

HEALTH
4 MEN

top to bottom



MSM IN YOUR POCKET

SEXUAL HEALTHCARE FOR MEN WHO HAVE SEX WITH MEN



MSM in your pocket - sexual health care for men who have
sex with men
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This pocket guide for healthcare workers is designed to be used in conjunction with Anova Health Institute's manual for healthcare providers 'From top to bottom: A sex-positive approach for men who have sex with men.' This manual can be downloaded from our website: www.anovahealth.co.za.

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INTRODUCTION

Many people believe that men who have sex with men (MSM) are a marginal group in our population. Male to male sex occurs throughout Africa, in all cultures, societies and geographical locations

Research in South Africa shows that many MSM (up to 50%) may identify as heterosexual and have female sex partners. This means that, in addition to MSM being particularly vulnerable to HIV infection themselves, they are influenced by and are influencing the broader heterosexual HIV epidemic¹.

Despite our progressive Constitution, MSM face stigma and discrimination across communities in South Africa and are thus often discouraged from seeking help for their health and wellbeing.

MSM face specific sexual health risks in comparison to the heterosexual population. Understanding these differences will help healthcare workers provide prevention and treatment services to MSM.

¹ see, for example, Lane et al., 2009

WHO ARE MSM?

MSM are men who have sex with men. Not all MSM see themselves as homosexual or gay. Many such men may be married, have children and have sex with women. Many have a “masculine” gender identity and cannot be identified as being MSM by their dress, mannerisms or social roles. They may see themselves as heterosexual.

The diverse collection of men included in the term MSM are men who are heterosexual, bisexual or homosexual and who can be either relatively masculine or effeminate in their dress and mannerisms.

The term ‘MSM’ does not refer to a sexual identity, but identifies a group of men who practice a particular behaviour, irrespective of whether they identify as heterosexual, homosexual or bisexual.

Healthcare workers are encouraged to become familiar with colloquial terms used by MSM to describe their sexual identities.

CHAPTER 1

THE HEALTHCARE PROVIDER & MSM

From a public health perspective it is imperative that people across all population groups are encouraged to utilise health services and in particular sexual health, TB and HIV services.

These services must be accessible and acceptable to HIV-vulnerable groups, for example adolescents, sex workers, those who abuse recreational substances and MSM. In addition, healthcare providers can form an important part of the support system for MSM, particularly in hostile communities.

Healthcare providers need to render quality care regardless of personal attitudes and beliefs.

Positive, non-judgemental attitudes by healthcare workers can encourage responsible health-seeking behaviour in clients.

Negative attitudes often create barriers to service utilisation.

HOMOPHOBIA & HOMOPREJUDICE

Homophobia is a commonly used term to describe negative attitudes toward MSM, and gay men in particular. A phobia generally relates to an irrational fear. Some suggest that this term is replaced with the term homoprejudice. A prejudice implies a more active form of discrimination, which in turn perpetuates dislike and anger.

As a healthcare provider it is important to be aware of your attitudes and prejudices. While you do not have to actively endorse the idea that men have sex with men, to do your job effectively you need to be able to suspend judgement. You need to be able to acknowledge that for many, male-to-male sex is a normal sexual activity. Your personal views and attitudes may not compromise the quality of care rendered to clients.

MYTH OR STEREOTYPE	FACT
Being MSM is unAfrican	Male-to-male sex has occurred throughout Africa, although MSM do not necessarily identify as gay or homosexual
MSM behaviour does not exist in my community or culture	MSM behaviours occur in all cultures, societies and geographical locations, irrespective of whether this is acknowledged or not
MSM can be visually identified because they look effeminate or act in an effeminate manner	Most MSM present with a masculine identity and cannot be visually identified
Homosexuality is a mental illness	MSM do not have a mental illness and do not need a "cure" – MSM are healthy, functional human beings
MSM are not entitled to the same healthcare as others	Ethically, morally, legally and from a public health perspective, all people irrespective of race, class and sexual behaviour are entitled to the same healthcare

INTERACTING WITH MSM

Statistically, it is likely that every service provider seeing more than 20 male clients per day has interfaced with an MSM. It is often assumed that, unless male clients are openly gay, that they only have sex with women.

MSM may be reluctant to volunteer their true sexual history to a healthcare provider who is perceived to be judgemental, and may fear being embarrassed or shamed in hostile communities where there is doubt about confidentiality at the healthcare facility. The following could be useful for healthcare providers when working with a male client:

- » *Any male client could potentially be an MSM. Don't assume that a male client only has sex with women.*
- » *A professional, non-judgemental attitude must be maintained.*
- » *Confidentiality must be discussed with clients, especially in a hostile community. The client's sexual identity and related information may be omitted from the file.*

- » *Learn about the local MSM scene and associated terms and words. Peer educators and non-governmental organisations are often helpful. Talk to your MSM clients to learn more about their lives.*
- » *Be sensitive when interacting with male clients. Do not automatically use feminine pronouns such as “she” when referring to sexual partners.*
- » *Be sensitive with transgender clients. Transgender people experience a level of conflict with their birth sex (male or female), and may incorporate factors such as dress, roles or mannerisms usually associated with the other gender in their daily lives. When dressed as a woman, a man may feel more comfortable being addressed as a female. If unsure, ask the client how they would prefer to be addressed*

TAKING A SEXUAL HISTORY

The majority of MSM are masculine in dress and behaviour and are seemingly heterosexual. A healthcare provider can only determine an individual's sexual behaviour by enquiring specifically about this.

Five factors are highlighted in this regard:

1. *A sexual history is only indicated when this would be in the interest of an individual client's care.*
2. *Client privacy and confidentiality is paramount, especially in hostile, prejudiced environments.*
3. *Gender sensitivities need to be considered, such as men in some settings being uncomfortable discussing their sexuality with a female healthcare provider.*
4. *Healthcare providers must not assume all men are heterosexual. Providers must create a supportive environment to enable clients to reveal that they engage in MSM behaviours.*
5. *The healthcare provider must monitor their own psychological and behavioural responses in order to contain and address their responses towards MSM clients, especially when specific sexual behaviour is discussed very frankly.*

Further guidelines for taking a sexual history:

- » *Develop a rapport with the client. A simple reassurance that the client can trust the healthcare provider without fear of judgement will enhance the value of the consultation.*
- » *Explain why a sexual history is required: "Sometimes it can be uncomfortable to talk about our sex lives. In order for me to help you I need specific information that may be very personal to you. I'm here to help you, not to judge you. Would you mind if I ask you a few questions?"*
- » *Begin with general questions: explore whether they are single or in a relationship, whether they are married (to a man or a woman - in South Africa same-sex marriage is legal), how many wives they have and what other sexual relationships they have, either with men or with women.*
- » *It may be useful to ask, "Over the past 6 months, have you had sex with one partner, 2-4 partners, 5-9 partners, 10 partners or more?" and "Over the past six months, have you had sex with only women, with only men or with both men and women?"*
- » *It is not particularly useful to ask a client if he is gay. Many MSM do not consider themselves to be gay.*

- » *The history needs to focus on determining risks associated with HIV and other STIs and could include details as listed below. Be direct; ask specific rather than open-ended questions. Treat this list as you would any health checklist. Where possible, and where you feel comfortable, use the client's local sexual terminology.*

ASSESSMENT OF HIV & STI INFECTIONS

INFORMATION REGARDING...	FACTORS TO EXPLORE INCLUDE...
...oral stimulation	...kissing or anilingus
...penetration	...oral or anal, penetrative or receptive or both
...condom usage	...no condom, incorrect condom usage or condom breakage
...lubricant usage	...an oil-based lubricant, saliva or dry sex
...ejaculation	...intra-oral, intra-anal, intra-ocular or on broken skin

CHAPTER 2

THE SEX-POSITIVE MODEL FOR WORKING WITH MSM

Health4Men's sex-positive model enables MSM to experience their sexuality in a positive manner and to assume responsibility for their sexual health.

Men who feel guilty or ashamed of their sexuality may be less likely to be honest about their sexual health needs with healthcare providers. Such men are unlikely to assume responsibility for their sexual health if they consider their sexual impulses to be "bad".

Provided the behaviour is between consenting adults, all sexual interactions should be equally valued.

Health4Men's sex-positive model principles:

- » *HIV is not caused by sex – it is caused by a virus*
- » *HIV is not spread through sex – it is spread through body fluids transferred from one partner to another, particularly semen and blood*
- » *Education about the risks of specific body fluids is needed, but moralising about sex is a barrier to education about responsible sexual behaviour.*

HIV TRANSMISSION

If HIV transmission is explained biologically, MSM are less likely to feel judged and will be more open to learning about sexual health.

MSM need to be informed that HIV is spread through body fluids. Various body fluids produced by someone who is HIV positive contain different concentrations of the virus.

Two elements are needed for infection to occur:

1. *A high risk body fluid, and*
2. *An entry-point into the HIV negative partner's bloodstream.*

Semen and blood are very high risk body fluids. The viral concentration in anal fluid (produced by the rectum during anal sex) is unknown but this fluid could also pose a significant risk.

Pre-ejaculate represents a lower risk for transmission between men. MSM who also have sex with women need to be informed about the risks associated with vaginal sex.

Other body fluids, including saliva, tears, perspiration and urine carry no risk for HIV transmission unless they are contaminated with blood.

RESPONSIBLE SEX

Responsible sex focuses on preventing semen or blood from an HIV positive person entering the bloodstream of an HIV negative person.

Examples of contact that could allow entry of the virus are:

- » *Semen or blood on any broken skin (for example, a genital ulcer from Herpes simplex)*
- » *Semen or blood in the eye*
- » *Semen or blood in the mouth, for example if the person performing oral sex has any oral lesions*
- » *Semen or blood in the rectum, as could occur during anal intercourse*

ANAL INTERCOURSE

It is a myth that all MSM engage in anal intercourse, and many heterosexual couples do engage in this form of sexual expression.

Men who engage in anal intercourse (insertive, receptive or both, and either with men, with women or with both) must be informed that HIV can pass through the delicate mucosal membrane of the rectum. For this reason, unprotected receptive anal intercourse poses a particularly high risk for infection.

Responsible anal intercourse requires the use of both condoms and water-based lubrication.

Lubrication is required for the comfort of the receptive partner, to prevent trauma to the fragile rectal mucosal lining and to prevent excessive friction on the condom to prevent condom failure. MSM must be informed not to use any lubricants containing oils, such as petroleum jelly (Vaseline), body or hand lotion, butter or cooking oil for penetrative anal sex, because oil weakens condoms.

TERMINOLOGY

The Health4Men sex-positive model advises against the use of particular words that are less effective in working with MSM. Two such words are:

- » *“Safer sex”*: Many MSM associate traditional messaging as disapproving of anal intercourse and only focusing on sex between men and women. The preferred term, used by Health4Men, is *responsible sex*.
- » *“Test”*: In the light of many MSMs’ anxiety around HIV testing, the suggested alternate term is *screening*. *“Test”* has *pass-or-fail* connotations.

The physical environment of the service must also be considered. Posters and other symbols displayed in the venue should not be restricted to heterosexual content. Many MSM are more comfortable interacting with male healthcare workers or with female healthcare workers who are sensitive to MSM issues and healthcare needs.

CHAPTER 3

HEALTH PROMOTION & HIV PREVENTION FOR MSM

THE IMPORTANCE OF FOCUSING ON MSM

MSM are more likely to be infected with HIV than the general population. In Africa an MSM client is 3-4 times more likely to screen HIV positive than a heterosexual client².

The high HIV prevalence among MSM in South Africa and other African nations is often hidden in the overwhelming country-specific heterosexual epidemics. Sexually transmitted infections (STIs) are common among MSM with increasing rates of syphilis and other STIs being reported worldwide indicating high levels of unprotected sex³. Local studies in South Africa have shown that condom use by MSM remains irregular⁴.

2 Baral s, et al. (2007). 'Elevated Risk for HIV Infection among Men Who Have Sex with Men in Low- and Middle-Income Countries 2000–2006: A Systematic Review'. PLoS Medicine, December 2007.

3 See, for example, Savage e J et al. 'Syphilis and Gonorrhoea in Men Who Have sex With Men: A European overview'. Eurosurveillance. Vol.14 (47) November 2009.

4 Lane t et al. (2009) 'High HIV Prevalence Among Men Who have sex with Men in Soweto, south Africa: Results from the Soweto Men's study'. AIDs Behav. Aug 2009.

Factors influencing higher rates of STIs and HIV among MSM:

- » *Cultural, religious and political stigmatisation*
- » *Discrimination resulting in marginalisation*
- » *Poor availability of, or access to, condoms and water-based lubrication*
- » *Poor screening for and treatment of anal STIs*
- » *Sexual practices, particularly unprotected receptive anal sex*
- » *The taboo surrounding anal sex, and analphobia*
- » *Recreational substances including alcohol and drugs*
- » *Mental health and psychosocial factors*

Health4Men's sex-positive model proposes that MSM are more likely to take responsibility for their own sexual health if they are allowed to experience their sexuality in a proud and positive manner. Prevention messages need to be communicated in a way that encourages normality, openness and dignity about sexual behaviour that many people regard as 'abnormal' and 'marginal'. Prevention messages need to be relevant to the types of sex that MSM are having.

COMMUNICATING ABOUT MSM SEXUAL HEALTH & HIV PREVENTION

Effective messaging targeting MSM should:

- » **Include diverse MSM identities.** *MSM is not a homogenous group. Many MSM do not identify as “gay”, some are single, some are in long-term committed and monogamous relationships and some are in long-term committed relationships while they also have other sexual partners. Heterosexual MSM must be included as far as possible.*
- » **Include MSM who are HIV negative,** *HIV positive and those who don't know their HIV status. MSM who are living with HIV also require preventive messaging.*
- » **Focus on STIs, not on HIV.** *Many MSM aren't sure of their HIV status, which causes anxiety. MSM are more responsive to messaging that focuses on STIs such as syphilis and gonorrhoea than to preventive messages that confront HIV directly. STIs are also an important health issue for men who are HIV positive.*

- » **Be realistic.** *Some behaviours are unlikely to change. For example, instead of trying to persuade MSM to stop using alcohol or drugs, messaging could state that substance abuse is not an “excuse” to disregard their sexual health. Place emphasis on reducing any harm related to the substance abuse while still providing the best possible HIV and STI care.*
- » **Deploy peer educators.** *Health4Men successfully utilises both ‘Ambassadors’ and peer educators. The former are trained to distribute condoms and free sachets of water-based lubricant in their respective areas, and to refer men to appropriate healthcare services as needed.*
- » **Use indirect messaging.** *Many men who may be unlikely to attend a workshop on “safer sex” may be more interested in a workshop on “better sex” that also includes content on responsible sex.*

HEALTH PROMOTION STRATEGIES

PROMOTE CONDOM & APPROPRIATE LUBRICANT USE

Both condom and water-based lubrication use must be emphasised in messaging about anal sex. MSM must avoid any oil-containing lubricants.

Water-based lubricants such as KY (manufactured by Johnson & Johnson) and Assegai (manufactured by tatt2) are available in South Africa. Where water-based lubricants are not available, suggest:

- » *Low-fat, unflavoured yoghurt, or raw egg white (albumin), or if a fridge is available, buying commercial fruit-flavoured jelly and preparing it in advance but using only a third of the recommended quantity of water.*

Saliva is not recommended for lubrication as it dries quickly and increases the risk of condom failure and damage to the rectal mucosal lining.

Some lubricants may cause inflammation of the epithelial lining of the rectum increasing the risk of acquiring HIV. Clients must be educated to use both water-based lubricants and condoms.

PROMOTING FEMALE CONDOMS FOR ANAL SEX

How to use female condoms for anal sex:

1. *Check the expiry date and open the packaging.*
2. *Engage in the usual foreplay and lubricate the anal area. When ready draw the condom onto the lubricated penetrating penis (like putting on a sock) and slowly insert it into the anus with the penis, with the fixed outer ring remaining outside of the anal opening.*
3. *If a penis is reinserted care should be taken to penetrate within the opening of the condom and not alongside the plastic ring - and it is only safe to do this if it is the same sexual partner, as there may be semen in the condom already.*
4. *The condom can be retained in position for a couple of hours.*
5. *After sex the outer ring should be twisted to avoid semen spillage and the condom carefully removed and disposed of.*

Benefits of using female condoms for anal sex:

- » *If made of polyurethane, oil-containing lubricants can be used without damaging the condom. Polyurethane condoms are also ideal for men with an allergy to latex.*
- » *Some anally receptive MSM are anxious about their rectal area being clean. This causes anal inhibition and difficulty in relaxing their anal sphincter muscles, making penetration uncomfortable. As the female condom remains in place after the penis is withdrawn, any traces of faeces are hidden until the condom is discreetly removed in private.*
- » *The advantage for the penetrating partner is that the penis is not in any way constricted or constrained, as with a male condom, allowing for increased sensation that many MSM describe as being similar to sex without a condom.*
- » *MSM who experience a degree of erectile dysfunction when using male condoms may have an incentive to use female condoms.*

MULTIPLE CONCURRENT PARTNERSHIPS & RESPONSIBLE SEXUAL RELATIONSHIPS

Multiple concurrent sexual partnerships with low consistent condom use are the main drivers of HIV in Southern Africa⁵. Addressing such partnerships among MSM is complex because having more than one sexual partner is a common characteristic of some MSM. The more sexual partners an MSM has, the greater his risk of contracting HIV and STIs.

Open, non-judgemental discussion concerning the reduction of the number of sexual partners should be promoted among MSM. The following strategies are suggested:

Encourage negotiated safety for MSM in relationships:

MSM in committed relationships, either with men or with women, often engage in clandestine sex with others. Such MSM must be encouraged to consider their primary partner's sexual health, by practicing responsible sex with others.

⁵ See, for example, Halperin D.T. and Epstein H. 'Concurrent sexual partners help to explain Africa's high HIV prevalence: Implications for prevention'. *Lancet*, 2005;363 (9428):4-6.

Where possible, MSM should be supported to negotiate issues concerning sexual health with their primary partner if they are also having sex with other partners. This is often easier to initiate with same-sex male couples who could agree on a level of sexual openness with other men.

Unless partners can allow each other the freedom to discuss possible HIV exposure with others, consistent condom use within the confines of the relationship must be promoted.

Establishing a limited number of sexual partners:

MSM can be encouraged to develop a small, closed network of known sexual partners as opposed to having frequent anonymous sex with strangers. Some MSM have repeated sexual interactions with specific men without any emotional bond between them (often referred to as ‘sex buddies’). Consistent use of condoms and water-based lubricant is essential.

Strategic positioning: Anally-receptive MSM are at a higher risk of HIV infection through being exposed to the partner’s semen in the event of condom failure or sex without a condom. Many HIV positive MSM assume the receptive (as opposed to insertive) role during anal intercourse in order to prevent infecting an HIV negative partner.

However, MSM must be educated that an insertive partner is also exposed to HIV and other STIs and that infection is possible for the penetrating partner. Consistent use of condoms and appropriate lubricant must still be encouraged.

Educate on sero-sorting: This is a strategy whereby HIV-negative men may choose to only have sex with HIV- negative partners or HIV-positive men may choose to have sex only with HIV-positive partners. For HIV-positive men, this strategy removes worry about infecting a negative man as their partners are already HIV-positive.

The problem with sero-sorting is that many men do not know their HIV status, might be in the window period if they have taken an HIV rapid test recently or may lie to prospective partners about their status in order to avoid rejection or to manipulate a partner into not using a condom.

It is important that HIV-positive men be informed of the risks of STIs, and should be encouraged to continue using condoms and water-based lubricant when having sex with other HIV positive people.

CHAPTER 4

BIOMEDICAL PREVENTION STRATEGIES

Biomedical prevention strategies use medication or medical devices to reduce a person's risk of acquiring or transmitting HIV. In addition, these strategies rely on a behavioural component, for example condoms are classified as a biomedical intervention but the decision to use them or not is behavioural

POST EXPOSURE PROPHYLAXIS (PEP)

PEP is an HIV-prevention strategy used by someone who is HIV negative and has been exposed to a body fluid that may contain HIV. It should be commenced as soon as possible after the exposure has occurred, ideally within 72 hours⁶.

PEP may be used by MSM after a high-risk sexual encounter, following the same guidelines that apply to other forms of exposure. Recommendations can be found on the South African Department of Health website and Guidelines for ARV use in Adults, the WHO and CDC websites as well as from the South African HIV Clinicians' Society.

6 Venter F et al. Guidelines Post Exposure Prophylaxis. Southern African Journal of HIV Medicine. Winter 2008: 36-44

Clients on PEP must be...

- » *HIV negative;*
- » *Appropriately selected to ensure PEP is indicated and to maximise the benefits and minimise the risks associated with PEP;*
- » *Monitored for ARV side effects and adherence;*
- » *Screened for and protected against other blood-borne infectious diseases (check hepatitis B immunisation status and syphilis status); and*
- » *Counselled about follow-up HIV screening and responsible sex.*

PEP is an emergency treatment and should not be used repeatedly. If clients require repeated PEP following repeated potential exposure to HIV, the underlying reason for ongoing risky behaviour needs to be explored.

ACCEPTABLE PEP REGIMENS FOR SOUTH AFRICA

FREELY AVAILABLE FROM STATE SERVICES:

AZT + 3TC + Aluvia	Reasonably low pill burden but high incidence of gastrointestinal side-effects and fatigue
D4T + 3TC + Aluvia	Higher pill burden but better gastric tolerance. Peripheral neuropathy may occur

ALTERNATIVES AVAILABLE FROM RETAIL PHARMACIES:

Tenofovir based ARVs	Well tolerated and very low pill burden. Monitor for renal dysfunction
NNRTIs e.g. Efavirenz Avoid Nevirapine	Effective as part of PEP regimen but neuropsychiatric side effects may be magnified in clients who are anxious about being on PEP. Avoid if pre-existing psychiatric diagnosis. Nevirapine may cause severe Hepatitis in HIV negative people
Boosted protease inhibitors e.g. Atazanavir	Lower pill burden and once daily dosing compared to Aluvia

PRE-EXPOSURE PROPHYLAXIS (PrEP)

PrEP is a new prevention strategy which has been shown to be effective for MSM in research studies. It involves HIV negative individuals using combinations of antiretroviral medication over a long period of time to prevent established HIV infection occurring should they be exposed to the virus.

Research studies have shown that PrEP is safe if medications such as Tenofovir and Lamivudine are used and one large study (iPrEx) has shown the strategy to be effective in MSM who are able to take their medications accurately. PrEP can be considered for MSM clients who have repeated high probable exposure rates to the HIV virus, for example discordant couples, commercial sex workers and clients who frequent sex-on-site venues or have multiple sex partners.

PrEP must be used as part of a larger prevention package to avoid giving clients a false sense of protection that might result in them increasing their risk of HIV exposure. MSM who use PrEP require frequent adherence counselling and HIV screening.

MALE CIRCUMCISION

Research shows that circumcised heterosexual men have a 60% lower risk of acquiring HIV from women than their uncircumcised counterparts. Medical male circumcision (MMC) has been included in South Africa's national prevention campaign.

The male foreskin is a moist membrane containing many immune cells that are susceptible to infection with HIV. The skin that remains behind after circumcision becomes thickened and more like regular skin, providing a better barrier with fewer HIV-susceptible cells.

MMC will not protect MSM who acquire HIV from receptive anal sex. MMC could provide protection to HIV negative MSM who also have sex with women.

MMC does not provide absolute protection against infection and must be included as part of a complete risk reduction strategy.

Clients who have had MMC performed must wait until the wound has healed (6 weeks) before resuming sexual activity.

TREATING AND PREVENTING STIs

HIV transmission requires the transfer of the virus from one individual to another. The condition of skin and mucosal barriers is a factor that affects transmission. Some STIs, such as Herpes simplex genital ulcer disease, cause open skin, abrasions or sores that provide entry points for HIV infection.

Some sexual infections can be prevented with vaccines. These include Hepatitis A and B as well as HPV vaccines (for example, Gardasil). Not all these vaccines are available in the public health sector, but some clients may choose to self-fund them if they are aware of their benefits.

All MSM should be screened and, if possible, vaccinated for Hepatitis B. Syphilis is often asymptomatic among MSM clients, who should be screened for this STI at least once a year.

All clients who seek STI services should receive risk-reduction counselling and condoms as well as advice about lubricants, partner notification and treatment.

TREATING HIV TO LOWER VIRAL LOAD

HIV positive MSM with high viral loads are more likely to transmit HIV because there is more virus in their bloodstream and sexual fluids. Clients who are on ARVs and have low or undetectable amounts of virus are much less likely to transmit HIV to their sexual partners.

One prevention strategy is thus to treat HIV-positive MSM who are most at risk of transmitting the virus (for example, sex workers) even when their CD4 count is high, to reduce their viral load and thus their “infectivity potential”. Known as ‘treatment as prevention’ (TasP), this is commonly done in the private health sector in South Africa.

Sero-discordant couples, commercial sex workers, people using drugs, especially if they inject, and MSM who regularly frequent sex-on-site venues or have multiple sex partners, should be considered. Although MSM are regarded as a group at high risk of HIV transmission, current guidelines suggest using the same ARV initiation criteria as for non-MSM men; treating at a CD4 of $< 350/\text{mm}^3$.

MENTAL HEALTH FACTORS AFFECTING MSM

MSM are a high-risk group for HIV infection and are frequently marginalised and stigmatised in society regardless of their HIV status. Consequently particular attention must be paid to mental health issues among MSM.

The mental health needs of MSM often relate to pressures and stressors stemming from the impact of living in a hostile environment that can result in depression, anxiety and issues related to substance abuse. Other problems can include sexual addiction, sexual anorexia, sexual dysfunction and problems in complex partner relationships.

The healthcare provider is not expected to be an expert on MSM mental health issues, but it is useful to have some knowledge, particularly in low-resource settings. The healthcare provider can listen and provide support, and where possible make referrals to relevant psychological services. In low-resource settings, where there are no accessible referral points, the client and healthcare provider can contact organisations such as Health4Men.

CHAPTER 5

MEDICAL MANAGEMENT OF MSM SEXUAL HEALTH

Healthcare providers are expected to provide services according to their levels of care and training. The information in this section aims to give a broad overview in terms of the medical management of potential sexual health problems affecting MSM. Many of these problems may need referral to specialist care. In low-resource settings, where there are no accessible referral points, the client and healthcare provider are encouraged to contact Health4Men for telephonic advice and support.

SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES

DIAGNOSIS	FIRST-LINE TREATMENT	SPECIAL CONSIDERATIONS: MSM
Uncomplicated Gonorrhoea	Cefixime 400mg PO stat OR Ceftriaxone 250mg IMI stat Always add empiric treatment for chlamydia	Anal pain or discharge may indicate anal gonorrhoea; non-resolving URTI should prompt consideration of a pharyngeal STI.
Uncomplicated Chlamydia	Doxycycline 100mg 12- hourly for one week OR Azithromycin 1g PO stat Always add empiric treatment for chlamydia	As for gonorrhoea; many cases of anal chlamydia are clinically silent.

DIAGNOSIS	FIRST-LINE TREATMENT	SPECIAL CONSIDERATIONS: MSM
Syphilis		Syphilitic chancres are usually painless, may go unnoticed and untreated- especially, for anal syphilis where the chancre could be internal. Yearly screening of asymptomatic sexually active MSM is recommended.
Primary syphilis	Benzathine penicillin 2.4mu IMI stat x1	
Secondary syphilis	Benzathine penicillin 2.4mu IMI stat x3	
Latent syphilis	Benzathine penicillin 2.4mu IMI stat weekly for three weeks Doxycycline 100mg 12 hourly for 14-28 days for penicillin- allergic patients	

DIAGNOSIS	FIRST-LINE TREATMENT	SPECIAL CONSIDERATIONS: MSM
Neurosyphilis	Penicillin G 5mu IVI for 14 days AND Follow with benzathine penicillin 2.4mu IMI weekly for three weeks OR Procaine penicillin 2.4mu IMI daily AND probenecid 500mg 6 hourly for 14 days AND Follow with benzathine penicillin 2.4mu IMI weekly for three weeks	Consider and refer all MSM with a positive blood syphilis serology and neurological deficits.

DIAGNOSIS	FIRST-LINE TREATMENT	SPECIAL CONSIDERATIONS: MSM
Lymphogranuloma venereum (LGV)	Doxycycline 100mg 12 hourly for 14 days OR Erythromycin 500mg 6 hourly for 14 days	Supposedly more common among MSM but unclear if this is true for South African MSM.
Human papillomavirus (HPV)	Topical therapy including cryotherapy, podophylin, acetic acid or imiquimod Large fungating warts or internal anal or urethral lesions should be referred for surgical excision	MSM who practice anal sex need anal exam to diagnose warts; MSM have an elevated risk of anal cancer especially if they have had anal warts.
Hepatitis A	Supportive therapy. Notify.	Hep A is usually a food-borne disease but becomes an STI among MSM.

DIAGNOSIS	FIRST-LINE TREATMENT	SPECIAL CONSIDERATIONS: MSM
Hepatitis B	Pegelated Inteferon therapy if available OR Tenofovir 300mg daily AND Lamivudine 300mg daily	Sexually spread among MSM. All MSM should be screened and vaccinated. MSM with ongoing potential exposure to Hep B should be vaccinated according to a condensed vaccine schedule.
Hepatitis C	Pegelated Interferon AND Ribavirin if available. Refer to specialist.	If HIV co-infected, avoid drugs that cause steatosis or hepatitis; treat early for HIV if co-infected and look for risk factor of IV recreational drug use.
Trichomonas	Metronidazole 2g PO stat	May be seen in MSM who also have female partners.

Always refer to local health department guidelines for treatment protocols for STIs. The above table is a summarised guideline only.

ANTIRETROVIRAL THERAPY FOR MSM

CRITERIA FOR STATE-FUNDED ART ARE THE SAME AS FOR NON-MSM

- » CD4 \leq 350
- » Any CD4 count AND a WHO stage IV “AIDS defining” opportunistic infection

RECOMMENDED STATE-FUNDED REGIMENS

- » First line: Tenofovir + Lamivudine + Efavirenz / Nevirapine
- » Second line: Zidovudine + Lamivudine + Aluvia
- » Treatment switches should be made according to SA DOH guidelines

SPECIAL CONSIDERATIONS FOR ARV USE IN MSM

Earlier treatment may be preferable	Anal sex carries a higher risk of transmitting HIV than vaginal sex; HIV-positive MSM are more likely to infect their sex partners and should be considered for treatment at higher CD4 counts.
Identify clients with particularly high HIV transmission risk	Discordant MSM couples, MSM who frequent sex-on-site venues or have multiple sex partners, commercial sex workers and MSM who use drugs should be identified for early treatment.
Primary resistance may be more common	International tourists may transmit HI virus strains with primary drug resistance when they have sex with local MSM; primary resistance should be considered in MSM with a history of sex with tourists or who fail first line medications despite good reported adherence.
Adherence may be more challenging	Innovative mechanisms of adherence support should be sought for MSM, including support groups and electronic reminders and messages.

Consider drug reactions

Recreational drug use, common among some groups of MSM, needs to be considered when initiating ART; take a history of recreational drug use to identify potential interactions; drug-using MSM need counselling about consequences of drug use but remain eligible for ART even if they choose not to stop their drug-taking behaviours. MSM may be using anabolic steroids, testosterone, growth hormone or other supplements to enhance their physique which may interact with ART.

Transgender clients may be using oestrogen or other hormones which may similarly interact.

If uncertain about potential drug interactions, contact the Medicines Information Centre toll free on 0800 212506, or visit www.mic.uct.ac.za

Visible or sexual side effects

Some MSM have been exposed to a lot of information regarding ART side effects. Examples include:

- » Body-conscious MSM refusing to take Stavudine due to lipoatrophy or lipohypertrophy.
- » Older MSM with vascular risk factors may develop erectile dysfunction on protease inhibitors.
- » Some ARVs (e.g. protease inhibitors) cause diarrhoea and flatulence which can lead to decreased adherence and anal sexual dysfunction.

SCREENING INTERVENTIONS FOR MSM

SCREENING	REASON FOR SCREENING MSM	BENEFITS OF SCREENING
HIV	Higher risk among MSM	Inform health care decisions and management; prevention
Viral hepatitis	Sexual transmission among MSM	Susceptible individuals to be vaccinated against Hepatitis A and B; infected individuals can receive treatment
Syphilis	Increasing rates worldwide	Identifies asymptomatic disease; treatment; contact tracing
Anal exam for HPV	Anal HPV occurs in MSM	Treatment; prevention counselling; monitoring to lower the risk of undiagnosed anal carcinomas. Exclusion of other anal diseases such as haemorrhoids and fissures

SCREENING	REASON FOR SCREENING MSM	BENEFITS OF SCREENING
Testicular examination	Most common cancer among young men	Early detection of testicular mass simplifies treatment and improves outcome
Prostate	Prostate cancer common in men aged > 45 years	Early detection simplifies treatment, improves outcome
Mental health	Depression and anxiety common; alcohol and recreational drug use are common	Can be managed to improve ART adherence; drug interactions can be anticipated and / or avoided

To find a Health4Men clinic near you go to www.health4men.co.za.

	LOCATION	CONTACT
HEALTH4MEN ADMINISTRATION	Cape Town: 1st floor, Anatoli building, 24 Napier Street, Green Point	021 421 6127 www.health4men.co.za info@health4men.co.za
	Johannesburg: Anova Health Institute, 12 Sherborne Road, Parktown, Johannesburg	011 715 5800 www.anovahealth.co.za info@anovahealth.co.za
HEALTH4MEN CLINICAL SERVICES	Cape Town: Ivan Toms Centre for Men's Health	021 447 2844
	Soweto: Simon Nkoli Centre for Men's Health	011 989 9865
OTHER	Pietermartizburg: Gay and Lesbian Association	033 342 6165 info@gaylesbiankzn.org
	Durban: Gay & Lesbian Community Centre	031 301 1245 Info@gaycentre.org.za
	Pretoria : OUT LGBT Well-Being	012 430 3272
	Cape Town : Triangle Project	021 448 3812 info@triangle.org.za
	Cape Town : Gender Dynamix	021 633 5287 info@genderdynamix.co.za

