MSM sensitivity training for health workers in Africa

SECOND EDITION

This is a print version of the online training course available at

www.marps-africa.org

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Introduction

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

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

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

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

Work done by SAFAIDS and other organisations in Africa has highlighted the existence of high levels of stigma and homophobia in the health care sector around MSM and lesbian gay bisexual transgender intersex (LGBTI) issues. Health care workers have a duty to provide services to all people, and their personal views should not affect their ability to provide these in a non-discriminatory way.

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

Learning outcomes

After completing the programme individuals should be able to:

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

Aims of this training course

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

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 service to all clients without 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.
Contributors

Benjamin Brown is a programmes manager for the Men’s Health Division at the Desmond Tutu HIV Foundation. His work focuses on engaging and educating MSM communities as well as risk-reduction counselling for MSM. He earned his BSc in Psychology from the University of North Carolina at Chapel Hill in the US.

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Eduard Sanders is a senior researcher at the KEMRI-Wellcome Trust Research Programme in Kilifi, Kenya. He is an epidemiologist affiliated with Oxford University and supported by the International AIDS Vaccine Initiative (IAVI). His work focuses on men who have sex with men (MSM) and female sex workers, and his interests include public health interventions to reduce HIV transmission in vulnerable populations; acute HIV infections; HIV and STD care; HIV-1 clinical trials and the impact of AIDS on mortality.

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Kevin Stoloff is a psychiatrist and honorary lecturer at the University of Cape Town with special interests in ‘mental health in HIV’, psychopharmacology and the mental health of MSM, for whom he provides outpatient services. His post is funded by PEPFAR via the ANOVA Health Institute.
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The dedication and hard work of all team members have resulted in a manual that will benefit health care workers and MSM in Africa. This version builds and improves on the previous manual, and provides a larger glossary and resource section. This manual is complemented by an online version, which can be accessed at http://www.marps-africa.org.

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

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Glossary

**Alcohol**
This includes beer, wine and spirits. These substances act as a central nervous system depressant. Alcohol is usually ingested orally as a drink

**Anal sex**
Sex that usually involves the insertion of the penis into the anus (penile-anal penetrative sex)

**Antiretrovirals (ARVs)**
Medication used to kill HIV. In combination it can be used to treat and prevent HIV infection

**Anus**
The region of the bowels which opens onto the skin

**Anxiety**
Feeling of nervousness, which may be an emotion, as well as symptoms felt in the body

**Bechet’s disease**
An autoimmune disease affecting joints, eyes, mouth and gut

**Bisexual**
Having sexual partners of both the same and the opposite sex

**Bisexuality**
The sexual orientation in which an individual has romantic and/or sexual feelings towards both males and females

**Chancroid**
STI caused by the bacterium *Haemophylis ducreyi*, resulting in ulceration and swollen lymph nodes

**Chlamydia**
A group of sexually transmitted bacteria commonly responsible for ‘the drop’/urethritis/proctitis

**Cocaine/crack cocaine**
Substances derived from the coca plant which act as a central nervous system stimulant, which can be snorted, injected or smoked

**Coming out**
The process of coming to terms with one’s own sexuality (sexual orientation and sexual identity)

**Concurrent partners**
Having more than one sexual partner at the same time

**Depression**
A bad feeling that is present for a few weeks in which mood is low, and sleep and appetite may be affected

**Discharge**
Fluid oozing from an area of inflammation, which includes cells aimed at fighting infection and the infectious agent. Discharge may be seen coming from the penis, anus, vagina or throat as a result of selected sexually transmitted infections
Dual diagnosis
This is given when an individual presents with signs and symptoms for two co-occurring conditions, each requiring treatment and management

Ecstasy
This belongs to the class of drugs known as amphetamines, which act as a central nervous system stimulant. They are usually ingested orally, but can also be snorted, smoked, injected or inserted anally

Ejaculation fluid (cum)
Fluid released from the penis during ejaculation (‘cumming’). Many viruses and bacteria that are responsible for sexually transmitted infections can be present in this fluid

Female condom
Loose-fitting polyurethane sheath with an inner ring at the closed end, and an outer ring at the open end, inserted inside the vagina or anus, for protection against pregnancy and/or HIV and STIs

Fingering
Using one or more fingers to stimulate the genitals, including the insertion of the fingers into the anus or vagina

Flashback
The feeling of experiencing or witnessing a situation again (usually a traumatic one)

Frottage
Rubbing penises together for sexual stimulation

Gay man
A man who has romantic, sexual and/or intimate feelings for other men. ‘Gay’ is generally a more commonly used term for homosexual. The term men who have sex with men (MSM) should be used unless individuals or groups self-identify as gay

Gender/biological sex
The term biological sex refers to biologically determined differences, whereas gender refers to differences in social roles and relations. Gender roles are learned through socialisation, and vary widely within and between cultures

Gender identity
A person’s sense of self as male or female. While most people’s gender matches their biological sex, someone may be born biologically male, yet have a female gender identity

Genital
Relating to sexual organs

Gonorrhoea
A sexually transmitted infection caused by the bacteria Neisseria gonorrhoea, commonly affecting the penis, anus and vagina, and less commonly the throat

Granuloma inguinale
An STI caused by the bacterium Calymmatobacterium granulomatis, resulting in many painless ulcers and abscesses in the groin

Heroin
This substance belongs to the class of drugs known as opiates, which act as a central nervous system
depressant and analgesic. It is usually taken intravenously (injected)

**Hepatitis**
Inflammation of the liver, which may be caused by a virus, drugs or, rarely, diseases of the immune system

**Herpes**
A group of viruses which are spread through direct contact. Herpes simplex type 1 is responsible for ‘cold sores’ – superficial ulcers around the mouth and nose. Herpes simplex type 2 causes most cases of painful sores found around the penis, anus or vagina (genital herpes)

**Heterosexuality**
The sexual orientation in which an individual has romantic or sexual feelings towards members of the opposite sex

**Homophobia**
Discrimination, stigma, fear or hatred based on homosexuality, directed at gays, lesbians, bisexuals and transgender people

**Homosexuality**
The sexual orientation in which an individual has romantic or sexual feelings towards members of the same sex

**Human papilloma virus (HPV)**
The virus responsible for genital warts. Different subtypes exist, some of which are associated with the development of anal, penile and cervical cancer

**Incidence**
The number of new people who develop a condition during a particular period of time. This measurement is different to prevalence.

**Insertive partner (‘top’)**
In anal sex, the partner who is inserting his penis into the other partner’s anus

**Intersexed people**
Previously referred to as ‘hermaphrodites’, this refers to individuals who are born with a combination of both male and female reproductive organs, chromosomes, and/or hormones that are either fully or partially developed

**Khat/cat**
This substance belongs to the class of drugs known as methcathinone which acts as a central nervous system stimulant. It is usually snorted, but can also be taken orally or intravenously, or smoked

**Lesbian**
A woman who has romantic, sexual and/or intimate feelings for other women. The term *women who have sex with women* (WSW) should be used unless individuals or groups self-identify as lesbians

**LGBTI**
Abbreviation for ‘lesbian, gay, bisexual, transgender, intersex’

**Lubricant**
Substance that reduces friction during sexual intercourse. Lubricants can be water based (e.g. K-Y Jelly®) or oil-based (e.g. Vaseline®, body cream, cooking oil). Latex male condoms should only be used with water-based lubricants, as oil-based ones weaken latex.
**Lymph nodes**
Glands which form part of the immune system and are involved in fighting infection. Major groups of glands exist in the inner thigh, in the armpits and in the neck.

**Male condom**
A sheath placed over the erect penis before sexual intercourse, which prevents pregnancy and HIV/STIs by blocking the exchange of sexual fluids.

**Mandrax**
This substance belongs to the class of drugs known as methaqualone. It acts as a central nervous system depressant, and is usually ingested orally, but can also be smoked.

**Marijuana/dagga**
This substance acts as a central nervous system depressant and hallucinogen and is usually inhaled by smoking it, but can also be ingested orally.

**Methamphetamine**
This includes speed, crystal meth/tik, which act as a central nervous system stimulant and can be snorted, ingested orally, injected or smoked.

**MSM**
Men who have sex with men. This term includes not only men who self-identify as gay or homosexual and have sex only with other men but also bisexual men as well as men who self-identify as heterosexual but have sex with other men.

**Multiple stigmas**
Stigmatising because of two or more perceived differences, e.g. sexual orientation, HIV-positive status and race.

**nPEP**
Non-occupational post-exposure prophylaxis – the use of post-exposure prophylaxis after exposure to an infectious agent which is not a result of work practices or exposure.

**Oral sex**
Contact between the mouth and tongue and genitals (penis, testicles, anus, vagina), which includes licking, sucking, kissing.

**Oro-anal sex**
Contact between mouth, tongue and anus, including licking (rimming) and kissing the area around the anus and rectum.

**Penetrative penile-anal sex**
Sex act describing the positioning or role of the ‘active’ partner or ‘top’ whose penis is being inserted into the anus of his sexual partner.

**Post-exposure prophylaxis (PEP)**
The use of medication to prevent infection after exposure to an infectious agent – preventive treatment (antiretroviral drugs typically taken for four weeks) started immediately (within 72 hours) after exposure to the HIV virus in order to prevent the virus from developing inside the body.

**Phobia**
Excessive anxiety or fear about a specific object or situation.
Physiological
Relating to the physical body

Prevalence
The number of people who currently have a particular condition within a particular period of time. This measurement is different to incidence

Prostate
A large internal gland which surrounds the urethra at the base of the bladder which produces some of the liquid and substances found in ejaculation fluid

Proctitis
Inflammation of the rectum, commonly due to a sexually transmitted infection in the rectum

Prostatitis
Inflammation of the prostate commonly due to an infection. This may occur as a complication of urethritis

Receptive anal sex
Sex act describing the positioning or role of the ‘passive’, ‘receptive’, ‘bottom’ whose anus is being entered

Receptive partner (‘bottom’)
In anal sex, refers to the partner whose anus is being penetrated by the other partner’s penis

Rectum
The lower region of the bowels linking the descending colon to the anus – also referred to as the rectal passage

Reiter’s syndrome
A collection of urethritis, joint disease and eye symptoms

Rimming
Licking/kissing the anus with the tongue/mouth (see oro-anal sex)

Sero-conversion
The time when an infectious agent is present in the body

Sero-discordant relationship
A romantic or sexual relationship between two people of differing HIV status

Serosorting
The process of selecting a sexual partner based on his or her HIV status. For example, an HIV-positive man may ‘serosort’ and seek out only other HIV-positive men as sexual partners

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

Sexual orientation
The term used to describe the set of emotional, physical and romantic feelings an individual has towards others. These feelings and behaviours are usually directed towards men or women, or both men and women
Sexually transmitted infection (STI)
Infection transmitted and acquired through sexual contact

Stereotype
To perceive all members of some group as if they all were all identical, e.g. to see all MSM as being effeminate

Stigma
Shame or disgrace attached to something regarded as socially unacceptable

Stigmatise
The action of treating someone differently or unfairly because of some perceived difference (e.g. sexual behaviour, gender)

Substance abuse
A pattern of repeated substance use despite the negative consequences (not to be confused with substance dependence)

Substance dependence
A pattern of habitual substance use that involves physical dependence (with increased tolerance and withdrawal), psychological dependence, and behavioural dependence

Symptom
Feeling or problem as experienced by a client, participant or individual

Syphilis
A sexually transmitted infection caused by *Treponema pallidum*, one of the ‘genital ulcer diseases’

Thigh sex
The act of rubbing the penis between the partner’s thighs

Transactional sex
The process of exchanging sex for goods, money, shelter, food or other items or services

Transgender
A person who has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as ‘he’ or ‘she’ according to their gender identity, i.e. the gender that they are presenting, not their sex at birth

Transphobia
The fear, rejection or aversion, often in the form of stigmatising attitudes or discriminatory behaviour, towards transsexuals, transgender people and transvestites

Transvestite
A person who wears clothes associated with the opposite gender in order to enjoy the temporary experience of membership of the opposite gender. A transvestite does not necessarily desire a permanent sex change or other surgical reassignment

Transsexual
A person is in the process of or has undergone surgery and/or hormonal treatment in order to make his or her body more congruent with his or her preferred gender
Ulcer
A sore which involves a break in the protective covering provided by skin

Unprotected anal intercourse
Anal sex, penis in anus, which occurs without the protection provided by a condom

Urethritis
Inflammation of the urethra, the pipe linking the bladder to the outside, along which urine passes. Commonly caused by the bacteria gonorrhoea and chlamydia

Vaginal sex
Sex which usually involves the insertion of the penis into the vagina (penile-vaginal penetrative sex)

Warts
Growths on the skin, caused by the human papilloma virus which is responsible for warts in the genital area

WSW
Abbreviation for women who have sex with women. This term includes not only women who self-identify as lesbian or homosexual and have sex only with other women but also bisexual women as well as women who self-identify as heterosexual but have sex with other women
MSM pre-course questionnaire

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

Previous MSM counselling experience

1. In the past three months how often have you asked your male clients about MSM behaviour?
   a. Never
   b. Sometimes
   c. Often
   d. Every time

2. In the past three months how many MSM clients have you counselled about safer sexual practices?
   a. None
   b. 1–5
   c. 5–10
   d. More than 10

3. Have you ever discussed anal sexual practices with any of your clients, male or female?
   a. Yes
   b. No

4. Have you ever asked male clients about sexual acts with other men?
   a. Yes
   b. No

5. Have you received any training on how to counsel about anal sex?
   a. Yes
   b. No

6. Have you received any previous training on how to counsel MSM clients?
   a. Yes
   b. No

7. Have you received any previous training on how to address specific health needs for MSM clients?
   a. Yes
   b. No
Pre-course assessment

1. How many countries in Africa provide protective legislation for MSM?
   A. None
   B. One
   C. Five
   D. Ten
   E. All

2. On average _________ of African people consider that homosexuality should not be accepted by society.
   A. 25–40%
   B. 40–55%
   C. 55–70%
   D. 70–85%
   E. 85–99%

3. The risk of a man acquiring an HIV infection during unprotected receptive anal sex is ________
   unprotected vaginal sex.
   A. About a tenth higher than
   B. About a fifth higher than
   C. About the same as
   D. About five times higher than
   E. About 10 times higher than

4. A health care worker can be stigmatised for counselling and treating HIV-positive MSM clients.
   [ ] True [ ] False

5. Moral judgement is a form of internal stigma.
   [ ] True [ ] False

6. Social withdrawal is a form of external stigma.
   [ ] True [ ] False

7. All men who have sex with men identify as being gay or homosexual.
   [ ] True [ ] False

8. Research shows that _________ of every community is homosexual.
   A. between 20 and 30%
   B. between 3% and 10%
   C. less than 2%
   D. between 10 and 15%

9. A person who feels pressure to change his or her sexual orientation may experience low self-esteem,
   poor self-confidence and depression.
   [ ] True [ ] False

10. Risk-reduction counselling is intended to help clients identify and change specific behaviours that
    may put them at risk for HIV or other STIs.
    [ ] True [ ] False
   [ ] True [ ] False

12. When a man reports anal sex with a man during counselling you should ask if he takes the insertive or receptive role.
   [ ] True [ ] False

13. Anal warts will not cause anal cancer.
   [ ] True [ ] False

14. Genital warts are caused by:
   A. HIV
   B. HPV
   C. Chlamydia
   D. Syphilis

15. Which is NOT likely to be an early symptom of HIV infection?
   A. Fever
   B. Rash
   C. Genital warts
   D. Sore throat

16. When people experience a sudden overwhelming fear during which they may feel they are ‘going crazy’, or ‘going to die’, it is called:
   A. Post-traumatic stress syndrome
   B. Panic attack
   C. Phobia
   D. Depression

17. Which substance, after long-term use, is most likely to cause violent and potentially homicidal or suicidal behaviour?
   A. Alcohol
   B. Marijuana
   C. Methamphetamines
   D. Crack cocaine

18. When anxiety becomes excessive and distressing, and affects the way we function in our everyday lives it becomes _______
   A. Addictive
   B. Depression
   C. Stigmatised
   D. A disorder

19. Condoms are 80–95% effective at preventing HIV and STIs.
   [ ] True [ ] False

20. If an MSM client complains that condoms always seem to break when he uses them, which would be the best response for a counsellor to give?
   A. Tell the client to use commercial condoms instead of the free ones.
   B. Provide a condom demonstration to the client then ask him to repeat the demonstration.
   C. Hand a few condoms to the client to replace the broken ones.
   D. Suggest he adds some Vaseline (an oil-based lubricant) to reduce friction.
21. When putting on a male condom, it is necessary to ensure that there is air at the tip to allow room for semen.
   [ ] True [ ] False

22. Asking key questions about an MSM's sexual behaviour will __________________________
   A. Cause the client to feel bad about himself
   B. Provide an assessment of the client's sexual risk taking
   C. Make the counsellor appear judgemental
   D. Reinforce the client's behaviour

23. Defining specific, achievable, and measurable _______ that take into consideration the influences and motivations of the client can help with risk reduction.
   A. Risks
   B. Costs
   C. Counselling
   D. Goals

24. When counselling an at-risk MSM, the counsellor's opinions and judgements should not affect the client's behaviours.
   [ ] True [ ] False
Module 1 - Men who have sex with men and HIV in sub-Saharan Africa

Introduction

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

Learning outcomes

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

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

Who are MSM?

‘Men who have sex with men’ or MSM describes those males who have sex with other males. ‘Sex between men’ includes anal sex, oral sex, masturbation or any combination of these practices. MSM include men who only have sex with other men, as well as men who have sex with both men and women. MSM may identify themselves as ‘homosexual’, ‘gay’ or ‘bisexual’, but may also see themselves as ‘heterosexual’ or ‘straight’ (Murray & Roscoe, 2001). MSM also include men who have sex with other men because of their situation rather than their sexual preference. For example, men may have sex with other men because their circumstances prohibit or preclude sex with women, such as in prisons, boarding schools or military barracks (Gear, 2005).

MSM in sub-Saharan Africa

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

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

Anthropologists, the people who study societies and culture, have reported examples of partnerships of:

1. men with older and younger men,
2. men taking on different gender roles (where one partner takes either a masculine or feminine role), and
3. men who appear more on a par with each other (Wilson, 1951).

**Same-sex sexual experimentation before marriage or in adolescence** has also been reported (Murray & Roscoe, 2001).

In some areas, male-to-male sex is a necessary component of certain traditional practices (Weiss, Quigley & Hayes, 2000).

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

It is difficult to know how many MSM there are in Africa because very few of the routine surveys about sexual behaviours have included questions on same-sex practices in Africa. Stigmatisation of same-sex behaviour also makes doing research difficult, as MSM may be afraid to reveal their behaviour. In Asia, Europe and Latin America, where such surveys routinely include these questions, between three and 20% of all men have had sex with other men at least once in their lives.

**Review Quiz 1.1**

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

A. Recent influence of foreigners has greatly increased MSM activity in Africa.
B. Routine surveys have not included questions on same sex practices in Africa.
C. Support, advocacy and research projects have only recently begun to collect data on MSM activities in Africa.
D. Both B and C

**MSM and HIV/AIDS**

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

**HIV epidemics in Africa**

Most adults newly infected with HIV in sub-Saharan Africa acquire the infection through heterosexual sex.

Personal risk of HIV infection can be increased by:
- having multiple sexual partners,
- older sexual partners,
- not using condoms,
- having sexually transmitted infections, and

To date, most national HIV/AIDS control programmes in Africa have concentrated upon reducing
heterosexual HIV transmission, and transmission between mother and child (Baral, Sifakis, Cleghorn & Beyrer, 2007).

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

MSM and HIV in Africa

Where there is information, it shows that in most African countries, MSM have a much higher rate of HIV infection than other men in their communities (Figure 1).

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

Figure 1: Percentage of African MSM living with HIV

Review Quiz 1.2

1. Most adults newly infected with HIV in sub-Saharan Africa acquire the infection through homosexual sex.  [ ] True  [ ] False

2. The rate of HIV infection among MSM in sub-Saharan Africa is estimated to be four to five times higher than the rate for other men.  [ ] True  [ ] False
Why does HIV affect MSM more than other communities?

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

A. Risk

Risk is defined as the chance that a person may acquire HIV infection. High-risk behaviours are those that offer more opportunities for the HIV virus to be transmitted from one person to another.

Examples of high-risk behaviours include:

1. unprotected sex with a partner whose HIV status is unknown or positive
2. multiple unprotected sexual partnerships and
3. using contaminated needles and syringes to inject drugs.

Risks among African MSM

Unprotected anal sex

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

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

Some MSM never have 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 own, or their partner’s, protection. For men that do have anal sex, the correct use of condoms and water-based lubricants for anal sex considerably reduces the risk of HIV transmission.

Drug and alcohol use

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

Multiple partners

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

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

**Other sexually transmitted infections**

A high proportion of MSM in surveys report recent symptoms of sexually transmitted infections. The risk of HIV transmission is increased when an individual has a genital or rectal sexually transmitted infection.

**B. Vulnerability**

A community’s vulnerability to HIV refers to conditions adversely affecting the community’s ability to avoid, prevent or cope with the threat of HIV/AIDS. MSM communities in Africa are very vulnerable to HIV infection. This is due to a combination of many factors, including:

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

**Personal factors that may increase HIV vulnerability**

**Knowledge of risks of MSM sexual practices**

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

**Safe sex skills**

The effective use of condoms (including female condoms) and lubrication for anal sex can reduce the risk of HIV transmission. This protection depends upon the skills of MSM to:

1. select and apply lubrication properly,
2. be able to negotiate the need to use condoms with their sexual partner, and
3. be able to access affordable supplies of condoms and water-based lubricants (Dahoma et al., 2011).

Unfortunately, many African MSM use oil-based lubricants, which may damage latex condoms.

**Testing and knowledge of HIV status**

Most MSM live unaware of their own HIV status, due in part to ignorance of the risks of their own sexual behaviours and/or a reluctance to use HIV testing services (Sandfort, Nel, Rich, Reddy & Yi, 2008). Most African countries that collect information on MSM HIV testing report that less than 40% of MSM have tested within the previous 12 months.
From the perspective of MSM, confirming HIV status can offer benefits regardless of whether the test result is positive or negative:

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

**Review Quiz 1.3**

1. **MSM are more at risk for being HIV positive than other men and women because:**
   a. MSM generally have more sexual partners than other African men.
   b. Men are more likely to be HIV positive than women.
   c. Lack of knowledge and skills due to poor quality and coverage of MSM services.
   d. There is no such thing as safe sex for MSM.

2. **Most African countries collecting information on MSM HIV testing report that ________ of MSM have tested within the previous 12 months.**
   a. less than 40%
   b. about 40%
   c. about 50%
   d. more than 60%

**Coverage and quality of services**

At the present time, **very few African countries include MSM in their national plans for HIV control, and almost none allocate HIV-control resources to provide services for MSM specifically.** In official figures in 2008, 46 African countries reported that no services were available for MSM (American Foundation for AIDS Research, 2008). This is in direct opposition to recommendations from the World Health Organisation (WHO) who recommend that ‘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’.

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

- Lack of MSM-appropriate sexual health materials (information, water-based lubricants, 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 that may increase HIV vulnerability**

**Law and politics**

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

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

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

**Public opinion**

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

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

**Covertness**

MSM may be fearful to disclose their sexual behaviours or same-sex orientation to members of their family or to health care staff. This often prevents them from accessing the knowledge, skills and services that would help meet their HIV prevention and treatment needs.

**Self-esteem**

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

**Consequences of multiple vulnerabilities**

MSM are individually and collectively more vulnerable to HIV risks due to:

- lack of knowledge and personal skills,
- the inaccessibility and unavailability of prevention and treatment services, and
- the hostile and stigmatising societal environment.

Each of the individual factors listed above could increase the HIV risk of an individual or community. Together these factors add up to make MSM at high risk for HIV infection and extremely vulnerable.

**Summary**

- MSM exist in Africa, as they do in every culture and society, although their existence has long been overlooked and denied by authorities.
- MSM may practise anal sex, oral sex, masturbation and combinations of these practices, and many MSM also have sex with women.
- MSM in Africa have a considerably higher rate of HIV infection than other African men.
- MSM experience multiple simultaneous factors that make them vulnerable to HIV infection.
- Unprotected receptive anal sex is the most risky sexual behaviour for the transmission of the HIV virus and is often practised among African MSM.
- Few African countries include MSM in their national plans for HIV control, and almost none allocate HIV control resources, despite WHO recommendations.
- More research about MSM in Africa needs to be done to inform the development of clinical and public health HIV prevention, treatment and care.
Module 1 assessment

1. How many countries in Africa provide protective legislation for MSM?
   A. None
   B. One
   C. Five
   D. Ten
   E. All

2. Reports of same sex practices and men who have sex with men have come from most African countries dating back to
   A. Before the 19th century
   B. The late 19th century
   C. The early 20th century
   D. The early 21st century

3. A man’s risk of HIV infection is higher if he
   A. Does not use condoms
   B. Has untreated sexually transmitted infections
   C. Is not circumcised
   D. Injects drugs
   E. All of the above

4. On average __________ of African people consider that homosexuality should not be accepted by society.
   A. 25 to 40%
   B. 40 to 55%
   C. 55 to 70%
   D. 70 to 85%
   E. 85 to 99%

5. HIV infection among MSM in sub-Saharan Africa is estimated to be ________ than the rate for other men.
   A. three times higher
   B. four to five times lower
   C. double
   D. four to five times higher
   E. twenty times higher

6. Sex between men need not always involve penetrative anal sex. Alternative types of sex include (choose all that apply):
   A. Receptive anal sex
   B. Masturbation
   C. Oral sex
   D. Thigh sex
   E. None of the above

7. __________ refers to when HIV positive men choose only HIV positive men as their sexual partners.
   A. Positive prevention
   B. Serosorting
   C. Selective partnership
8. In sub-Saharan Africa, most national HIV/AIDS control programmes include HIV programs targeting men who have sex with men. [ ] True [ ] False

9. There is not enough data to provide reliable estimates on how many African men have sex with other men. [ ] True [ ] False

10. Studies prove that MSM in Africa have more sexual partners than other African men. [ ] True [ ] False

11. Recent legal reforms in some East African countries have aimed to strengthen homophobic (anti-homosexual) legislation. [ ] True [ ] False

12. Countries that have offered legal protections to MSM usually see more MSM coming forward for prevention, testing and treatment. [ ] True [ ] False
Module 2 - Homophobia: Stigma and its effects

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

• Define ‘stigma’
• Define the differences between external and internal stigma
• Relate stigmas to their own experience of being treated differently
• List the ways in which a person can be stigmatised for being MSM
• List the effects of stigmas on MSM
• Describe homophobia
• Explain the double stigma that MSM who are HIV positive may experience
• Define stereotyping of MSM
• Describe how to support an MSM client who is stigmatised.

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

Stigma Defined
A stigma can be defined as:

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

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

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

A. **External stigmas** cause certain people to be treated unfairly and differently to everyone else. For example, a person who is an MSM may be refused treatment by health care workers, or be made to sit in a separate waiting area from other patients.

B. **Internal stigmas** cause a stigmatised person to feel a certain way about themselves because of external stigmas. For example, an MSM’s confidence may suffer, and he may feel sad and depressed (Hamilton, 2006).
Exercise 2.1

Think back to a time in the past when other people treated you differently. 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, and who treated you with less love and affection than they did their own children.

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

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

Homophobia

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

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

Anti-gay bill finds support in conservative Uganda (TheVJM Movement)

YouTube Video: [http://www.youtube.com/watch?v=_-ojsXXRXE&feature=player_embedded](http://www.youtube.com/watch?v=_-ojsXXRXE&feature=player_embedded)
External stigma

Signs of external stigma are:

- Avoidance: people avoiding MSM or not wanting to sit near them.
- Rejection: people rejecting MSM. This could be family members or friends no longer being willing to associate with the MSM or it could be that a society or group of people do not welcome MSM.
- Moral judgement: people blaming MSM for their behaviour or seeing them as immoral.
- Stigma by association: people who associate with MSM are stigmatised because of their association.
- Gossip: talking about MSM in a negative way to other people.
- Unwillingness to invest in MSM: MSM may be marginalised within an organisation because of their behaviour, and so denied training or promotion.
- Discrimination: opportunities denied to MSM, e.g. being denied employment, proper medical care or access to medical aid schemes, and service providers denying services to MSM.
- Abuse: MSM being physically or verbally abused (being shouted at, called names).
- Victimisation: MSM being blamed, for example, by politicians for problems in a country.
- Abuse of human rights: for example, denying MSM their basic human rights, such as breaching of confidentiality in HIV testing.
- Violence: attacks on and in some cases even murder of MSM for their sexual orientation.

Internal stigma

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

KTN television feature story about being gay in Kenya

YouTube Video: [http://www.youtube.com/watch?v=JcOMSvCeUd4&feature=player_embedded](http://www.youtube.com/watch?v=JcOMSvCeUd4&feature=player_embedded)
Signs of **internal stigma** are:

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

**Stereotyping and making assumptions**

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

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

**Sexual diversity: an interview with Gay and Lesbian Coalition of Kenya (GALCK)**

YouTube video: [http://www.youtube.com/watch?v=e2202n0QiDg](http://www.youtube.com/watch?v=e2202n0QiDg)

**Addressing stigma**

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

**How to deal with stigma directed a MSM**

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

Exercise 2.2
Read the case study below and indicate what types and forms of stigma are present.

Case study A
Jalil is a young MSM who lives in Nairobi, the capital of Kenya. Jalil is 19 years old, and has been living on the streets since his parents threw him out of their home when they found out he was gay.

Jalil then engaged in sex work to survive, but was not aware of the risks of HIV, so he did not ask clients to use a condom when he allowed them to penetrate him anally. Jalil then became HIV positive.

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

What forms of external stigma are present in this case? (select all that apply)
A. Gossip
B. Avoidance
C. Rejection
D. Suicide
E. Discrimination

Summary
• A stigma is defined as an attribute or quality that shames an individual or group of people in the eyes of another individual or group.
• Stigma is a common experience for MSM and has multiple impacts on them.
• The stigma experienced by MSM is also known as homophobia. It is fuelled by certain religious and cultural beliefs, and is often more harsh for effeminate MSM.
• MSM who are HIV positive may experience the burden of double stigma because of both their sexual orientation and their HIV-positive status.
• External stigma refers to how MSM are treated negatively by others. Examples include gossip, being ignored, avoidant behaviour, judgement, abuse and violence.
• Internal stigma refers to how MSM feel and act because of external stigma.
• Examples include low self-esteem, depression, not seeking medical assistance, withdrawal from contact with people, and suicide.
• Stigma affects the health and wellbeing of everyone who is stigmatised and needs to be addressed.
• Appropriate support and counselling can minimise the effects of stigma and assist MSM in their wellbeing.
Module 2 assessment

1. A health care worker can be stigmatised for counselling and treating HIV-positive MSM clients. [ ] True [ ] False

2. Moral judgement is a form of internal stigma. [ ] True [ ] False

3. Social withdrawal is a form of external stigma. [ ] True [ ] False

4. Double-stigma involves more than one person. [ ] True [ ] False

5. Individuals experiencing internal stigma may have a higher risk of engaging in drug use and experiencing depression. [ ] True [ ] False

6. A doctor discovers that his HIV-positive patient is an MSM, the doctor tells him that he is incurable and he will suffer for his sins. This same doctor has provided appropriate treatment for several female patients who were HIV positive. The doctor's behaviour is an act of _____.
   A. Discrimination
   B. Gossip
   C. Avoidance
   D. Violence

7. A hospital has a policy to refuse health care treatment for patients who identify as MSM because homosexuality is illegal. Refusal to provide basic healthcare based on a person's sexual orientation is abuse of ______.
   A. Moral judgements
   B. Human rights
   C. Self-esteem
   D. Mental health

8. If an MSM becomes depressed because he is afraid that his family will disown him if his family finds out he is gay, it is a(n) _____ type of stigma.
   A. External
   B. Internal
   C. Positive
   D. Negative

9. If a man is physically beaten by a gang of men who suspect him to be an MSM, this is a(n) ______ type of stigma.
   A. Internal
   B. External
   C. Positive
   D. Negative
10. _______ is a form of stigma where people say negative things to others about a certain person or group of people.

- A. Discrimination
- B. Rejection
- C. Avoidance
- D. Gossip

Case study

Read the case study below and indicate what types and forms of stigma are present.

Tsepho is a very effeminate 27-year-old man who lives in Daveyton, a township in Gauteng, South Africa. He has engaged in sexual activity with men for the last 10 years.

Recently, he went for a health check-up to the local clinic, which included an HIV test. The nurse who tested him shouted at him when she met him and called him a ‘sissy girl’. She accused him of immoral behaviour and of disobeying the teachings of his church. Tsepho is afraid now of seeking health care or testing again for HIV.

What forms of external stigma are present in this case? (select all that apply)

- A. Rejection
- B. Violence
- C. Moral judgement
- D. Verbal abuse

What behaviours resulting from internal stigma are present in this case? (select all that apply)

- A. Self-exclusion from services
- B. Not seeking health care
- C. Violence
Module 3 - Sexual identity and coming out

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

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

Introduction
This module describes the difference between sexual identity and sexual behaviour. It introduces the complex process of *coming out* and explains that just because they differ from the social norm, MSM do not have an illness or a disease, and do not have a choice about their sexual orientation. Finally, this module will offer guidelines on how to support someone who is coming out, and addresses the impact of the coming-out process on the family.

Definitions

• **Sexual identity** = who you are sexually (e.g. ‘gay’ or ‘straight’), what you think of yourself as.
• **Sexual orientation** = who you are sexually attracted to (e.g. heterosexual, homosexual, bisexual)
• **Sexual behaviour** = what sex you have, what you DO sexually (e.g. anal sex, oral sex, etc.)
• **Anal taboo** = the general social avoidance of any reference to the anus because of complex factors that associate that body part with shame, guilt and dirt.
• **Analphobia** = an irrational fear of anything to do with that part of the body.

Sexual Identity

What is sexual identity?

Many people believe that all people can be grouped according to whether they are male or female, and whether they are homosexual (gay) or heterosexual (straight). This simplistic view does not allow for the reality of each and every person having a unique **sexual identity**. Our sexual identity is determined according to three independent levels that include a spectrum of individual difference:

**Level 1:** The **biological level** determines our physical sex, male or female, according to our genitals and other physical features. A very small number of people are born **intersex**, either with ambiguous or inconclusive genitals or with internal tissue secreting hormones of the opposite sex. It is a myth that MSM are intersex.
Level 2: This psychological level relates to our sexual orientation – the extent to which we are sexually, emotionally and romantically attracted to either the opposite sex, the same sex or to both sexes. Heterosexual people will be primarily attracted to people of the opposite sex, while homosexual people are primarily attracted to people of the same sex. Many people are bisexual, being aware that they are attracted to both men and women. Importantly, an individual’s sexual orientation can shift or develop over time. Note that no one, whether they are heterosexual, bisexual or homosexual, chooses their sexual orientation.

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

MSM and sexual identity

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

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

What is sexual behaviour?

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

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

Sex between men can include a more complex range of behaviours. A man can choose to be either penetrative or receptive during oral or anal intercourse, or may enjoy both roles. There are many variations and preferences in sexual activity (Makadon, Mayer, Potter & Goldhammer, 2008).

Situational MSM

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

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

Gay in Kenya (CNN feature news story)

YouTube Video: http://www.youtube.com/watch?v=ONV6bgHs81A&feature=player_embedded

The social environment of MSM identities and behaviours

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

Cultural norms regarding homosexuality differ around the world in the same manner that the rights of women differ in various countries. Religion is often used to express negative attitudes towards MSM. Some Christians or Muslims, for example, quote selective Biblical or Koranic texts to justify prejudice against MSM.

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

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

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

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

Exercise 3.1

1. Homosexuality is unhealthy and unnatural and needs to be treated as a disease.
   [ ] True  [ ] False

2. Sexual orientation is another term for homosexuality.
   [ ] True  [ ] False
The Coming Out Process

What is the coming-out process?

*Coming out* refers to an individual becoming increasingly aware of his or her non-heterosexual sexual orientation, and coming out of ‘hiding’ by disclosing this to others.

The process of coming out is different for every individual; some are comfortable with their experiences, while others experience a crisis period. Some people become very depressed and may even become suicidal. The way individuals experience the coming-out process is often influenced by their social surroundings, especially their family’s attitudes towards diversity.

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

Following is one model of a male that includes six stages in the coming-out process, which could last for a very brief time to many years and may occur in any sequence.

**Stage 1: Identity confusion**

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

**Stage 2: Identity comparison**

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

**Stage 3: Identity tolerance**

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

**Stage 4: Identity acceptance**

The individual begins to explore the concept of possibly being homosexual and begins to experience less conflict about his identity. He may seek out other homosexual people and information on homosexuality. He experiences anxiety about disclosing his sexual orientation to someone else but does manage to do so.
Stage 5: Identity pride

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

Stage 6: Identity synthesis

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

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

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

Supporting someone who is ‘coming out’

An individual who is going through the complex coming-out process often feels confused, anxious, fearful of being rejected, depressed, alone and isolated. Following are a few suggestions you could make to someone who is coming out:

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

• Encourage him to get further information on what it means to be homosexual. He could use the Internet to do this, or if he lives in a large city you could help him find a gay organisation that could give him information and support.

• Encourage him to meet and talk with other men who have experienced the coming-out process. This will allow him to feel less isolated and to learn from their experiences.

• If he is anxious about the sexual aspects of being homosexual, inform him that he should not engage in any sexual activity until he feels ready for this. He may be wary of the notion that all male-to-male sex includes anal sex; assure him that this is not true. Encourage him to make sure he is aware of what ‘safer sex’ means for male-to-male sex before he has sex with another man.

• If he is a mature man who is coming to terms with his homosexuality, encourage him to meet other men to whom he can talk about this. If he has the means to do so he may want to talk to a social worker or a psychologist to help him through this process.

• If he has a wife and perhaps children, it is likely that he will be experiencing high levels of anxiety, guilt and shame. He might fear the loss of his family and the scorn of his friends and family. Assure him that many men only become conscious of, or come to terms with, their true sexuality later in life. Acknowledge that his sexual orientation does not in any way negate his love for his wife and family and that he is fearful of causing them emotional distress. Encourage him to consider the value of honesty, and the fact that it may be in both his own and his wife’s interests for him to resolve the situation by having an honest conversation with her.

• Acknowledge the fact that he will need to proceed at his own pace, and that he could benefit from professional support. Encourage him to ensure he is fully informed of safer sex behaviours, and that he practises responsible sex at all times.

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

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

**Coming out and the family**

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

When confronted with the reality of a homosexual son, many parents react angrily, or they may choose to believe that it is only a phase he is going through and that he will change if he meets the right girl. Parents often wonder what caused their son to be homosexual and may blame each other. Some parents refuse to accept a son’s homosexuality and may banish him from the home or react violently towards him.

It is sometimes advisable for a son to not disclose his sexual orientation to either one or both parents, especially in instances where the family culture is clearly homoprejudiced or homophobic, or in instances where he may be placing himself at risk.
Ideally, parents will attempt to gather more information on homosexuality in order to understand their son’s situation better. By so doing they will learn that neither of them caused him to be homosexual; that his sexual orientation is not a disease or an illness, and that it cannot be changed or ‘cured’; and that he did not choose it. If parents are unsure of how to respond they should be advised to seek professional help from a psychologist or social worker in order to ensure that they react in their child’s best interests.

**Difference between coming out and disclosure**

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

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

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

**Benefits of disclosure**

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

**Risks of disclosure**

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

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

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

**Exercise 3.2**

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

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

**In what ways should the counsellor address the issue of HIV status disclosure to Boniface? (select all that apply)**

A. Offer a story about an HIV positive man who received support from his family after disclosing his status.
B. Tell Boniface that he might never be able to work if people find out he is HIV positive.
C. Suggest that Boniface join a support group where he can discuss disclosure.
D. Ask him what fears he has surrounding disclosure.
E. Offer to tell Boniface's family next week that he is HIV-positive.

**Summary**

- Not all MSM identify as gay; in fact, many MSM have sex with women as well.

- Sexual identity, sexual orientation and sexual behaviour are unique for every person and may not always be in line with societal expectations.

- Coming out is a complex and lifelong process that involves many stages.
Module 3 assessment

1. __________ refers to the set of emotional, physical and romantic feelings they have towards other individuals.
   A. Sexual behaviour
   B. Sexual preference
   C. Sexual orientation
   D. Sexual identity

2. Many factors can influence the way a person develops his / her sexual identity EXCEPT:
   A. Social factors
   B. Biological factors
   C. Religious factors
   D. Psychological factors

3. ____________ refers to when a man has sex with other men due to certain circumstances, such as being in prison.
   A. Anal taboo
   B. Situational homosexuality
   C. Coming out
   D. Sexual orientation

4. ___________ refers to the general social avoidance of any reference to the anus.
   A. Analphobia
   B. Homophobia
   C. Anal taboo
   D. Homoprejudice

5. ______ refers to a time when an individual becomes aware of his or her non-heterosexual sexual orientation.
   A. Disclosure
   B. Coming out
   C. Discretion
   D. Curing

6. ______ is the process through which a person makes known he is gay or HIV positive.
   A. Disclosure
   B. 'Coming out'
   C. Discretion
   D. Curing
7. Which of the following is usually an initial stage of 'coming out'?
   A. Finding new social groups
   B. Telling others they are gay
   C. Increased sexual activity
   D. Confusion and anxiety

8. Rejection, being treated differently and losing employment are all potential risks of disclosing one’s HIV status. [ ] True [ ] False


10. All men who have sex with men identify as being gay or homosexual. [ ] True [ ] False

11. A gay man often begins to accept his homosexuality after meeting another gay person to whom he can relate. [ ] True [ ] False

12. As a result of intolerance and negative attitudes, many homosexuals do not disclose or openly share their sexual identity with family members. [ ] True [ ] False

13. Gay men choose to be homosexual and can also choose to be heterosexual if they wish. [ ] True [ ] False

14. ‘Identity pride’ refers to when an individual reinforces his sexual identity by separating himself from heterosexual norms. [ ] True [ ] False
Module 4 - Anal sex and common sexual practices

Learning objectives

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

• understand that anal sex is practised by men with women, and men with men

• recognise different roles during anal sex (insertive/receptive)

• discuss anal sex with your clients

• explain various sexual behaviours that are practised by MSM

• explain different levels of risk associated with MSM sexual practices.

Overview

Around the world, discussing anal sex can be challenging because it is often surrounded by stigma and taboo, both from a health care provider’s as well as a client’s point of view. In this module you will learn that anal sex is practised by ‘heterosexual’ men and women, and by MSM. For a woman, anal sex is always ‘receptive’ (she can only receive the penis in her anus). For a man, anal sex can be either ‘insertive’ (he can insert his penis into the anus of a woman or a man) or ‘receptive’ (he can receive the penis in his anus).

As a health care worker you will provide services to men who report sexual intercourse with men and women (bisexual), with men only (homosexual), and with women (heterosexual). You will also learn to ask what role a man takes when he reports practising anal sex and why this is important. In this module you will also learn more about anal sex between men and women (penile-anal penetrative sex).

What is anal sex?

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

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

• **insertive anal sex** – which occurs when a man uses his penis to penetrate his partner. This is also called topping, fucking, being the active role, etc.

• **receptive anal sex** – which occurs when he is penetrated by his partner’s penis. This is also called bottoming, being the passive partner.

MSM who engage in anal sex may prefer to engage in only one type of anal sex, insertive or receptive, or to engage in both roles (World Association of Sexology, 2000).
Anal sex practice among heterosexual men and women

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

In Africa, very little is known about how common anal sex is among heterosexual men and women. A study in South Africa in 2003 of almost 12000 men and women aged 15–24 years found that anal sex was practised by 4% of heterosexual men and women (Lane, Pettifor, Pascoe, Fiamma & Rees, 2006). A more recent study of almost 2600 men and over 1800 women sampled from townships in South Africa found that 360 (14%) men and 172 (10%) women reported practising anal sex in the three months before the study (Kalichman et al., 2009).

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

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

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

Exercise 4.1

1. A study in US and European countries indicated that anal sex is practised by __________ of heterosexual men and women, aged 15-33.
   A. 10 - 14%
   B. 5 - 10%
   C. 30 – 34%
   D. 40 - 51%

2. A study of Kenyan female sex workers indicated that __________ reported having anal sex.
   A. 41%
   B. 4%
   C. 14%
   D. over 50%
HIV infection through anal sex vs. vaginal sex

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

Figure 3: The anorectum

Figure 4: Female vaginal and anal mucosa
Table 1: Differences between penile-anal and penile-vaginal sex

<table>
<thead>
<tr>
<th>Penile-anal sex</th>
<th>Penile-vaginal sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>No natural lubrication in anus</td>
<td>Vagina produces natural lubrication when sexually aroused</td>
</tr>
<tr>
<td>Anus has limited elasticity</td>
<td>Vagina has elasticity and stretches</td>
</tr>
<tr>
<td>Colon and rectum only a single layer of epithelial cells (one cell thick)</td>
<td>Vagina much thicker epithelial layer (approximately 40 cells thick)</td>
</tr>
<tr>
<td>Tears easily with no lubrication</td>
<td>Vagina doesn't tear as easily, and is more robust</td>
</tr>
<tr>
<td>Presence of faecal matter possible (containing bacteria)</td>
<td>No faecal matter present</td>
</tr>
<tr>
<td>Many inflammatory cells (CD4 receptors) under surface in rectum</td>
<td>Fewer CD4 receptor cells in vagina than rectum</td>
</tr>
</tbody>
</table>

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

**Figure 5:** Male risk for HIV during different sex acts. *Source: Smith et al. (2005)*
Figure 6: Female risk for HIV during different sex acts. Source: Smith et al. (2005)

Case studies

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

Case study 1

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

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

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

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

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

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

Case study 2

In both the above case studies Fatima Jean is a 19-year-old male sex worker who works mostly around bars in the city centre. He is not very proud of his work but feels he has no choice as he did not go to secondary school and has no training or professional skill. Tonight he is hungry and has only enough money for his fare home. Jean is quite small and not very physically strong.
Festus is 42, married with three children and a successful businessman. He occasionally comes into
the city at night to pay for sex with men and sometimes street boys. He does not consider himself to be
gay. He enjoys sex with men because he can ‘be rough’. Festus knows about HIV and STIs but
assumes that anal sex is safe. Tonight he wants rough sex and approaches Jean.

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

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

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

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

**Exercise 4.2**

Do you agree or disagree with the following statements?

1. **Anal sex is a natural behaviour.**
   
   Agree / Disagree

2. **There should be no laws against anal sex.**
   
   Agree / Disagree

3. **Anal sex goes against my religion.**
   
   Agree / Disagree

4. **Anal sex was brought to Africa from the West.**
   
   Agree / Disagree

5. **It is not possible for a woman to enjoy anal sex.**
   
   Agree / Disagree

**Discussing anal sex with your client**

During the HIV testing session, a client will be asked about the number of sex partners he has had in a certain
period. For instance: ‘In the past month, how many partners have you had?’ With that one question and the
answer to it, however, a counsellor will not know what ‘exposure’ took place (what kind of sex?), and
counselling on possible risk behaviours will not be sufficiently tailored to the behaviour of that client,
therefore other questions are required to gain more information. For example:
• Was there oral, anal or vaginal sex?
• Was there penetrative sex with the regular partner and oral sex with the one-off partner?
• Which sex act was protected?
• Were condoms used the first round and not in the second round?

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

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

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

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

**Anal sex and HIV testing**

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

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

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

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

When we think of MSM, we often think only of anal sex. The above shows that there are many ways in which two men can sexually stimulate each other, not just by engaging in anal sex.
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. However, not all MSM engage in anal sex, therefore it is necessary as a counsellor working with MSM to be familiar with these other behaviours. Some of these include the following:

- **Kissing.** This is the act of using one’s lips to touch another person or object. Kissing is used to express emotions like love and affection. While kissing traditionally occurs between two people’s lips, a person can use their lips to kiss anywhere on someone else’s body.
- **Dry sex, dry humping, rubbing, frottage.** All these describe a sexual activity in which two people rub their bodies (or body parts) together using similar movements as penetrative sex but without penetration.
- **Mutual masturbation.** This is a sexual act in which two or more people stimulate themselves sexually using their hands.
- **Oral-penile sex (‘blow job’, ‘sucking off’, ‘giving head’).** This is the sexual act that involves stimulating a person’s genitalia using the mouth and tongue.
- **Using sex toys.** A sex toy is any object that can be used to sexually arouse or stimulate a person. There are countless varieties of sex toys but the most familiar, like the dildo for example, are shaped to resemble the penis.
- **Fingering.** This is a sexual act in which a finger or fingers are used to penetrate and stimulate a partner’s genitalia.
- **Oro-anal (rimming, anilingus, ‘ass licking’).** A sexual activity that involves the mouth and tongue to sexually stimulate another person’s anus.

Summary

- Anal sexual practices occur in Africa between men and women, and between men.
- Counselling sessions are opportunities to enquire about and provide information about the risks of anal sex.
- Asking about, and counselling on, anal sexual behaviours is an important part of HIV and STI prevention.
- Counsellors and clinicians should know the risks associated with different sexual behaviours and advise clients on how to reduce their risk of becoming infected with HIV and other STIs, or transmitting HIV and STIs.
- MSM may take both receptive and insertive anal sex roles.
Module 4 assessment

1. At first enquiry, clients very commonly deny engaging in anal intercourse and do not disclose this information until the second or third clinical visit. [ ] True [ ] False

2. Only homosexual men practice anal sex. [ ] True [ ] False

3. When a man reports anal sex, you know he is an MSM. [ ] True [ ] False

4. When a woman reports anal sex, you need to ask if she is doing receptive anal intercourse. [ ] True [ ] False

5. When a man reports anal sex, you need to ask if he does it with men, women, or both. [ ] True [ ] False

6. When a man reports anal sex with a man you should ask if he takes the insertive or receptive role. [ ] True [ ] False

7. MSM always engage in receptive anal sex. [ ] True [ ] False

8. Some women may engage in anal sex to ‘preserve their virginity’. [ ] True [ ] False

9. Evidence shows that condom use for anal sex by ‘heterosexuals’ is lower than condom use by ‘homosexual men’. [ ] True [ ] False

10. Why is there a greater risk of HIV infection from anal sex than vaginal sex?
    A. People who engage in anal sex usually have rougher sex.
    B. Because gay men are more likely to transmit HIV than heterosexual men.
    C. The anus and rectum is thinner than that of the vagina.
    D. There is no difference in risk between anal and vaginal sex.

11. For men, receptive anal sex is ________ times more risky for HIV infection than vaginal sex.
    A. 100
    B. 5
    C. 10
    D. 50

12. For women, receptive anal sex is ________ times more risky for HIV infection than vaginal sex.
    A. 100
    B. 5
    C. 10
    D. 50
Module 5 - HIV and sexually transmitted infections (STIs)

Learning outcomes

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

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

Introduction

Sexually transmitted infections (STIs) are a group of diseases that can be passed between individuals during sexual activity. MSM in Africa have a high burden of sexually transmitted infections. Studies done among men in South Africa, Senegal and Kenya found that about four out of every 10 men were infected with an STI (Ghebremichael & Paintsil, 2009; Wade et al., 2005).

Currently, existing STI treatment guidelines in Africa are insufficient for MSM as they do not take into consideration receptive anal intercourse and do not suggest treatment for certain diseases that may especially affect MSM. 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.

What are common symptoms of an STI?

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

- Sores on the penis, testicles, anus and surrounding area
- Burning urine
- White discharge (pus) from the penis or anus
- Painful testicles (balls)
- Swollen glands on the inside of the leg
- Growth on the penis, testicles, anus and surrounding area
- Pain or bleeding with defecation (bowel movements)
How are STIs spread?

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

Is there a link between HIV and STIs?

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

What STIs are common among MSM?

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

Human immunodeficiency virus (HIV)

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

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

A few weeks after infection, a flu-like illness may be experienced. Fever, skin rash, sore throat, muscle pain and tiredness may be present. During this time HIV is very easily spread to others. Years without any obvious symptoms may follow until the immune system (the body’s army which fights sickness) weakens. Infected people may then develop tuberculosis (TB); chest infections; skin rashes; sores in the mouth; diarrhoeal illnesses; and some types of cancer. They may also lose weight.

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

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

**The use of antiretrovirals to prevent HIV**

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

**Post-exposure prophylaxis (PEP)**

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

**The post-exposure prophylaxis regimen**

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

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

**Does availability of PEP lead to increased risky behaviour?**

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

**Counselling and management of a client that requires HIV PEP**

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

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

**Pre-exposure prophylaxis (PrEP)**

PrEP is an approach currently under development that aims to use HIV medications to prevent HIV among individuals who are not yet infected with the virus. The idea is that PrEP prevents HIV from replicating in the body and will prevent HIV infection (Grant et al., 2010). Only HIV-negative individuals would be able to use PrEP under the care of an experienced medical practitioner, and would need to continue to use condoms, lubrication, responsible sexual behaviours, laboratory work-up and regular HIV testing to maximise protection against HIV infection. Studies looking at how well PrEP would work in the ‘real world’ and the cost implication of its widespread use still need to be completed before it becomes part of standard HIV prevention among MSM.

**STIs**

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

*Neisseria gonorrhoea* and *Chlamydia trachomatis* are the bacteria or germs which commonly cause most infections in the urethra of the penis (the pipe joining the bladder to the outside). These germs can also infect the testicles, anus and mouth.

Infection of the urethra may cause:

- white or clear fluid to leak from the penis
- an itchy or burning sensation in their penis when urinating.

*Photos: Urethritis (US Center for Disease Control)*

Symptoms usually develop from about three to five days after exposure, but may take longer. *Infection can also occur without any symptoms*, and individuals may not know that they are infected (International HIV/AIDS Alliance, 2003).
Urethritis is spread through contact with the penis, anus, mouth or vagina. Scarring of the urethra and spread of the infection to the testicles and prostate can occur if the infection is not treated. Infection with gonorrhoea and chlamydia may spread beyond the genital tract and may cause painful glands, painful joints and muscles, and skin rash.

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

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

Genital herpes
Herpes is the most common STI in Africa (WHO, 2007). A recent study among high-risk MSM in South Africa found 15% of participants (about one in every six) to be infected with genital herpes (Grant et al., 2010). Infection is for life and no cure exists.

• **Herpes simplex type 1** is responsible for ‘cold sores’ – superficial ulcers around the mouth and nose which usually heal by themselves.

• **Herpes simplex type 2** most commonly causes a few painful sores around, on or near the penis, anus or vagina (genital herpes) surrounded by a red area.

The virus is spread through direct contact. By touching open sores with a body part (hand to penis; penis to anus; mouth to penis, etc.) the virus can be passed to other people. The virus may also be spread from person to person even if there are no open sores and the skin is intact (CDC, 2010b). Treatment is expensive and not freely available, and works to control the sores if it is started early. Treatment is needed for severe sores or for those which do not heal.

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

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

Hepatitis A

In Africa many people become infected during childhood. Lifelong protection can be obtained from natural infection or through immunisation. Among MSM it may be spread through oral-anal sex. In adults the disease is usually short lived – causing nausea, vomiting, yellowing of the skin (jaundice), abdominal pain, swollen glands and joint pain. For those not previously infected, there is an effective immunisation available for hepatitis A (Makadon, Mayer, Potter & Goldhammer, 2008).

Hepatitis B

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

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

Genital warts

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

Other STIs and rectal STIs

Lymphogranuloma venereum (LGV) is another infection caused by a type of chlamydia bacteria. It may cause a sore in the genital area and swelling of the glands in the groin, and result in abscesses. Antibiotics are needed to treat this infection (NCBI, 2009).
Many of the bacteria mentioned above may cause infection in other parts of the body. *Neisseria gonorrhoea* and *chlamydia* may also infect the anus and mouth. **Infection in the anus may cause painful bowel movements and painful receptive anal sex, and there may be a white or bloody discharge from the anus (proctitis).** Diagnosis may be made by direct observation using a protoscope – an instrument inserted into the anus that allows a health care professional a better view of the lining of the anus. Laboratory tests on a sample from the anus can also be used to make the diagnosis. Treatment is by means of antibiotics to cover the most likely bacteria (WHO, 2003).

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

Clients with symptoms should not wait for them to go away, but should be seen by a health care professional. Infestation with parasites like lice and scabies is common, which is a possible cause of itchiness in the genital area. Hepatitis A and C are other viruses that can be spread through sexual contact among MSM.
Exercise 5.1

1. Which of the following STIs are caused by bacteria? (you may select more than one answer)
   A. HIV
   B. Urethritis
   C. Genital ulcers (Herpes)
   D. Syphilis
   E. Hepatitis B
   F. Genital warts

2. Which STI can be prevented by getting a vaccination?
   A. HIV
   B. Syphilis
   C. Hepatitis B
   D. Herpes

How can you ask about STI symptoms?

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

- Have you noticed any sores on your private parts (penis, anus and surrounding area)?
- Do you find it uncomfortable to pass urine?
- Do you have any burning sensations when urinating?
- Have you noticed clear or white fluid on the tip of your penis that is not semen?
- Are you experiencing any pain in your testicles, which is new?
- Is receptive anal sex more painful or uncomfortable than before?
- Have you noticed any blood when having a bowel movement?
- Have you noticed any white fluid or pus leaking from you anus?
- Do you have any irritation or itchiness in your private parts that is new?

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

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

- STIs, including HIV, are common among MSM.
- Early identification and treatment of STIs can minimise the spread and effects of STIs.
- HIV is transmitted more easily when one/both partners have an STI, open sores or wounds, or broken skin.
- PEP should be offered to HIV-negative individuals within 72 hours of exposure to HIV or sexual assault, under the guidance of a medical practitioner, if available.
- PrEP as a concept has been shown to provide some protection against HIV among HIV-negative MSM, but more studies are needed before it can be widely recommended.
- As a counsellor you are able to inform men about the risks associated with different sexual behaviours.
- All suspected or confirmed symptoms of an STI should be assessed by a health care professional.
- Screening for common STIs should be included in all HIV counselling sessions.
Module 5 assessment

1. Herpes, or genital ulcers, can be spread from person to person through direct skin contact, even if no ulcers are present.   [  ] True   [  ] False

2. Genital warts often heal without treatment.   [  ] True   [  ] False

3. Most men presenting with urethral or rectal discharge will be treated without further tests (i.e. syndromic treatment).   [  ] True   [  ] False

4. Even if symptoms of syphilis are treated properly, a man infected with it will have it for the rest of his life.   [  ] True   [  ] False

5. If left untreated, symptoms of syphilis may go away but the infection may spread and infect the brain years later.   [  ] True   [  ] False

6. Anal warts will not cause anal cancer.   [  ] True   [  ] False

7. Genital warts are caused by:
   A. HIV
   B. HPV
   C. Chlamydia
   D. Syphilis

8. Which is NOT likely to be an early symptom of HIV infection?
   A. Fever
   B. Rash
   C. Genital warts
   D. Sore throat

9. Which STI may cause cirrhosis (scarring) of the liver?
   A. Syphilis
   B. Hepatitis B
   C. HPV
   D. Gonorrhoea

10. Penicillin is usually prescribed to treat which STI?
    A. Syphilis
    B. Hepatitis B
    C. HPV
    D. Gonorrhoea

11. Rectal infections presenting a white discharge from the anus are generally treated with:
    A. Vaccination
    B. Antiretrovirals
    C. Penicillin injections
    D. Antibiotics
12. The treatment for HIV is:
   A. Penicillin injections
   B. Antibiotics
   C. Antiretrovirals daily, for life
   D. Antiretrovirals for six weeks

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.

Which is likely to be the cause of Abdul's symptoms (burning urine, white fluid on tip of penis)?
   A. HIV
   B. Syphilis
   C. Bacterial infection of urethra
   D. Hepatitis B

What counselling advice would you give to Abdul? (choose all that apply)
   A. Tell him that he probably does not have HIV and tell him there is no reason to get an HIV test.
   B. Explain that he probably had a bacteria infection and will need to take antibiotics.
   C. Take time to educate Abdul about the risks of unprotected anal sex and ways to have safe sex.
   D. Tell him that anal sex is illegal in the eyes of the government and a terrible sin in the eyes of God.
   E. Explain to Abdul that he can spread STIs to his wife and others if they do not use condoms while having sex.

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.

What is the most likely cause of the sores on Tshepo's penis?
   A. Herpes
   B. HIV
   C. Gonorrhoea
   D. Genital warts
What is the best advice for Tshepo about what it means to have an STI and what he should do? (select all that apply)

A. Explain that unprotected anal sex has a high risk of contracting STIs.
B. Suggest that Tshepo gets an HIV test in a couple of weeks, because early tests may show as negative even if he does have HIV.
C. Explain that his sores should go away on their own, but the virus that causes them will stay with him and he will likely spread the disease to others without safe sex practices.
D. Tell Tshepo that anal sex is un-African and if he was a true African, he would not do such things.
Module 6 - Condom and Lubricant Use

Learning outcomes

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

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

Introduction

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

Male and female condoms

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

Male condoms are usually made out of latex (rubber). Female condoms are usually made out of polyurethane (a thin strong plastic). Male condoms made out of polyurethane also exist (but are not widely available) – these are useful for avoiding latex allergies.

Currently, the female condom is approved for vaginal use only – that is why it is called the ‘female condom’. However, female condoms can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection (Gross et al., 1999).
Table 2: Similarities and differences between male and female condoms

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

How well do condoms work?

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

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

Exercise 6.1

1. **Which of the following is true of most male and female condoms?**
   A. Most male condoms are polyurethane (plastic) and female condoms are latex (rubber)
   B. Most male condoms are latex (rubber) and female condoms are polyurethane (plastic)
   C. Both male and female condoms are made of latex (rubber)
   D. Both male and female condoms are made of polyurethane (plastic)

2. **When used correctly and consistently, condoms are _______% effective at preventing HIV and STIs.**
   A. 50 - 75%
   B. 70 - 80%
   C. 80 - 95%
   D. 95 - 100%
Instructions for correct male condom use

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

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

Diagrams for the correct use of condoms for anal sex are given on the following page (Figure 7).
2. Open the condom packaging with your fingers using the serrated edge (it is easier to open) or the V sign

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

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

5. Unroll the condom, using two fingers from your other hand, right to the base of the penis while still pinching the end of the condom
MSM sensitivity training for health workers in Africa, 2nd edition

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

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

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

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

Common errors

- Putting on the condom halfway through sex, i.e. after sexual contact has already occurred
- Removing the condom and resuming intercourse without one
- Using a condom for the first round of sex, but not for the second or third round
- Failing to pinch the tip of the condom (to remove the air) when putting it on
- Withdrawing after the penis has softened
- Failure to add lubricant, especially during anal sex
- Use of oil-based lubricants (e.g. lotion, vegetable oil, Vaseline®) that can damage the latex
- Lengthy or vigorous sex
- Engaging in sexual positions that may increase the likelihood of slippage
- Putting on two male condoms at the same time
Instructions for correct female condom use

*Method 1: Use by receptive partner*

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

*Method 2: Use by insertive partner*

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

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

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

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

**Guidelines for re-use of the female condom**

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

- **Disinfection:** As soon as possible after use, soak the female condom for two to five minutes in a solution of water and household bleach using a ratio of 1:20 (i.e. one unit of bleach for 20 units of water).
Note: Do not try to remove the ejaculate prior to putting the condom in the bleach/water solution. Do not soak the condom overnight as extended exposure to bleach/water may damage it. Do not try to disinfect the condom by boiling it or applying high temperatures.

- **Washing:** Remove the female condom from the solution and wash it with soap and water, then rinse it with water to remove the soap. Dry both sides using a clean cloth, or air dry.

- **Visual inspection:** Hold the condom up to the light to check for holes. If there are none, replace the inner ring. If holes are observed, throw the condom away.

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

- **Relubrication:** Relubricate the condom just prior to re-use. This makes it easier to insert, and makes intercourse more comfortable. The best lubricants are water-based ones, such as K-Y Jelly® which can be obtained at a local pharmacy. Oil-based lubricants (e.g. Vaseline®/petroleum jelly) may also be used since they do not damage polyurethane. Avoid using substances that may cause allergies or inflammation, such as hand or body lotions.

**Exercise 6.2**

1. **When putting on a male condom, it is important to pinch the tip of the condom.**
   - [ ] True   [ ] False

2. **The female condom can only be used for vaginal sex with a female partner.**
   - [ ] True   [ ] False

**Lubricants**

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

**Water-based and oil-based lubricants**

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

**Water-based lubricants can be used with male latex condoms as they do not damage the latex.** Examples include K-Y Jelly® and Assegai®. Most male and female condoms already have water-based lubricant on them; however, adding lubricant is especially important for anal sex as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing.

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

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

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

**Giving advice on lubricant use to clients**

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

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

**Condom use among MSM**

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

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

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

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

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

**Barriers to condom use**

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

- They may believe that HIV cannot be transmitted during anal sex.
- They may have a negative attitude and misconceptions about condoms.
• They may believe condoms are not effective at preventing HIV and STIs.
• They may find it difficult to insist on condom use with their partner
• Because they are afraid that:
  ◦ their partner might think they have been unfaithful
  ◦ their partner or client might think they are HIV positive
  ◦ their partner might think they do not trust them.
• They may lack knowledge and skills for correct condom use.
• They may think that sex is more pleasurable without condoms.
• MSM sex workers may earn less money or lose clients if they request sex with a condom.
• They may lack the power to suggest condom use, especially if they are in an imbalanced relationship, e.g. with differences in age and/or economic status.
• They may have impaired judgement due to the use of drugs or alcohol.
• They may be short on condom supplies, e.g. if engaging in several rounds of sex.
• They may not have easy access to condoms (e.g. if living in rural areas).
• They may forget to carry condoms when going out.

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

**Negotiation skills**

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

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

• Use the clear stance of ‘no condom – no sex’.
• Emphasise that condom use makes it easier to feel relaxed and enjoy the sexual act more.
• Bring a leaflet on condom use from the counselling session and use it to help introduce the topic to the partner.
• Make a packet of condoms easily available (e.g. on the bed, in a pocket, etc.).
• Make condom use an activity for both partners, and offer to put it on the partner (using the mouth or hands).
• Make the experience sexy and exciting by using flavoured, coloured or ribbed condoms. Perceiving the condom as a ‘sex toy’ may help persuade the partner to use it.
• Suggest the use of a water-based lubricant (e.g. K-Y Jelly®) to increase sensitivity.
• Offer to engage in a range of non-penetrative sexual activities (touching, fingering, mutual masturbation, rimming and oral sex) instead of penetrative sex.
• Suggest using the female condom instead of the male condom. Female condoms can be a good way to flatter the partner by saying he has a big penis and needs to use the big condom.

Summary

• When used correctly and consistently, condoms are 80–95% effective at preventing HIV transmission.
• Female condoms offer an added option in cases where male condoms cannot be used.
• Water-based lubricants, such as K-Y Jelly®, decrease the risk of slippage and breakage during anal intercourse.
• Condoms can be promoted as an added way of enhancing pleasure when negotiating condom use with a partner.
Module 6 assessment

1. The inner ring of a female condom can be removed when using a female condom for anal sex. [ ] True   [ ] False

2. Condoms are 80% to 95% effective at preventing HIV and STIs. [ ] True   [ ] False

3. Oil-based lubricants do not damage the female condom’s polyurethane material, but do damage the male condom’s latex material. [ ] True   [ ] False

4. Lubricants reduce friction and help reduce the risk of condom breakage during sex. [ ] True   [ ] False

5. It is safe to reuse male condoms. [ ] True   [ ] False

6. Using two condoms at once is safer than using only one condom. [ ] True   [ ] False

7. If putting a male condom on an uncircumcised penis, the foreskin should be pulled back before putting on the condom, and pushed forward after the condom has been put on. [ ] True   [ ] False

8. MSM do not need to use condoms if they trust their partner and have been together for a long time. [ ] True   [ ] False

9. Which of the following is NOT recommended when using a male condom?
   A. Pinch the air out of the tip as you place the condom on the penis.
   B. Roll the condom halfway down the shaft of the penis instead of all the way down.
   C. After ejaculation, hold the condom at the base of the penis to avoid slippage.
   D. Pull out while the penis is still erect.

10. If washed, stored and re-lubricated adequately, female condoms may be used up to:
    A. 10 times
    B. 5 times
    C. 3 times
    D. they cannot be reused

11. Use of lubricants with condoms during anal sex will reduce the risk of all of the following, except:
    A. Slippage
    B. Discomfort
    C. Condom breakage
    D. Sensitivity

12. If an MSM client complains that condoms always seem to break when he uses them, which would be the best response for a counsellor to give?
    A. Tell the client to use commercial condoms instead of the free ones.
    B. Provide a condom demonstration to the client then ask him to repeat the demonstration.
    C. Hand a few condoms to the client to replace the broken ones.
    D. Suggest he adds some Vaseline (oil-based lubricant) to reduce friction
13. An MSM client says he has gone for HIV-testing and is HIV-negative, is faithful to his partner, and wants to stop using condoms. What important piece(s) of information has the MSM client forgotten to mention?

A. Whether his partner has also recently gone for HIV testing
B. Whether his partner is also HIV-negative
C. Whether his partner has also committed to being mutually monogamous
D. All of the above
Module 7 - Mental health: Anxiety, depression and substance abuse

Learning objectives

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

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

Overview

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

SECTION 1: Anxiety and depression

Anxiety: What is anxiety and when is it excessive?

Anxiety is a normal emotion in everyday life and is closely related to fear. Figure 8 helps to show how this reaction can prepare us for fight (if we have to protect ourselves) or flight (if we have to run away). Anxiety prepares the body by involving other organs, like blood, lungs and muscles, which then enable the fight or flight response. In our everyday lives, anxiety in small amounts helps us perform better, for example in exams (Cochran, Sullivan & Mays, 2003).
However, when anxiety becomes excessive, is difficult to control and affects the way we function in our everyday lives, it becomes a disorder. When people feel anxious they may exhibit mental (in the mind) and physiological (in the body) signs and symptoms (Cochran, Sullivan & Mays, 2003).

**Signs and symptoms of anxiety**

Mental aspects include:

- fear
- uneasiness
- worry.

Physiological aspects include:

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

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

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

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

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

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

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

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

**Anxiety and people living with HIV/AIDS**
In addition to the risks of anxiety that MSM face, being HIV positive can further increase anxiety because of the following:

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

**What should you do if you identify an anxious patient?**

1. Screen for depression and substance abuse.
2. Ask questions which will give you an idea about the severity of the anxiety, and distress caused, and/or if their lives are negatively affected by it:
   a. Do you feel worried or anxious most of the time?
   b. Do you have spells when suddenly you feel very frightened, anxious or uneasy in situations when most people would not be nervous (panic attacks)?
   c. Have you ever witnessed or experienced a traumatic event that involved you or someone else getting hurt? If you have, do you get troubled by flashbacks, nightmares or thoughts of the trauma?

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

**Exercise 7.1**

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

1. **What symptoms of anxiety does Oliver exhibit?**

2. **What form of anxiety does Oliver’s symptoms indicate?**

**Depression: What is depression?**

It is usual for most people to have ‘ups and downs’. We may feel miserable on a Monday morning, but very happy on payday, or our birthday, for example. When we talk about depression, however, we refer usually to a ‘down’ that is normally longer and more intense than just a ‘bad mood’.

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

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

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

**MSM and depression**

**Why are MSM more prone to depression?**

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

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

**Depression and people living with HIV/AIDS**

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

As with anxiety, being HIV positive makes a person vulnerable to certain infections in the brain which can cause depression. Furthermore, the effects of the virus itself can cause depression. Lastly, there are treatments for HIV which can negatively affect a person’s mood.

**What to do when a client is depressed**

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

<table>
<thead>
<tr>
<th>Mild – moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>A few symptoms</td>
<td>Many symptoms</td>
</tr>
<tr>
<td>Brief</td>
<td>Longer-lasting</td>
</tr>
<tr>
<td>Effect on activities is small</td>
<td>Struggles to do things</td>
</tr>
<tr>
<td></td>
<td>May be thinking about dying</td>
</tr>
<tr>
<td></td>
<td>May hear voices</td>
</tr>
<tr>
<td></td>
<td>May stop eating or drinking</td>
</tr>
</tbody>
</table>

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

If there are **a few symptoms with little effect on day-day functioning**, then a ‘problem-solving’ approach **by a lay counsellor would be appropriate**. The counsellor would probe to identify specific problems that may be causing/contributing to the depression, and work with the patient on practical, creative ways to find solutions. However, it is important that the lay counsellor attends supervision sessions with someone who has more knowledge of mental health issues, and reports regularly on the counselling sessions.

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

**Suicide**

Many people who feel sad or hopeless about their life will attempt suicide.

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

**What to do if you have a patient who is suicidal**

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

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

**SECTION 2: Substance abuse amongst MSM**

**MSM and substance use**

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

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

**How does substance use increase the risk of contracting HIV?**

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

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

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

**How do I identify substance abuse?**

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

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

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

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

- **Alcohol** generally produces a state of pseudo relaxation and happiness. Continued consumption can lead to blurred vision, coordination problems and aggressive behaviour. The long-term use of alcohol may affect vital organs in the body. Regularly consuming alcohol is correlated with an increased risk of developing cardiovascular disease, alcoholic liver disease and cancer (Stoppard, 2000). Alcohol consumption is associated with high-risk sexual behaviour.

- **Marijuana/dagga** produces feelings of relaxation, causes slow and uncoordinated movement, and increases appetite. Large doses may result in paranoia, hallucinations and psychosis. Short-term effects include learning problems, loss of coordination and memory, limited problem solving and irrational thinking. Physical consequences include increased heart rate and reduced blood pressure, anxiety, fear, distrust or panic (Livingston & Morkel, 2009).

- **Methamphetamine** (tik, speed, crystal meth) produces a rapid pleasurable feeling, which is followed by feelings of depression and irritability when the drug wears off. It is known to heighten sexual arousal and has a strong association with high-risk sexual behaviour. Use often occurs in the context of sexual encounters with anonymous partners of undisclosed HIV status (Halkitis et al., 2008). Long-term use can result in violent or psychotic behaviour, mood disturbances, and homicidal or suicidal thoughts. Methamphetamine use is particularly problematic because it is generally cheap, easily obtainable and highly addictive. Particularly with tik, the drug may include a variety of ingredients (e.g. rat poison, drain cleaner, paint thinners, etc.) and the effects experienced may vary considerably. The possible long-term effects of tik use, depending on the specific ingredients used, may lead to respiratory problems, decreased appetite, severe itchiness, dental problems, insomnia, cognitive impairment (concentration and memory), and psychiatric complications (depression, anxiety, obsessive-compulsive, aggression, sexual dysfunction, psychosis, etc.) (Livingston & Morkel, 2009).

- **Cocaine and crack cocaine** (a cheap and impure form of cocaine) cause a feeling of extreme happiness, confidence and sexual arousal. This is usually followed by agitation, depression, anxiety, paranoia and decreased appetite. Crack is highly addictive and is a potent and dangerous drug. Side effects include possible cardiac arrest or seizures, respiratory problems, insomnia, blurred vision and vomiting.

- **Ecstasy** induces feelings of extreme well-being and happiness. Large doses can lead to an increase in core body temperature, confusion, irrational behaviour, palpitations, shaking, dehydration, collapse and convulsions. The long-term effect of ecstasy use can lead to cognitive impairment sleep disturbance, psychiatric complications (depression, anxiety, psychosis) and an increase in impulsivity.

- **Heroin** generally produces an initial pleasurable sensation, warmth, dry mouth, heaviness in the arms and legs, and possibly nausea, vomiting and severe itching. This may be followed by drowsiness, a slow and irregular heart rate, shallow breathing, delayed reaction time and a loss in concentration. Large doses can lead to nausea, vomiting, respiratory paralysis, heart attack, stroke, anaphylactic shock, coma and death. The long-term effect of heroin use may lead to skin infections, fatigue, respiratory problems, collapsed veins (if injecting), cognitive impairments, psychiatric complications (depression, anxiety, sexual dysfunction, psychosis), increased risk of intentional injury, and extreme withdrawal when not using. (Stoppard, 2000).
• **Khat/cat** generally produces a state of euphoria, and increased confidence and energy, heart rate, core body temperature, alertness and impulsivity. Large doses can lead to **insomnia, shaking, muscle twitching, irregular heart rate, profuse sweating, dehydration, headaches, anxiety, delusions, depression, convulsions, stroke and even death**. The **long-term use of khat/cat may lead to excessive weight loss, skin infections, blueness in the hands and feet, distinct personality changes, cognitive impairments and psychiatric complications** (depression, anxiety, psychosis).

• **Mandrax** generally produces initial feelings of euphoria, followed by feelings of relaxation and drowsiness, slowed breathing, reduced heart rate, reduced sensitivity to pain, impaired judgement, slurred speech, slowed reaction time, and brief loss of consciousness. Large doses can result in seizures, coma and death. Mandrax can be lethal when used in combination with alcohol or heroin. **Long-term use of mandrax can lead to anaemia, impaired liver functioning, severe weight loss, impaired vision and slurred speech, cognitive impairments, poor muscle control, dental problems, psychiatric complications (anxiety, depression, psychosis), and increased risk of intentional or accidental injury.**

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

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

**What is dual diagnosis?**

Dual diagnosis refers to the situation in which a client suffers simultaneously from substance abuse and a mental illness. This is a very common occurrence, and studies have shown that **roughly 60% of people who are diagnosed with substance abuse have a co-occurring mental disorder**. This means they will need to be treated both psychiatrically and medically. The most common mental health problems associated with addiction include depression, bipolar mood disorder, and antisocial and borderline personality disorders. There is also the possibility of developing substance-induced psychosis – a temporary psychotic episode that may last for several days or weeks (see the earlier section on anxiety and depression) (Nocon, Berge, Astals, Martin-Santos & Torrens, 2007).

**Summary**

• Stigma and rejection from others may cause mental health problems among MSM.
• The most common mental health issues which counsellors are likely to come across are depression and anxiety.
• Excessive anxiety is abnormal and has a negative affect on a person’s ability to function.
• Depression and anxiety can be treated with counselling, medication or a combination of both.
• Counsellors also need to be aware of the signs of suicide, and know what action to take to prevent an MSM who is suicidal from killing himself.
• Substance abuse is common among MSM and may lead to increased risk-taking behaviour.
• Substance abuse should be managed by a health care professional.
Module 7 assessment

1. When a person experiences a sudden, overwhelming fear during which he/she may feel they are ‘going crazy’, or ‘going to die’, it is called:
   A. Post Traumatic Stress Syndrome
   B. Panic Attack
   C. Phobia
   D. Depression

2. ________ is when a person is fearful of certain types of objects or situations.
   A. Phobia
   B. Anxiety
   C. Panic disorder
   D. Generalised anxiety disorder

3. Which substance, after long term use, is most likely to cause violent and potentially homicidal or suicidal behaviour?
   A. Alcohol
   B. Marijuana
   C. Methamphetamines
   D. Crack cocaine

4. About ______ of people who are diagnosed with substance abuse are also diagnosed with having a mental disorder.
   A. 20%
   B. 60%
   C. 10%
   D. 80%

5. When anxiety becomes excessive, distressing and affects the way we function in our everyday lives it becomes ________ .
   A. Addictive
   B. Depression
   C. Stigmatised
   D. A disorder

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 and says he feels hopeless. He has obviously lost weight and cannot sleep at night.
1. What diagnosis can you give for Victor's situation? (select all that apply)
   A. He is depressed
   B. He is at risk for suicide
   C. He is neither depressed nor at risk for suicide

2. How would you handle Victor's condition?
   A. Suggest counselling sessions
   B. Refer him to a doctor or social worker for further psychological assessment
   C. Escort him directly to a doctor or nurse

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.

1. What diagnosis can you give for Ahmed's situation? (select all that apply)
   A. He is depressed
   B. He is at risk for suicide
   C. He is neither depressed nor at risk for suicide

2. How would you handle Ahmed's condition? (select all the apply?)
   A. Suggest counselling sessions
   B. Refer him to a doctor or social worker for further psychological assessment
   C. Escort him directly to a doctor or nurse
Module 8 - Risk-reduction counselling with MSM

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

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

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

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

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

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

Standard risk-reduction counselling methods
Following is an outline for one particular method of risk-reduction counselling.
**Step 1: Assess the behaviours of clients**

It is firstly important to **gain a better understanding of a client's sexual practices, including both safe and risky behaviours**. Focus can be placed on behaviour from the previous three months, which may impact their need for further HIV testing. This basic assessment can be achieved by asking key questions regarding the number and type of sexual partners, the types of sexual acts they have engaged in, and use of alcohol or other substances.

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

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

**Step 3: Discuss the ‘cost and benefits’ of this behaviour**

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

**Step 4: Set goals**

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

**Step 5: Discuss barriers**

It can also be helpful to discuss with clients any **potential barriers that may prevent them from achieving their goal and to help them to develop strategies to overcome them**. Barriers could include things like pressure from friends or an addiction to a drug. Predicting potential barriers that could make behaviour difficult for the client is particularly helpful if you have infrequent contact with clients or will only see them once.
Step 6: Reinforcement

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

Is risk-reduction counselling conducted differently with MSM?

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

Exercise 8.1

1. The objective of risk-reduction counselling is to set a realistic goal for behaviour change that could reduce their chances of getting HIV or STIs.
   - [ ] True  [ ] False

Understanding the effect of personal beliefs and knowledge

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

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

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

The effect of closeted clients

Studies in South Africa have shown that some MSM may not feel comfortable enough to disclose their personal sexual practices to a health care worker or doctor. As a risk-reduction counsellor, this can be a significant challenge to successfully helping a client. After all, if clients are unwilling to explain their true sexual practices, how can effective risk-reduction counselling take place?

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

The significance of confidentiality

All risk-reduction counselling sessions, regardless of the client, must remain completely private between the client and the counsellor (CDC, 2001). For MSM in particular, ensuring confidentiality is critical. MSM, particularly those who have not come out, could face a number of negative effects should knowledge of their sexual behaviour be made public. If MSM begin the session with this fear or concern, they may be less likely to engage productively in the counselling, therefore it must be a priority in each session to express to the clients the ways in which their privacy will be respected.

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

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

It is important for a counsellor to be familiar with various sexual activities and their risks, and possible alternatives to those activities, in order to provide the best options for behaviour change to a client. Below is a brief review of some risk behaviours, influences on behaviour and possible behaviour changes for MSM that may be discussed during a risk-reduction session.

Sexual risk behaviour

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

Potential influences on behaviour

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

Methods of changing behaviour

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

Exercise 8.2

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

1. Which of the following put Simphiwe at risk for HIV? (select all that apply)
   A. Unprotected receptive anal sex.
   B. Unprotected pentrative anal sex.
   C. Having a high number of sex partners.
   D. Having an STI while being sexually active.

2. Which of the following behaviour changes might help lower the risk of HIV for Simphiwe? (select all that apply)
   A. Decreasing alcohol and drug intake.
   B. Not visiting venues that lead to once off or anonymous sex.
   C. Getting tested for HIV/STI regularly.
   D. Using a latex condom with water based lubrication.
Improving communication during risk-reduction counselling with MSM

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

*Use the types of words the client is using*

As long as the counsellor remains comfortable, using the same language a client uses to describe his sexual practices can create a sense of understanding. For example the terms *passive* and *bottom* both refer to acting as the receptive partner during anal sex but a client may use the terminology that is applicable for his social network or community.

*Do not automatically label clients or assume details about their behaviour*

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

*Do not include value judgements or personal beliefs*

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

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

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

*Create a safe space*

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

Engaging MSM for HIV testing and risk-reduction counselling

Because of discrimination and stigma within their communities, MSM may be forced to lead secret lives. This can make both individual MSM difficult to find and entire MSM communities hard to reach. Lack of service provision can also make it difficult to help MSM access vital services like HIV testing.

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

**Establishing a key informant**

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

**Creating a trusting relationship**

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

**Educating the community**

Once a trusting relationship has been built with an MSM or with a group, attempts can then be made to educate them about the services or activities that are available for their participation. This would also be an excellent opportunity to address any concerns they may have about confidentiality by explaining the ways in which this is guaranteed by your service or organisation. Promoting MSM-friendly services using other MSM as face-to-face promoters can effectively spread information about your service to MSM while protecting it from more public criticism.

**Summary**

- Risk-reduction counselling is an effective behavioural intervention that can help reduce an individual’s risk for STIs and HIV.
- Appropriate and socially relevant language should be used with MSM to make them feel comfortable.
- Personal bias or stigma should be addressed before working with an MSM so as not to affect the client negatively.
- The use of health care services by MSM can be improved by:
  - Establishing key informants
  - Creating trusting relationships
  - Educating the community.
Module 8 assessment

1. Appropriate risk reduction counselling may help in reducing one’s risk for STIs and HIV.  
   [ ] True    [ ] False

2. When counselling an at-risk MSM, the counsellor's opinions and judgements are helpful for affecting the client's behaviours.  [ ] True    [ ] False

3. Each risk reduction session, no matter the background of the client, should be unique and require different strategies and techniques.  [ ] True    [ ] False

4. In a counselling session, it is important to tell the client the ways in which their privacy will be respected.  [ ] True    [ ] False

5. Asking key questions about an MSM's sexual behaviour will:
   A. Cause the client to feel bad about himself  
   B. Provide an assessment of the client's sexual risk taking  
   C. Make the counsellor appear judgmental  
   D. Reinforce the client's behaviour

6. Discussing ____________ can provide insight for the client into the motivations and influences that could be driving their behaviour.  
   A. Strategies  
   B. Reinforcement  
   C. Costs and benefits  
   D. Discrimination

7. Defining specific, achievable, and measurable _______ that take into consideration the influences and motivations of the participant can help with risk reduction.  
   A. Risks  
   B. Costs  
   C. Counselling  
   D. Goals

8. Using the same words as the client to describe his sexual practices will:  
   A. alienate the client  
   B. make the client feel stigmatised  
   C. give a sense of understanding  
   D. have no effect on the client

9. The client can be made to feel safe by:  
   A. reminding them of their ensured confidentiality  
   B. asking questions that show you are open minded  
   C. asking questions to show that you are not judgemental  
   D. all of the above

10. A ______________ can give insight into the behaviours of MSM in their network, such as where and how they socialise.
   A. key informant  
   B. nurse or doctor  
   C. sex worker  
   D. political leader
Case study

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.

1. Which of the following assumptions can be made about Lindiwe? (select all that apply)
   A. Lindiwe engages in unprotected receptive anal sex.
   B. Lindiwe engages in unprotected insertive anal sex.
   C. Lindiwe may be at higher risk of having HIV or other STIs
   D. None of the above.

2. What goals would be most appropriate to suggest to Lindiwe? (select all that apply)
   A. Stop wearing women’s clothes and acting effeminate.
   B. Learn to use the condom each time she has sex.
   C. Stop engaging in sex for money.
   D. Consider interests and skills that Lindiwe might use to start her own business or that might allow her to work in a less discriminatory environment.
Post-course assessment

1. How many countries in Africa provide protective legislation for MSM?
   A. None
   B. One
   C. Five
   D. Ten
   E. All

2. On average _________ of African people consider that homosexuality should not be accepted by society.
   A. 25–40%
   B. 40–55%
   C. 55–70%
   D. 70–85%
   E. 85–99%

3. The risk of a man acquiring an HIV infection during unprotected receptive anal sex is ________ unprotected vaginal sex.
   A. About a tenth higher than
   B. About a fifth higher than
   C. About the same as
   D. About five times higher than
   E. About 10 times higher than

4. A health care worker can be stigmatised for counselling and treating HIV-positive MSM clients.
   [ ] True [ ] False

5. Moral judgement is a form of internal stigma.
   [ ] True [ ] False

6. Social withdrawal is a form of external stigma.
   [ ] True [ ] False

7. All men who have sex with men identify as being gay or homosexual.
   [ ] True [ ] False

8. Research shows that _________ of every community is homosexual.
   A. between 20 and 30%
   B. between 3% and 10%
   C. less than 2%
   D. between 10 and 15%

9. A person who feels pressure to change his or her sexual orientation may experience low self-esteem, poor self-confidence and depression.
   [ ] True [ ] False

10. Risk-reduction counselling is intended to help clients identify and change specific behaviours that may put them at risk for HIV or other STIs.
    [ ] True [ ] False
   [ ] True [ ] False

12. When a man reports anal sex with a man during counselling you should ask if he takes the insertive or receptive role.
   [ ] True [ ] False

13. Anal warts may lead to anal cancer.
   [ ] True [ ] False

14. Genital warts are caused by:
   A. HIV
   B. HPV
   C. Chlamydia
   D. Syphilis

15. Which is NOT likely to be an early symptom of HIV infection?
   A. Fever
   B. Rash
   C. Genital warts
   D. Sore throat

16. When people experience a sudden overwhelming fear during which they may feel they are ‘going crazy’, or ‘going to die’, it is called:
   A. Post-traumatic stress syndrome
   B. Panic attack
   C. Phobia
   D. Depression

17. Which substance, after long-term use, is most likely to cause violent and potentially homicidal or suicidal behaviour?
   A. Alcohol
   B. Marijuana
   C. Methamphetamines
   D. Crack cocaine

18. When anxiety becomes excessive and distressing, and affects the way we function in our everyday lives it becomes ________
   A. Addictive
   B. Depression
   C. Stigmatised
   D. A disorder

19. Condoms are 80–95% effective at preventing HIV and STIs.
   [ ] True [ ] False

20. If an MSM client complains that condoms always seem to break when he uses them, which would be the best response for a counsellor to give?
   A. Tell the client to use commercial condoms instead of the free ones.
   B. Provide a condom demonstration to the client then ask him to repeat the demonstration.
   C. Hand a few condoms to the client to replace the broken ones.
   D. Suggest he adds some Vaseline (an oil-based lubricant) to reduce friction.
21. When putting on a male condom, it is necessary to ensure that there is air at the tip to allow room for semen.
   [ ] True [ ] False

22. Asking key questions about an MSM's sexual behaviour will __________________________
   A. Cause the client to feel bad about himself
   B. Provide an assessment of the client's sexual risk taking
   C. Make the counsellor appear judgemental
   D. Reinforce the client's behaviour

23. Defining specific, achievable, and measurable _______ that take into consideration the influences and motivations of the client can help with risk reduction.
   A. Risks
   B. Costs
   C. Counselling
   D. Goals

24. When counselling an at-risk MSM, the counsellor's opinions and judgements should not affect the client's behaviours.
   [ ] True [ ] False
STI and HIV resources

  http://www.aidsetc.org/pdf/p02-et/et-17-00/msm_toolkit.pdf

**HIV treatment guidelines:**

**The Body:**

**Centres for Disease Control and Prevention:**
- Sexually transmitted infections, including treatment guidelines:
  - [http://www.cdc.gov/std](http://www.cdc.gov/std)

**ShoutOutHealth:** [www.shoutouthealth.com](http://www.shoutouthealth.com)

**Project inform:** [http://www.projectinform.org](http://www.projectinform.org)

**HIV biomedical prevention information**
- [http://www.globaliprex.com](http://www.globaliprex.com)
- [http://www.avac.org](http://www.avac.org)

**Responding to HIV-related needs of MSM International HIV/AIDS Alliance:**
- Workshop Guide on Responding to the HIV-related Needs of MSM in Africa.  
MSM resources in Africa

CAMEROON

Alternatives-Cameroun
Email. alternatives.cameroun@gmail.com Tel. +237 99 20 03 29

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

GHANA

Centre for Popular Education and Human Rights
Tel. +233 (0) 277 754247, +233 (0) 244808280

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

ISHTAR MSM, Nairobi
Email. info@ishtarmsm.org
Tel. +254 713 797157; +254 20 2497228
http://www.ishtarmsm.org

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

KEMRI-Wellcome Trust Research Programme, Mtwapa and Kilifi
Tel. 041 7522063; 041 7522535; 041 7525044

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

Kibera Community Empowerment Organisation (KCEO), Nairobi
Email. kceo2008@gmail.com

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

LVCT (Liverpool VCT, Care & Treatment), Nairobi
Email. ldias@liverpoolvct.org
Tel. +254 20 2714590/2715308
www.liverpoolvct.org

- Innovative and integrated HIV counselling & testing service provision
- Condoms and water-based lubricant distribution
- IEC development and distribution
- Referral and follow-up to HIV/SRH and other related services
- Clinical and laboratory monitoring, opportunistic infection management and ART
- Targeted Support Groups and Post Test Clubs
• Sensitivity training for health workers
• Capacity Building
• Policy Advocacy
• Formative and action research.

PEMA Kenya, Mombasa
Email. Cliffordduncan2@gmail.com; pemakenya@gmail.com; ejabizo@yahoo.com
Tel. +254 713 681 341; +254 724 922 592; +254 721 924 147
• Provide training and services to LGBTI and MSM on health related human rights
• Train health service providers to reduce stigma and give the same attention to MSM and LGBTIs
• Training members on security management
• Peer education sessions/ in reaches
• Intense condom and lubricants promotion
• Media sensitization
• Intense STI screening and treatment
• Health workshops
• Small and large social events to disseminate information on HIV/AIDS, condom and lubricants distribution and HTC services
• 24 hr referral centre
• Sensitization of Religious leaders on LGBTIs issues.

UHAI - the East African Sexual Health and Rights Initiative, Nairobi
Tel: +254(020)2330050/ 8127535
Email. wanja@uhai-eashri.org
www.uhai-eashri.org
• Grant-making initiative that provides grants and capacity support to sexual minority rights organisations in the 5 East African countries – Burundi, Kenya, Rwanda, Tanzania and Uganda
• Actively supports LGBTI and sex worker organizing in the East African region by providing flexible and accessible resources to these organizations and support activism around sexual minority health and rights.

MALAWI

College of Medicine-University of Malawi, Blantyre
Email. jkumwenda@jhu.medcol.mw
• There are no services at present that are provided to MSM in Malawi.
NGERIA

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

Email. contactus@maleattitudenetwork.com; oanene@maleattitudenetwork.com;
Tel. +234 704 292 6723
www.imh-initiative.org/welcome

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

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

Email. Sylvia Adebajo; sadebajo@popcouncil.org
Tel. +234 806 887 9584

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

SOUTH AFRICA

Desmond Tutu HIV Foundation Men’s Division, Cape Town

Tel. +27 21 650-6969
Email. ben.brown@hiv-research.org.za
www.desmondtutuhivcentre.org.za

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

Durban Lesbian & Gay Community & Health Centre, Durban

Tel. +27 31 301-2145
Email. info@gaycentre.org.za
www.gaycentre.org.za
Part of the KZN Coalition for Gay & Lesbian Equality. Offers a safe and secure space for the lesbian, gay, bisexual, transgender and intersex communities of Durban and KwaZulu-Natal.

Projects and Services offered by the Community Centre

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

Gay and Lesbian Network, Pietermaritzburg

Email. a_maharaj@ananzi.co.za
Tel. +27 33 342 6165

- Ensure optimum commitment and services for the upliftment and recognition of the LGBTI community through creative programmes that foster Equality, Tolerance, Respect and Acceptance
- Developing safe spaces
- Direct psychosocial support.
- Personal development and ongoing skills development work
- Practical skills dissemination
- Providing HIV&AIDS services, HIV support groups and workshops
- Advocating for an enabling environment – introducing positive changes to the environment in which LGBTI people, live, work and play
- Sensitize general society by creating awareness and educating society about sexual orientation.

Health4Men ANOVA HEALTH INSTITUTE

www.anovahealth.co.za

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

The free services offered by the Health4Men clinics include:

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

Health4Men Treatment sites:
• CAPE TOWN: Ivan Toms Center for Men’s Health, Woodstock
  Tel. +27 (0)21 447 2844
• SOWETO: Simon Nkoli Centre for Men’s Health, Soweto
  Tel. +27 (0)11 989 9756/9865

OUT Well-being, Tshwane, Gauteng
Tel. 012-430-3272
Helpline. 0860 OUT OUT (0860 688 688)
www.out.org.za
• Direct Services (including full-time clinic, face-to-face and telephonic counselling, and range of psychosocial support groups)
• Outreach Activities (including Play Safe Campaign, One2One Peer Education Programme, and Barrier Method Distribution Service)
• Training and Development (including mainstreaming of service providers).

Sexual HIV Prevention Programme (SHIPP), Futures Group
Tel. +27-12-362-0584
• Capacitate and enable the deliverers of services, so organizations can get capacitation and resources (through the small grants programme under SHIPP)
• Technical assistance
• Training and coordination at the local level.

Triangle Project, Cape Town
Email. info@triangle.org.za
Tel. +27 21 448 3812
www.triangle.org.za
• Advocating for the human rights, wellbeing and empowerment of the Lesbian, Gay, Bisexual, Transgender & Intersex (LGBTI) community
• Offers defined services holistically to LGBTI persons, their families and those who support them and work towards gender equality;
• Challenging harmful stereotypes, disempowering forms of patriarchy and masculinity within hetero-normative gender roles and identities.

UGANDA

Frank & Candy, Kampala

Email. FrankCandy.Uganda@gmail.com
Tel. +256 772 444 826

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

INTERNATIONAL

amfAR, The Foundation for AIDS Research, New York, USA

Email. kent.klindera@amfar.org
Tel. +1.212.806.1600 www.amfar.org/msm

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

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

Email. sbaral@jhsph.edu

• HIV Epidemiology and Prevention Research for MSM in Africa.

International HIV/AIDS Alliance, Brighton, United Kingdom

Tel. +44-1273-718900
Email. mail@aidsalliance.org
http://www.aidsalliance.org

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

United Nations Development Programme, New York, USA

Email. cheikh.traore@undp.org
Tel. (1) 212 906 6573
• Addresses HIV and sexual diversity through attention to legal and policy environment
• Partnering with municipal governments to strengthen their understanding and response to men who have sex with men, sex workers and transgender people
• UNDP co-convenes with UNFPA the working group on “Men who have sex with men, sex workers and transgender people”
• Strengthening the evidence base related to HIV and sexual diversity
• Catalysing and supporting municipal action on HIV and sexual diversity Human rights and access to justice initiatives for marginalized populations.

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

Email. m.maietta@sidaction.org
Tel : +33 (0)1 53 26 45 66
http://www.sidaction.org
• Mobilize funds to develop and maintain high-quality HIV programs, including scientific research
• Grant-making initiative, jointly managed with AIDES, that provides grants and capacity support to NGOs in francophone Africa to develop access to care and prevention for men who have sex with men and living with HIV.
References

American Foundation for AIDS Research. (2008). MSM, HIV, and the road to universal access – how far have we come?


Global Forum on MSM and HIV. (2010). *Key challenges to HIV prevention with MSM.*


