called bottoming, being the passive partner, getting fucked, etc.

MSM who engage in anal sex may prefer to engage in only one type of anal sex, insertive or receptive, or they may prefer to engage in both.

Is anal sex only practised by MSM?

In Africa, there is very little known about how common anal sex is among heterosexual men and women. A study in South Africa of almost 12 000 men and women aged 15 to 24 years in 2003 found that anal sex was practised by 3.6% of heterosexual men and women ²¹. Surveys conducted in the United States and European countries reveal higher reports of heterosexual men and women practising anal sex; 30% of women and 34% of men aged 15 to 44 years had never practised anal sex. In men and women aged 15 to 19 years, this was 11% ²².

While questions about anal sex in the general population are rarely asked, anal sex practise among female sex workers (FSW) in Africa has been assessed in some surveys.

They showed that, of the FSWs who participated, nearly half of them had participated in anal sex. Furthermore, half of those who had engaged in anal sex had done so at least, if not more than once a month. Almost all women said that the client asked for anal sex and that they charged more for anal sex ²³. Thus, anal sex is not exclusively practised by MSM.

EXERCISE

Reflect on your own attitudes towards anal sex; between men and between men and women. Before you do the exercise, ask yourself what you actually think about anal sex. For instance, when did you first hear about anal sex and have your views changed since?

Do you agree or disagree with the following statements?

1. Anal sex seems unnatural to me.

Agree / Disagree

2. Anal sex is illegal in my country. And that is how it should be.

Agree / Disagree

3. Anal sex goes against my religion.

Agree / Disagree

4. Heterosexual men and women should know for themselves if they do anal sex or not.

Agree / Disagree

5. Anal sex is un-African behaviour.

Agree / Disagree

6. Anal sex between two men. That is difficult to imagine.

Agree / Disagree

7. Some men do anal sex for pleasure.

Agree / Disagree

8. MSM do anal sex mostly for money.

Agree / Disagree

9. Insertive anal sex is as risky as receptive anal sex.

Agree / Disagree

10. The majority (about 60%) of African MSM are bisexual.

Agree / Disagree

PRACTICES WITH CLIENTS

During HIV testing, a client may be asked the number of sex partners they've had in a certain amount of time. With that one question, however, a counsellor will not know exactly what 'exposure' took place. Therefore, other questions are required to gain more information. For example, was there oral or penetrative sex? Did he or she do penetrative sex with his or her regular partner and oral sex with his or her once-off partner? Which sex act was protected? Were condoms used the first round, and not the second round?

Counsellors 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. There are a number of variables to anal sex and thus counsellors must ask similar questions in order to gain a clearer understanding of their clients' behaviour and risk.

Below are helpful questions that can be asked in order for the counsellor to gain a deeper understanding of their clients' behaviour.

1. Did you practise anal sex with a woman, with a man, or with both?

2. When you practised anal sex were you the receptive partner, the insertive partner, or both.

3. Did you use a condom during anal sex?
4. Was lubrication used during anal sex? If so, what kind?

These questions can be asked along with other standard sexual behaviour questions.

EXERCISE (15 MINUTES)

Recall the last time that you conducted an HIV-counselling and testing session of 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 offered), or a research-initiated test (purposefully offered in view of participation in a research protocol).

Reflect on the brief moment that you explained to your client what you were going to do. 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 counselled and tested an adult for HIV.

Did you ask about anal sex practice?

If you did: write down your question (s) and how the client responses.

If you did not: write down the possible reasons why you did not. You may separate these in 'presumed counsellor barriers' & and 'presumed client barriers'.

Counsellor barriers	Client barriers

OTHER SEXUAL BEHAVIOURS OF MSM

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. Not all MSM engage in anal sex. Therefore it is necessary as a counsellor working with MSM to be familiar with these behaviours. Some of these include:

- **Kissing.** 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.** All describe a sexual activity in which two people rub their bodies together using similar movements as penetrative sex but without penetration.
- **Mutual masturbation.** Is a sexual act in which two or more people stimulate themselves sexually using their hands.
- **Oral sex** (blow job, sucking off, giving head). Is the sexual act that involves stimulating a person's genitalia using mouth and throat.
- **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.** Is a sexual act in which the use of an individual's fingers is used to penetrate and stimulate a partner's genitalia.
- **Oro-anal** (Rimming, anilingus, ass licking) – is a sexual activity that involves the use of an individual's mouth and tongue to sexually stimulate another person's anus.

EXERCISE 1

On a sheet of paper list the many ways in which you think two men can engage in sexual behaviour.

Afterwards, rank them in order of what you believe is the most risky to the least risky.

Once you have finished, compare your answers to table 1.0.

How were your responses similar?

How were they different?

Are there any behaviours that you were surprised to see?

Table 1.0 to follow on next page

Table 1.0 MSM sexual behaviour ranked according to risk of HIV/STI infection

Sexual behaviour	Type of risk		
	Low risk	Intermittent risk	High risk
Receptive anal sex (unprotected)			x
Insertive anal sex (unprotected)			x
Giving oral sex		x	
Receiving oral sex	X		
Mutual masturbation	X		
Rimming	X		
Fingering	X		
Kissing	X		
Touching/caressing	X		
Thigh sex	X		

SUMMARY

- Anal sexual practices occur in Africa between men and women and between men.
- Counselling sessions are a good time to 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 should know the risks associated with different sexual behaviours among MSM and need to be able to counsel clients on how to reduce their risk of getting infected with HIV and other STIs.
- MSM often take both receptive and active anal sex roles.

Module 5

HIV & SEXUALLY TRANSMITTED INFECTIONS (STIs)

OVERVIEW

MSM in Africa have a high burden of sexually transmitted infections. Studies done among men in South Africa, Senegal and Kenya found that about 4 of every 10 men were infected with a STI, which can be passed between MSM through oral, anal and oro-anal sex.^{27, 28}

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.

Therefore, it is crucial for counsellors to know about the STIs that are common in men because as primary contacts for clients, counsellors possess a rich opportunity to assist in referring clients with a potential STI to a health care professional.

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.

Learning outcomes

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

- I. List the common STIs that affect MSM.
- II. List common symptoms of STIs.
- III. Describe how to ask clients about symptoms of STIs.
- IV. Explain how STIs are spread.
- V. Explain what to do if a client has, or may have, an STI.
- VI. Explain the link between HIV infection & STIs.

Core knowledge section

COMMON STIS AMONG MSM?

HIV, syphilis, gonorrhoea, chlamydia, herpes, hepatitis B virus, and warts (caused by a virus called HPV, human papilloma virus).

Human Immunodeficiency Virus

HIV is a virus, that is spread through bodily fluids. Receptive unprotected anal sex carries the highest risk of becoming infected with HIV. Penetrative unprotected anal sex also carries a high risk of contracting HIV. Oral 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 most 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, 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; lose weight and get some types of cancer.

HIV is a manageable infection. Regular medical follow-up is needed to prepare individuals to start antiretroviral therapy. Once started, antiretrovirals need to be taken daily, for life.

All sexually active individuals should be offered HIV testing yearly. For people who have many risky exposures (many times unprotected anal receptive or insertive intercourse) a repeat test should be done after 3 - 6 months, and regularly thereafter. For a person who presents with a flu-like syndrome following a risk exposure and tests HIV negative, a repeat HIV test should be taken (possibly 6 weeks after exposure).^{29, 30}

Urethritis (Urethral discharge syndrome)

Gonorrhoea and chlamydia are the bacteria or germs, that 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 with this infection may have a burning feeling when

urinating, but sometimes have the infection without knowing it. Symptoms usually develop from about 3 to 5 days after exposure, but symptoms may take longer to develop.³¹

Urethritis is spread through contact with the penis, anus, mouth and 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. The World Health Organisation recommends treatment of both germs with a combination of antibiotics in resource limited settings. Antibiotics are needed to cure these infections. Men may be infected again and need to be retreated whenever symptoms are present.³²

Genital Ulcers

Genital ulcers, or sores, may be either painful or painless. Painful sores are most commonly caused by the Herpes virus. Herpes is the most common STI in Africa.³³ Infection is for life and no cure exists. Most commonly, a few painful sores are found on, or near the penis and anus. This virus can also cause sores on the mouth (cold sores). The sores usually heal by themselves.

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. The virus is also able to be spread through intact skin. Treatment is expensive, and not freely available. Treatment works to control the sores if it is started early. Treatment is needed for severe sores or for sores that do not heal.

Syphilis

Syphilis is caused by bacteria, and can first appear as a painless sore on the penis, anus or surrounding area. This sore heals, and individuals may 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 diagnosed only through a blood test. Penicillin, given as three injections over three weeks, is effective for treating most cases of syphilis. ^{31, 32}

Hepatitis B

Hepatitis B is an illness that is also caused by a virus. Hepatitis B is part of a family of different viruses that affect the liver. Hepatitis B is spread through bodily fluids, similar to 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, about one quarter have long-term infection. Some of these people develop scarring of the liver (cirrhosis) and some people with scarring of the liver may develop liver cancer. ²⁹

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, is not very effective and available only in areas with extensive resources. Hepatitis B vaccination is recommended for all people who practise riskier sex, such as sex workers, and men who have sex with men. ³²

Genital warts

Another virus, the HPV (human papilloma virus) causes warts in the genital area. Genital warts appear as growths around the penis and anus. Sometimes they are itchy and may bleed if scratched. Warts often heal without treatment. Large warts need treatment with medication or may need to be removed by surgery. Warts may be numerous, and become very large in HIV positive individuals. The presence of genital or peri-anal warts are signs of unprotected sex. ³⁴ Rarely these warts may lead to anal cancer, which is ¹⁷ more likely to occur in MSM than in non-MSM. ³⁵

Rectal infections and other STIs

Many of the germs mentioned above may cause infection in other parts of the body. Gonorrhoea and chlamydia may also infect the anus and mouth. Infection in the anus may cause painful bowel movements, 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 professional to access 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 germs.³⁴ 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'.³⁰ Clients with symptoms should not wait for them to go away, but should be seen by a health professional. Infestations with bugs like lice and scabies is common, this is possible if people complain of itchiness in the genital area.

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 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).
- Itchy genital area, penis or anus.^{29, 31, 32}

DISCUSSING STI SYMPTOMS

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 by a health care professional.

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 professional for assessment.

- Have you noticed any sores in 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 new pain in your testicles?

- 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 your anus?
- Do you have any irritation or itchiness in your private parts which is new?

HOW STIS ARE SPREAD

STIs among MSM 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 STI infection. Unprotected penetrative anal sex is also high risk for infections which can occur in the penis or the anus.³²

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).³⁴

THE LINK BETWEEN HIV AND OTHER STIS

People who are HIV infected and also have an STI spread the virus more easily to other people. This is because STIs cause swelling and increased blood flow to infected areas and infections that cause sores (or ulcers) break the skin's surface. The increase blood flow and broken skin make it easier for HIV to enter the body.²⁹

ADDRESSING SUSPECTED STIS WITH CLIENTS

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 STIs. Sexual partners also need to be referred for medical review, even if they do not have any symptoms.³⁴

GROUP EXERCISE 1:

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 to act as the counsellor for one of the case studies below. Allow 10 minutes to discuss difficult issues and answer questions in a group.

Case study A

Abdul, a 40 year-old father of two, comes to the clinic for an HIV test. He tells you that for the past 3 days he has had a burning sensation while urinating, and noticed white fluid on the tip of his penis when he woke up this morning. He tells you that he had unprotected anal sex with a male sex worker a week ago.

- Explain to the client what could be causing the burning urine and 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 B

Tshepo is a 20 year-old male who lives with his parents in Johannesburg. At a party two weeks ago, he shared some crystal meth (TIK/methamphetamines) with an older gay male. He remembers having had sex with the guy, 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 among people with a STI.
- 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 professional.
- Screening for common STIs should be included in all HIV counselling sessions.

Module 6

MENTAL HEALTH: ANXIETY, DEPRESSION, AND SUBSTANCE ABUSE

OVERVIEW

Anxiety, depression, and substance abuse are the most common mental disorders affecting MSM. Despite increasing publicity, and programmes to improve awareness about mental health, these disorders remain poorly diagnosed, and ineffectively treated. Studies have shown that MSM are more likely to suffer with depression, anxiety and substance abuse in their lifetimes. For this reason, it is important that counsellors know how to recognise these disorders, and refer them for appropriate care.

Learning Objectives:

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

- I. Define anxiety and depression.
- II. List the symptoms and signs of anxiety and depression.
- III. Explain why men who have sex with men may be more prone to depression and/or anxiety.
- IV. Explain why people who are HIV positive may be more prone to depression.
- V. Describe what to do when a client is depressed or anxious.
- VI. List the substances commonly abused by MSM and their effects.
- VII. Explain how substance abuse increases the risk of contracting HIV among MSM.

Core Knowledge

WHAT IS ANXIETY?

Anxiety is a normal emotion in everyday life and can be seen as a cousin of fear. It has been around as long as humans have had to defend themselves from wild animals. It helps us to prepare for fight (if we have to protect ourselves), or flight (if we have to run away). It 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.³⁶

However, when anxiety becomes excessive and very distressing, and affects the way we function in our everyday lives, it becomes a disorder. These disorders cause great distress, interfere with relationships, and the ability to work effectively.

Anxiety affects our whole being, and causes mental (in the mind), and physiological (in the body) signs and symptoms. ³⁶

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 feel only slightly uneasy, or if the anxiety is severe, panicky or terrified.

EXPERIENCING 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 powerfully in their bodies (the physiological symptoms mentioned above). This would be a panic attack and when these happen again and again, we call this panic disorder.

Generalised anxiety disorder

Generalised anxiety disorder causes people to be in a state of constant worry and anxiety about many things in their lives. They are often tense, and shaky, and also may complain of having upset stomachs.

Phobias

People may be very fearful of an object, e.g. spiders, or of a situation e.g. heights, or social situations. When this is so severe, that it causes them to avoid these things, or situations, we call it a phobia.

Post Traumatic Stress Syndrome

People who have been traumatised e.g. hijacked, raped, beaten up or been 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. The effects of the trauma cause lots of stress in their lives and may lead them to avoid situations e.g. traveling at night. If severe this is called the Post Traumatic Stress Syndrome.

MSM AND ANXIETY

MSM may be more likely to experience anxiety (and depression) due to causes that are not fully understood. It has been suggested that it is related to the effects of social stigma surrounding homosexuality, or the subtle ways that MSM live their lives compared to heterosexuals.³⁶

Additionally, MSM are more likely to abuse alcohol and drugs which may cause, or worsen anxiety.^{37, 38}

Furthermore, studies have shown that MSM 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 social situations.³⁹

Anxiety and people living with HIV

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

- The illnesses that the virus causes, or the virus itself, can cause anxiety because of direct effects on the brain.
- The treatments for HIV can cause anxiety.³⁹

Identify an anxious patient

1. Screen for depression and substance abuse (see Depression and Substance Abuse sections in this module)
2. Ask these 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 very 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 sister, or doctor at the clinic, or a mental health professional, who will be able to make decisions about the need for counselling, psychotherapy, or medication.

Case Study A (10 minutes)

Review the following case study. Identify the symptoms and signs of anxiety and develop an interview technique that you would use to counsel this client.

Sibo is a 23-year old man from Cape Town, who was getting out of a taxi late one Saturday evening, returning from Bronx (a gay club in Cape Town) when he noticed three men getting out of a car that had been driving behind the taxi. Someone shouted: 'poof' and they ran up to him and threw him down on the ground. One person held him down, while the other two people punched him in the face, and kicked him in his crotch. The attack lasted 10 min, and he was left bleeding by the side of the road. For several weeks after the accident, he feels nervous, and feels his heart is racing all the time. He sweats especially when he is in a taxi, and has difficulty talking about what happened, or going anywhere near where the attack took place. He has poor sleep, and his nights are often disturbed by bad dreams.

DEPRESSION

Depression is a word that is often used to describe someone who is feeling very *low-down* or sad.

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

- Feeling sad.
- Feeling apathetic and lacking motivation to act.
- Feeling hopeless.
- Feeling lonely and cut off from other people.
- Having no pleasure in life or in normal activities.

- Feeling tired and having no energy.
- Feeling worthless or bad about themselves.
- Sleeping badly – either sleeping too much or sleeping too little.
- Change in eating habits – either eating too much or eating too little.
- Thinking of, or planning to kill themselves.
- Difficulty concentrating.
- If a person has three or more of these signs, then they may be suffering from depression.

MSM VULNERABILITY TO DEPRESSION

Why are MSM more prone to depression?

MSM are prone to depression for several reasons. The most important reason is that many people see sex between men as unacceptable. In fact, in many African countries it is still regarded as a criminal act. This means that MSM often grow up believing that their attraction to men is wrong or sinful. They may feel stigmatised and excluded from mainstream society. MSM end up hiding their behaviour and having to lead double lives (one life where they pretend to be like everyone else, and another life where they are able to be open about their sexuality.)

Being part of a stigmatised social minority, as MSM are, causes all kinds of stress and potentially mental health problems. MSM may come to feel bad about themselves because friends and family may not support them, and they may be treated badly. Research has shown that people who feel badly about themselves are more likely to suffer depression.^{42, 43}

People who are HIV positive are also more prone to depression. One of the main reasons for this is the stigma that HIV positive people experience, in the form of rejection and blaming by others. They may then hide their status and feel that they have done something wrong or sinful. In turn, this may cause feelings of isolation and loneliness, and lead to depression.⁴¹

The implication for an MSM who is HIV positive is that he may be doubly stigmatised, and so the chances of depression are even higher.

MANAGING A DEPRESSED CLIENT

If a counsellor detects any signs of depression (see list above), or on asking questions of an MSM about these signs, then the counsellor should take action. The following action is appropriate:

- If the MSM has fewer than three signs of depression and there is no evidence that the MSM want to kill themselves, counselling by a lay counsellor is appropriate. 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 the MSM has three or more signs of depression, then he needs to be referred if possible for help to a clinic and / or a professional such as a nurse, a doctor or a social worker for assessment. The professional may decide that the MSM needs professional counselling therapy, anti-depressant medication, or both.
- If the MSM shows any serious intention to kill himself, more urgent action is needed (see section on Suicide below).

SUICIDE

Every year, many people who feel sad or hopeless about their lives will attempt to kill themselves. It is estimated that somewhere in the world, a person successfully commits suicide every 40 seconds. Suicide is a higher risk among people who feel depressed. There is also a higher risk of suicide when a person loses their employment, when they lose a loved one, when they test HIV positive, when a person is in their teenage years or elderly, and when they lose their partner.⁴⁴

SIGNS OF SUICIDE

- The most important signs of suicide are:
- The person expresses a desire to kill themselves.
- The person has a plan for how to kill themselves (e.g. shooting themselves with a gun, taking an overdose of tablets).
- The person has access to the means to kill themselves (e.g. a gun, pills, a place to jump from, railway tracks, etc.).
- The person has attempted to kill themselves before now.

If one or more of these signs are present, it is important to take clear action. Remember that an MSM who falls into one of the following categories: old, recently unemployed, teenager, recent loss, substance abuse or has a history of depression, is also at higher risk for suicide.⁴⁴

MANAGING A POTENTIAL SUICIDE

It is important to take every threat of suicide seriously. It is not true that a person who talks about killing themselves is not really serious about doing it.

It is difficult to predict who will successfully kill themselves, but every person who talks about killing themselves and has a definite plan and access to the means to do it is at risk. Remember too that asking someone about whether they have thought of killing themselves will not make them commit suicide. Do not leave a suicidal person alone until you have found help.

If there is a risk of suicide, the person should be referred to a health-care worker such as a doctor or nurse. Get the suicidal MSM to a casualty department of a clinic or hospital.

It is very important not to let the person out of your sight until you have got help for them. If they are allowed to leave, there is a high risk they will carry out their threat of suicide.

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 A

Victor is an MSM who is 17 years-old. He has 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 B

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

Case study C

James comes to see you. He is an MSM, 20 years of age, who lives on the street. He seems very quiet in the counselling session. He seems to look sad and hopeless. However, he has put on weight since the last time you saw him, and is better dressed than before.

SUBSTANCE ABUSE

MSM and substance abuse

Not all MSM use alcohol and drugs but like most groups in society there are members in the MSM community that abuse substances. In fact, some studies show that the prevalence of drug use is higher among MSM than among heterosexuals.⁴⁵

Why do many MSM abuse substances?

People abuse drugs and alcohol for many reasons. For MSM specifically, one of those reasons may be because of the discrimination they face from being a minority group in society.⁴⁶ For some MSM, drug use provides a sense of social acceptance and community while bonding at gay clubs and circuit parties.

SUBSTANCE ABUSE AND HIV

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

- Not using condoms or forgetting about them.
- Having sex with people they didn't know.
- Having an increased number of sexual partners.
- Engaging in prolonged sex sessions.
- Having unsafe sex to acquire drugs.

Also, abusing drugs may put MSM directly at risk for acquiring HIV if they are using injection drugs since this could directly expose a user.^{45, 46, 47}

IDENTIFYING SUBSTANCE ABUSE

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

- **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.
- **Loss of control** around use of 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 is spent using the substance so that the amount of time spent in other activities (e.g. work, recreation, relationships) is decreased.

- **Continued use of substance despite negative consequences** (e.g. loss of job, break-down of relationships, poor physical health).⁴⁹

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

- **Behaviour** – they are unreliable, deceptive, restless and find it difficult to concentrate.
- **Finances** – a visible impact occurs. They experience financial problems with cash flow and incurring debt.
- **Career** – frequent change of jobs or unemployment.
- **Relationship** – these are negatively impacted with instability, betrayal, multiple partners, and prostitution.
- **Appearance** – lack of self-care and personal hygiene i.e. dirty clothing, unwashed hair.
- **Emotions** – irritable, depressed or aggressive.⁴⁹

COMMON SUBSTANCES USED BY MSM

- **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 effect of alcohol is capable of damaging vital organs in the body. Regularly consuming alcohol is correlated with an increased risk of developing alcoholism, cardiovascular disease, alcoholic liver disease, and cancer⁵⁰ Alcohol consumption is associated with high risk sexual behaviour. It is readily available, legal and helps people lose their inhibitions.
- **Marijuana** – Short term effects include: learning problems, loss of coordination and memory, limited problem solving and rational thought. Physical consequences include increased heart rate and reduced blood pressure, anxiety, fear, distrust, or panic.
- **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.⁵¹ Long term use can result in violent or psychotic behaviour, mood disturbances, homicidal or suicidal thoughts. Methamphetamine use is particularly problematic because it is generally cheap, easily obtainable and highly addictive.

- **Crack cocaine** – Induces a feeling of ecstasy, well-being 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, insomnia, blurred vision and vomiting.

HELPING AN MSM CLIENT WHO IS ABUSING SUBSTANCES

The best thing to do is to refer them for professional specialised help – see list of resources in Appendix ii.

DUAL-DIAGNOSIS

Dual diagnosis refers to the situation in which a client suffers from substance abuse and at the same time, another mental illness. It is very common for substance abuse to occur along with another mental illness. In fact, studies show that roughly 60% of people who are diagnosed with substance abuse have a co-occurring mental disorder.⁵² This means that will need to be treated 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 earlier section on anxiety and depression.⁵²

SUMMARY

- Stigma and rejection from others may cause mental health problems among MSM.
- The most common mental health issues that 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 a suicidal MSM from killing himself.
- Substance abuse is common among MSM and may lead to increase risk behaviour.
- Substance abuse should be managed by a health professional.

Module 7

CONDOM AND LUBRICANT USE

OVERVIEW

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 use, identify common user errors, and tailor your prevention messages to the sexual behaviours of MSM clients.

Learning outcomes

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

- I. Highlight the effectiveness of condoms for preventing HIV and STIs.
- II. Explain the main differences between male and female condoms.
- III. Highlight the difference between oil-based and water-based lubricants, and their effect on the male latex condom.
- IV. Tailor condom promotion messages to take into account the range of sexual behaviours of MSM clients.
- V. Situate condom use within the wider spectrum of HIV prevention strategies.

Core knowledge

WHAT IS A CONDOM?

A condom is a barrier device used to protect people from HIV and STI infection during sexual intercourse. It achieves this by creating a physical 'barrier' between the sexual fluids of two partners engaging in intercourse. There are two main types of condom – they are 'male' condoms and 'female' condoms.

MALE AND FEMALE CONDOMS

Male condoms are usually made out of latex (rubber) and rolled onto a man's penis whereas, female condoms are made out of polyurethane (a thin strong plastic) and are inserted into the body. Polyurethane male condoms exist and can be used by men with a latex allergy.

Currently, the female condom is approved for insertion in the vagina only. In practice, however, reports indicate that MSM also use the female condom for anal sex.⁵³ Compared to the male condom, however, use of the female condom is associated with increased risk of slippage (condom coming off the penis during sex act), discomfort and rectal bleeding, if not used correctly.⁵⁴

Both types of condoms are manufactured according to strict quality standards and are tested for strength, leakage, lubrication, packaging and labeling.

EFFECTIVENESS AND PROPER USE OF CONDOMS

When used correctly and consistently, condoms are 80% to 95% effective at preventing HIV and STIs. These estimates are based on research among heterosexual couples engaging in regular sexual intercourse using condoms consistently.⁵⁵⁻⁵⁸

See Appendix 7.2.1 for more details on correct male and female condom use.

Do not assume the client knows how to use condoms. Use the counselling session to give a condom demonstration. Then ask him to repeat the demonstration, and point out any errors. Encourage him to practise in his own time, including practising in the dark to mimic real-life conditions.

LUBRICANTS

Lubricants (or 'lubes') are products, that reduce friction between the penis, vagina or anus during sexual acts. Lubrication helps prevent condom breakage during sex. During anal sex specifically, added lubrication decreases the risk of slippage.⁵⁹

TYPES OF LUBRICANT

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 KY 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 lubricants.⁶⁰

Therefore, as a counsellor it is useful to understand lubricants and be ready and able to recommend water-based lubricants for clients.

COMMON ERRORS ASSOCIATED WITH MALE CONDOM

In order for condoms to be effective in preventing HIV and other STIs they must be used correctly. Below are a number of common mistakes that MSM could make when using a condom:

- Putting on the condom after penetration.
- Removing the condom and then resuming intercourse without a condom.
- Using a condom for the first round of sex, but not for the second or third round.
- Removing the penis after the penis has softened, increasing the likelihood of the condom slipping off.
- Failure to add lubricant when needed, especially during anal sex, increasing the likelihood of the condom breaking.
- Use of oil-based lubricants (e.g. lotion, vegetable oil, Vaseline ®), that can damage the latex and increase the risk of breakage.
- Lengthy or vigorous sex, associated with an increased likelihood of breakage.
- Engaging in sexual positions that may increase the likelihood of slippage.
- Putting on two male condoms at the same time, increasing the risk of friction between the two condoms and increasing the likelihood of breakage.

CHALLENGES WITH FEMALE CONDOM USE AMONG MSM

Research among MSM in the United States documented a range of challenges associated with female condom use for anal sex.⁶¹

Among **receptive** users:

- Pain.
- Discomfort.
- lack of pleasure.
- Difficulty inserting the device.
- Difficulty keeping it in place if the inner ring was removed.

Insertive users reported:

- Loss of pleasure, and contact with the inner ring.
- Difficulty inserting device after removing inner ring.
- Did not remain in place during sex and/or withdrawal of the penis.
- Irritation.
- Bunching up.
- Unpleasant texture.
- Noise of the condom.⁶²

MSM AND PATTERNS OF CONDOM USE

Despite high levels of awareness of HIV, condom use among MSM populations is not yet systematic or consistent.^{60, 63, 64} Many factors can influence when and how an individual uses a condom. For example, individuals often decide whether or not to use a condom based on their own perceptions of the partner, e.g. whether he/she looks healthy, whether he/she has had many partners, whether they have been together for a long time.

In order to help facilitate consistent condom use, counsellors should encourage MSM clients to always be prepared and have condoms readily available, for example by keeping a supply of condoms at their lodgings and/or taking condoms with them when going out.

Additionally, MSM may stop using condoms after being tested with their partner and entering in an exclusive and monogamous relationship. Particularly for MSM, mutual monogamy, may not be a chosen option for MSM given the high number of sexual partners that MSM can have.^{60, 63} Furthermore, 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, in order to ensure long-term use in the context of stable partnerships.⁶⁵

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. Emphasising the importance of condoms in terms of physical, as well as emotional wellbeing, through a combined sense of intimacy and safety, may help promote condom use both in short-term and long-term partnerships.

If a partner refuses to use condoms, there are a range of options counsellors may suggest to negotiate condom use:

- Where the MSM client is sufficiently empowered to control his own sexuality – the ultimatum of “No condom – No sex” is a powerful one.
- Indicate that condom use makes it easier to be relaxed and therefore facilitates the sexual act.
- Bring back a leaflet on condom use from the counselling session and use it to help introduce the topic.
- Convince the partner to use a flavoured condom to make the experience of oral sex more pleasurable. This will make the transition to using a condom for anal sex easier.
- A partner may refuse to use a condom because he/she does not have any or is not sure about correct condom usage. Make a packet of condoms easily available (e.g. on the bed, in a pocket, etc), and offer to put it on for him.
- Try to make the experience more novel and exciting by introducing new type of condoms, such as a flavoured, coloured or ribbed condoms. If the condom is perceived as an added ‘sex toy’ in the sexual experience, this may help convince the partner to use it.
- Suggest the use of a water based lubricant (e.g. KY Jelly ®) to increase sensitivity.
- If the partner cannot be convinced to use a condom immediately, offer to engage in a range of non-penetrative sexual activities in the meantime (touching, fingering, rimming and oral sex).

- In cases where a female partner may oppose condom use, possible negotiation points include the contraceptive properties of the product, and highlight that adding extra lubricant may make the sensation more pleasurable. The use of the female condom might also be an entry point for further discussion on condom use.
- If a partner refuses to use a condom yet still insists on engaging in anal sex, the female condom may offer an option which the receptive partner may control and choose to insert instead.

The extent to which an MSM client is able to negotiate condom use is further complicated by power dynamics created with differences in age and economic status, and whether or not sex is being bought or sold. In cases where judgment is impaired, due to the use of drugs or alcohol, condom negotiation skills also become more difficult.

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 also draw on your personal experiences where appropriate.

In each case study, describe what the counsellor/clinician could have done better, and how he/she could have incorporated some of the key information and messages from this module.

Case study A

During the counselling session, a MSM client 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.

Questions

- 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 B

During the counselling session, an MSM client 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 device is for women only and that he should therefore not worry about it.

Questions:

- Is the counsellor right in stating that the female condom is for women only? In what situations could the female condom be useful to an MSM client?
- What are the steps associated with correct female condom use?
- In situations where male condom use is not possible and where female condoms are hard to obtain, can the female condom be re-used?
- What are the steps involved with re-using a female condom?
- How would you have dealt with this situation?

Case study C

During the counselling session, an MSM client explains that he would like to start using condoms with his long-term regular partner, but does not see how he can convince 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 shows sympathy, and encourages the MSM client to end the relationship, since continuing to have unprotected sex would put him at risk of HIV and STIs.

Questions:

- 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 D

During the counselling session, an MSM client explains that he had sex with his partner, whom he knows is HIV-positive. His partner is taking ART and is healthy. They always use condoms. However, while his partner was engaging in insertive anal sex with him, the condom broke. This occurred three days ago, 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 risk of being infected with HIV is reduced. He then recommends the MSM client to return three months later, after the window period, 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?

SUMMARY

- When used correctly and consistently, condoms are 80% to 95% effective at preventing HIV transmission.
- Female condoms offer an added option in cases where male condom use may not be feasible.
- Water-based lubricants, such as KY-Jelly®, decrease the risk of slippage and breakage during anal intercourse.
- Condom negotiation strategies should promote condom use as an added way of enhancing pleasure, for example, through the use of flavoured or textured (ribbed/studded) condoms.

Module 8

RISK REDUCTION COUNSELLING

OVERVIEW

This module will explore how risk reduction counselling can specifically address the needs of MSM clients. You will need to incorporate lessons learned from other modules to understand the ways in which risk reduction counselling can differ when conducted with MSM. You will learn tips and strategies that could improve your ability to effectively counsel MSM. This module will focus on strategies of risk reduction counselling aimed at MSM specifically.

Learning Objectives

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

- I. Define risk reduction counselling and describe its effectiveness.
- II. Explain how risk reduction counselling with MSM can differ from sessions with other populations.
- III. Describe key subjects that should be addressed in a risk reduction counselling sessions with MSM.
- IV. List different tips for improving risk reduction with MSM.
- V. Describe different ways for engaging MSM in risk reduction counselling and HIV testing.

Core knowledge

WHAT IS RISK REDUCTION COUNSELLING?

Risk reduction counselling is a behavioural intervention that attempts to decrease an individual's chances for acquiring HIV. This is achieved by helping the client to identify and change specific behaviours that may put them at risk for becoming infected.

It has been recommended around the world to include risk reduction counselling in standard HIV testing procedures and to be implemented particularly for individuals with high-risk behaviours ⁶⁶.

Additionally, risk reduction counselling has been shown to be effective in increasing condom usage and in decreasing the risk of future STIs ^{67, 68}.

As a prevention tool, risk reduction counselling is the most effective when it is patient centered and focused on the specific risks and needs of the client.

RISK REDUCTION PROCESS

The objective of risk reduction counselling is for the client, after having discussed their behaviours and the influences that affect them, to set a realistic goal for behaviour change that could reduce their chances of getting HIV ⁶⁶.

Following is a brief outline for one type of risk reduction counselling process ⁶⁹:

Step 1: **Assess the risk behaviours of the client.** Gain a better understanding of the client's sexual behaviour in the last three months by asking them key questions.

Step 2: **Chose a risk behaviour to address.** The client should help select a behaviour they are motivated to change; otherwise the counsellor can select the most useful behaviour to address.

Step 3: **Discuss the cost and benefits of this behaviour.** This can provide insight for the client into the motivations and influences that could be driving their behaviour.

Step 4: **Goal Setting.** Creating a specific, achievable, and measurable goal that takes into consideration the influences and motivations of the participant.

Step 5: **Discussion of barriers.** Discuss with participants any potential barriers that may prevent them from achieving their goal and help develop strategies to overcome them.

Step 6: **Reinforcement.** Make the participant feel proud and motivated to leave the session with a goal and a new opportunity to improve their behaviour.

Is risk reduction counselling conducted differently with MSM?

Risk reduction counselling should always be focused on the participant by taking into account their specific needs, background, and challenges ⁷⁰.

Therefore, each risk reduction session, no matter the background of the client, will be unique and require different strategies and techniques ⁶⁷.

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, that need to be taken into consideration.

Understanding the effect of personal beliefs and knowledge

The most significant influence in counselling sessions is the counsellor 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. Ultimately, a counsellor may not approve of a man having anal sex with another man but they have a responsibility and a duty to help their client protect themselves and engage in safe sexual behaviours, whatever those behaviours may be.

The effect of closeted clients

Studies in Cape Town have shown that some MSM may not feel comfortable enough to disclose their personal sexual practises to a health 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 a client is 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. To prevent such mistakes ask the same questions every time. For example, if a man is married to a woman, it may be helpful to still ask about having sex with other men.

The significance of confidentiality

All risk reduction counselling sessions, regardless of the client, must remain completely private between the client and the counsellor ¹. 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 client the ways in which their privacy will be respected.

What should be addressed in a risk reduction session with an MSM?

The sexual behaviour of the client should be discussed with an emphasis on understanding the influences which place them at risk for HIV.

Ultimately, behaviour change goals which address these risks need to be developed and put into action.⁷⁰ Below is a review of these key areas as they relate to MSM specifically:

RISK BEHAVIOUR WITH MSM

- Unprotected receptive anal sex.
- Unprotected penetrative anal sex.
- Having a high number of sex partners.
- High use of alcohol or 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 MSM RISK BEHAVIOUR

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

METHODS OF CHANGING THAT BEHAVIOUR

- Lowering number of partners.
- Decreasing alcohol and drug intake.
- Not visiting venues that lead to once off or anonymous sex.
- Getting tested for HIV/STI regularly.
- Having treatable STI treated.
- Using a latex condom with water based lubrication.

EXERCISE

For each of the case studies below first determine the risk factors for each individual and then explore the various possible influences for that behaviour.

Case study A

Simphiwe is a 31 year-old man who is married to woman and has three kids. 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 and in exchange have penetrative anal sex with them. He says he doesn't like to use condoms because they don't fit well and he doesn't carry them because he doesn't want his wife to suspect him.

Case study B

Lindiwe is a 20 year-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 her father did not like her behaviour and did not want a 'moffie' 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 don't have to use condoms.

Case study C

Leonardo is a 34 year-old male who defines himself as gay. He lives in the typical 'gay' neighborhood and goes out to the bars and clubs every weekend with his close friends. Many nights his friends end the evening at the local gay bath house and Leonardo likes to tag along. Practically every time Leonardo goes to the sauna he is offered cocaine. When he gets high he regularly will have sex with a number of guys whom he doesn't know.

COMMUNICATION TIPS DURING RISK REDUCTION

Using the appropriate language and terminology with MSM is a key component to creating an environment in which they feel comfortable to engage 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:

1. Use the types of words they use. As long as the counsellor remains comfortable, using the same language a client uses to describe their sexual practices can create a sense of understanding.
2. Do not automatically label or assume details about the client. Culturally, it may be common to assume things about an MSM because of the way they dress or act. For example, you might assume that a feminine client who dresses in women's clothing may only be a receptive partner or 'bottom'. This is certainly not the case and these types of assumptions could not only offend the client but influence the type of questions that are asked.
3. Do not include value judgments or beliefs. It is not the job of a counsellor to judge their clients because this will not provide a client with any useful service. For example, if a man is married but having sex with other men a counsellor should not encourage him to stop having sex with the man 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.
4. Repeat statements about behaviour or identity. 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 a client labels themselves, to ask them for a deeper explanation of what they mean so that as a counsellor you fully understand their perceptions.
5. Create a safe space. This can be achieved by making your client feel comfortable by ensuring their confidentiality, asking questions to show you are open-minded, knowledgeable and non judgmental. One useful strategy, when working with MSM, is to have literature like pamphlets or books, posters, or other objects within the counselling space so that your client can identify you as someone who is aware of their community.

EXERCISE

Risk reduction counselling practice

In pairs, select a case study below. One individual should be the participant and one individual should be the health worker. For 20 minutes practice a counselling session together. Afterwards answer the following questions:

- Did the session address the key risk behaviours for the client?
- Were helpful strategies created to help the client reduce their risk?

Did the client ever feel judged?

Was the language the health worker used appropriate?

Case Study A

Patrick 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 past six months he has had 30 male sexual partners. On most weekends Patrick likes to visit the shebeens with his friends where they drink until heavily intoxicated. Often on these outings, Patrick finds a man to have sex with. Patrick says he likes to be penetrated but that he always uses condoms. He admits that when he is drunk, he sometimes doesn't remember all of the details.

Case Study B

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. During counselling he 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.

He is afraid of his wife finding out and so does not go to the bars where gay men frequent. Instead, he often will find a male sex worker and pay him to have sex in private. Sandile says he has sex only with a man about once a month and that because he doesn't like the way condoms feel so he doesn't use them.

ENGAGING MSM FOR HIV TESTING AND RISK REDUCTION

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 such as HIV testing. Following are a few key strategies that 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, like where and how they socialise. They can also provide further contacts within the network.

Create 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.

Educate 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 confidentiality is guaranteed by your service or organisation.

EXERCISE

As a group, individually, or in pairs, brainstorm different ways you could engage MSM in your community on an individual, organisational, and community level. Afterwards share these ideas with your group. Also discuss ways in which it might be difficult to contact or interact with MSM in your communities. Why are those barriers present? What can your organisation do to help minimise those barriers?

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 client so that as to not negatively effect the client.
- Use of health services by MSM can be improved by :
 - Establishing key informants.
 - Creating trusting relationships.
 - Educating the community.

Post-course assessment:

Congratulations on completing the MSM sensitivity training course.

Please take the time to complete this post course questionnaire and commitment form.

We suggest that photocopied versions of the questionnaire and assessment are used.

The questionnaire will give us an idea of how effective the course has been. Comments and suggestions will be appreciated.

The commitment form is to assist you as a counsellor to commit to putting this new knowledge into action!

Post-course assessment

Make a circle or a cross on your response.

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. Maybe
- c. No

2. I believe that my own sexual orientation or spiritual beliefs would cause me to treat a man who has sex with other men in a negative way.

- a. Yes
- b. Maybe
- c. No

3. I believe that it is not necessary to ask married male clients about having sex with other men.

- a. Yes
- b. Maybe
- c. No

4. I feel comfortable asking my clients about anal sex practises.

- a. Yes
- b. Not completely
- c. No

5. I am aware of common sexual activities which MSM may engage in and the risks associated with these behaviours.

- a. Yes
- b. Not completely
- c. No

For each statement circle true if you think the statement is correct or circle false if you think it is not correct.

STIs, including HIV, are major health problems among African men	True	False
Research done in Africa has shown that sexual behaviour between men does occur	True	False
Many countries in Sub-Saharan Africa still have laws that criminalise homosexuality	True	False
Stigma against MSM places them at high risk of acquiring HIV	True	False
'Coming out' means letting others know about a person's sexual orientation	True	False
Anal sex is only practised by MSM	True	False
Unprotected receptive anal sex carries the highest risk of getting HIV	True	False
HIV, Herpes, Chlamydia, Gonorrhoea, Hepatitis B and Genital Warts are all sexually transmitted infections (STIs) which affect MSM	True	False
Excessive feelings of fear, or anxiety, can cause mental illnesses, and are common among MSM	True	False
Some symptoms of depression include: feelings of sadness, changes in appetite, feeling tired all the time & thoughts of death	True	False
Alcohol and drug use is common among MSM	True	False
Alcohol and drug use has been associated with increased risk of contracting HIV	True	False
MSM with substance abuse problems should be referred to a health professional if possible	True	False
If used correctly, and consistently, condoms prevent most STIs	True	False
Oil based lubrication, like Vaseline ®, can safely be used with latex condoms	True	False

Post programme commitment

I have completed the MSM sensitivity training course. We covered topics about sexual practises 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 practises 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 counsellors three months after course completion.

May we contact you to complete a short questionnaire after completion of the course?

Yes

No

Please provide work contact details:

Name and surname _____

Facility name & address _____

Contact number _____

Alternate contact number _____

Pre- and Post-course assessment solutions

STIs, including HIV, are major health problems among African men	True X	False
Research done in Africa has shown that sexual behaviour between men does occur	True X	False
Many countries in Sub-Saharan Africa still have laws which criminalise homosexuality	True X	False
Stigma against MSM places them at high risk of acquiring HIV	True X	False
'Coming out' means letting others know about a person's sexual orientation	True X	False
Anal sex is only practised by MSM	True	False X
Among MSM unprotected receptive anal sex carries the highest risk of getting HIV	True X	False
HIV, Herpes, Chlamydia, Gonorrhoea, Hepatitis B and Genital Warts are all sexually transmitted infections (STIs) which affect MSM	True X	False
Excessive feelings of fear, or anxiety, can cause mental illnesses, and are common among MSM	True X	False
Some symptoms of depression include: feelings of sadness, changes in appetite, feeling tired all the time & thoughts of death	True X	False
Alcohol and drug use is common among MSM	True X	False
Alcohol and drug use has been associated with increased risk of contracting HIV	True X	False
MSM with substance abuse problems should be referred to a health professional if possible	True X	False
If used correctly, and consistently, condoms prevent most STIs	True X	False
Oil based lubrication, like Vaseline ®, can safely be used with latex condoms	True	False X

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Appendix i:

Additional resources for condom information

Online videos of condom demonstration:

- Male condom: <http://www.howcast.com/videos/44353-How-To-Correctly-Use-a-Condom> (US-based female presenter)
- Male condom: <http://www.youtube.com/watch?v=FwCXi-4O78I> (Planned Parenthood, BUT HAS NO SOUND)
- Female condom: http://www.youtube.com/watch?v=zjmoQIAQP4Y&feature=player_embedded (Female Health Company)

Website offering comprehensive HIV prevention information, including condom use:

www.avert.org (Avert – International AIDS Charity, Homepage)
<http://www.avert.org/condom.htm> (male condom)
<http://www.avert.org/condoms.htm> (condom effectiveness)
<http://www.avert.org/female-condom.htm> (female condom)

Counsellors/clinicians should encourage patients to visit the Avert website, in cases where the clients have internet access and would like to access further information in their own time.

Instructions for condom use – male condoms

- Store condoms in a place away from heat and humidity. Check the expiration date on the package.
- Be careful you don't rip the condom when opening the package – do not use sharp objects and be careful with fingernails.
- Make sure the tip of the condom points through the round ring in a way that will let it roll down.
- Place the rolled condom on the head of the penis.
- Pinch the air out of the tip with one hand. Leave some space at the tip to hold the semen.
- Unroll the condom over the penis with the other hand.
- Roll the condom down to the based of the penis
- Smooth out air bubbles.
- Add water-based lubricant (e.g. KY Jelly) to the outside of the condom if necessary. Do NOT use oil-based lubricants, such as skin lotions, baby oil,

cooking oil or Vaseline.

- After ejaculation, hold the condom at the base of the penis, and pull out before the penis softens.
- Remove the condom, taking care not to spill any semen.
- Wipe any ejaculate off the penis.
- Make a knot and throw the condom away.
- Never re-use condoms – always use a new condom for each new act of intercourse.

If the penis is not circumcised:

- Pull back the foreskin before putting on the condom.
- After the condom has been put on, push the foreskin forward again. (towards the tip) to let the foreskin move without breaking the condom.

If the condom breaks or slips during intercourse:

- STOP, remove the broken/used condom, and put on a new condom.

Instructions for condom use – female condoms

- Check the expiry date.
- Find the arrow on the packaging and tear downwards.
- Hold the inner ring between your fingers.
- Squeeze the sides of the inner ring together.

For vaginal use:

- Decide on a comfortable position to insert the female condom. This can be done sitting, squatting or lying down.
- Locate the opening of the vagina and separate the outer lips.
- Push the inner ring up into the vagina as far as possible.
- Insert a finger into the female condom to push it upwards. The inner ring of the female condom will reach the cervix – this is a closed space at the top of the vagina, so the female condom cannot disappear inside the body.
- Leave the outer ring on the outside of the body.
- Add lubricant to the inside of the female condom or on the penis if needed.
- 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, STOP, adjust the outer ring, and start again to

guide the penis.

- To take out the female condom, twist the outer ring, and gently remove. Tie a knot and dispose of it in the trash.

For use during anal sex:

- Decide whether to keep or remove the inner ring. This depends on personal use and comfort.

Guidelines for re-use of the female condom – for settings with low availability

In situations where access to female condoms is limited, female condoms may be used up to 5 times, provided they are washed, stored and lubricated adequately (21).

The WHO recommended protocol for washing the female condom is:

Disinfection: As soon as possible after use, prepare a quarter of a litre (250 ml) of water with a small amount (5%) of household bleach. The ratio of bleach to water should therefore be 1:20. Pour some solution in the female condom, then drop the female condom in the solution, and swirl it so that the solution covers all the surfaces of the condom. Soak for 2 to 5 minutes.

Note: Do not attempt to remove the ejaculate prior to submersion in the bleach/water solution. Do not soak the condom overnight, as extended exposure to bleach/water may damage the condom. Do not try to disinfect the condom by boiling it or applying high temperatures.

Washing: Remove the condom from the solution, and wash it with soap (non-abrasive) and water in order to remove the bleach and any residual lubricant. Remove the inner ring. Rinse with clean water to remove the soap. Dry both sides of the condom by using a clean cloth, or by air-drying

Visual inspection: hold the condom up to the light to check for holes. If holes are observed, throw the condom away. If there are no holes, replace the inner ring.

Store the cleaned, dry, unlubricated condom in a clean dry place, away from heat and sharp objects.

Re-lubrication: Re-lubricate the condom just prior to re-use. This makes it easier to insert and makes intercourse more comfortable. The best lubricants are water-based lubricants, such as KY Jelly which can be obtained at a local pharmacy. Oil-based lubricants (e.g. petroleum jelly, baby oil, vegetable oil) may also be used, since they do not damage polyurethane. Avoid using substances which may cause allergies or inflammation, such as peanut or groundnut oil, or hand or body lotions containing lanolin or fragrances.

Appendix ii:

Additional resources for Substance abuse in South Africa

1. CTDCC – Mitchell’s Plain. Phone: (021) 391 0216 Fax: (021) 391 0218
2. CTDCC – Observatory. Phone: (021) 447 8026 Fax: (021) 447 8818 Email: ctdcc@iafrica.com Postal address: PO Box 56 Observatory 7935.
3. SANCA – Phone: (011) 781 6410 or 08614SANCA Fax: (011) 781 6420 Email: sanca@sancanational.org.za Website: <http://www.sancanational.org.za> Postal address: PO Box 663 Auckland Park 2006.
4. AA – Alcoholic Anonymous. Phone: (021) 510 2288 Email: [aa@westcape@telkomsa.net](mailto:aa@westcape.telkomsa.net) Website: <http://www.aaanonymous.org.za>
5. NA – Narcotics Anonymous. Phone: 083 900 6962 Email: ct-helpline@na.org.za Website: <http://www.na.org.za>
6. Harmony Addictions Clinic. Phone: (021) 790 7779 Email: info@harmonyclinic.co.za Website: <http://www.harmonyclinic.co.za>. Postal and physical address: 7 Valley Road, Hout Bay, Cape Town,

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

This introductory guide was developed to assist HIV counsellors and health care workers to be mindful about MSM practices in Africa and to equip them with the skills needed to counsel on such behaviours in the African context.

Contributors experienced in working with MSM in Africa have collaborated to create this modular text.

The guide covers the following topics:

- MSM and HIV in Sub-Saharan Africa
- Stigma
- Identity, Coming Out & Disclosure
- Anal Sex and Common Sexual Practices
- HIV & Sexually Transmitted Infections (STIs)
- Mental Health: Anxiety, Depression & Substance Abuse
- Condom & Lubricant Use
- Risk Reduction Counselling

The results of relevant African MSM research and experience are presented in an accessible manner.

Practical suggestions & assistance to improve MSM relevant risk behaviour counseling practices are provided.

Case studies & exercises to aid the development of MSM inclusive counselling skills are included.



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authors and do not necessarily reflect the
views or policies of the European Union.