

Three dark teal silhouettes of men's heads and shoulders are arranged in a row, facing right, against a lighter teal background. The silhouettes are of varying sizes, with the largest on the left and the smallest on the right.

FROM TOP TO BOTTOM

A SEX-POSITIVE APPROACH FOR MEN WHO HAVE SEX WITH MEN:
Guidelines for healthcare providers

Two dark teal silhouettes of men's bodies are shown from the waist down, facing right, against a lighter teal background. The silhouettes are of varying sizes, with the larger one on the left and the smaller one on the right. The smaller silhouette has its hands clasped together.

FROM TOP TO BOTTOM

A SEX-POSITIVE APPROACH FOR
MEN WHO HAVE SEX WITH MEN

A manual for healthcare providers



ANOVA
HEALTH INSTITUTE



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FOREWORD

This manual draws on the experience of the Anova Health Institute's Health4Men project that provides sexual health services for men who have sex with men (MSM) in South Africa. The manual is a resource to assist healthcare workers to provide appropriate and accessible psycho-social and medical care for MSM.

The Health4Men project was initiated in 2008 when the South African Department of Health started to focus on providing HIV-related services for MSM in accordance with the National Strategic Plan (NSP).

The Anova Health Institute supported this initiative by developing the sex-positive model for addressing MSM sexual health – with an emphasis on HIV – for implementation throughout South Africa. Health4Men provides a comprehensive package that includes combination HIV prevention linked to competent MSM sexual health and HIV services. Health4Men now has services throughout the country. Two clinics have been awarded the title of Centres Of Excellence (COE) for their specialised HIV-related care and treatment – the Ivan Toms Centre for Men's Health in Woodstock, Cape Town and the Yeoville clinic in Johannesburg.

MSM, competent services are integrated into public health facilities to maximise reach and sustainability. In addition to MSM services, Health4Men focuses on the health needs of other high-risk male populations, including displaced persons and refugees, prison populations, commercial sex workers and intravenous drug users.

The Anova Health Institute undertakes research and specialises in innovative projects that extend to hard-to-reach populations. The Health4Men project has significant expertise in preventative interventions specifically with diverse groupings of MSM.

1 PEPFAR (2011) Technical Guidance on Combination HIV Prevention. (released May 2011) www.pepfar.gov/documents/organization/164010.pdf

There are many barriers to MSM accessing healthcare. These include:

- » A lack of understanding, prejudice and judgement by healthcare providers and among MSM themselves
- » Stigma related to sexual and gender diversity
- » A perception that health services cater mostly for heterosexual people

The Anova Health Institute has identified a need to disseminate the Health4Men project's expertise and experience in working with MSM. This is being done through a series of publications and, more specifically, through training. The latter includes establishing competent MSM services, specifically in community clinics, in partnership with the Department of Health and local health authorities.

This manual is the result of work undertaken by the staff of Health4Men. Glenn de Swardt and Kevin Rebe were the main contributors with support from James McIntyre and Helen Struthers. Many of the men who have utilised the organisation's diverse services contributed to the insights contained in this manual. Melanie Pleaner, Melissa Meyer and Ruth Becker assisted in producing the manual.

SECTION 1

INTRODUCTION

Men who have sex with men (referred to in this manual as MSM) are a diverse group presenting specific diagnostic and management challenges to healthcare providers. Clients who are MSM have specific risk factors and behaviours that change the epidemiology, presentation and management of many diseases – including HIV – when compared to the heterosexual population.

Knowledge of these differences will enable healthcare providers to competently provide prevention and treatment services to MSM. In addition, there are psycho-social and cultural issues that impact on the problems presented and the willingness of the client to seek healthcare. This manual gives healthcare providers the knowledge to enable them to improve healthcare provision for MSM.

To deliver professional, competent MSM services, healthcare providers should be able to create an environment conducive to interacting with MSM. Healthcare providers need to be aware of their own attitudes towards MSM and improve their ability to understand and communicate with MSM clients.

MSM are vulnerable as a result of social discrimination, stigma and prejudice. In order to provide services where both healthcare providers and MSM feel comfortable, healthcare providers need to become familiar with local MSM practices, world views, language and resources. Some of these practices may be unfamiliar to healthcare providers and some practices may be contrary to healthcare providers' own values and world views. Healthcare providers need to be cautious that their personal views and/or lack of knowledge of MSM do not impact negatively on their ability to provide quality healthcare to this population.

Many people believe that MSM represent a small, marginal group of our population. However, research in South Africa shows that many MSM (up to 50%) also 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 epidemic².

Despite our constitution, MSM face stigma and discrimination across communities in South Africa and, as a result, are discouraged from seeking help for their health and wellbeing. This manual aims to assist healthcare providers to redress the prevailing prejudice, to provide the healthcare to which all South Africans are entitled and to better understand their MSM clients in order to increase access to public health services for everyone.

Overview of the manual

The manual is divided into six sections, followed by appendices referred to in the text.

Section 1 provides an introduction to the manual.

Section 2 seeks to answer the question ‘Who are MSM?’ The section provides an overview of MSM in terms of sexuality and sexual identity and defines terminology related to these concepts.

Section 3 looks at broader public health strategies relating to MSM, with a focus on communicating sexual health messages in terms of sexual health promotion and HIV prevention.

Section 4 explores the role of the healthcare provider in terms of providing quality, competent MSM services.

Section 5 discusses the potential mental health problems that affect MSM.

Section 6 provides practical guidelines in relation to the medical management of sexual health problems that may affect MSM.

² See, for example, Lane et al., 2009

Who has the manual been written for?

The manual has been written for all healthcare providers who encounter MSM in the normal course of their work:

- » It has been developed for health professionals and support staff at public health facilities, with a specific focus on primary healthcare level nurses.
- » Section 6 targets health professionals (nurses and doctors) for the medical management of sexual health problems that may affect MSM.
- » Additional information is included for counsellors, psychologists and social workers who provide psycho-social services to MSM.
- » The manual will be of use to staff involved in health promotion, health education and peer education with MSM.
- » It is also hoped that the manual will be a useful resource for the private sector, NGOs, health organisations and services with targeted interventions for MSM.

Terms and abbreviations used in the manual

Healthcare provider: is used as a generic term for personnel rendering health services to MSM. Whilst the focus is on nurses in primary healthcare services, the word is used to embrace other health professionals and support staff.

MSM: is a generic term to describe men who have sex with men. The term is explained fully in Section 2.

Competent MSM services: is used to refer to acceptable, accessible and MSM-friendly services. Implicit in the term competent is that the healthcare provider will have the knowledge and skills to provide an appropriate quality service to MSM.

Unfamiliar words: There are words in the text that may be unfamiliar to healthcare providers. These are useful terms in the context of HIV, MSM and public health. This manual includes a glossary of MSM-related terminology.

SECTION 2

MEN WHO HAVE SEX WITH MEN: SEXUAL IDENTITY AND SEXUAL ORIENTATION

SECTION OVERVIEW

Although there is the common assumption that all MSM are gay men, with similar values, lifestyles and dress, MSM is in reality a very broad term to describe a widely diverse group of men – the common thread is **a behavior** that these are men who have sex with men.

In this section, the term MSM is unpacked. An overview of the different factors influencing sexual identity is discussed. This is helpful to understand the concepts that underpin MSM and aims to clarify how gender, sexuality and sexual orientation all contribute to the identities, social issues and sexuality of MSM.

The relationship between MSM, homosexuality and being gay are also explored and clarified.

Understanding sexual identity and sexuality

Every person has their own sexual identity that is made up of a combination of three interrelated factors – biological sex, sexual orientation and gender. These factors combine to shape the identities of MSM.

Factor 1: Biological sex

Male _____ (Intersex) _____ Female

Most people are born biologically either male or female. However, even biologically there are exceptions when people are born intersex. This means they are born either of indeterminate sex (with male and female genitals or undeveloped genitals) or hormonal conditions due to internal ovarian tissue (in boys) or testicular tissue (in girls).

For a child that is intersex, it is important not to automatically do ‘remedial’ surgery to choose a ‘gender’ for the child as was common before. The issues can be resolved taking into account the child’s development. Intersex does not indicate a specific sexual orientation – it reflects biological features. An intersex person may be heterosexual, homosexual or bisexual.

Factor 2: Sexual orientation

Heterosexual _____ (Bisexual) _____ Homosexual

The basic model of sexual orientation is that people are heterosexual or homosexual – **heterosexual** means sexually and emotionally attracted to people of the opposite sex and **homosexual** to the same sex.

Over time, everyone knows whether they are mainly sexually attracted to people of the same or the opposite sex. This usually happens by adulthood but it may shift over time and some individuals may never be certain.

A significant number of people, irrespective of culture or social norms, may be sexually attracted to people of both sexes. This is often referred to as being bisexual. Such people may form long-lasting, intimate and loving relationships with people of either sex.

Factor 3: Gender identity

Feminine _____ (Transgender) _____ Masculine

Gender identity relates to cultural customs and social roles. Gender roles are socially defined and will determine acceptable behaviours and roles for women and men. In patriarchal societies, a masculine gender identity usually assumes relative power over a feminine gender identity.

*Transgender*³ people challenge traditional cultural concepts of gender and experience a conflict between their assigned sex at birth and their gender identity. For example, a man who is transgender may choose to dress as a woman or to assume a lifestyle generally associated with being female. Being transgender does not define the person's sexual orientation and a transgender person may be attracted to either men or women, or both.

Who are MSM?

MSM are men (assigned sex at birth) who have sex with other men (assigned sex at birth). Not all MSM see themselves as homosexual. Many such men may be married, have children and have sex with women; the fact that they have sex with men often remains hidden within their communities. Many have a masculine gender identity and cannot be identified as being MSM by their dress, mannerisms or social roles and they may see themselves as being heterosexual.

Recent publications are starting to contribute to our understanding of this diverse group of men who do not consider themselves as gay or homosexual but who have sex with men⁴. In addition to their having sex with women, these MSM may have sex with men on a regular or occasional basis, either secretly or openly.

³ For more information on transgender people, please visit <http://www.genderdynamix.co.za/>

⁴ See, for example, Sandfort and Dodge, 2009

Some MSM identify as gay. The term *gay* is often associated with a more Westernised (Eurocentric/American) gay culture. The term gay-identifying men refers to men who see themselves as gay in terms of sexual orientation and identity, as well as cultural and social issues related to being gay in a predominantly heterosexual society.

Within the broad group of gay identifying males, there is diversity – in terms of dress, language, values, attitudes, sexual preferences and interests. These different groups are known as sub-groups, sub-sets or sub-cultures. Some MSM have sex with other men on an occasional basis and may also have sex with women, while other MSM only have sex with other men.

In summary, the diverse collective 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.

MSM and sexual activity

Sexual interactions between men include a range of behaviours such as kissing, hugging, masturbation, mutual masturbation, oral sex (fellatio), anal stimulation (digital or oral – oral is known as anilingus or *rimming*) or penile-anal penetration. Some men prefer not to engage in penetrative anal sex and may prefer *thigh sex* (rubbing the penis between a partner's thighs). Some MSM may have a preference for being the more active (penetrative) partner during oral or anal sex, while other men may prefer the more passive (receptive) role, although many men may not have a preference. Importantly, not all MSM engage in anal sex. There are many variations and preferences in sexual activity including massage, web-cam sex via the internet, sexting (sending sexual pictures and text via cellphone) and the use of toys.

SECTION 3

SEXUAL HEALTH PROMOTION AND HIV PREVENTION FOR MSM

SECTION OVERVIEW

Section 3 deals with issues relating to health promotion and HIV prevention programmes. The section begins with placing MSM within the broader context of public health, where the importance of focusing on MSM as a separate target group with specific needs for sexual health and HIV prevention interventions is described.

Strategies for the effective communication of health messages to MSM are then looked at, and a framework for more effective communication is provided. Several health promotion strategies are outlined, including condom use (male and female condoms), the use of appropriate lubrication and addressing the issue of multiple and concurrent partners.

This is followed by several biomedical prevention strategies—some of which are already available (for example, HIV screening, PEP and STI management), some are being made available (for example, PrEP), whilst others are currently being researched (for example, rectal microbicides and vaccines to prevent HIV).

The importance of focusing on MSM

MSM are more likely to be infected with HIV than the general population. In Africa this means that an MSM client is 3-4 times more likely to test HIV positive than a heterosexual client⁵. The high HIV incidence and 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 sex⁶. Local studies in South Africa have shown that condom use by MSM remains irregular⁷.

There are many factors that influence the higher rates of STIs and HIV among MSM, including:

- » Cultural, religious and political stigmatisation
- » Discrimination resulting in marginalisation
- » Poor availability of, or access to, condoms and water-based lubrication
- » Sexual practices, particularly unprotected receptive anal sex
- » Recreational substances including alcohol and drugs
- » Mental health and psycho-social factors

Therefore it is critical that health promotion and HIV prevention programmes address MSM sexual health issues. Prevention programmes for MSM need to emphasise STI and HIV prevention and the promotion of responsible sexual behaviours.

5 Baral S, et al. 2007

6 See, for example, Savage EJ et al. Syphilis and Gonorrhoea in Men Who Have Sex With Men: A European Overview. *Euro-surveillance*, Volume 14, Issue 47, 26 November 2009 and Hughes G et al. Data from UK Genitourinary Medicine Clinics, 2006: A Mixed Picture. *Sex Transm Infect* 2007 83: 433-435

7 Lane T et al. High HIV Prevalence Among Men Who have Sex with Men in Soweto, South Africa: Results from the Soweto Men's Study. *AIDS Behav.* 2009 Aug 7. Center for AIDS Prevention Studies, University of California San Francisco, CA, USA

The way this is communicated is of critical importance. Health promotion messages need to be sensitive to the different groupings within the broader category of MSM, and also be sensitive to the range of prejudices and negative responses MSM experience.

The Health4Men sex-positive model approach proposes that MSM are more likely to assume 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.

Communicating about MSM sexual health and prevention

Current challenges

There is very little HIV prevention messaging aimed specifically at MSM in South Africa. Most of the advertising images addressing HIV are of heterosexual couples. The promotion of the *ABC* (abstain, be faithful, condomise) model of HIV prevention is viewed by many MSM as only being applicable to heterosexuals.

Current sexual health messaging does not reflect the reality of MSM sexual expression and sexual activity that for many men includes secretive, clandestine and anonymous sex.

While the ongoing campaign promoting consistent condom and water-based lubricant use is important, the phenomenon of prevention fatigue (people becoming bored and tired of the same repetitive messaging) requires innovative and engaging messaging. In order to encourage responsible sex, and communicate health messages effectively, resistance to condom use needs to be understood within the specific MSM context.

The following points explain some of the factors contributing to the resistance to consistent condom use amongst MSM:

Sexual practices and sexual preferences: For some MSM, having sex without a condom is a conscious choice (referred to by some MSM groups

as *barebacking*). There are also a range of sexual activities and an erotic association related to semen that further discourages condom use.

Mental health issues: Issues such as low self esteem, fear of the future, loneliness and a sense of powerlessness and depression often result in a sense of hopelessness and pessimism, contributing to some MSM being willing to engage in risky behaviour.

Recreational drugs and alcohol: The use of alcohol or recreational drugs plays a role in the social and sexual interactions of many MSM. Such substances result in disinhibition and possibly sex without condoms.

Misconceptions about antiretroviral (ARV) treatment: A willingness to engage in irresponsible sexual behaviour is fed by an incomplete understanding of ARV treatment. Some MSM erroneously view HIV as a *simple* chronic disease, comparable to diabetes, that is *easily* controlled.

Lack of knowledge and access to resources: On a simply practical level, many MSM engage in unsafe sexual practices because they lack knowledge about and access to water-based lubrication for anal intercourse.

A variety of oil-containing products for comfortable anal penetration are used, including household items such as cooking oil, body and hand lotions and Vaseline (petroleum jelly), all of which contribute to condom failure because of their oil content. There is a need for more education about suitable water-based lubrication, together with making this more available with condom distribution.

Dissatisfaction with available condoms: Not all condom brands are identical and many MSM are dissatisfied with using the particular condom brand distributed freely by the Department of Health. For example, some MSM complain that these condoms are uncomfortably restrictive, or simply too small, which could contribute to erectile dysfunction during intercourse. Brands of larger condoms are commercially available but may not be affordable to many MSM who prefer to forgo using condoms completely.

Communicating effectively about MSM sexual health and prevention: some suggestions

The Health4Men sex-positive approach has been looking at effective ways to communicate more effectively around sexual health promotion and HIV prevention. Based on this experience, the following guidelines have been developed:

Effective messaging targeting MSM should be as inclusive of diverse MSM identities as possible. MSM is not one homogenous⁸ group, so healthcare providers should not make assumptions.

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.

Messaging for MSM needs to include MSM who are HIV negative, HIV positive and those who don't know their HIV status. Infected and affected populations require ongoing preventive messages.

Many MSM are unsure of and experience anxiety related to their HIV status. It is therefore helpful to focus on sexually transmitted infections (STIs) rather than on HIV.

MSM are often more likely to respond to preventive messaging that addresses STIs, such as syphilis and gonorrhoea, than to preventive messages that confront HIV directly.

STIs are less intimidating and more immediate than HIV and are easier to deal with in the short term. Messaging should focus on both the genital and anal STI infections. Engaging MSM about STIs allows for a more natural way to address HIV.

STIs are also an important health issue for men who are HIV positive.

8 Homogenous means a group that is all the same

Message content should always be realistic. Some behaviours are unlikely to change. For example, instead of focusing on persuading MSM to stop using alcohol or recreational substances, messaging could rather suggest that substance abuse is not an excuse to disregard their sexual health.

Emphasis should be placed on reducing any harm related to the substance abuse while still providing the best possible HIV and STI care. This is known as a harm reduction strategy. Harm reduction strategies may be more successful than attempts to prohibit all forms of substance abuse.

Another example of being realistic relates to oral sex: within MSM groupings, condom use during oral sex is highly infrequent. MSM are likely to reject suggestions that condoms be used for oral sex but may heed advice to avoid a partner ejaculating in their mouth or getting semen in their eye. In this instance, the risk of HIV infection is not oral sex as such but potential oral exposure to the virus through a HIV-positive sex partner's semen.

Use peer educators. Health4Men deploys several ambassadors and peer educators, which has proved to be a successful approach.

Ambassadors are trained in communicating about responsible sex and distribute condoms and free sachets of water-based lubricant in their respective areas. They also refer men to appropriate healthcare services as needed.

Peer educators have completed a structured training course including understanding male sexualities, HIV and STIs, biomedical prevention, basic counselling skills and ethics.

Health promotion strategies

Promote condom and appropriate lubricant use

Promoting condom use must be accompanied by equal emphasis on the use of water-based lubrication for anal penetrative sex. Silicon-based lubricants are also suitable for use with condoms but are generally expensive.

The majority of MSM in South Africa are uninformed about the need to avoid oil-containing lubricants with condoms and remain unaware of the availability of water-based lubricants such as K-Y Jelly® (manufactured

by Johnson&Johnson®). Oil-based household items such as Vaseline, body and hand lotions, cooking oil and margarine should be avoided. In instances where water-based lubricants are not available, the following can be suggested:

- » Low-fat, unflavoured yoghurt;
- » Raw egg white (albumin).

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

MSM need to be educated about the benefits of using appropriate water-based lubrication and, if possible, such lubrication should be made available in order to promote responsible condom use.

Health4Men includes the following core message in all preventive campaigns:

“ Consistent use of condoms with water-based lubricant and reducing your number of sexual partners are your best defence against STIs and HIV ”

The use of female condoms for anal sex

A lesser known alternative to male condoms is female (vaginal) condoms. Female condoms are generally promoted for use by women but have become increasingly popular among MSM for anal intercourse. It is important to demonstrate the use of female condoms for MSM – the packaging and branding of female condoms are only directed at women for vaginal use and does not appeal to men.

Instructions for the use of female condoms for anal sex for MSM

- » Check the expiry date and carefully remove the condom from the packaging so that it is at hand for use;
- » Engage in the usual foreplay, including lubricating the anal area, until the point of anal penetration;

- » Draw the condom over 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;
- » The body heat of the penetrated partner will gradually soften the condom and mould it to the rectal lining, so that it remains in place when the penis is withdrawn;
- » 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);
- » The condom can be retained in position for a couple of hours;
- » After sex the outer ring should be twisted to avoid semen spillage and the condom carefully removed and disposed of.

In promoting the use of female condoms to MSM, the following benefits can be highlighted:

- » If made of polyurethane (dependent on the brand) as opposed to latex, oil-containing lubricants can be used without damaging the condom. Polyurethane condoms are also ideal for men with an allergy to latex.
- » Many MSM who are anally penetrated are anxious about their rectal area being clean and free of traces of faeces. This leads to anal inhibition and difficulty in relaxing their anal sphincter muscles that makes being penetrated uncomfortable. Since the female condom remains in place after the penis is withdrawn, any traces of faecal matter remain hidden until the condom is discreetly removed in private.
- » The primary advantage for the penetrating partner is that the penis is not in any way constricted or contained – as occurs with a male condom – and this allows for increased sensation that many MSM describe as being similar to sex without a condom. The penetrating partner does not have to be concerned about correctly rolling a condom onto his penis and, in the case of polyurethane female condoms, does not have to be concerned that the condom may have broken during sex.

9 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.

Addressing multiple concurrent partnerships and responsible sexual relationships

Research shows that multiple concurrent sexual partnerships with low consistent condom use are one of the main drivers of HIV in Southern Africa⁹. However, addressing multiple concurrent partnerships among MSM is particularly challenging and complex because having more than one sexual partner is such a common characteristic of the sexual behaviour of some MSM.

Nevertheless, communicating about multiple concurrent partners is an important and essential aspect of communicating about responsible sex. Open, non-judgemental discussion concerning the reduction of the number of sexual partners should be promoted among MSM. The critical point is that the more sexual partners, the greater his risk of contracting HIV and STIs.

The following added strategies are advocated to adapt responsible sex messages related specifically to the lifestyles and sexual behaviour of MSM:

Encouraging negotiated safety for MSM in relationships:

Many MSM in long-term committed relationships, either with men or with women, engage in secretive or anonymous sex with other men. Such MSM must be encouraged to consider their primary partner's sexual health and to practice responsible sex with people outside of the relationship. Where possible, MSM should be supported to enter into negotiated safety with their primary partner, which is often easier to initiate with same-sex male couples.

While some MSM have sex with others without their primary partner's knowledge, many couples negotiate the sexual boundaries of their relationships and enter what is referred to as an *open relationship* (versus a *closed relationship*, where sex with others is not approved). There are several degrees of openness to relationships that range from the couple having sex with a third person, to both partners being individually allowed to freely engage sexually with other men. Sometimes there are mutually agreed limits (such as no penetration or no sex without a condom) and often there is a limit on the number of times a sexual partner can be seen in order to avoid emotional infidelity (versus sexual infidelity) developing.

Negotiating such safety within a relationship needs to focus on open communication and strategies (such as PEP) that can be implemented in the event of exposure to HIV infection. Unless partners can allow each other the freedom to discuss possible HIV exposure with others, consistent condom use within the confines of the relationship needs to be strongly promoted.

Establishing a limited number of sexual partners

Single 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 appropriate lubricant must be encouraged.

Sero-adaptive behaviours

Strategic positioning

Men who are receptive during anal intercourse are at a higher risk of HIV infection if rectally exposed to the partner's semen in the event of condom failure or sex without a condom.

For this reason many MSM who are HIV positive assume the receptive (as opposed to insertive) role during anal intercourse in order to prevent infecting their 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 therefore be encouraged.

Sero-sorting

Sero-sorting also referred to as sero-adaptation, is a strategy that some MSM use to lower their risk of acquiring HIV. In this strategy, HIV negative men may choose to have sex only 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. HIV negative men believe that this strategy lowers their risk of being exposed to the virus. The problem with both sero-sorting and sero-positioning is that many men do not know their HIV status, might be in the window period if they have been recently screened for HIV, or may lie to prospective partners about their status in order to avoid rejection or to manipulate a partner into not using a condom. Also, HIV positive men can become re-infected with further strains of HIV that might lead to HIV treatment complications.

Biomedical prevention strategies

Post exposure prophylaxis (PEP)

PEP is an HIV prevention strategy used after someone who is HIV negative has been exposed to a body fluid that may contain HIV. PEP consists of taking antiretroviral medication for 28 days. It should be commenced as soon as possible after the exposure has occurred, ideally within 72 hours. The antiretrovirals target any virus particles that have entered the body and block their replication cycle preventing HIV infection.

PEP may be used after risky sexual encounters, after sexual assault or rape and after a needle stick injury or sharing a needle. In South Africa free PEP is generally only available from public health facilities¹⁰, but may be purchased from private clinics and hospitals, general practitioners, workplace clinics and retail pharmacies.

There are many different ARV combinations that are recommended for PEP. For significant exposures, most experts recommend using triple combinations of ARVs as South Africa has a high background prevalence of HIV and exposure to the virus is common. Suitable 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.

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

Clients on PEP must be:

- » Monitored for ARV side effects;
- » Screened for and protected against other blood-borne infectious diseases, such as hepatitis B and follow up syphilis status;
- » Counselling about follow-up HIV testing.
- » Screened for HIV at completion of PEP and at three and six months thereafter.
- » HIV screening after completing PEP is often difficult as testing is being done during the window period.
- » Counselling about responsible sex.

Most public health ARV clinics that are experienced at providing PEP are closed after hours when PEP may be needed. Clients should be encouraged to attend their local emergency unit for assessment for PEP if their usual clinic is not open. Clients who initiate PEP at an emergency service must be counselled to attend their local sexual health clinic as soon as possible for counselling and appropriate medical assessment.

PEP is an emergency treatment and should not be used repeatedly. If clients need 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® (lopinavir / ritonavir)	Reasonably low pill burden but high incidence of gastro-intestinal side effects and fatigue.
D4T + 3TC + Aluvia® (lopinavir / ritonavir)	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.
Boosted protease inhibitors e.g. atazanavir	Lower pill burden and once daily dosing compared to Aluvia®

Pre-exposure prophylaxis (PrEP)

PrEP refers to a regimen of ARVs (Tenofovir Disoproxil Fumarate and Emtricitabine) that can be taken daily by HIV negative people in order to prevent infection with HIV.

PrEP in SA

- **The South African Medicines Control Council registered TDF/FTC for use as PrEP in 2015.**
- **The prescription of PrEP should follow guidance from the Department of Health.**
- **PrEP guidelines developed by the Southern African HIV Clinician's society can also be consulted.**

PrEP, while relatively new, is a safe and effective method for HIV prevention that has been proven by numerous clinical trials and demonstration projects around the world. When taken daily, PrEP can provide an additional 92%-100% protection against HIV. PrEP is well tolerated in most people with few reported side effects that are often self-limiting within 4 weeks (i.e. nausea).

Concerns regarding the development of HIV drug resistance or of behavioural disinhibition are not widely supported by evidence. Risk behavior among PrEP users has been shown to remain relatively stable over time. PrEP should be provided as part of a larger HIV Prevention package of services including HIV and STI testing and treating, condoms and lubricant distribution, and risk reduction counseling. The development of drug resistance has been shown in individuals who initiate PrEP during their window period after they have been infected. It is essential therefore to ensure that users are HIV negative prior to starting PrEP.

Who can benefit from PrEP?

PrEP may be taken for many reasons and can easily be added to other ongoing HIV prevention strategies for many MSM. Ideal patients for PrEP include MSM who meet any of the following criteria:

- » **Multiple sexual partners**
- » **Inconsistent condom use**
- » **Substance use**
- » **Sex work**
- » **In a sero-discordant partnership with an HIV positive partner**
- » **An MSM who self-selects for PrEP user**

A lead in period of 7-10 days is required for PrEP to reach protective levels in MSM and a minimum of 4 days of daily use per week is required to maintain the minimum level of protection. Daily use (7 days of use per week) is the recommended dosing for PrEP and is required to reach its maximum levels of protection.

Unlike ART, PrEP users will not need to remain on PrEP for the rest of their lives. Users may cycle on and cycle off PrEP as their circumstances change. It is very important however to educate PrEP users that while on PrEP they must adhere to the regimen and take it daily for it to be effective.

Who is Eligible for PrEP?

In order to be eligible for PrEP MSM will need to be:

- » 18 years old or older
- » Confirmed HIV negative
- » Creatinine Clearance <60 ml/min
- » No counter indications for the use of TDF/FTC
- » No symptoms of acute viral infection

Summary of PrEP Provision

A brief summary of PrEP prescription guidance is provided below; however, please refer to the full guidance developed by the SA HIV Clinician Society and the Department of Health on their respective websites prior to prescribing PrEP.

Screening Visit

- » Complete HIV testing to confirm status
- » Provide additional prevention services:
 - » Risk reduction counseling, condoms, lubricant, STI screening as needed.
- » Pull bloods for Creatinine Clearance Testing
- » Determine eligibility for PrEP (i.e. age/behavior/)

Initiation Visit

- » Complete HIV test
- » Confirm all eligibility (creatinine, HIV, no symptoms of viral infection, etc)
- » Provide additional prevention services:
 - » Risk reduction counseling, condoms, lubricant, STI screening, as needed.
- » Adherence counseling and education regarding the PrEP regimen
- » Provide prescription for 1 month

Maintenance Visits (1 month after initiation, then 3 monthly)

- » Complete HIV test
- » Assess side effects
- » Check creatinine clearance
- » Provide additional prevention services:
 - » Risk reduction counseling, condoms, lubricant, STI screening, as needed.
- » Assess pill taking and provide adherence counseling
- » Provide prescription for 3 months

Male circumcision

Research has shown that circumcised heterosexual men have a 60% lower risk of acquiring HIV from their female partners than uncircumcised counterparts. The evidence has been convincing enough for *medical male circumcision* (MMC) to have become included in South Africa's national HIV prevention campaign.

The reason male circumcision works is as follows: The male foreskin is a moist membrane that contains many immune cells that are susceptible to infection with HIV. The skin that remains behind after circumcision becomes thickened and more like regular skin. This skin provides a better barrier and has fewer HIV-susceptible cells.

One important consideration with circumcision is that it does not provide absolute protection against infection and therefore needs to be included as part of a complete risk reduction strategy. Clients who have had MMC performed need to wait until complete wound healing has occurred (about 6 weeks) before resuming sexual activity – the unhealed wound could form an easy entry point for HIV.

Research has not shown the same protective effect of male circumcision for anal sex as it does for vaginal sex. Obviously MMC will not work to protect MSM who acquire HIV from receptive anal sex.

For now, other strategies such as consistent condom and appropriate lubricant use, reducing the number of sexual partners, strategic positioning and education about sero-sorting might provide effective risk reduction strategies for MSM.

Treating and preventing sexually transmitted infections

Some STIs cause open skin abrasions or sores and this provides entry points for HIV infection. An example of this is Herpes simplex genital ulcer disease. Rapid diagnosis and treatment of STIs may help prevent HIV transmission.

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

All clients who seek STI services should receive risk-reduction counselling and condoms as well as advice about lubricants, partner notification and Treatment as Prevention (T as P).

Treating HIV to lower viral load

HIV positive individuals who have high viral loads are more likely to transmit HIV simply because there is more virus in their bloodstream and sexual fluids.

Clients who are on ARV treatment with 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 people who are most likely to transmit HIV with a high viral load. Although the WHO

recommends universal access to treatment with a test and treat policy, South Africa still uses an eligibility criteria. Special consideration should be used at a clinician's discretion to initiate treatment in high risk groups who may have high viral load.

Strategies that allow for earlier treatment include:

- » Test and link to care (TLC): HIV testing sites immediately link clients who test positive with treatment services where they are followed up and start ARVs.
- » Test and link to care plus (TLC+): Clients who test HIV positive are referred to begin taking ARVs immediately, even at high CD4 counts. Clients who test negative but are at high risk should be referred to begin taking PrEP immediately.

When considering which MSM might benefit most from early initiation of ARVs, examples include sero-discordant couples, commercial sex workers, intravenous drug users and clients who frequent sex-on-site venues or have multiple sex partners. Although MSM are regarded as a group at high risk of HIV transmission, current South African guidelines suggest using the same ARV initiation criteria as for heterosexual men.

Vaccines to prevent HIV

Research into vaccine development is ongoing. Although there have been some promising vaccine candidates, none are currently effective enough against HIV to be marketed commercially. Even if a vaccine is shown to be effective, it is likely that there will be a long delay before the vaccine can be perfected, manufactured and distributed. In addition, vaccines may not provide 100% protection against HIV infection. Because of this, vaccines will need to be combined in a larger package of HIV risk-reduction strategies.

Microbicides

Microbicides are products that can be used to prevent sexual transmission of HIV. They consist of gels, creams or foams that contain anti-HIV substances to kill HIV before it has a chance to enter a person's body. Recent research has shown that a microbicide containing a small amount of tenofovir can lower women's risk of acquiring HIV by 39% if used vaginally before sex. Research is currently underway to test if tenofovir gel might provide similar protection if used anally.

SECTION 4

THE HEALTHCARE PROVIDER AND MSM

SECTION OVERVIEW

This section begins with a discussion concerning the need for healthcare providers to understand the nature of attitudes and prejudices and how their own views are shaped by these factors. It is important for healthcare providers to be aware of their own feelings towards MSM and homosexuality, and to understand how negative attitudes may cause barriers to service utilisation on the one hand and, on the other, how positive, non-judgmental attitudes can encourage health-seeking behaviour.

The lessons of the Health4Men project are shared as examples of ways to open up communication about issues relating to sexual preferences, HIV screening and responsible sexual behaviour. They also illustrate how taking a client's sexual history and doing a risk assessment in a sensitive and skilful manner can provide a useful tool to engage with MSM about these issues.

The section incorporates a sex-positive approach for working with MSM, developed by Health4Men, which provides practical guidelines for communicating with MSM about responsible sex.

Introduction

The constitution of South Africa makes provision for access to healthcare for all – irrespective of race, ethnicity, language, class, religion or sexual orientation. This is supported by certain rights-based frameworks such as the Batho Pele Principles and the Clients' Rights Charter. Health services for MSM need to be underpinned by these rights.

Despite our progressive constitution, many sectors of government and society in general remain homophobic and may fail to uphold the principles of equity enshrined in the constitution. Healthcare providers may have to actively advocate for non-judgmental services for MSM and other marginalised, stigmatised groups attending their healthcare centres.

Healthcare providers may have certain personal views about the sexual behaviour of many of their clients. The attitude of healthcare providers has been shown to be a major barrier to health facility utilisation due to (real or perceived) judgmental, rude and humiliating behaviour. This can affect the provider-client relationship and drive clients away from services.

The challenge is for healthcare providers to render quality healthcare in spite of their personal attitudes and beliefs. This becomes even more important in the era of HIV.

HIV knows no boundaries, and from a public health perspective it is imperative that people across all population groups are encouraged to utilise health services, in particular, sexual health, TB and HIV services.

It is important that these services are 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.

Attitudes towards MSM

Countries vary in terms of their legislative framework and protective rights towards sexual orientation. However, legislation is only one aspect of tolerance; religious and other beliefs will have an influence on communities' attitudes regarding sexuality and the ability or willingness of those with different sexual orientations to be open about their sexuality. South Africa, for example, has one of the most progressive constitutions

in the world that protects the rights of gay men. However, MSM are still victims of discrimination, ridicule and violence.

MSM behaviour occurs in all communities in South Africa – across race, culture and class. Whilst there are small pockets of tolerance, on the whole there is still judgement and hostility that make it difficult for MSM to be open about their sexual preferences and sexual practices.

In order to provide competent MSM services, healthcare providers need to begin by exploring their own views and attitudes to MSM. A helpful starting point is to understand the factors that contribute to this prejudice and discrimination.

Some people are homophobic. Homophobia is a commonly used term to describe negative attitudes towards 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*¹¹. Whilst a phobia is a fear and is to be avoided, a prejudice implies a more active form of discrimination, which in turn encourages dislike, anger and active discrimination.

This prejudice towards MSM can partially be explained through many peoples' discomfort relating to MSM deriving sexual pleasure through anal stimulation and penetration. This anal taboo¹² is found in almost all cultures and societies where the anus is associated with excrement, dirt and even sin.

The underlying reasons for these taboos lie in anthropology, psychology, sociology and theology and are beyond the scope of this manual. It is important to understand that anal sex is an alternative form of sexual expression practised by many men and indeed women.

There are several myths and stereotypes relating to MSM that contribute to analphobia and homoprejudice. It is therefore helpful to unpack these to deal with one's attitudes towards MSM.

11 See, for example, Logan 1996. This view is also supported by the Health4Men sex-positive approach

12 A taboo: to avoid, forbid, or prohibit a certain act, belief, behaviour, or person etc. based on cultural or social norms or attitudes.

Interacting with MSM – Some helpful guidelines for healthcare providers

Statistically, it is likely that every service provider interfacing with more than twenty male clients per day has interfaced with an MSM, who was most likely not recognised as such. Many healthcare providers assume that, unless male clients are openly gay, 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. This may result in missed opportunities for sexual health prevention and care, and the particular healthcare needs of MSM clients being neglected.

Here are some points to note to ensure that the consultation with an MSM client is used optimally:

- » It is important for healthcare providers to understand that any male client is a potential MSM. This may be evident or known already, or it may be revealed during the consultation. Never just assume that a male client only has sex with women.
- » The importance of attitude has been discussed and, as with any clients, a professional, non-judgemental stance is important.
- » It is important to discuss confidentiality with clients, especially in a hostile community. A client's right to confidentiality is a challenging issue in many healthcare facilities where a range of staff have access to medical records. In this respect, the healthcare provider may choose to omit mentioning the client's sexual identity and related information from the record.
- » Healthcare providers are encouraged to learn about the local MSM scene and associated terms and words. Peer educators and NGOs are helpful in this respect, as is developing a rapport with clients and finding out more about their lives, social meeting places, sub-cultures and communities.
- » Healthcare providers need to be sensitive to the use of pronouns when interacting with MSM people. For example, do not use feminine pronouns such as she when referring to sexual partners. It is also important to be sensitive to the pronouns used with transgender clients. When dressed as a woman, a man may feel more comfortable being addressed as a female. If unsure, a healthcare worker can ask a 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:

A sexual history is only indicated when this would be in the interests of individualised client care, as may occur at an STI or HIV clinic.

The need for client privacy and confidentiality is paramount, especially in hostile, prejudiced environments. The healthcare provider needs to make a professional judgement in terms of the detail recorded in the medical notes and respect the rights and safety of the client in this respect.

Gender and cultural sensitivities need to be considered, such as men in some settings being uncomfortable discussing their sexuality with a female healthcare provider.

Healthcare providers must not assume all men are heterosexual and need to be open so that clients can reveal that they engage in MSM behaviours.

The healthcare provider must at all times monitor their own psychological and behavioural responses in order to contain and address their responses toward MSM clients, especially when specific sexual behaviours and local terminology is used.

Some further guidelines:

- » An important part of the consultation is developing a rapport with the client. A simple reassurance that the client can trust the healthcare provider and encouragement to speak freely without fear of judgement can enhance the value of the consultation. Repeated or follow-up consultations are useful in allowing a trusting healthcare worker–client relationship to develop.
- » After establishing a rapport with the client, the healthcare provider needs to establish a context for the sexual history by explaining why this is required. For example, a statement such as the following can be useful and reassuring for the client: *“Sometimes it can be uncomfortable to talk about our health especially when it relates to our sex lives, but 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?”*

- » Reassure the client that the health service is there to provide healthcare, not to moralise about people's sexual behaviour. Encourage the client to be open and honest, as this will mean that a proper health check can be done. Discuss with the client that they do not need to answer any questions that they find particularly personal or distressing, but that this information might allow for better healthcare planning. Also reinforce confidentiality.
- » Begin with general, neutral questions such as whether the person is single or in a committed relationship with one person (either a man or a woman), married (to either a man or a woman – remember that same-sex marriage is legal in South Africa), whether he has one wife or more, and whether the client has other sexual relationships, either with men or with women.
- » It may be useful to ask, for example, *“Over the past six months, have you had sex with only women, with only men or with both men and women?”* and *“Over the past 6 months, would you say you have had sex with one partner, 2-4 partners, 5-9 partners, 10 partners or more?”*.
- » It is not particularly useful to ask a client if he is gay as many MSM do not consider themselves to be gay.
- » Where a male client has engaged sexually with other men, the history needs to focus on determining risks associated with HIV and other STIs. Explain this to the client; reassure the client to feel free to be open and emphasise that, as a healthcare provider, you deal with sexual issues on a regular basis. Be direct, ask specific rather than open-ended questions and treat this list as you would any health checklist. Where possible, and where you feel comfortable, use the client's local sexual terminology.

Health4Men guidelines for taking a sexual history

START BY:

Reassuring and relaxing your patient

Explain why you are asking sexual history questions:

- » This is a routine assessment to establish your risk of contracting an STI to ensure that nothing is missed and that we can correctly address your risks.
- » This process allows us to tailor an investigation and management plan to meet your specific needs
- » This discussion is private and confidential
- » If the questions are not understood or very uncomfortable to answer, we respect your right to privacy and will not pressurise you to answer

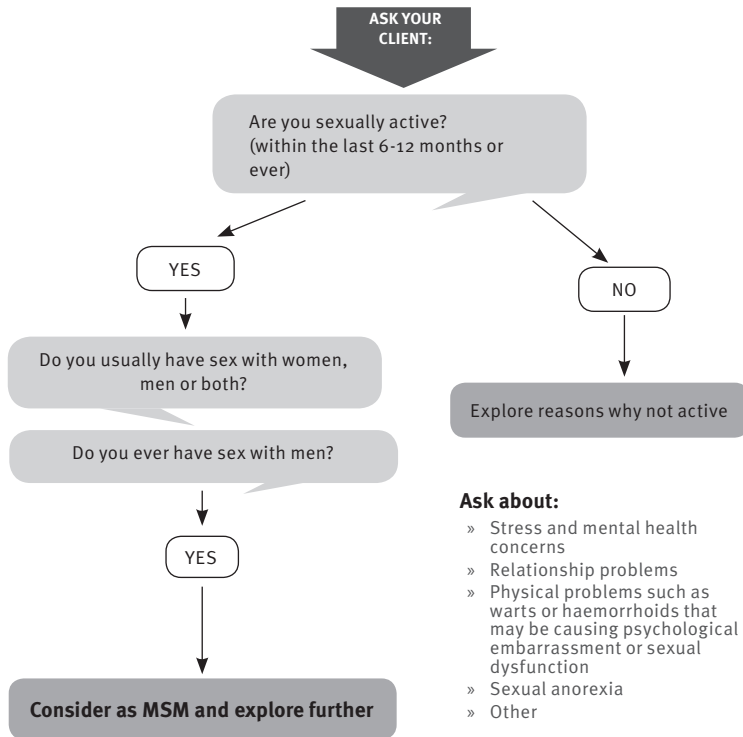
Develop a rapport with your client

Adopt an accepting and reassuring attitude:

- » Your interest in the patient's sexual history is medical not voyeuristic
- » Use terms that are local and familiar to your patient

Do not express any emotional or moral judgements.

NOW ASK:
(next page)



Ask about:

- » Patient's HIV status and testing history
- » More detailed sexual history as below

Further questioning to explore risk of HIV and STIs

- » Sexual partners → primary partner, duration, secondary partners
- » Partner(s) status → Positive, negative or unknown
- » Sexual risks → Behaviours that may expose him to infectious fluids or other bacterial STIs
- » Condom use → If not, explore reasons and discuss how to improve condom use
- » Lubrication → If not, explore reasons why not
- » Address specific risks → Substance abuse, sexual addiction, sex-on-site, others

Sexually Transmitted Infections

- » Have you been diagnosed with any prior STIs and what were the symptoms?
- » What treatment did you receive?
- » Did you complete the treatment course?
- » Was your partner notified/screened and/or treated?

ASSESSMENT OF MSM SEXUAL RISK FOR HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS

Information regarding...	Factors to explore could include ...
oral stimulation	kissing, anilingus or felatio (penetrative and/or receptive)
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

A sex-positive approach for working with MSM

The sex-positive approach has been developed by Anova Health Institute's Health4Men project, and is based on the need for MSM to experience their sexuality in a positive manner, in spite of hostile attitudes by others, in order to assume responsibility for their own sexual health.

The approach draws on the experience of the project, and seeks to establish a framework for effective sexual health messaging and HIV and STI prevention and management.

Men who are made to feel guilty or ashamed of their sexuality, by either explicit or implicit negative attitudes conveyed by society at large and healthcare providers in particular, cannot be expected to be honest when discussing their sexual health needs with medical personnel. Indeed, such men are unlikely to assume responsibility for their own sexual health if they consider their own sexual impulses or behaviours to be bad.

Provided the behaviour is between consenting adults, all sexual interactions should be equally valued. For the purposes of this model, the following principles are upheld:

- » 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.

- » People need to be educated about the risks associated with specific body fluids and do not need moralising around their sexuality. Moralising merely distances people and is a barrier to education about responsible sexual behaviour.
- » By having HIV transmission explained biologically, as opposed to referring to specific sexual acts, MSM are less likely to feel they are being judged and will become less defensive to messaging and more open to learning about sexual health.

MSM need to be informed that HIV is spread through body fluids. Different body fluids produced by someone who is HIV positive contain different quantities of HI viral tissue. However, for infection to occur, we need two elements:

- » A high-risk body fluid and
- » An entry-point into the HIV negative partner's bloodstream.

High risk body fluids (containing a relatively high concentration of the virus) are semen and blood. Pre-ejaculate represents a lower risk for transmission as it contains a lower concentration of the virus. All other body fluids, including saliva, tears, perspiration and urine, carry no risk for HIV transmission unless they are contaminated with blood.

Responsible sex is thus focused on preventing the semen or blood from an HIV positive person making contact with a mucosal surface of an HIV negative person and entering the latter's bloodstream. Such contact that could allow entry of the virus includes the following:

- » 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 during oral sex, especially if the person performing oral sex has any oral lesions such as micro-abrasions which occur during teeth-brushing
- » Semen or blood in the rectum, as could occur during anal intercourse

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

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

Anal sex requires lubrication 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 should be advised not to use any lubricants containing oils, such as petroleum jelly (Vaseline), body or hand lotion, butter or cooking oil, for penetrative anal sex using latex/rubber condoms.

The Health4Men sex-positive approach further advises against the use of particular words that have been found to be less effective in working with MSM. Two such words are as follows:

- » The term *safer sex* is avoided as it is often associated with heterosexist messaging that is hostile to MSM. 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*.
- » The word *test* is generally associated with a level of anxiety in that it refers to tests at school, for example, and includes elements of failing or passing. In the light of many MSM's anxiety around HIV testing, the suggested replacement term is screening. Health4Men's messaging thus refers to *screening* for HIV and other STIs.

The physical environment of the service also needs to be conducive to men. For example, 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. Many MSM are employed and so an after-hours service dedicated to men's sexual health needs would be ideal.

SECTION 5

MENTAL HEALTH FACTORS AFFECTING MSM

SECTION OVERVIEW

While MSM identities are not in any way associated with mental illness MSM do have particular mental health needs to which healthcare providers should be sensitive. In this section, an overview of the range of mental health needs of MSM is provided. These relate to the possible pressures and stressors relating to life phases of MSM, such as coming out and ageing, the impact of living in a hostile environment that can result in depression and anxiety, and issues related to substance abuse. Other problems, such as sexual addiction, sexual anorexia and sexual dysfunctions are briefly explained, as are problems in multiple sexual partner relationships.

The healthcare provider is not expected to be an expert in the field of MSM mental health issues but it is useful to have some knowledge – particularly in low-resource settings. This section provides a brief overview of the range of mental health problems that may emerge. The healthcare provider can listen and provide support and where possible make referrals to relevant psychological services and support. In low-resource settings, where there are no accessible referral points, the client and healthcare provider are encouraged to contact NGOs and organisations such as Health4Men.

MSM and stressful life stages

There are two significant developmental life stages that often predispose MSM to significant levels of stress, anxiety and depression— during the *coming out process* and as MSM mature into *middle age and beyond*.

Coming out

Coming out is a term commonly used to describe the complicated process of an MSM becoming conscious that he is not heterosexual and coming to terms with his realisation that he is sexually and emotionally attracted to other men.

It is important to understand that the process is not merely related to the disclosure of the individual's sexual orientation to others. Rather, it is a complex emotional and psychological process that frequently places the individual in a personal crisis related to his sense of self that may conflict with his own, society's and his family's expectation of him.

Feelings of shame, guilt and fear may be overwhelming, especially if the process occurs during the vulnerable age of adolescence. However, this process could occur during a later life stage, for example when a heterosexually married man becomes aware of his sexual attraction to other men. In such instances, a man could fear rejection and the anger of his wife, children, extended family, colleagues and friends and, in small communities, the community itself.

The coming out process, which could last from months to several years, can manifest in isolation, social withdrawal or clinical depression. Often the individual concerned feels too ashamed to disclose his inner turmoil to a healthcare provider for fear of judgement or rejection; at other times, he may not have the necessary vocabulary to express his conflicts or desires.

It is useful for the healthcare provider to explore this if it is suspected that he may be coming to terms with his sexual orientation or sexual identity. The sexual history-taking process provides an opportunity to discuss this.

It is important that individuals come to terms with their sexuality and sexual preferences in order to develop a healthy sense of self, engage in healthy relationships and in order to assume responsibility for their sexual health.

Maturing and beyond

Whilst the term *midlife crisis* might apply to men in general, it gains particular significance for MSM, and more so for gay-identifying MSM, as they reach or pass through middle age.

Ageing can result in a loss of confidence and a sense that they are no longer attractive or desirable in a sub-culture that puts a lot of value on youthfulness, body beauty and fitness, virility and potency, resulting in both explicit and implicit *ageism*. Such men often feel out of place in social spaces where MSM socialise and may be made to feel invisible, or even unwelcome, by younger MSM.

This can result in reduced self esteem and depression. Maturing MSM who are not in an enduringly intimate relationship often need to come to terms with the idea that their chances of finding a partner may be reduced. Similarly, many MSM who do not have a partner or children to look after them in their old age may begin fearing or experiencing social isolation.

In both of these instances (the coming out process and challenges related to ageing), non-judgemental and supportive counselling may be necessary, while referral to more specialised psychological or social work care may be necessary in cases of severe crisis or depression.

Post-traumatic stress

MSM living in particularly hostile environments with high levels of prejudice in relation to homosexuality are often exposed to increased levels of stress. This can include youth being excessively bullied at schools, MSM being verbally abused in public, being seen as soft targets for crimes such as robbery or assault as well as rape and hate crimes committed against them because of their sexuality. MSM may also be vulnerable to blackmail and other forms of extortion.

The accumulated effects of this persecution, and possibly having to hide their true sexual orientation from others, can culminate in some MSM developing an anxiety-related disorder or even post-traumatic stress disorder. It is worth noting that South Africa does not record hate crimes and such crimes committed against MSM are often unreported and undocumented.

Male-on-male rape is recognised as a criminal offence in South Africa but often goes unreported due to intimidation and the shame and stigma associated with being anally penetrated and due to homophobic attitudes among members of the police force.

Rape can be particularly prevalent among prison populations, areas where gang activity occurs or in situations of social conflict or unrest. Such rapes often result in physical trauma to the victim's rectal area due to excessive force and a lack of lubrication, greatly increasing the risk of HIV and other sexually transmitted infections.

When a male client presents as having been physically assaulted it is incumbent on the health-care provider to sensitively explore the extent of the assault in order to preclude the possibility of rape. Obviously the timely introduction of PEP (post-exposure prophylaxis) needs to be considered.

Referral to a healthcare provider or a specialist rape/sexual assault centre where there is knowledge about rape assessment and rape specimen collection may be necessary. An experienced healthcare provider, for example a District Surgeon, with expert knowledge of rape assessment and rape kit specimen collection may need to be consulted. Post-rape counselling should aim to normalise the resultant feelings of powerlessness and shame. Where available, this would include referral for additional counselling and support.

Depression and anxiety

A hostile social environment and feeling marginalised can result in MSM experiencing a sense of shame and a lack of self respect. This internalised negative sense of oneself is referred to as internalised homophobia in most literature.

“ The Health4Men sex-positive model proposes an alternative term, internalised homo-negativity. In addition to resulting in low self esteem, depression and anxiety, MSM experiencing these feelings may be less likely to practice responsible sex because they are not able to value their sexuality or themselves ”

A decline in sexual desire, a frequent feature of depression, can be very stressful for MSM. Other factors that could predispose MSM to depression are social isolation and loneliness and experiencing varying degrees of discrimination and rejection.

It is helpful to identify resources and psycho-social support networks that are accommodating to the needs of MSM. Recreational substances may also be a source of depression. Clients on the ARV efavirenz may be more inclined to experience anxiety or depression.

Adolescent MSM may be at an increased risk of suicide due to experiencing psychological conflicts, fearing rejection by their families or being bullied at school. MSM may experience more thoughts of suicide than non-MSM men.

Recreational substance abuse

Functioning within a prejudiced, hostile environment may predispose some MSM to abuse recreational substances, including alcohol, as a form of self-medication. Other factors that contribute to such abuse include the following:

- » MSM frequently meet potential sexual partners in public social spaces such as bars, taverns and clubs where alcohol is consumed.
- » Recreational substances such as cannabis or alcohol may provide some MSM with enhanced courage – by reducing inhibition – to go out and socialise with others. This could be particularly significant among heterosexual-identifying MSM who are conflicted about their attraction to men or who fear being socially identified as homosexual.
- » Some recreational substances are used by MSM in order to prolong sexual interactions and to intensify sensual sensitivity. Patterns of recreational drug use vary according to geographical area and over time. An example of this is crystal methamphetamine that has reached marked levels of abuse and resultant addictions primarily in the Western Cape where it is also referred to as tik. Amyl nitrite (or nitrate), a short-acting inhalant, is endemically used by particularly gay-identifying MSM living in mainly urban areas, where it is often freely available, in order to intensify sexual sensations. Amyl nitrite is colloquially referred to as poppers.
- » A relatively new trend among some predominantly urban MSM is intravenous administration of stimulants such as crystal methamphetamine. Referred to by some as slamming or spiking,

this practice exposes MSM to additional health risks associated with needle sharing, including HIV and hepatitis B and C. Recreational substances are also administered rectally for rapid absorption, sometimes colloquially referred to as booty bumping by gay-identifying men in predominantly urban settings.

- » Many recreational substances used by MSM contribute to erectile dysfunction and may thus be combined with others substances that boost erectile functioning such as viagra. Combinations of viagra, recreational substances and antiretrovirals can be extremely dangerous.
- » In MSM populations with an emphasis on a muscled physique some men explore various anabolic steroids to supplement their training regimes. The effects of such substances on an individual's psychological and physical wellbeing are well documented and can result in extreme mood swings, aggression and violence as well as potentially interact negatively with ARVs or other medication that the client may be taking. Other substances often used by this group of MSM include testosterone, creatine and human growth hormone. While these substances fall outside of the category of recreational drugs, they can have negative health consequences.

Health4Men initiated a multifaceted harm reduction needle and syringe-exchange programme at their clinic in Cape Town.

“ The Health4Men sex-positive approach includes direct probing about recreational substance use. Suggested questions include the following: ‘What role do recreational drugs play in your life?’ and ‘What role does alcohol play in your life?’ Where there are indications of a chemical addiction, the health worker should also explore issues related to sexual addictions. For many MSM a chemical addiction is layered by an accompanying addiction to sex, with sex being a significant trigger to substance abuse ”

Sexual addiction

The concept of *sexual addiction* is controversial and there is a debate as to whether it should be categorised as an obsessive-compulsive disorder or an impulse-control disorder. Proponents of the term sexual addiction point out that the syndrome responds to remedial interventions used for other addictions, such as the twelve-step programme used by Alcoholics Anonymous to manage alcohol addiction.

There is no single definition of what constitutes addictive sexual impulses or behaviour. However, there is general consensus that the need for sex could become pathological when the preoccupation with the pursuit of, or indulgence in, sex negates the individual's effective functioning related to occupation or studies, relationships or social life in general.

Sexual addiction can manifest in excessive watching of pornography— for example on the Internet where individuals may also spend excessive amounts of time in chat rooms focused on sex. It can assume a pattern of regular or periodic binges – for example over weekends or when under the influence of recreational substances.

Note that sexual addiction is not peculiar to MSM. However, for some MSM, especially in hostile social environments, sexual interaction becomes a primary means of relating to other men.

Other sexual problems

Sexual anorexia: Sexual anorexia, often seen as part of the addictive process related to sex, is the withholding or avoidance of sex. There are many reasons why MSM could avoid sex, including a sense of shame or guilt related to sexual preferences and desires, fear of HIV and STIs, the presence of a sexual dysfunction and a negative association with sex, either consciously or unconsciously, after screening HIV positive.

In the private sector, Aluvia® (lopinavir / ritonavir) can be switched to other protease inhibitors such as atazanavir that are less likely to contribute to atherosclerosis.

Evaluating and managing erectile dysfunction is a good way of attracting men to the clinic where they can be counselled regarding STIs and HIV screening.

Sexual dysfunctions: MSM can present clinically with any sexual dysfunction generally attributed to men, including inhibited sexual desire, erectile dysfunction, issues related to ejaculation (such as premature ejaculation) or orgasm. There are also associated problems relating to anal intercourse, including:

- » Anal Inhibition Syndrome refers to anxiety related to being anally stimulated or penetrated. This anxiety may also be caused by gastrointestinal discomfort side-effects such as diarrhoea and flatulence caused by some ARVs
- » Anismus relates to unconscious and involuntary clenching of either the internal or external anal sphincter muscle at the time of desiring penetration, making comfortable anal penetration difficult or impossible
- » Anodyspareunia refers to enduring, non-subsideing pain in the anal area during penetration
- » Erectile dysfunction is common among HIV positive men including MSM. Drugs such as D4T (causing neuropathies) or protease inhibitors including Aluvia® (lopinavir / ritonavir), causing accelerated atherosclerosis, contribute to erectile dysfunction and should be avoided if alternatives are available. D4T can be switched to tenofovir which cause less neuropathy

It is important to note that any sexual dysfunction can impact negatively on an MSM's self esteem and can result in significant stress within their relationships. Where available, referral to psychological services may be necessary.

Same-sex couple counselling

MSM form enduring and loving relationships with other men and these are no different to heterosexual relationships. Such relationships can be highly functional and are based on love, romance and issues relating to commitment. There are also similar problems and crises that the healthcare provider may have to deal with.

A healthcare provider may need to provide counselling to same-sex couples when, for example, a sero-discordant couple needs information on responsible sex or in the event of domestic violence or when a couple would like to be screened together for HIV. Here are some important points to note when doing same-sex counselling:

- » It can be offensive to seek out the stereotypically male and female roles in the relationship. It is preferable to avoid making these assumptions or inferences.
- » When a male same-sex couple presents for counselling, it is possible that either one or both parties have other intimate relationships as well. It also may be the case that either one or both partners may be married to a woman in order to avoid being socially labelled as homosexual. It is also possible that the same-sex relationship may not be monogamous; some couples value emotional fidelity over sexual fidelity and may condone sexual interactions with other men. Note, however, that it is a myth that MSM are not capable of monogamy or that all MSM are necessarily promiscuous.

Whatever the nature of the relationship, issues relating to sexual health, responsibility to all partners and HIV screening and status are important.

SECTION 6

THE MEDICAL MANAGEMENT OF MSM SEXUAL HEALTH

SECTION OVERVIEW

This section provides medical information on the management of the range of sexual health problems common to MSM. Even if these services are not available in your health facility, it is useful to have the information for your clients and to assist with appropriate referrals. A summary of the kind of packages that ideally should be offered to MSM is described, followed by information about the medical management of HIV, STIs and other medical conditions to consider among MSM.

Healthcare providers are expected to offer 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. Additional information is offered for those healthcare providers who wish to have more detailed knowledge although it is likely that some of the issues discussed will not be manageable in resource- limited, primary healthcare settings.

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 projects such as Health4Men for telephonic advice and support.

Summary of services recommended for MSM

DISEASE	MINIMUM	DESIRABLE/OPTIMAL
HIV and AIDS		
	Rapid test yearly	Rapid test six monthly
	Monitor CD4 count <ul style="list-style-type: none"> » Twice yearly » Lab-based 	Monitor CD4 count <ul style="list-style-type: none"> » Twice yearly or more if indicated » On -site rapid test plus lab-based
	Commence ART when indicated <ul style="list-style-type: none"> » Follow local guidelines » CD4 <500/mm³ or WHO stage 3 or 4 	<ul style="list-style-type: none"> » Commence early ART » Use tenofovir in first line regimen » All discordant couples » All HBV or HCV positive patients » MSM support groups
Sexually Transmitted Infections		
Gonorrhoea	Clinical screen <ul style="list-style-type: none"> » Empiric treatment » Partner tracking and treatment 	Rapid on-site diagnostic test <ul style="list-style-type: none"> » Directed treatment » Regional sensitivity monitoring » Partner tracking and treatment » Public education among MSM
Chlamydia	<ul style="list-style-type: none"> » Clinical screen » Empiric treatment » Partner tracking and treatment 	<ul style="list-style-type: none"> » Rapid on-site diagnostic test » Directed treatment » Partner tracking and treatment » Public education among MSM
Syphilis	<ul style="list-style-type: none"> » Clinical screen » Laboratory RPR / VDRL » Laboratory confirmatory test » Local treatment protocol » Partner tracking and treatment 	<ul style="list-style-type: none"> » Clinical screen » Rapid diagnostic test » Laboratory confirmatory test » Local treatment protocol » Partner tracking and treatment
LGV	<ul style="list-style-type: none"> » Clinical screening » Local treatment protocol 	<ul style="list-style-type: none"> » Clinical screening » Laboratory confirmation » Local treatment protocol

HPV	<ul style="list-style-type: none"> » Screening for ano-genital warts » Cryotherapy for external lesions or topical therapies including podophylin, acetic acid or imiquimod » Referral pathway for internal or extensive disease 	<ul style="list-style-type: none"> » Screening for ano-genital warts » Anoscopy and biopsy » Cryotherapy for external lesions » Imiquimod ointment » Anal PAP smear to exclude AIN » Coagulase laser therapy of high grade AIN lesions » Referral pathway for extensive and internal lesions and for suspected malignancy
Viral Hepatitis A (HAV)	<ul style="list-style-type: none"> » Risk assessment » Laboratory HAV IgG if at risk » HAV vaccination 	<ul style="list-style-type: none"> » Laboratory HAV IgG for all MSM » HAV vaccination
Viral Hepatitis B (HBV)	<ul style="list-style-type: none"> » Laboratory HB SAg if HIV positive for ART » HB vaccination 	<ul style="list-style-type: none"> » On-site HBV SAg and AB or laboratory based testing » HB vaccination » Rapid schedule HBV vaccination if ongoing exposure risk
Viral Hepatitis C (HCV)	<ul style="list-style-type: none"> » Risk assessment – IDU » HCV IgG if at risk 	<ul style="list-style-type: none"> » HCV IgG » Referral pathway if positive » Start early ART if HIV co-infected

PSYCHO-SOCIAL	MINIMUM	DESIRABLE/OPTIMAL
Risk reduction counselling	<ul style="list-style-type: none"> » Counselling about risks of HIV and STI transmission during MSM sexual activity » Condoms » Water based lubricant » Female condoms for anal use » Mental health assessment » Substance use assessment 	<ul style="list-style-type: none"> » Counselling about risks of HIV and STI transmission during MSM sexual activity » Variety of condoms » Water based lubricant » Female condoms for anal use » Mental health assessment » Substance use assessment » Needle exchange » Alcohol swabs » Safe injection technique information

HIV

HIV screening

Due to their sexual exposure, MSM are more likely to screen positive for HIV than heterosexual men. Despite this, many MSM do not know their status or present late due to issues relating to denial or fear of discrimination at local HIV screening sites.

Clinics that are known to be more receptive to MSM and their healthcare needs may encourage MSM to seek help for their health and improve HIV screening uptake.

HIV screening of MSM provides an opportunity to screen for common STIs and to provide supportive risk-reduction information and strategies. This includes addressing the range of risk factors to which MSM may be exposed, including for example: unprotected anal intercourse; high numbers of sexual partners; alcohol and recreational chemical use; inconsistent condom use and lack of information/availability of water-based lubricants. Where possible, all MSM clients should be provided with condoms and latex-compatible lubrication.

Regular repeat HIV screening should be encouraged. This should probably be done six monthly but more frequently if there is a higher risk of exposure to HIV – for example, with discordant couples, commercial sex workers and MSM who have unprotected sex with multiple partners. MSM who are not sexually active or in monogamous relationships can be screened less frequently.

HIV treatment

HIV positive MSM should be managed as for all other HIV positive clients with some additional considerations.

MSM are a group who are at high risk for transmitting HIV

Some MSM have special circumstances that place them at even more risk than other MSM, including HIV positive MSM in discordant relationships, those who have multiple partners, MSM intravenous drug users and male commercial sex workers. Ideally, these groups of MSM should be

treated with ARVs early irrespective of their CD4 count in order to lower the risk of their transmitting HIV.

For healthcare providers in the private sector, initiating ARVs early, even above the usual guideline of CD4 \leq 500/mm³ is advisable, provided the client is treatment-ready and able to commit to long-term therapy. In the public sector, MSM need to be monitored and initiated as per South African Department of Health guidelines.

Antiretroviral use in MSM

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

- » CD4 \leq 500/mm³
- » WHO stage 3 or 4

RECOMMENDED STATE-FUNDED REGIMENS

- » First line: tenofovir + lamivudine + efavirenz - Fixed dose combination (FDC)
- » Second line: zidovudine + lamivudine + Aluvia® (lopinavir/ritonavir)
- » Treatment switches should be made according to SA DOH guidelines
- » Fixed Dose Combination : tenofovir (TDF), emtricitabine (FTC) and efavirenz (EFV) for new clients and pregnant woman

Physical appearance and sexual desirability

Some groups of MSM place a lot of value on physical appearance and sexual desirability and will not tolerate visible side effects of ART. D4T should ideally be avoided due to the risk of lipoatrophy and tenofovir first line regimens should be used according to South African Department of Health guidelines.

Some body-conscious MSM may be more inclined to use anabolic steroids, testosterone and other exercise supplements that may interact with ARVs. This should be asked about when considering starting MSM clients on ART.

These drug interactions are complex, poorly studied and sometimes unpredictable. If you are unsure about a possible drug interaction, advice is easily available from services such as the Medicines Information Centre

at the Department of Pharmacology at the University of Cape Town. (Toll free hotline 0800212505 or www.mic.uct.ac.za).

HIV Hepatitis co-infection

Co-infection with HIV and hepatitis viruses is common among MSM and these should be screened. Clients who are co-infected with HIV and hepatitis B should ideally be managed with tenofovir- based regimens (e.g. tenofovir plus 3TC plus efavirenz) and referred for liver assessment if this is possible. If these clients fail first line ARVs and require second medications these should be added to tenofovir and 3TC which should not be stopped.

Tenofovir does not have any activity against hepatitis C but is still the agent of choice in HIV and hepatitis C co-infected clients due to its favourable side effect profile.

Clients with HIV and hepatitis C co-infection should be referred for liver assessment if this is possible. If referral for liver assessment is not possible, liver function tests such as ALT should be performed at regular intervals.

Gastro-intestinal side effects

Many ARVs, especially protease inhibitors such as Aluvia® (lopinavir/ritonavir) cause gastro-intestinal side effects such as diarrhoea and flatulence. This may negatively affect the anal sexual function of MSM and may have a negative impact on adherence to treatment.

Adherence

There needs to be a continuous discussion with clients about adherence. There are certain factors that may negatively impact on adherence. These may include: mental health problems; substance abuse; lack of family support and fear of disclosure about their HIV status linked to their MSM identity.

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	Tourists may transmit HIV 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 unprotected sex while travelling 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	<p>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 react.</p> <p>If uncertain about potential drug interactions, contact the Medicines Information Centre toll free on 0800 212506, or www.mic.uct.ac.za</p>
Visible or sexual side effects	<p>Some MSM have been exposed to as much information regarding ART side effects. Examples include:</p> <ul style="list-style-type: none"> • 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.

Sexually transmitted infections

Diagnosis and treatment of sexually transmitted infections (STIs) are well discussed in other standard reference texts and guidance is given in other tables in this manual. Here we will concentrate on basic diagnosis and treatment as well as the differences that can be found among MSM in comparison to heterosexual clients.

STIs are common and, since they disrupt mucosal barriers, may place individuals at increased risk of HIV acquisition. STIs cause localised inflammation which makes it easier for HIV to infect mucosal cells. In addition, they cause generalised inflammation within the body which increases the rate of HIV replication and progression to AIDS in clients who are HIV positive. They should therefore always be screened for and treated as appropriate.

Tracing partners is often difficult among MSM where anonymous sex may be more common. Where possible, regular sex-partners or life-partners should be contacted and screened to prevent further spread of the STI to other contacts or re-infection. Contact tracing is important but given the nature of MSM sex networks it might not be practical.

Client confidentiality needs to be respected at all times.

In instances where a cluster of STIs is noticed, a basic attempt should be made to consider if they are linked. For example, high rates of gonorrhoea that occur among MSM attending a specific sex-on-site MSM venue might prompt a public service notice of the issue rather than trying to contact trace anonymous sexual contacts.

Bacterial STIs

Gonorrhoea and Chlamydia

What are gonorrhoea and chlamydia? Gonorrhoea is caused by the bacteria *N. gonorrhoea* and chlamydial STIs are caused by *Chlamydia trachomatis*. Both of these diseases are bacterial infections that can be acquired sexually. It is often impossible to tell the difference between gonorrhoea and chlamydia infections clinically without laboratory testing and so it is recommended to treat both bacterial infections together. These infections cause a variety of clinical conditions including:

- » urethritis (infection of the urethra)
- » epididymo-orchitis (infection of the spermatic cord and testes)
- » pharyngitis (throat infection)
- » prostatitis (acute infection of the prostate gland)
- » proctitis (rectal infection)

Untreated proctitis: Note that untreated proctitis dramatically increases the risk of HIV acquisition in MSM who engage in unprotected receptive anal sex and should be actively screened for by taking a sexual history and treated if there are suspicious symptoms. Proctitis may present with anal pain during sex or passing stool and a mucoid or bloody anal discharge.

Asymptomatic symptoms: Many infections among MSM, especially pharyngeal chlamydia, cause no symptoms but are still transferable during sex. Screening for asymptomatic infection is recommended if resources allow but is not a priority in resource-limited healthcare settings.

Treatment of suspected gonorrhoeal and chlamydial infections: South African Department of Health guidelines for management of STIs advocate syndromic treatment for suspected gonorrhoeal and chlamydial infections and these protocols should be followed locally. These guidelines incorporate knowledge of background antibiotic resistance rates and recommend the correct choice of antibiotics e.g. quinolone resistant gonococci are very common, necessitating a recent guideline change from quinolone to cephalosporin therapy.

HIV status does not influence gonorrhoea or chlamydia treatment. Gonorrhoea is treated with cephalosporin antibiotics, either cefixime orally or intramuscular ceftriaxone. Chlamydial infections respond to oral doxycycline or azithromycin. It is advisable to treat for both infections simultaneously.

Syndromic treatment of urethral, anal, penile and pharyngeal infections is with azithromycin oral 1g PO stat or ceftriaxone 250mg intramuscularly. For more extensive local infections including prostatitis and epididymo-orchitis, the recommended treatment is ceftriaxone 250mg IM stat and doxycycline 100mg 12-hourly for 14 days. For severe disseminated gonorrhoeal infections that cause arthritis, ceftriaxone 1g IM or IV is indicated for 14 days. Note that cefixime resistance is becoming an increasing problem in some countries and is being monitored in South Africa.

Syphilis

What is syphilis? Syphilis is a sexually transmitted disease caused by the bacteria *Treponema pallidum*. Syphilis causes a large variety of clinical conditions that are usually divided into primary, secondary (latent) and tertiary (including neurological) syphilis.

Primary syphilis causes a painless ulcer known as a chancre which may be difficult to locate or may be missed entirely in MSM as they can occur on the genitals but also in the throat or anus where they are invisible.

Secondary syphilis presents with rashes on the skin which may be very non-specific and may mimic a large variety of other skin diseases so always consider this diagnosis in clients with unusual rashes especially if the palms and soles are involved as this is a clue that the rash could be syphilis. Secondary disease can also cause ulcers or sores in the mouth.

Latent syphilis occurs when a client with primary or secondary syphilis does not receive treatment. As the name suggests, it is common to have no symptoms at all during the latent phase but the bacteria are still present in the body and can cause harm.

Tertiary syphilis presents with a variety of organ complications including nervous system problems such as gait abnormalities, confusion and even strokes.

Screening for syphilis: Sexually active MSM should be screened yearly for syphilis or more often if they have many sexual partners. HIV positive clients may have faster progression of untreated syphilis and more neurosyphilis may be seen than in HIV negative clients. Neurosyphilis should be considered in clients with mental health or neurological disorders and positive blood serology and such clients should be referred to physician opinion if available.

Testing for syphilis can be done with rapid tests if available or more commonly in South Africa with laboratory testing. An RPR or VDRL is the test that is usually done first. Unfortunately these tests may come back with low falsely positive results in clients who are HIV positive. In such cases, the positive result must always be confirmed by a second confirmatory syphilis test. The TPHA or similar test is usually done in state laboratories to confirm infection. Syphilis serology may be difficult to interpret in cases which are weakly positive and the treatment history is uncertain. It is advisable to treat any confirmed positive serology if the

client has not received recent syphilis therapy. If there is doubt about a positive result, it may be better to treat and document that treatment has been successfully given and completed.

Treatment for syphilis: Treatment is with intramuscular penicillin as shown in the table on STI treatment at the beginning of this section. For clients who are penicillin allergic, doxycycline, azithromycin or erythromycin are alternatives but do not achieve the same cure rates as Penicillin. Penicillin allergic clients who fail treatment with the oral agents listed above should be referred for possible Penicillin desensitisation.

Other bacterial infections

Because of the exposure to the bowel and potentially small amounts of faecal material during sex, MSM are at risk of contracting a range of gastrointestinal bacteria that can cause fever, diarrhoea and even sepsis. Examples of these bacteria include *Escherichia coli* and *campylobacter* species. Other non-bacterial bowel organisms can also be contracted during anal sex due to faecal contamination, including diarrhoea-causing viruses and amoebiasis.

Viral STIs

Human papilloma virus (HPV)

What is HPV? HPV is one of the most common STIs amongst MSM and transmission is not entirely prevented by using condoms. HPV infection causes clinical warts. Warts are transmitted by skin to skin contact so, although only partly effective, condoms should be advised to decrease transmission of anal or penile warts. Treatment does not necessarily decrease transmissibility.

Warts may present any- where on the genitalia, anus, rectum or even mouth of MSM. Anal warts may be external only but up to 30% of clients will also have internal anal warts. Treatment is aimed at controlling local lesions, preventing future cancers and limiting virus transmission. Anal or penile warts may lead to sexual dysfunction among MSM. Anal HPV may increase the risk of anal cancers among MSM who have an increased risk of this condition compared to heterosexual clients.

Treatment of HPV: Treatment modalities for HPV include topical therapies, freezing, cauterization and surgical procedures.

Topical preparations such as podophyllin or imiquimod cream may be effective but are not always accessible or easy to use. Imiquimod in particular is expensive and often the only therapy available in resource-limited settings is podophyllin ointment. Cryotherapy with liquid nitrogen or coagulation laser therapy is effective where this is available. Surgery may be required for extensive lesions or troublesome internal ones. For clinics limited to podophyllin, referral of uncomplicated warts may need surgical referral as podophyllin is difficult to use in the peri-anal area and treatment often fails. Internal warts often do not require specific treatment unless there is concern over the diagnosis, local discomfort or malignancy is suspected. Complex cases, where the lesions are extensive or internal or there is uncertainty about the diagnosis, should be referred to a tertiary hospital for assessment and/ or surgery.

HPV vaccinations: HPV is preventable by vaccination but this is extremely costly (approximately R1000 per dose and three doses are required) and thus unavailable in public healthcare settings. The vaccine needs to be administered prior to acquisition of the virus, i.e. often prior to sexual debut. Public health programmes aimed at vaccinating young men prior to sexual debut remain undeveloped. For clients able to access this vaccine privately, there is evidence of protection against warts and a decrease in the risk of anal cancers and the vaccine should be promoted to MSM.

HPV and ART: HPV in HIV positive men may develop HPV immune reconstitution inflammatory syndrome in the context of starting ART. Warts should be managed as usual, ART should be continued and steroids avoided.

Hepatitis A

What is Hepatitis A (HAV)? HAV disease is caused by a hepatitis virus that is spread via the faecal – oral route. Most infections in the heterosexual community are from faecal contamination of food. Acute HAV causes jaundice, fever and other symptoms including acute liver failure but it does not cause chronic liver disease or complications. HAV is an STI risk for MSM due to the likelihood of oral-anal contact during sex from activities such as anilingus or sharing sex toys without washing them.

Causes of HAV: Many developing countries experience high levels of food-borne HAV outbreaks and most of the adult population has natural immunity as they have been exposed to the virus during childhood. Outbreaks of HAV at crèches are not uncommon and the disease is not serious or life-threatening to children. The disease is far more serious if acquired in adulthood.

Clients from wealthier socio-economic backgrounds with better sanitation services may not have been exposed to the virus and may be susceptible to sexual transmission during adulthood.

Screening and prevention of HAV: Ideally all MSM should be screened and vaccinated. In resource limited settings, screening can be directed towards clients who are least likely to have natural immunity i.e. MSM and clients from good socio-economic backgrounds. Use of dental-dams or plastic barriers during anilingus may prevent HAV transmission. Screening is only worthwhile if HAV vaccine can be provided to those who are at risk.

Hepatitis B

What is Hepatitis B (HBV)? HBV is caused by another virus that has a preference for liver tissue. HBV is spread fairly easily through many body fluids including (but not limited to) blood and sexual fluids. Acute HBV causes many of the same symptoms as acute HAV but has the potential to cause a chronic infection if the virus is not cleared from the body. Chronic HBV leads to liver complications such as liver failure, cirrhosis and future liver cancers.

HIV and HBV co-infection is common, especially in African countries. Co-infection leads to early onset of liver and other complications. Co-infected clients should ideally have their HIV and HBV treated early, even at high CD₄ counts to retard liver complications of cirrhosis and cancer. Currently this is not part of the South African Department of Health ARV guidelines and cannot be done in resource-limited settings without special motivation to local ART managers.

Treatment of HB: Some ARVs including tenofovir and lamivudine are effective in treating chronic HBV so are the ideal drug choice for HIV and HB co-infected clients. HBV can be treated with interferon but access is limited to some academic health centres and cure is not easy to achieve. If available, referral for academic assessment for interferon

therapy should be considered, particularly if the patient has abnormal liver function tests. If referral to an academic institution is not possible, treat HIV and HBV co-infected with tenofovir based ART. Once a client with HBV has started tenofovir and lamivudine, these drugs should not be stopped, even if different (second line) ARVs become indicated for treatment of HIV.

All MSM should ideally be screened for this disease with a HBV surface antigen and for immunity with a HBV surface antibody. All antibody negative clients should be vaccinated. The HBV vaccine is safe and effective. It needs to be given in three doses and is usually given at start, one month and then six months. For clients who have ongoing high risk for acquiring HBV (e.g. commercial sex workers or men whose partners are HBV positive), should be vaccinated as rapidly as possible and the three doses should be given monthly over three months and a booster dose given at one year.

Hepatitis C

What is Hepatitis C (HCV)? HCV is caused by another virus that also has a preference for infecting the liver. Co-infection with this virus and HIV is common worldwide but has thus far been uncommon in Africa.

HCV is not as commonly transmitted as HBV and requires a larger exposure to infected body fluids. Recognised risk factors for HCV infection are intravenous drug use. It also occurs during MSM sex, those at risk being mainly MSM who are HIV positive. MSM who are HIV negative are also at risk (though its lower than for heterosexual sex) Our experience at the Health4Men Clinic in Cape Town confirms the emerging consensus that MSM are at risk of HCV even when injection drug use is not a feature of behavior.

HCV and HIV co-infection: HCV and HIV co-infection leads to rapid progression of cirrhosis and other liver complications.

Treatment of HC: Co-infected clients should ideally be treated early for HIV irrespective of their CD4 count although the DOH ARV guidelines currently do not allow for this. It would be beneficial for patients if clinicians could motivate to their local ART managers for early treatment on a case by case basis. Tenofovir based ART should be used if possible even though it does not have direct HCV activity, it is a preferable choice as D4T and DDI may worsen liver disease by causing hepatic fat accumulation.

As in the case of HBV, interferon therapy is effective in managing HCV but it is expensive and only available at some state academic hospitals. MSM who are HIV and HCV positive with abnormal liver function tests should be referred for assessment.

There is no effective vaccination against HCV so risk-reduction counselling to reduce sexual exposure and substance abuse transmission is the only effective prevention strategy. New protease inhibitor drugs are being researched and have shown some promise in the treatment of HC, although at present these are still experimental.

USING ARVS IN CLIENTS WITH HIV AND VIRAL HEPATITIS CO-INFECTION		
ANTIRETROVIRAL DRUG	COMMENT	USE
D4T, DDI	May result in mitochondrial toxicity and hepatic steatosis or steatohepatitis which accelerates liver fibrosis / cirrhosis	Avoid
AZT	<ul style="list-style-type: none"> • Less risk of hepatic steatosis • Problematic shared drug side effects with IFN including anaemia and neutropaenia 	Use if TDF not available
TDF, 3TC	<ul style="list-style-type: none"> • Considered safe • Effective against HB • No direct anti HCV activity 	Use preferentially
Efavirez	Considered safe	Use preferentially
Nevirapine	Increased risk of hepatitis	Use if no other safe choice
Aluvia® (lopinovir/ritonavir)	Risk of hepatitis	Use if no other choice
Atazanavir	May cause jaundice but this does not reflect direct liver injury	Use if PI is indicated

Herpes Simplex Virus

What is Herpes simplex (HSV)? HSV is a common sexually transmitted virus, well adapted to persistence in the human host. It cannot be eradicated but can be treated and effectively suppressed. HSV infection causes genital, anal or oral ulcers. Since HSV causes mucosal damage

it is suspected that HSV infection may increase the risk of acquiring or transmitting HIV. Clinically, HSV causes outbreaks of painful ulcers.

Treatment of HSV: HSV ulcers can be treated with acyclovir 400mg tds for a week. HSV suppression should be used in clients who have multiple outbreaks (>4 episodes in a year) and can be achieved with acyclovir 400mg bd. Acyclovir is available from state pharmacies for treatment and suppression of HSV.

Other medical conditions to consider among MSM

Testicular cancer in young MSM

What is testicular cancer? Testicular cancer is one of the most common cancers that occur in young men with a peak incidence in the 20's and 30's. Risks for testicular cancer include a positive family history of cancers, undescended testes and cannabis use. The usual presentation is a painless lump on the anterior or lateral part of the testis.

Self-examination and prevention: Clients should be taught to examine their testes monthly to check for size, smoothness and pain. The correct method is to examine the testes after a warm bath or shower when the scrotum is relaxed. First the scrotum should be examined for redness or swelling. Note that one testis is normally slightly larger than the other and hangs slightly lower. The testes should then be examined one at a time while the client is lying down. Clients should be taught to examine the testes by rolling them between their fingers feeling for any tenderness, abnormal consistency or irregular swelling. If a painless lump is felt in the testes, this should be confirmed by a healthcare worker and then the client referred for assessment and biopsy by an urologist.

Treatment of testicular cancer: If detected early, testicular cancer is curable. Testicular cancer is treated by surgical removal of the affected testis and sometimes with additional chemotherapy or radiotherapy

Prostatic disease

What is prostatic disease? The prostate is a small gland located at the base of the bladder that surrounds the urethra. The gland is responsible for production of some of the seminal fluid in which sperm are contained. The commonest diseases of the prostate gland include prostate cancer, benign prostatic hypertrophy in older MSM and sexually acquired infections (prostatitis).

What is BPH? Benign prostatic hypertrophy (BPH) is age related growth of the prostate and is non cancerous. BPH often presents with suggestive urinary symptoms such as difficulty initiating urination, poor urine stream and dribbling after completing urination and a clinically enlarged prostate on rectal examination.

Treatment of BPH: BPH symptoms can be treated with oral medications if mild. These medications are aimed at increasing the flow of urine through the prostatic part of the urethra.

BPH may require surgical intervention if symptoms are severe or the flow to urinary obstruction causes bladder or renal complications such as infection and even renal failure BPH can become so severe that it causes complete obstruction of the urethra and urinary retention. Clients with this symptom require a catheter that may need to be inserted suprapubically. Clients with severe symptoms should be referred to a urologist for assessment and possible prostatic surgery.

What is prostate cancer? Prostate cancer results from malignant overgrowth of prostate cells. Prostate cancer may be completely silent and needs to be actively screened for with physical examination and blood testing.

Screening for prostate cancer: Screening is done clinically by feeling the prostate via the anus and by blood test screening with a prostate specific antigen (PSA) test. (Note: the blood test should be done before the clinical examination as manipulating the prostate will falsely elevate the PSA level). A PSA of >4.0 may be suggestive of prostate cancer and the client should be referred to an urologist (or a general surgeon). Older men >45 years of age should be screened yearly.

Anal cancers

MSM and anal cancers

- » MSM have a higher risk of developing anal cancers than heterosexual men.
- » MSM who have had anal HPV might be at particular risk. Screening with anoscopy or colonoscopy is recommended after age 50. Anal warts may be prevented by using HPV vaccines such as Gardasil. HPV vaccines may lower the risk of anal cancers in MSM although no formal vaccination protocol has yet been developed for South Africa. Local screening for anal cancers is very problematic as there is very limited access to scope facilities and thus this remains impossible to access for most South African MSM. For MSM clients attending private health services, anal pap-smears can be done to check for early anal pre-cancers which can then be treated before they become clinically severe.

Mental health challenges among MSM

Mood disorders, substance abuse and other mental health issues, are discussed elsewhere in this manual. HIV encephalopathy and central nervous system opportunistic infections such as TB, cryptococcal meningitis or toxoplasmosis affect both physical ability and mental health. Clients who have new neurological signs on examination should be referred for further assessment which might include invasive tests such as lumbar puncture for CSF analysis or radiological brain imaging.

Other conditions

- » Rectal and anal trauma and bleeding: Bleeding can also occur from diseases such as polyps or haemorrhoids.
- » Priapism (inability to lose an erection) can be caused by the use of penile rings and viagra or similar drugs. Note that some ARVs (e.g. Aluvia® - lopinavir / ritonavir) will interact with viagra and prolong its effect.
- » Tobacco, alcohol and substance abuse is high among MSM and leads to a variety of negative health consequences.

GLOSSARY OF TERMS

Active (penetrative) partner — refers to the partner who assumes the penetrative role during either anal or oral penetration

AIDS — acquired immunodeficiency syndrome is a fatal disease caused by HIV, the human immunodeficiency virus. HIV destroys the body's ability to fight off infection and disease, which can ultimately lead to death. Currently, antiretroviral drugs slow down replication of the virus and can greatly enhance quality of life, but they do not eliminate HIV infection. (Description from UNAIDS.)

AIN — anal intra-epithelial neoplasia. Equivalent to CIN (cervical intra-epithelial neoplasia). A pre-cancerous lesion which may progress to an anal cancer but may also resolve.

Ambassador — similar to a peer educator, the Health4Men term for peer educators

Anal dysfunction — sexual dysfunctions related to the anus that negate comfortable or successful anal intercourse

Anal Inhibition Syndrome — an anal sexual dysfunction

Anal taboo — a general avoidance of any reference to the anus because of complex psychological and social constructs that associate the anus with dirt, shame and guilt

Analingus — see also rimming — oral stimulation of the anus

Analphobia — an irrational fear of anality, especially focused on associating the anus with any sense of pleasure

Anismus — an anal sexual dysfunction

Anodyspareunia — an anal sexual dysfunction

Antibody — a protein often found in the bloodstream that attacks other proteins known as antigens with the aim of destroying them

Antigen — a substance often found in the bloodstream that stimulates an immune response in the body

Barebacking — sexual penetration without the use of a condom, usually used in the context of a conscious decision to engage in unprotected intercourse

Bisexual — refers to individuals who are sexually attracted to both men and women and are capable of entering into enduring intimate relationships with either men or women

Body fluid — in this manual refers to body fluids that contain varying concentrations of the HI virus

Bottom — a colloquial term referring to the receptive partner during anal or oral penetration

CD4 Test — a blood test used to measure immune system strength in HIV positive clients

Closed relationship — refers to an enduring relationship where partners have mutually agreed to be sexually exclusive and monogamous to each other

Concurrent — means at the same time

Coming out — a term describing the complex process of an individual realising he is not heterosexual and resolving related conflicts due to heterosexuality being viewed as the norm

Condom failure — refers to unsuccessful condom use including condom breakage or condom loss during intercourse and could necessitate the use of PEP

Condom fatigue — refers to men becoming increasingly wary of the chronic need to use condoms during intercourse and the resultant loss of spontaneity and sexual sensation

Crystal Methamphetamine — see also Tik, a commonly used recreational stimulant drug, colloquially referred to as crystal, meth and tina

Disclosure — refers to the process of disclosing an HIV positive status to others including potential sexual partners in the context of fear of rejection

Disinhibition — a state of increased impulsivity that could contribute to sexual risk-taking

Douching — the practice of cleansing the rectum prior to receptive anal intercourse that may harm the delicate lining of the rectum and promote a more likely environment for the transmission of a virus or infection

Drag — a colloquial term for cross-dressing (dressing as a member of the opposite sex), often for entertainment purposes.

Emotional fidelity — refers to an emphasis on emotional as opposed to sexual fidelity between partners in enduring intimate relationships; aimed at preserving the emotional bond of the relationship while allowing an element of sexual interaction with others

Erectile dysfunction — a sexual dysfunction related to the inability to achieve or sustain an erection for sexual function.

Fact sheets — print media containing topical responsible sex information usually limited to one subject

Felching — oral extraction of semen from an anus following bareback intercourse, engaged in by a subset of MSM

Fellatio — oral stimulation of a penis, often to the point of orgasm, commonly referred to as a blow job

Female condom — condoms designed specifically for placement within the vagina prior to heterosexual intercourse, also appropriate for anal intercourse

Fetish — a non-sexual object or body part that becomes significantly sexually stimulating, such as leather, rubber or feet

Flooding — refers to a level of resistance to responsible sex messaging due to either too much or ineffective messaging

Fuck buddies — colloquial term used by some MSM to describe repeated sexual interactions between partners without overt emotional aspects to the relationship

Gay — colloquial term, used predominantly in Euro- and Western-centric contexts to describe homosexual men who identify with a shared set of values

Gender — refers to social constructs of what constitutes maleness and femaleness, including roles and social presentation

Gender identity — an element of each individual's sexual identity, relating to their expression of preferred gender roles

Hetero—normative — the predominant social construct that overvalues heterosexuality and assumes a heterosexual orientation unless otherwise indicated. A hetero- normative view-point considers heterosexuality as normal and any other behaviour as abnormal

Heterosexual — refers to individuals who are sexually attracted to members of the opposite sex

HIV — Human Immunodeficiency Virus

HIV Counselling and Testing (HCT) — closely akin to VCT, HIV-related counselling and testing is offered to all people attending healthcare settings

Homophobia — a commonly used term to describe hetero-normative undervaluing of homosexual identities resulting in prejudice and bias against homosexual individuals

Homophobia — the hetero-normative prejudice against people with diverse homosexual identities, in part based on the anal taboo

Homosexual — refers to individuals who are sexually attracted to members of the same sex, often used in a medical context

Internalised homo—negativity — the accumulated internalisation of hetero—normative social messages that undervalue non-heterosexual men, resulting in a sense of shame or guilt around their sexuality

Internalised homophobia — a commonly used term to describe internalised homo—negativity

Intersex — refers to individuals that are born either with undefined genitalia or genitalia of both sexes

LFT — Liver function test

LGV — Lympho granuloma venereum, a sexually transmitted infection

Lubrication — a slippery and slick fluid used to make sexual stimulation more pleasant and to facilitate anal penetration and reduce the risk of condom failure

MCP — Multiple concurrent partners

Medical Male Circumcision — surgical removal of the foreskin from the penis under clinical conditions

MSM — men who have sex with men, irrespective of sexual orientation or gender identity

Multiple concurrent relationships — refers to engaging in several intimate relationships at the same time

Open relationship — refers to an enduring relationship where partners have mutually agreed to allow sexual interactions with others

Passive (receptive) partner — refers to the partner who assumes the receptive role during either anal or oral penetration. Colloquially often referred to as the bottom

Patriarchy — a pervasive social norm that affords men power relative to women

PCR — Polymerase chain reaction, also called a nucleic acid amplification test (NAAT). A test that increases a small amount of protein found in many pathogens to the point where it can be detected and used to diagnose infection. PCR can also be used to amplify HIV proteins and calculate how much HIV there is in a blood specimen (i.e. the HIV viral load)

Peer educator — a person who has been trained with HIV knowledge who can educate those around them about the disease and how to protect themselves

Penile ring — an object that is placed around the penis to facilitate erection by limiting the blood flow from that organ, colloquially referred to as a cock ring

Phobia — an intense, irrational fear response to an object or situation

Poppers — a colloquially used term for amyl nitrate, a commonly used recreational inhalant

Post Exposure Prophylaxis (PEP) — combinations of antiretroviral medications used after possible exposure to HI virus to lower the chance of becoming HIV positive

Pre-exposure Prophylaxis (PrEP) — a strategy of using combinations of antiretroviral medications in HIV negative clients to lower their risk of becoming HIV positive if they are exposed to the virus

Prejudice — an irrational preconceived opinion that is not based on reality or actual experience, often resulting in dislike, hostility or unjust behaviour

Prevention fatigue — see condom fatigue

Prostatic health — the absence of symptoms or diseases relating to the prostate gland. The prostate is a gland under the base of the bladder that is responsible for manufacturing sexual fluids

Recreational substances — refers to various substances including drugs and alcohol, used by MSM for various reasons including enhancement of sex

Re-infection — acquiring a second strain of HI virus in someone who is already HIV positive. May have negative consequences for long term HIV treatment

Responsible sex — Health4Men’s preferred term to safer sex, emphasising preventing the transmission of sexual infections through consistent condom and water-based lubricant use and reducing the number of sexual partners

Rimming — see anilingus

RPR — rapid plasma regain, a screening test for syphilis infection

Same-sex practicing (SSP) — an inclusive term referring to both men and women who have sex with members of the same sex

Screening — Health4Men’s preferred term to testing

Seeding — see also barebacking, colloquial term regarding the exchange of semen

Sero-sorting — a strategy used by a subset of MSM to prevent HIV transmission dependent on being able to identify sexual partners with the same HIV status

Sexual addiction — a somewhat controversial term denoting a preoccupation with the pursuit or engaging in sexual activity to the extent that other areas of daily functioning are negated

Sexual anorexia — the pathological avoidance of sexual interactions

Sexual orientation — an indication of an individual’s attraction to either the same, opposite, or both sexes

Slamming — colloquial term for intravenous drug abuse

STIs — sexually transmitted infections which could be either bacterial or viral

Strategic positioning — a strategy used by a subset of MSM to prevent HIV transmission in a sero-discordant sexual setting by the HIV positive partner adopting the receptive role for intercourse so as not to expose the HIV negative partner to HIV-infected semen

Super-infection — see re-infection

Tik — see also Crystal Methamphetamine, a commonly used recreational drug, colloquially referred to as crystal, meth and tina

Top — a colloquial term referring to the penetrative partner during anal or oral penetration

TPHA — Treponema pallidum haemagglutination test, a confirmatory test for syphilis performed to confirm infection if previous screening tests may be inaccurate or difficult to interpret

Transgender — people who experience a conflict between their sex assigned at birth and their gender identity.

VDRL — Venereal diseases research laboratory test, a screening test for syphilis infection

VCT — Voluntary Counselling and Testing, closely akin to HCT: HIV-related counselling and testing initiated by the client seeking a screening service

Versatile — refers to individuals who are comfortable and confident in adopting both the receptive or penetrative role during anal or oral intercourse

Viral load — the relative concentration of the HI virus in blood

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APPENDIX 1

Advice for healthcare providers screening MSM for HIV

Screen all MSM according to a provider-initiated, opt-out model, because:

- Men who have sex with men are at higher risk of HIV than heterosexuals;
- HIV is very common in South Africa and most people don't know their status; and
- Screening is free, accurate and confidential.

Explain the benefits to clients of knowing their HIV status, tell them:

- Having a test does not change your status;
- Knowing your status allows good healthcare planning and allows you to minimise the effects of HIV and avoid AIDS;
- Knowing your status improves health and may improve relationships and sex;
- Screening allows healthcare providers to individualise and optimise your health according to your specific needs; and
- South African constitution prevents discrimination on the basis of HIV status, no matter what your result.

Educate clients about the risks of HIV transmission

demonstrate health4men's sex-positive model:

- HIV is not spread by sex
- HIV is spread by transferring HIV-containing fluids from one person to another;
- For transmission there must be HIV in the fluid and it must have an entry point:
 - » HIV-containing fluids: blood and semen;
 - » Possible HIV-containing fluids: pre-ejaculate– low risk but not no risk
 - » Non HIV-containing fluids: urine, faeces, sweat, saliva, tears, vomitus
- Anal sex – high risk of transmission (due to fragile anal lining)
- Oral sex – lower risk managed by avoiding body fluid transfer
- Reducing the number of partners lowers HIV risk;

- Discuss the risks associated with unprotected sex;
 - » Recreational drug or alcohol use during sex

Encourage the client to think about their personal risks and assess their own personal risk. **DO NOT** extract a sexual confession to assess client's risk. **Answer** or refer any sexual risk questions that the client may have.

Consent the client

- Ask the client to sign the Department of Health's HIV testing form.

Test for HIV

- Perform test according to the Department of Health's protocol for HIV testing.

Testing procedure

inform the client of the following:

- The results of the test are confidential
- The client may use pseudonym if desired
- The HIV test is a rapid test – results in 15 minutes, no overnight waiting!
- Use finger prick blood test if just doing HIV OR offer full STI
- Screen with full blood draw (more blood but similar pain)
- Explain test for antibodies rather than virus itself
- A positive HIV test will always be confirmed using a second rapid HIV test
- Explain window period (time period during which the test will fail to diagnose an early HIV infection – 8 weeks)

Support

All clients irrespective of result must be provided with some post-test support.

HIV-negative result:

- You have screened negative for HIV antibodies
- Emphasise window period
- If in window period, schedule testing for 8 weeks time and stress condom use until result is confirmed negative
- Risk reduction counselling. Schedule repeat test in 6-12 months depending on risk profile

HIV-positive result:

- You have screened positive for HIV antibodies
- We will now confirm this with a second rapid test and a laboratory test
- You have thus been exposed to the virus sometime in the past
- Cannot tell:
 - » How long has the infection been present
 - » How much virus is present
 - » How much damage has occurred to the immune system
- We are experts in HIV management and care
- We will look after you!
- We will design a plan with you to take care of your health and HIV needs
- We will help with medical and psychological problems
- We will measure your immune system by doing a CD4 count
- We will check for any organ effects of HIV by blood screening
- You will see our specialist doctor to discuss and review the results
- All treatment is free and easy to access
- Treatment may not be required for a long period of time if your immune system is strong
- Treatment is well researched and understood. Easy to take and side effects are predictable and can be minimised or avoided
- Taking ART if needed should not interfere with your lifestyle.
- Positive re-enforcement for testing. Knowing status prevents progression to AIDS and allows for excellent health and a near normal or normal lifespan
- Knowing status allows you to reduce the risk of HIV transmission to your partners
- Avoid information overload – the client is no longer listening to you
- Contain the client by making concrete plans until next medical visit
- Discuss disclosure if a supportive person is known to the client

Risk reduction*for all clients irrespective of HIV result*

- Dispense Condoms and lube
- Appropriate educational fact sheets
- Book appointment for all clients
 - » Repeat VCT 8 weeks if window period
 - » Repeat VCT 6-12 months if negative outside of window period
 - » Doctor appointment ASAP if positive
 - » Psychosocial appointment ASAP if required
 - » Supply information and contact details

13 See <http://www.actshivtest.org.za/toolkit.htm>

Please note that the information above is meant as general advice to assist healthcare providers who screen MSM clients for HIV. It is not practical to cover all of this information with clients at the time of screening and only the essential information should be addressed.

The HIV screening should be done according to the Department of Health's ACTS model (Advise, Consent, Test and Support)¹³. The information given here can be discussed with clients at repeat visits when they are likely to be more receptive. It is therefore extremely important to make follow up plans for your clients.

APPENDIX 2

HEALTH4MEN HIV SCREENING GUIDELINE

- » Offer everyone testing, irrespective of their reason for attending.
- » Screening should be done in a secure, private area to ensure confidentiality.
- » Screening is done as stipulated by the SA Department of Health.
- » A register of tests must be completed.
- » A register of bloods drawn and submitted to the lab must be completed.
- » Test kit instructions must be readily available and adhered to.
- » Universal precautions for handling of sharps and infectious waste products must be followed.

ADVISE

- » Benefits of testing
- » What a rapid HIV test result means
- » Stress confidentiality
- » Stress expertise in managing positive results

CONSENT

- » Signed consent is required for medico-legal reasons
- » All state patients need to sign the DOH HIV Screening form

TESTING PROCEDURE

- » Finger prick blood if only screening HIV
- » Ante-cubital phlebotomy if performing HIV confirmatory testing, CD4 count or VDRL

SUPPORT

- » Counselling and follow-up for all clients according to test results
- » Condoms, lube, education material for all clients

Step 1: Perform First HIV Rapid Test

Step 1

RAPID 1 POSITIVE

- » Explain result
- » Perform step 3

Step 2

RAPID 1 NEGATIVE

- » Explain window period and assess need for retest
- » Strategies for remaining negative
- » Re-book for repeat screening
- » 8 weeks if window period
- » 3-5 months if high risk behaviours
- » 6-12 months if low risk behaviours

Step 2

RAPID 1 UNCERTAIN

- » Explain result
- » Blood for lab ELISA Gen 4
- » Refer to next level of care ASAP

Step 3: Perform Second HIV Rapid Test

Step 4

TEST 2 POSITIVE

- » Counselling and support
- » Send CD4 count
- » Refer for HIV / ARV care

Step 4

TEST 2 NEGATIVE/UNCERTAIN

- » Explain results
- » Blood for lab ELISA Gen 4
- » Refer to physician / HIV specialist

APPENDIX 3

STI treatment

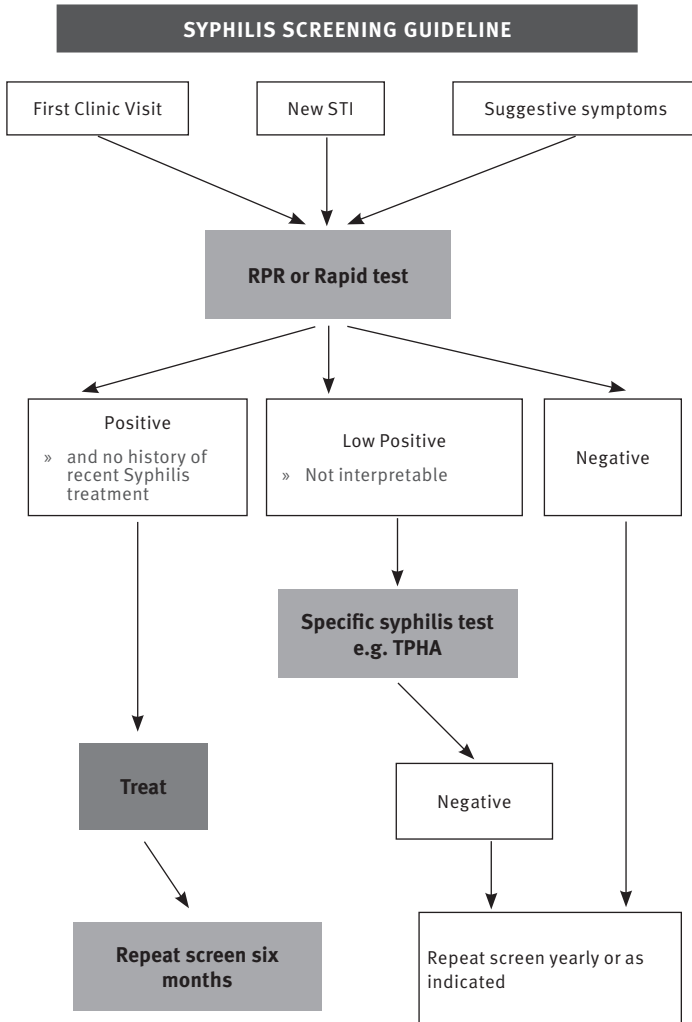
SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES		
Diagnosis	Recommended Treatment	Special considerations: MSM
Gonorrhoea	Ceftriaxone 250mg IMI stat Always add empiric treatment for gonorrhoea	Anal pain or discharge may indicate anal gonorrhoea; non-resolving URTI should prompt consideration of a pharyngeal STI.
Chlamydia	Azithromycin 1g PO stat Always add empiric treatment for chlamydia	As for gonorrhoea; many cases of anal chlamydia are clinically silent.
Syphilis		Syphilitic chancres are usually painless, may go unnoticed and therefore untreated - especially for anal syphilis, where the chancre could be internal. Regular (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 <i>Doxycycline 100mg 12 hourly for 14-28 days for penicillin-allergic patients</i>	

SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES		
Diagnosis	Recommended Treatment	Special considerations: MSM
Neurosyphilis	<p>Penicillin G 5mu IVI for 14 days</p> <p>AND</p> <p>Follow with benzathine penicillin 2.4mu IMI weekly for three weeks</p> <p>OR</p> <p>Procaine penicillin 2.4mu IMI daily AND probenecid 500mg 6 hourly for 14 days</p> <p>AND</p> <p>Follow with benzathine penicillin 2.4mu IMI weekly for three weeks</p> <p>Refer penicillin-allergic patients with neurosyphilis to a specialist</p>	<p>Consider and refer all MSM with a positive blood syphilis serology and neurological deficits.</p>
Lymphogranuloma venereum (LGV)	<p>Doxycycline 100mg 12 hourly for 14 days</p> <p>OR</p> <p>Erythromycin 500mg 6 hourly for 14 days§</p>	<p>Supposedly more common among MSM but unclear if this is true for South African MSM.</p>
Human papilloma virus (HPV)	<p>Topical therapy including cryotherapy, podophylin, acetic acid or imiquimod</p> <p>Large fungating warts or internal anal or urethral lesions should be referred for surgical excision</p>	<p>MSM who practise anal sex need anal exam to diagnose warts; MSM have an elevated risk of anal cancer especially if they have had anal warts; warts are easily transferred during anal sex, counselling is required.</p>

SEXUALLY TRANSMITTED INFECTIONS (STIS) – TREATMENT GUIDELINES		
Diagnosis	Recommended Treatment	Special considerations: MSM
Hepatitis A (HA)	Supportive therapy. Notify and trace contacts	HA is usually a food-borne disease but becomes an STI among MSM.
Hepatitis B (HB)	Pegelated Inteferon therapy <i>if available</i> AND Tenofovir 300mg daily AND Lamivudine 300mg daily	Sexually spread among MSM; all MSM should be screened and vaccinated; MSM with ongoing potential exposure to HB should be vaccinated according to a <i>condensed vaccine schedule</i> .
Hepatitis C (HC)	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.

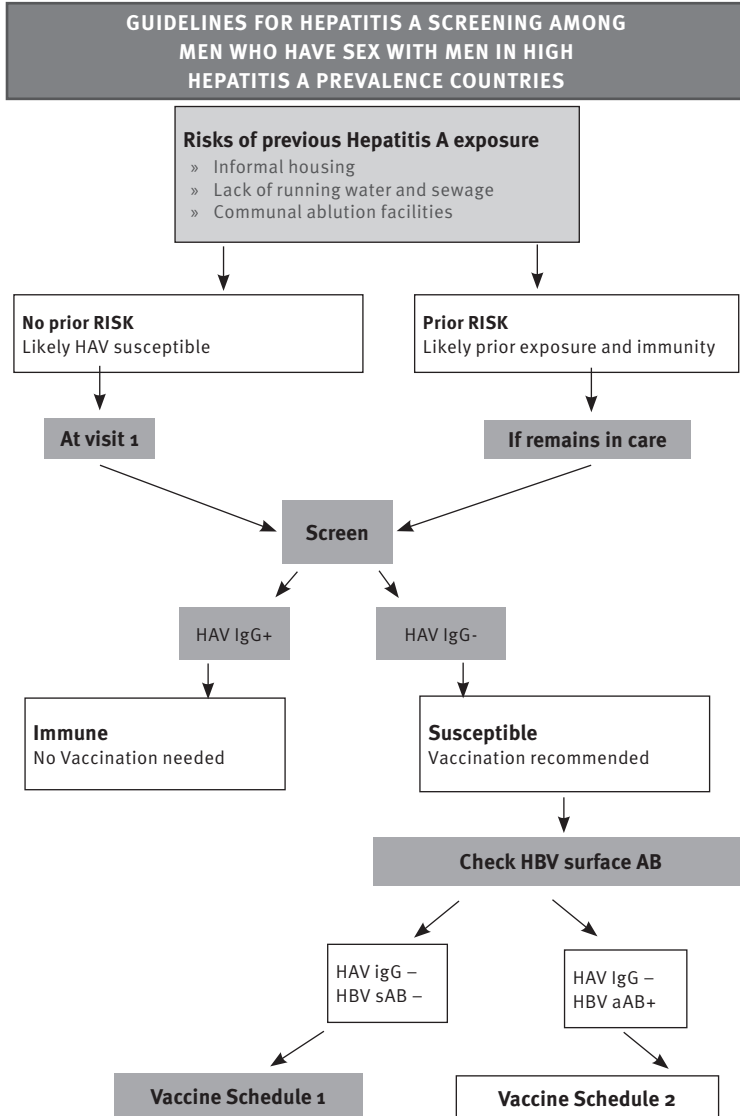
APPENDIX 4

Syphilis screening guidelines



APPENDIX 5

Guidelines for Hepatitis A screening



APPENDIX 6

Hepatitis C (HCV) and HIV Co-infection Treatment Guidelines

- HCV and HIV co-infection is common in the developed world;
- Co-infection is uncommon in South Africa but more cases are being seen at primary care clinics;
- Spontaneous cure of HCV occurs in <30% of HIV positive patients;
- High risk groups for HCV include drug users (especially intravenous) and men who have sex with men;
- Co-infection leads to a risk of rapid liver fibrosis and progression to cirrhosis; and
- Treatment of HIV in co-infected cases markedly slows the progression of liver disease

Assessing HCV in HIV positive patients

- Screen for HCV if
 - » Client with high risk factor profile e.g. intravenous drug use
 - » Abnormal LFTs with negative HBV studies and no other explanation
- Hepatitis C IgG
 - » Usually positive within 1-5 months after exposure, very rarely lost in advanced HIV
- Liver biopsy is not required to treat HCV
- LFTs should be monitored by checking serial ALT
- Ideally, all HCV positive patients should be referred to an academic hospital for further assessment to include the following:
 - » HCV viral RNA level
 - » HCV genotype
 - » Liver ultrasound / fibrosis assessment
 - » Possibly liver biopsy

Treatment depends on availability of inteferon alpha and ribovirin at academic hospitals or in the private sector. This treatment is very expensive and has profound psychiatric side effects and thus may not be available or suitable for all patients.

IFN not available

- Treat HIV early to retard liver cirrhosis
- Start ART in all clients with irrespective of CD4 count
- Use tenofovir/lamivudine (or truvada)/efavirenz preferentially
- Avoid medications known to cause hepatic steatosis

IFN available

- Refer all clients to academic hospital for assessment for IFN
- Start ART in all clients with CD4<500/mm³
- Defer ART in clients with CD4>500/mm³ until decision is made regarding interferon. If IFN is not suitable, then start ART regardless of CD4 count
- IFN and treatment response to be monitored at tertiary hospital

ANTIRETROVIRAL DRUG	COMMENT	USE
D4T, DDI	May result in mitochondrial toxicity and hepatic steatosis or steatohepatitis which accelerates liver fibrosis / cirrhosis	Avoid
AZT	Less risk of hepatic steatosis Problematic shared drug side effects with IFN including anaemia and neutropaenia	Use TDF not available or contraindicated
TDF, 3TC	Considered safe No direct anti HCV activity (c.f. HBV)	Use preferentially if accessible Use if IFN available Use if HBV co-infected
Efavirenz	Considered safe	Use preferentially
Nevirapine	Increased risk of hepatitis	Use if no other safe choice
Aluvia® (lopinavir/ritonavir)	Risk of direct liver injury	Use if no other choice
Atazanavir	May cause jaundice but this does not reflect direct liver injury	Use if PI is indicated

Selecting patients for IFN

Patients who meet the following criteria are most likely to benefit from IFN

- HCV genotype 2 or 3
- Absence of insulin resistance
- Acute HCV infection
- $CD4 > 500/mm^3$ (Immune restoration should be commenced with
- ART in all patients with severe immunosuppression)
- Less cirrhosis and clinical liver disease

Monitor for **INSULIN RESISTANCE** as this is commonly associated with hepatitis.

New protease inhibitor medications which are active against HCV are being investigated. These have shown some promise but are not yet available and are not yet considered as standard treatment.

APPENDIX 7

Summary of Screening Interventions for MSM

SCREENING INTERVENTIONS FOR MSM		
Screening	Reason for screening MSM	Benefits of screening
HIV	Higher risk among MSM	Inform healthcare 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 anally in MSM	Treatment; prevention counselling; monitoring to lower the risk of undiagnosed anal carcinomas. Exclusion of other anal diseases such as haemorrhoids and fissures.
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, anxiety, and alcohol and recreational drug use are common	Can be managed to improve ART adherence; drug interactions can be anticipated and / or avoided.

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PROVINCE	ADDRESS	OFFICE NUMBER
KwaZulu-Natal	18 Underwood Road Pinewood Park Unit 7A, Pinetown 3610	031 701 1178
Northern Cape	6A Edmeades Street Labram, Kimberly 8301	053 831 1896
Eastern Cape	29 Tecoma Road Berea, East London 5214	043 721 2368
Western Cape	1 st Floor, Anatoli Building 24 Napier Street Green Point	021 421 6127
	Ivan Toms Centre for Men's Health Top Gate, Woodstock Hospital, Victoria Walk Road, Woodstock	021 447 2844
Free State	49A Kellner Street Westdene, Bloemfontein 9301	051 430 0043



Mpumalanga	Nelspruit Community Health Centre	082 075 7105
Limpopo	Tzaneen Clinic (Next to Bus Rank) 47 Claude Wheatley Street, Tzaneen	082 075 7344
Gauteng	Yeoville Clinic Kenmere Road, Yeoville, Johannesburg	072 654 0816

OTHER ORGANISATIONS

Durban Gay & Lesbian Community Centre

42 McKenzie Road, Morningside, Durban, 4001

T: 031 312 7402

info@gaycentre.org.za

Pietermaritzburg Gay and Lesbian Association

187A Burger Street, Pietermaritzburg, 3201

T: 033 342 6165

info@gaylesbiankzn.org

LEGBO

22 Stamford Street, Utility, Kimberley

T: 053 831 1313

info@legbo.co.za

SHE

Oxford Street, Zanempilo Building, Office 22, East London

T: 043 722 0750

admin@transfeminists.org

Rainbow Seeds

44 West Burger Street, 110 Library House, Bloemfontein, 9301

T: 051 430 1023

OUT LGBT Well-Being

1081 Pretorius Street, Hatfield, Pretoria

T: 012 430 3272

hello@out.org.za

Gender DynamiX

Saartjie Baartman Centre, Klipfontein Road, Athlone, Cape Town

T: 021 633 5287

info@genderdynamix.co.za

FROM TOP TO BOTTOM

A SEX-POSITIVE APPROACH FOR
MEN WHO HAVE SEX WITH MEN

A manual for healthcare providers



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