

Talking about HIV with Men who have Sex with Men and with Transgender People in Asia

A self-study and reference manual for outreach workers,
case workers and other HIV service providers

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Unit 1

Outreach and the HIV service cascade

What is the role of the outreach worker?

In every major Asian city, men who have sex with men and transgender women are disproportionately affected by the human immunodeficiency virus (HIV). This is mainly because HIV is transmitted much easier via anal sex than it is via vaginal sex. In addition, many men have sex in both the insertive and receptive role, again facilitating more rapid transmission than in a scenario in which people have only insertive (men) or receptive (women) sex.

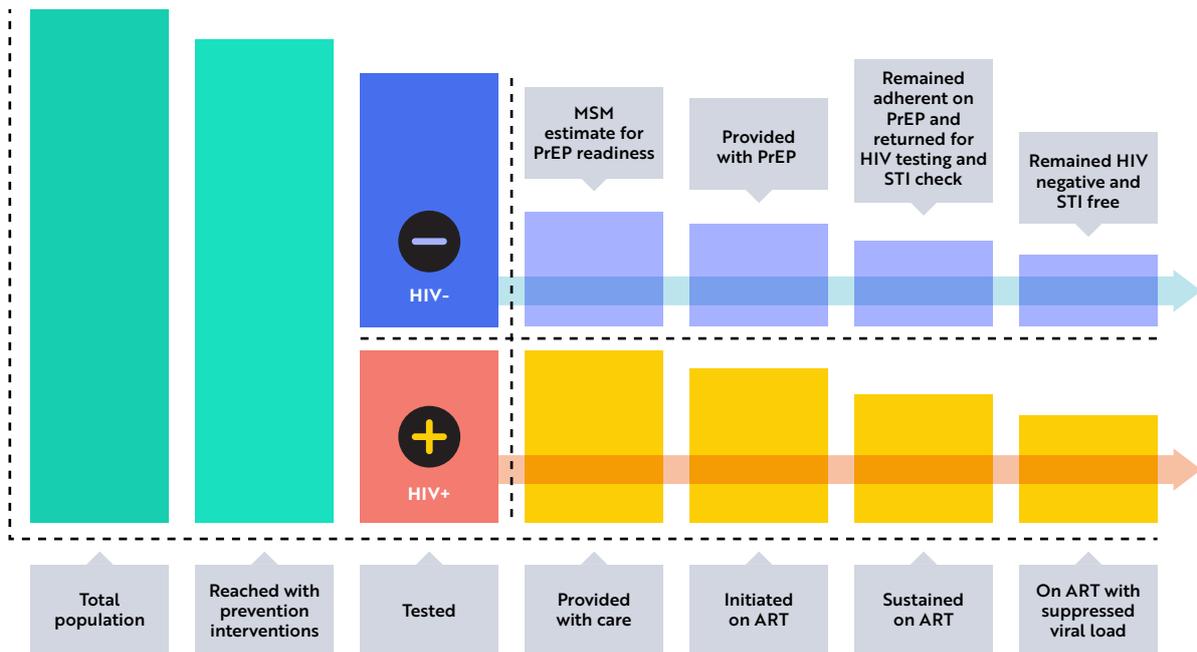
Many men who have sex with men and many transgender people avoid HIV testing services even when such services are available. They do so mainly because of (actual or perceived) stigma by health care providers and inconvenient locations or opening hours. This typically means they are unaware of their HIV status, cannot access life-saving antiretroviral treatment (ART) and may be spreading the disease to their partners, thus perpetuating the HIV epidemic.

Outreach workers have for many years had a critical role in disseminating HIV prevention information and commodities (condoms and lubricant), identifying undiagnosed HIV infection among men who have sex with men and among transgender people and in facilitating access to HIV counselling and testing services. In recent years, however, a consensus has emerged that preventing HIV will require not only strong prevention services but strong links across a continuum of HIV prevention, care and treatment services, as illustrated in Figure 1.

Evidence has shown that the links between programmes and the extent to which client 'flow' from one service level to the next have been woefully inadequate at every stage of this "HIV service cascade". Outreach programmes often reach high-risk individuals and refer them to HIV testing services. But a huge segment of those reached never go for an HIV test. If people who receive an HIV test are diagnosed HIV-positive, they often leave a facility without the medical or social support to start early antiretroviral treatment. Many seek treatment late, when they have multiple health problems.

FIGURE 1

Continuum of HIV prevention, testing and treatment services



Note MSM=men who have sex with men; PrEP=pre-exposure prophylaxis; STI=sexually transmitted infections; ART=antiretroviral treatment.

In short, loss to follow-up is rampant across the continuum in many settings, with HIV infection remaining unacceptably high and access to antiretroviral treatment for people living with HIV unacceptably low, both leading to unnecessary HIV-related deaths. Trained and well-supported outreach staff, such as yourself, can have an important role in identifying and plugging these “leaks” across the HIV service cascade so that men who have sex with men and transgender clients, once engaged, are supported and retained within the system. This also means help with access to the services they need to safeguard their own health and to prevent the further spread of infection.

This section discusses the varying roles that an outreach worker can have across the HIV service cascade.

How can we reach potential clients?

One critical role of outreach workers is to identify people who have not been reached by HIV services. There are numerous models for achieving this reach, including (but not necessarily limited to) targeted face-to-face outreach in locations where men who have sex with men and transgender people gather, so-called “cyber outreach” via internet and social media platforms and peer-driven recruitment models wherein our clients help us recruit additional members of our targeted audiences.

Whatever the “reach” model, these activities have traditionally focused on provision of correct information about HIV transmission and prevention, the promotion of condom use and the provision of condoms and referral to STI and HIV counselling and testing services that are friendly to men who have sex with men and to transgender people. There has been less focus on building clients’ motivation and skills for behaviour change (safer sex, HIV testing, etc.) or on providing specific information or assistance to access testing services. Outreach workers have been less likely to address alternative sexual risk-reduction strategies (including pre-exposure prophylaxis (PrEP) or sexual behaviours) or to discuss more entrenched issues, such as managing drug use and HIV risk behaviour; dealing with sexual or gender identity issues; or handling stigma, discrimination and/or gender-based violence that occurs due to sexual or gender identity or preference, HIV status or involvement in sex work.

This manual is intended to help outreach workers expand their messages and topics for discussion and move beyond simplistic, black-and-white messages, such as “no condom, no sex”.

What does it take to get more people tested?

Traditionally, outreach staff have been primarily responsible for raising awareness about the existence of HIV testing services and, in some cases, providing (accompanied or unaccompanied) referral to those services. In some settings, this is still the case; however, increasingly, HIV programming for men who have sex with men and transgender people is recognizing the potential for “task shifting”—moving the responsibility for some services, previously solely the domain of the formal health care sector, onto lay health workers, including outreach workers. There are a number of models by which this can be accomplished, including HIV testing services delivered through community-based drop-in centres or mobile clinics, outreach-based rapid testing delivered by an outreach worker (what the World Health Organization refers to as “test for triage”) and even self-testing in some settings, which may or may not be assisted by a professional or lay health worker. Testing regulations differ from country to country, so it is difficult to identify one single gold standard testing model. But it is safe to say that, across this region, outreach workers are increasingly being responsible for both referral to testing and for the actual delivery of high-quality, HIV counselling and testing services that are friendly to men who have sex with men and to transgender people.

What happens if a client tests positive?

The role of the outreach worker does not necessarily stop when a client tests HIV positive. One of the biggest “leaks” in the HIV service cascade is among individuals who test positive but do not initiate treatment. There are numerous reasons for this, including clients’ beliefs (often outdated) about HIV treatment, such as often-

unfounded fears about the side effects of HIV medicines, concerns about stigma and discrimination and structural barriers that can make it difficult to access treatment. Outreach workers can give up-to-date and accurate information about treatment. They can work with clients to build up motivation, seek services, provide emotional support and assist in overcoming any structural barriers to treatment, such as confusing clinic processes or regulatory issues. There are various models by which this might be accomplished—in some programmes this might be the role of the outreach workers; in others it might be the responsibility of a specialized worker called a “case manager” or a “clinic navigator”. There is no requirement that the person fulfilling this role be a person living with HIV, but case managers who themselves are living with HIV can speak with additional experience when supporting a newly diagnosed client.

If your role as an outreach worker includes these responsibilities, we can't emphasize enough the importance of keeping regular communication with your client for follow-up. There are numerous means by which you may prefer to maintain communication with your client: via LINE or WhatsApp or Facebook messenger, SMS or telephone. You should be available to provide information, encouragement and support 24 hours a day, particularly if a client was recently diagnosed or recently started treatment.

Once my client is on treatment, I'm finished—right?

Another important leak in the cascade is among clients who start antiretroviral treatment but drop out, perhaps because they cannot make their appointment schedule or they are having issues handling the side effects; or, in some cases, because they feel better and think that treatment is no longer necessary! Stopping treatment threatens the health of the HIV-positive client. Additionally, a person living with HIV who is not adhering to treatment is much more likely to transmit HIV to others than a person who is sticking to their treatment. This is why it is critical that we support HIV-positive clients to adhere to treatment.

Here also, outreach workers have a significant role. Case managers or clinic navigators may follow up with clients who are on antiretroviral treatment via telephone, home visits or other activities. In doing so, they should provide both practical and psychosocial support to help clients stick to their treatment. But through their activities, outreach workers can also help by identifying clients who are on antiretroviral treatment who are lost to follow-up and by working with them to reconnect with health care services. Because the treatment-initiation guidelines have changed, this assistance is especially critical. Previously, HIV-positive clients typically did not start treatment until they reached a certain stage of infection (often determined by their CD4 count (a type of white blood cells). The World Health Organization now recommends immediate treatment for all HIV-positive individuals, and more countries are beginning to adopt these guidelines. There are many HIV-positive individuals in our communities who were denied antiretroviral treatment under the previous guidelines who would now be eligible. Peer outreach workers can help locate these individuals and help them access treatment.

What about clients who test negative?

The HIV service cascade has typically focused on service uptake and retention of people who test HIV-positive. But many people test HIV-negative and are never seen again. This is another leak in the cascade—people at high risk of infection (such as sexually active men who have sex with men and transgender persons) should take an HIV test regularly. If ever they become infected, they can start treatment as soon as possible. Regular HIV testing is also a good way for clients to access new options for HIV prevention, such as PrEP. Outreach workers should follow up with their HIV-negative clients to encourage regular testing and to help them access (and adhere to) PrEP, if this is a prevention option they want to try.

This sounds like a lot of work—why am I doing this?

People choose to become outreach workers for all kinds of reasons:

- You may be concerned about the HIV epidemic in general.
- You may be living with HIV and want to prevent your friends from becoming infected.
- You may have been introduced to this work by friends and would like to join in.
- You may have confidence in your ability to make a difference with your friends or with strangers, using your charisma and social skills.
- You may like the feeling that you are useful to society or to your community.
- You may be interested in advocacy work among the general public to help reduce stigma and discrimination against men who have sex with men and against transgender people.
- You may enjoy the opportunity of networking and meeting new people.

What do I say when someone asks, “Why do YOU care about my health?”

This question is sometimes asked in a cynical manner, almost like “please go away and mind your own business”. People asking such a question often do not know or do not like to be reminded that they may be putting themselves (and their sex partners) at risk of a serious disease; their reaction can be one of indifference, disinterest or even hostility. It is not easy to deal with this attitude, but you could respond by saying:

- 1 “I care about our community, ‘our kind of people’. I do not want you or my friends to be affected by this disease, which is easily preventable and possible to treat.”
- 2 “I care about it because HIV and other STIs are easy to prevent. Think about your family—if you catch a disease that is preventable, who will take care of you or your family?”

- 3 "I care about it because if you are infected with HIV already, it is not too hard to control the virus using modern medicines, and treating it will keep you and your partners healthier."
- 4 "How would you feel if you did not know you had HIV but had infected others just because you did not like to use a condom?"
- 5 "I care about HIV because many men having sex with men and many transgender people are infected with it already."
- 6 "I care because it is a basic right that we should have access to information and HIV treatment, and I can help people access such treatment."

What are the basic principles for outreach and HIV service workers?

- 1 **Confidentiality:** Personal issues raised by your client should remain a secret. You can use examples about people who you know in your work or from your social network, but make sure the person you are talking with can never identify them. You need to respect confidentiality to keep the trust of your friends; without trust, you cannot do your work. This principle is especially critical because many health care tasks, including HIV testing, are slowly shifting to outreach workers.
- 2 **Respect:** Always accept the person you talk to, even if they do not believe what you say or refuse to take your advice or if they have different opinions. Do not judge them. Remember that it might take time for them to become aware of the right thing to do for their health and the health of others (such as getting tested for HIV, enrolling in treatment if testing positive for HIV or using condoms). By disparaging them, you might lose them forever; by respecting them and continuing to do so, you might convince them eventually.
- 3 **Anonymity:** If a person you talk to does not want to reveal their name or age or other personal information that is fine. Respect and honour it!
- 4 **Benevolence:** Always speak to your client from the perspective that you have their best interest in mind.
- 5 **Reducing harm:** Your aim is to reduce your client's exposure to HIV or other STIs and to encourage them not to expose others to HIV or STIs. Do not expect them to adopt safer sexual practices right from the start. It will take time and effort; small steps towards greater safety are the norm, as will be discussed in a later unit.
- 6 **Appropriateness:** Always try to provide information, support and skills that are in line with your client's situation. Many outreach workers tend to repeat the same message, again and again. Try to figure out what information or service your client needs (see [Unit 7](#)). In particular, avoid using simplistic slogans, such as "no condom, no sex". Reality is too complicated for simple solutions, which often take time, effort and skill to gradually implement.

- 7 Be professional:** If you encounter a client who you are sexually attracted to, refer him to a fellow outreach worker. It is not appropriate to flirt or date with clients or potential clients during your work. During working hours, you represent the organization that recruited you. You are a professional outreach worker and should have strict rules about your behaviour during working hours and in your free time. You should never use your position as an outreach worker to get your client's phone number or Facebook address if your motivation is not entirely professional.
- 8 Being unable to answer a question is fine:** It is better to provide no information than wrong information. It is fine to say to someone that you cannot answer a question and that you will come back to this person later. But make sure you do go back to them later with an answer. Keep yourself updated with new information from your supervisor, from the internet and from this manual.
- 9 Diffuse information through your clients' networks:** Encourage clients and peers to take a proactive role to inform, educate and influence their friends to get tested for HIV regularly and to have safer sex, or you may even ask clients and peers to refer their friends to you.
- 10 Be empathetic:** Try to always place yourself in the position of the person you are talking to; try to see the challenges they face in getting tested for HIV, treated for HIV or changing any risky behaviour. Then work with your client to analyse and overcome these challenges. Be patient and do not become angry or discouraged if your friend does not (yet) follow your advice or if they relapse again into unsafe sex.
- 11 Show evidence of what you do:** Make sure you record your work, and ensure that supervisors learn about it. Keep detailed records and use monitoring tools. This will help you as well as the organization you work for to improve the programme over the long term.

Unit 2

Basic information about HIV

What is a virus?

A virus is an organism that is so small it is invisible to the human eye. There are many types of human viruses, and not all of them affect us in the same way. For example, the flu is caused by the influenza virus; this virus can be transmitted through the air when we cough or sneeze. There are also viruses that are transmitted through food, which can upset the stomach. The human immunodeficiency virus (HIV) can lead to the acquired immunodeficiency syndrome (AIDS), which is a serious disease. If HIV is not treated, it usually leads to death. HIV is transmitted via blood, semen and pre-cum, breast milk, vaginal fluids and rectal fluids. Fortunately, HIV is not as easy to transmit as the flu is, and its transmission can be prevented relatively easily.

How does HIV affect the human body?

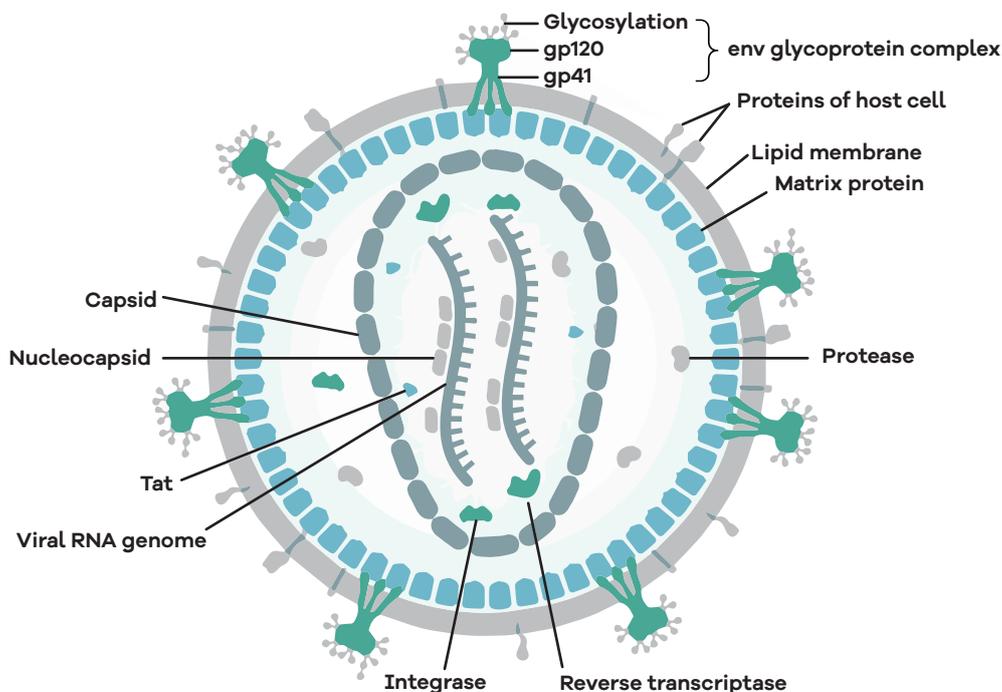
The body's ability to fight off any disease is called the "immune response" and is managed by the immune system. It consists, among other things, of "defence cells" in our blood, which are known as the white blood cells, including CD4 cells (which is a subgroup of white blood cells). Normally, these CD4 cells help attack and destroy diseases and infections that enter the body. HIV attacks the immune system by killing these cells. After some time, with HIV continuously but slowly attacking white blood cells, the immune system will wear down and start to become less effective. As a result, diseases and infections, some of which usually have little success in attacking the body, may find an open window through which they can do their damage. People infected with HIV die after their immune system is brought completely down. This is the AIDS stage in the disease progression. The process of attacking the immune system can take many years, during which the infected person does not have any symptoms of disease but is infectious and able to transmit the virus to others.

What is AIDS?

A syndrome is a set of symptoms of disease that often occur together. With AIDS, these symptoms are a result of severe damage to the immune system. When the immune system is seriously damaged by HIV it becomes unable to defend the body against certain "opportunistic" infections and tumours. These are also known as HIV-related diseases. At this stage, the human body is highly vulnerable to a wide range of possible diseases, including tuberculosis, pneumonia and cancer. Unlike most other diseases, people with AIDS may experience different clinical problems, depending on which opportunistic infections they catch or develop. For this reason, AIDS cannot be diagnosed by a single symptom or sign, it can only be confirmed by a doctor.

FIGURE 2

Diagram of an HIV virus particle



Source <http://en.wikipedia.org/wiki/HIV>.

What is the difference between HIV and AIDS?

When a person is infected with HIV, they may look well and feel as healthy as any other person. But without treatment and after continued attacks by HIV on the immune system, the person may develop illnesses and symptoms and become weak. At this point, the HIV infection has progressed into the AIDS stage. This process can take between 3 and 10 years from the moment of initial infection, depending on several factors.

A person with HIV may show no physical symptoms of any disease for a long time. This stage of infection is called “asymptomatic” (meaning, no symptoms). As HIV continues to gradually destroy the immune system, a person may develop certain illnesses related to HIV infection. Having a number of these specific illnesses together means the HIV infection has become “symptomatic” and becomes visible as AIDS. If a person with symptomatic HIV, or AIDS, has no access to medicines, care and support, they will most likely eventually die of illness.

A person can often lead a normal life without knowing that they are infected with HIV. It is therefore easy to understand how someone may, without knowing it, transmit HIV to others. HIV also makes a person more vulnerable to other STIs.

How long will it take before a person with HIV develops AIDS?

Depending on a person’s physical and mental health as well as other factors, including the extent to which a person with HIV has support and a healthy lifestyle with plenty of rest, sports, proper nutrition and peace of mind, it can take many years to develop AIDS, if at all. From the point of initial infection, it can take between 5 and 10 years for most “types” of HIV; most often, it is between 9 and 10 years. However, scientists recently discovered a new subtype of HIV, called CRF19, which develops from HIV into AIDS three times faster, at around three years after infection. With the increased availability of HIV treatment, if a person with HIV is under medical supervision and promptly starts treatment with antiretroviral medicines (see Unit 11), they may live a long and healthy life. A recent study conducted in the United States found that a 20-year-old person with HIV who was taking antiretroviral drugs and who was under regular medical supervision could expect to live, on average, till the age of 71.¹

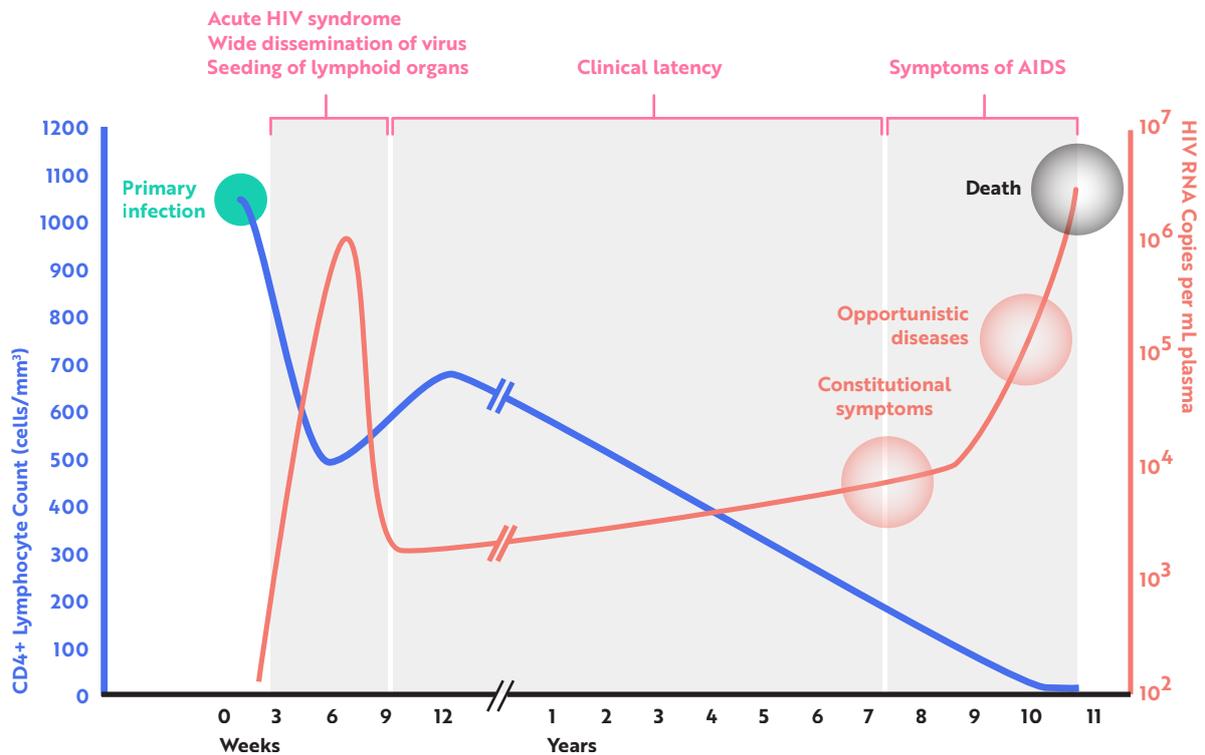
How long will it take before a person with AIDS dies?

When a person who has entered the AIDS stage does not have access to appropriate antiretroviral medicines and medical care, he will usually die within 12 to 18 months. When a person has access to medical care and antiretroviral medicines (see Unit 11), life and health can be extended for many years; many people will die of old age rather than of complications associated with HIV or AIDS. With increasing access to antiretroviral medicines, more people with AIDS are successful in bringing down their HIV levels and recovering their immune system, returning to the asymptomatic stage of their HIV infection and living long and healthy lives.

1

See <http://pag.ias2013.org/Abstracts.aspx?AID=2451>.

FIGURE 3
Progress of HIV disease without treatment



Source <http://en.wikipedia.org/wiki/HIV>.

Is it possible to see whether a person has HIV?

No one can see or feel from the outside whether a person has HIV. There are no characteristics or symptoms. Many people have misconceptions about this. They think people with HIV are particularly thin or that their skin looks different. This is nonsense. The only way to know whether anyone is infected is with a clinical test (blood or saliva test).



See **Unit 12** and see **Annex 1** for a list of clinics in your country.

Who gets HIV?

Anybody who is exposed to the virus can become infected. Typically, exposure occurs during risky behaviour. But risky behaviour refers to a range of activities, from unprotected sex to the re-use of a syringe or the distribution of unchecked blood transfusions. Many people think that people who look fat, healthy or are of a higher social class cannot contract HIV or that only poor people, sex workers

and drug users get HIV. This is not true. A virus cannot know whether a person is of high social class or not or whether they are fat or thin. HIV is transmitted by behaviours, and people who engage in these behaviours can be exposed to HIV and become infected (including through blood transfusion, if the blood supply is not properly screened for HIV, but this is rare these days). It is not related to class, looks, age, education level, profession, ethnicity or anything else. The only exception to this is with babies, who can become infected from their HIV-positive mothers without engaging in any risk behaviour.

What are the body fluids that transmit HIV from one person to another?

Body fluids that contain and are able to transmit HIV include:

- 1** blood;
- 2** semen and sperm, including pre-cum;
- 3** fluids that exist in the female vagina;
- 4** fluids that are secreted in the rectum; and
- 5** breast milk.

Unit 3

HIV and its transmission

How can HIV be transmitted?

For the virus to be transmitted, one of five body fluids (blood, semen/sperm, including pre-cum, vaginal fluid, rectal secretions or breast milk) of an HIV-infected person needs to enter the bloodstream of a person who is not infected with HIV. Even if this happens, there is only a relatively small chance that transmission occurs—it is never a 100% certainty ([Table 1](#)).

The most efficient route of transmission is HIV-infected blood that directly enters the bloodstream of a non-infected person, for example, by sharing needles and syringes with an HIV-infected person or by receiving a blood transfusion with HIV-infected blood.

HIV can be transmitted through sexual activity. The easiest way for sexual HIV transmission to occur is through unprotected anal sex between an infected person and an uninfected partner. Unprotected vaginal sex also carries a risk for HIV transmission. The risk of HIV transmission through condomless oral sex is extremely small. It is deemed only possible if a person has problems with oral hygiene leading to bleeding gums or sores. Even then, the chance of infection is extremely small. However, the risk of STI transmission through condomless oral sex is much higher. The risk for the receiving partner in anal, oral or vaginal sex is higher than for the insertive partner.

HIV also can be transmitted from an HIV-infected woman to her child during pregnancy or childbirth or through breastfeeding.

Is sex between men who have sex with men and transgender people always risky for HIV infection?

No. If two men have sex, there is only risk for HIV transmission if one of the two partners is living with HIV. The problem is that we often are not sure if someone has HIV or not. Because anal sex is the easiest way of sexually transmitting HIV, men who have sex with men and transgender people who would like to reduce their risk can enjoy sex in other ways that do not involve penetration or ejaculation inside the partner's body, like hugging, body rubbing, erotic massage, kissing, licking and thigh sex.

Many men, however, enjoy anal sex and find it difficult or impossible to do without it. Fortunately, when one partner is HIV-positive, the chances of infecting the negative partner are low if condoms and water-based lubricant are used correctly and consistently during anal sex. The chances are even lower if the infected partner is on treatment and is taking HIV medication every day.

Of course, the challenge is that many people do not know they are HIV-positive, which is why it is important to keep using condoms and to consider other prevention measures, like the daily use of PrEP for people who risk exposing themselves to possible infection but are still HIV negative (see [Unit 6](#)).

In short, it is relatively safe for men to have penetrative sex with other men when they use condoms and water-based lubricant consistently. Even more effective is the use of antiretroviral drugs, either for prevention (such as PrEP for people who are HIV-negative) or to prevent infecting others (antiretroviral treatment, for people living with HIV), together with condom and lubricant use.

Which sexual behaviours are no risk, low risk, medium risk and high risk?

A wide range of sexual behaviours are cited in [Table 1](#). The possibility of HIV transmission is defined as "no risk" for HIV transmission (safe sex), "low risk" (extremely small chance for HIV transmission that could be ignored after informed decision-making), "medium risk" (small chance for HIV transmission) and "high risk" (the highest chance for HIV transmission).

As well as always promoting condom use to make penetrative sex safer, as an outreach worker, you should also discuss the possibility of avoiding high-risk (especially anal) sex and trying out other less-risky sexual acts. The table may help you think of suggestions to make during your work.

TABLE 1
Risk level of sexual behaviours

PRACTICE	RISK	NOTES
Abstinence	●	
Masturbation	●	
Unshared sex toys	●	If there is no exchange of bodily fluids between different users.
Phone sex	●	
Cyber or webcam sex	●	
Hugging	●	
Massaging each other	●	
Telling each other sexual fantasies	●	
Watching pornographic movies	●	
Rubbing genitals together fully clothed	●	
Rubbing genitals together without penetration, unclothed	●	Provided there are no lesions on the genitals and no exchanges of body fluids.
Manual sexual stimulation of the genitals	●	Provided that basic hygiene is ensured and if there are no cuts or broken skin on the hands and no contact with semen.
Mutual masturbation	●	There is no risk if there are no cuts or broken skin on the hands and if there is no contact with semen.
Sharing sex toys that have been cleaned or using sex toys with a new condom	●	Sex toys need to be cleaned with soap and water after each use. It is even better to use a condom on the sex toy and remove it after use.
Rubbing sweaty bodies together	●	No HIV transmission risk, although some STIs (herpes and scabies, for instance) can be transmitted through contact with skin not covered by a barrier if there are lesions.
Biting as part of sexual play	●	It is no risk if there are no lesions or open sores or cuts in the mouth and provided that the biting does not cause the person to bleed.
Deep (tongue) kissing	●	There is no risk if there are no sores or cuts in the mouth or bleeding gums. Also, there is no risk due to saliva; saliva can contain antibodies to HIV but not the virus itself.
Oral sex on a man with a condom	●	If the condom is used correctly, there is no risk. Some STIs can be transmitted through contact with skin not covered with a barrier. Risk also depends on dental and oral hygiene. Make sure to pick a condom that has a nice flavour! (Unit 7)
Oral sex on a man without a condom	●	STIs can be transmitted through oral sex from the person receiving it to the person giving oral sex (the person who does the sucking). However, risk for HIV transmission in oral sex is extremely low and is much lower than that of anal or vaginal sex. It is even safer if no ejaculation in the mouth occurs.
Fingering or fisting	●	Provided that basic hygiene is ensured and if there are no cuts or broken skin on the hands and no contact with semen or blood (fisting has a much greater chance of tearing rectal tissues), this practice can be safe.
Anal sex with a condom	●	The risk of condom breakage is greater than for vaginal sex. It is safer if water-based lubricant is also used. Some STIs can be transmitted through contact with skin not covered by a barrier.
Licking the anus	●	STIs can be transmitted through oral sex, but the risk is lower than for penetrative sex. The risk for the person licking is the same as in kissing or oral sex. However, parasites can be transmitted, too, which can be particularly unhealthy for HIV-infected people. There is no risk when a dental dam is used.
Anal sex with multiple partners; condom use every time	●	Having multiple sex partners increases probable risk; however, correct and consistent condom use lowers risk. Some STIs can be transmitted through contact with skin not covered by a barrier, and therefore sex with multiple partners increases STI risk.
Withdrawal of the penis before ejaculating while having anal sex without a condom	●	HIV can be present in pre-ejaculate, and therefore risk of transmission is high. Withdrawal may slightly reduce the risk for HIV transmission but is unlikely to reduce the risk of other STIs.
Anal sex without a condom	●	Anal sex is one of the highest risk activities. The receptive partner is at greatest risk because the tissue lining of the rectum is more susceptible to tears or lesions during intercourse. Risk increases if a person has unsafe sex with many partners.
Sex with a circumcised man without a condom	●	There is evidence that circumcised men are at reduced risk for getting STIs and HIV because the absence of foreskin prevents bodily fluids from becoming trapped and exposure to infection is decreased. However, this does not mean that male circumcision prevents STI or HIV transmission, nor does it mean that infected circumcised men are less likely to transmit infection to their sexual partners. Both circumcised and uncircumcised men need to use condoms and practise safer sexual behaviours.
Anal or vaginal intercourse using oil-based lubricants and condoms	●	Oil-based lubricants can seriously damage condoms and increase the likelihood of condom breakage during intercourse.
Using the same condom twice	●	Condoms should not be re-used because it is not hygienic and increases the likelihood of breakages and slippage.
Using more than one condom at the same time	●	Using more than one condom increases the likelihood that the condoms will break or slip off during sex.

● No risk ● Low risk ● Medium risk ● Medium to high risk ● High risk

Source Adapted from MSM outreach training manual. Hanoi, FHI Vietnam, 2005 (?)

Can HIV be transmitted through anal sex?

Yes. The tissue inside the rectum is delicate; therefore, lesions and tears may occur during anal intercourse. This creates entry points for STIs and HIV to enter the bloodstream via the infected semen of the insertive partner. The chance of this occurring is significant when intercourse takes place without condoms, if an HIV-positive partner is not using antiretroviral treatment and/or if the HIV-negative person is not using PrEP (see [Unit 6](#)—please note that even when using PrEP or if an HIV-positive partner is on antiretroviral treatment, condom use is recommended to further reduce the risk of transmission of HIV as well as of other STIs).

Transmission chances are close to zero if the infected “inserter” is on antiretroviral treatment and has an undetectable HIV viral load. An infected “bottom” person can infect a “top” person if no condoms are used and if the bottom is not on antiretroviral treatment with a suppressed viral load. In this case, infected blood caused by small ruptures in veins and blood vessels lining the rectum and other rectal secretions can enter the bloodstream of the penetrating partner via the penis. For STI and HIV infection, anal sex remains the most high-risk sexual activity.

Does it matter whether someone is a “top” or a “bottom” person when it comes to HIV risk?

Yes, it does, very much so! On average, when a receptive person (bottom) is penetrated by an HIV-infected person, the chance of infection is 1.4% per sexual act. Receptive anal sex is higher risk than insertive anal sex: when an HIV-negative insertive person (top) penetrates an HIV-infected person, the chance of infection is 0.11% per sexual act.²

It is important to emphasize here that these percentages can be much higher if one or both partners have an STI or if the partner living with HIV is in the stage of acute HIV infection or in the symptomatic phase, when the HIV viral load is high and infectiousness increases. The percentages provided here are population-based estimates, which can vary widely per individual.

For someone who is HIV-negative who is having unprotected sex with someone whose HIV status they are not sure about or who is HIV-positive, it is a sensible prevention strategy to be the inserter in anal intercourse and to not let the person with HIV or of unknown status penetrate! This can reduce the chance of HIV transmission by a factor of 12.5.

2

See <http://www.cdc.gov/hiv/policies/law/risk.html>.



An Ottoman drawing depicting two men having anal sex, nineteenth century

Source <http://www.gay-art-history.org/gay-history/gay-art/turkey-gay-art/sawaqub-al-manaquib-gay/gay-sex-liwat-saki.html>

Can HIV be transmitted through vaginal sex?

Yes. The chance of transmission is smaller than in anal sex. The chance for transmission of an infected man to an uninfected female is two times greater than the reverse because the area in the vagina through which HIV can penetrate the body is larger than the area in the tip of the penis. The chance of infection from an HIV-positive man to an HIV-negative woman is 0.08% per sex act; with the other way around, it is 0.04%. But remember, these percentages can be much higher if one or both partners have an STI or if the partner with HIV is in the stage of acute HIV infection or in the symptomatic phase, when the viral load is high and infectiousness increases. These percentages are population-based estimates, which can vary widely depending on the stage of infection, the presence of STIs as well as other factors.

Can HIV be transmitted through oral sex?

It is assumed that HIV can be transmitted through oral sex; however, the chance of transmission is extremely small. Transmission is assumed possible if a person has bleeding gums or cuts in the mouth and that the risk is bigger for the one who sucks than for the one who is being sucked. Other STIs, including chlamydia, gonorrhoea, herpes and syphilis (see [Unit 10](#)), are known to be transmitted through oral sex. The virus that causes genital warts (human papillomavirus, or HPV) is also transmitted orally, as are intestinal parasites (amebiasis) and the viruses that cause hepatitis A or B infection (see [Unit 10](#) and [Annex 2](#)).

Why is it so difficult to transmit HIV orally?

HIV needs to enter the blood stream of an uninfected individual for infection to take place through one of the body fluids mentioned (blood, semen/sperm/pre-cum, vaginal fluids, rectal secretions or breast milk). During oral sex, it is difficult for HIV to enter another person's body because the virus is likely to be in the mouth for only a short time and then is likely to be killed by the acids in the stomach. Just to be safe, it is advised not to let semen of a man come into the mouth.³

What do I say when someone asks, "If someone ejaculates in my mouth, should I swallow or spit it out?"

You can advise that they either swallow quickly or spit it out. The stomach acids will quickly kill the virus. Theoretically, it is not sensible to have infected spunk come in contact with mucous membranes (inside the mouth and throat) for very long. Minimizing this contact decreases the risk that HIV will be absorbed. So spit when possible or swallow quickly.

What is genital enhancement and what are its risks?

Some men try to enhance their or their partner's sexual pleasure by changing the shape, size or hardness of their penis. They may have pearls, polished glass or other objects inserted into the foreskin or shaft of their penis, just under the skin. Some men inject silicone, penicillin or some type of oil (such as olive oil) into their penis, which sometimes has serious medical consequences. Some people also use a type of modified condom that is not authorized for sale, such as a hairy condom or a condom with plastic pieces embedded in it. These condoms are dangerous for both partners because they are not effective in preventing HIV or STI infection. They can cause irritations or lesions to the inner surface of the rectum or vagina that then eases the transmission of HIV to the receptive partner.

If a friend of yours or a client is contemplating doing this, you should warn them about the negative consequences this can have for themselves and their sexual partners. There are many unauthorized so-called "doctors" who do this kind of operation (inserting things), often under poor hygienic conditions and using unauthorized methodologies. Some men have lost their ability to have erections as a result or have developed other complications, including a "dying" of the skin or parts of the penis, or cancer.

You should promote only condoms that are approved for use by health authorities.

3

See the latest updates on oral sex transmission risk at: <http://www.cdc.gov/hiv/risk/behaviour/oralsex.html>.

Does circumcision protect against HIV?

Studies have proven that among heterosexual men having vaginal sex with women, circumcised men had a much lower risk of getting HIV from an infected woman, compared with men who are uncircumcised. This is because in uncircumcised men, the inner surface of the foreskin of the penis provides an opportunity for HIV to access the bloodstream via a type of cells that is present there, called 'Langerhans Cells'. If the foreskin has been removed, it means less opportunity for the HIV virus to access the body of a man through the penis. Logically, there is no beneficial protective effect of circumcision for the receiving partner. Because there is still a risk for HIV transmission from an infected partner, circumcised men, like those who are uncircumcised, must continue to use condoms.

For men practising anal sex, there is some evidence that circumcision has a protective effect. But of course, this is only the case when a man is the top (insertive) and never, ever the bottom in unprotected anal sex! Because many men have experienced being bottom as well as top during their lifetime, circumcision is not generally a recommended prevention strategy for men who have sex with men or for transgender people.

Is group sex riskier than sex with only one partner?

In principle, the more partners someone has unprotected sex with, the more risk for HIV infection there is; and this is true whether someone has a different partner every week or two partners at the same time every two weeks. However, when having sex with two or more partners at the same time, it is important to remember that the inserting partner can transfer HIV-infected body fluids from the rectum of one partner to the rectum of another partner if he uses the same condom. An STI also can be transmitted in this way. The golden rule is that everyone should always take the same basic precautions for safe sex, no matter the sexual encounter context: always use a new condom with each partner when engaging in anal sex.

Can HIV be transmitted by rimming (licking the anus)?

The chance of HIV transmission when the anus is stimulated and licked by a human tongue is extremely small and can be considered negligible. But other infections can be transmitted, especially those transmitted via human excrement: hepatitis A and B, for instance, and certain parasites and bacteria are the most common.

Can HIV be transmitted by kissing or hugging?

No. These activities do not lead to the possibility of HIV-infected blood or semen entering the bloodstream of a non-infected person.

Can HIV be transmitted by mosquitoes?

No. First of all, HIV cannot survive for long outside the human body. Mosquitoes do not inject blood into another human being; they suck and “eat” it. The “H” in HIV stands for “human”, meaning that the virus can live only in the human body.

Can HIV be transmitted by having a bath in the bathroom of someone with HIV?

No. The reason is that there are no infected body fluids of the infected person entering the body of an uninfected person in a bathroom.

Can HIV be transmitted by sharing toothbrushes with an infected person?

No. Transmission of HIV in a household setting (without sexual contact or needle sharing) is almost impossible. HIV does not survive long outside the human body. After getting out of an infected person’s body, it would have to find a way into the body of an uninfected person; it is difficult to imagine how this could happen without having sexual intercourse or sharing needles!

Can HIV be transmitted by sharing razors or other sharp utensils?

In theory, if fresh blood remains on a sharp object that is then immediately used by an uninfected person who is then also immediately cut with it, transmission is possible. In practice, however, HIV transmission in this way is unheard of. Just to be sure, however, it is good to advise people living with HIV not to share razors with others.

Unit 4

Prevention of HIV infection

What do I say when someone asks, “How can I prevent myself from getting HIV?”

You need to first emphasize that while HIV infection can now be treated, it cannot yet be cured. And then you should stress that is why it is so important to avoid it. The most radical way to prevent HIV infection is to not have sex (intercourse, oral or anal). For most people, of course, this is not a realistic choice. Sex is part of our life and we enjoy it, and that is fine.

What are options for preventing HIV while still enjoying a sex life?

The most common option—which is not easy or possible for everyone—is to use a condom and water-based lubricants every time someone has anal or vaginal sex (see [Unit 5](#)). The latest US Centers for Disease Control and Prevention estimates suggest that condoms are generally 80% protective against HIV. This is less than you might have thought: the reason is because condoms are often not used correctly or not available in the right size, causing breakage or slippage. You should advise friends and clients that when they find a well-fitting condom and learn the skill of using it correctly, the protective effect of condoms can be much closer to 100% (see [Unit 5](#)).

A second and more recent option is to use Pre-exposure Prophylaxis (PrEP) consistently, which can reduce the chance of infection by up to 96% (see [Unit 6](#)). When both condoms and PrEP are used, the risk is reduced by 99.2%.

For people who have sex with more than one person, strategies to reduce their risk can be to reduce the number of partners and sexual encounters they have. They can do this, for example, by masturbating more, which is a safe (and fun) way of reducing their urges and desires for sex (see [Unit 7](#)).

If they choose to not reduce the number of sex partners or encounters, they can at least shift away from anal sex. By having more oral sex and less anal sex, sexually

active people can dramatically reduce their risk for getting (or transmitting) HIV. Instead of oral sex, they can also engage in mutual masturbation, thigh sex, rubbing or hugging. Other super-safe options include webcam sex or phone sex (see [Unit 7](#)).



**KEEP CALM
AND
ENJOY
ORAL SEX**



You can read more about HIV prevention techniques at:

<https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/>

Can people reduce their risk of HIV without bothering with condoms or PrEP?

A study in Sydney, Australia found that even when men do not use condoms or PrEP or even when none of their partners takes antiretroviral treatment, they still can employ certain strategies to reduce their risk for HIV infection (or for transmitting HIV to their partners, if they are already HIV-positive).⁴ Three of these strategies were found to significantly reduce the chance of getting HIV, when compared with men who did not use any strategy (and no condoms/PrEP). These strategies are not as effective and not as safe as always using condoms or PrEP, but nevertheless, they may offer some limited protection against HIV infection.



Please note that these strategies help reduce some infection risk but only for people who get tested regularly, which is not the case in many Asian settings. These strategies are definitely not as safe as using condoms, lubricants and PrEP consistently. The study also found that men who practised these strategies had higher levels of STIs other than HIV.

4

See <http://europepmc.org/articles/pmc2768371>.

First, there is what the researchers call strategic positioning. This means that if a person living with HIV has sex without condoms with a male partner who is HIV-negative or who is not sure about his status, then the person living with HIV is the receptive partner in anal intercourse. This is because, as discussed previously, the receptive partner is up to 10 times more likely to get HIV from an infected insertive partner than the other way around.

Second, there is negotiated safety. This means that two HIV-negative men date each other in a steady relationship in which they practise unsafe sex, but they promise each other that when having sex with others, they will always be safe. If an “accident” occurs, meaning that one of the partners break their promise, they must tell their steady partner. If two men are going to enter into this type of arrangement, they should, of course, get tested first to ensure that they really are both negative. And if they have sexual activity outside their steady relationship, they must keep testing for HIV regularly.

In the Sydney study, while both strategies significantly reduced HIV infection risk, they were not as effective/safe as consistent condom use.

The third strategy is called serosorting. This means that HIV-negative men only have (condomless) sex with HIV-negative men, and men living with HIV have sex only with other men who are living with HIV. This led to an intermediate risk of HIV infection—higher than when consistently using condoms or when employing one of the other two strategies, but lower than having unprotected sex indiscriminately, without exchanging information about presumed serostatus. Serosorting is usually not recommended because some HIV-negative men may in fact be positive but the virus may have entered their body so recently that it does not show up in an HIV test yet. The period in which a person is infected already but the virus cannot yet be detected is called the “window period”. It is also possible that a presumably HIV-negative person had his last test quite a while (and quite a few partners) ago. He may have become infected already but is still relying on his last (negative) test result. Even so, serosorting reduced the chance of transmission in the study; it was simply better than having unprotected sex with partners of whom the serostatus was not known or discussed but not as good as the other two strategies or consistent condom use.



For more information in non-scientific language, see www.janwillemdelindvanwijngaarden.com/single-post/2016/09/09/Alternatives-to-condom-use-can-help-reduce-HIV-transmission-among-gay-men

Unit 5

Basic information about condoms and lubricants

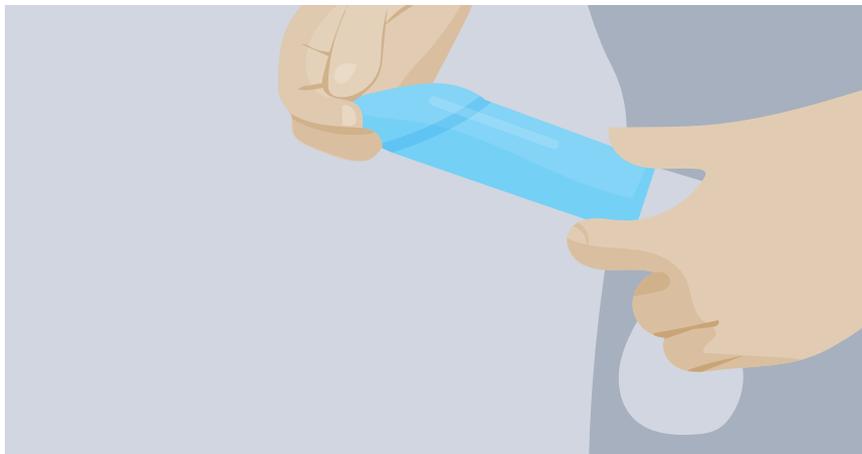
Is withdrawal from the rectum while having condomless sex effective to prevent HIV infection?

No. This is due to the infectiousness of pre-cum of the insertive partner and the risk of transmission from an infected bottom to an uninfected top, which does not have anything to do with the moment of ejaculation.

What is a male condom?

A condom is like a tight-fitting penis-shaped bag, usually made of latex or, more recently, polyurethane, that is used during sexual intercourse. It is put on a man's erect penis and physically blocks and captures ejaculated semen, preventing it from entering the body of a sexual partner. Condoms are used to prevent unintended pregnancy and transmission of STIs (such as gonorrhoea, syphilis, hepatitis B and C and HIV).

Latex condoms are the most common condoms in Asia and are usually lubricated.



Source <http://www.nlm.nih.gov/medlineplus/ency/imagepages/17082.htm>.



There is a video on YouTube that shows how a condom is put on and taken off. It is explicit—a real person is demonstrating—so make sure you are in a private setting when you watch it: <https://www.youtube.com/watch?v=F7DizZTkfi4>

For what types of sex are condoms used?

Condoms can be used for anal, vaginal or oral sex. From an HIV-prevention perspective, using condoms for anal and vaginal sex is more crucial than using them during oral sex.

What is lubricant?

Lubricant (often referred to as “lube”) is a slippery gel or paste made of water and some other substances. Lubricant serves to reduce friction with the vagina, the anus or other body parts when using it in penetrative sex, especially when applied to a condom. This enhances sexual pleasure, enables penetration of the rectum (which can be narrow) and prevents latex condoms from tearing or breaking. Many condoms are packed already lubricated. But for anal sex, the amount of lubricant inside a condom package is not enough. Additional lubricant should be applied. Lubricant is sold in tubes or in plastic containers (see picture) and sometimes in handy pocket-sized sachets.



Source http://www.iloveu.com.sg/Prd1_DUREX_condom.html

What types of lubricants are there?

Lubricants are usually divided into two types: water-based and oil-based lubricants. Only water-based lubricants (including Durex and K-Y Jelly) are safe to use with latex condoms. Oil-based lubricants (this can be Vaseline or any type of cream, including Nivea or sun lotion) are not safe to use with latex condoms—they can be used with female condoms or with polyurethane condoms (which are not widely available in most Asian countries).

There are several subtypes of water-based lubricants—some include smells or odours, some are edible and some give a special effect (they cause a tingling or warm sensation when applied).

What if someone wants to have sex but does not have water-based lubricant?

The first option in this case is to not have anal or vaginal sex. Thigh sex or oral sex might be alternatives.

If they insist to have anal sex in this situation or if they have no choice, they can use their saliva (spit). Saliva is a natural, water-based substance that can be applied to the condom before having sex. However, the person who is the receptive partner should use their own saliva. They should either finish quickly or keep spitting on the condom while having sex—saliva does not stick to the condom the same way a “real” lubricant does. It can be much more painful for the receiving partner in anal sex to use saliva instead of water-based lubricants, and the chance for tears and bleeding inside the rectum is greater. In this situation, they should be careful if they re-apply saliva to a condom after it already has been inside the rectum; people in this situation must make sure they do not get bacteria from the gut inside their mouth. They should spit on their hands from a distance and do not touch their mouth or tongue with any fingers that have touched a condom that has been inside the anus.

For what types of sex should water-based lubricants be used?

Water-based lubricants can be used for any anal or vaginal sex.

Is it possible to have safe oral-vaginal or oral-anal sex?

“Dental dams” are used to have safe oral-anal and oral-vaginal sex.

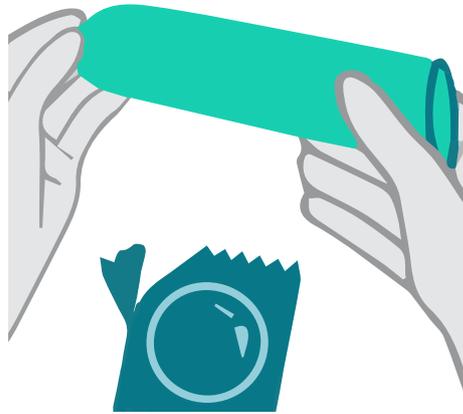
What is a dental dam?

Dental dams are small, thin square pieces of latex that are placed between the mouth or tongue and the anus or vagina. Dental dams help to reduce the transmission of STIs during oral sex by acting as a barrier against bacteria and viruses.

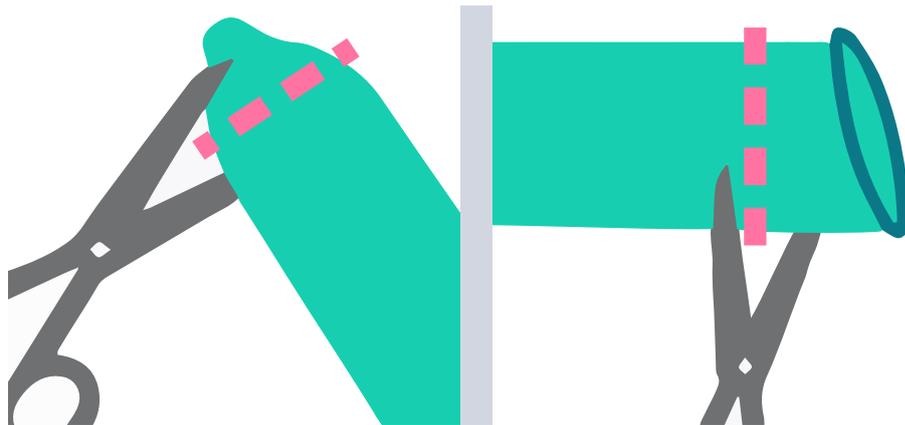
How is a dental dam made?

A dental dam can be made easily from a male latex condom.

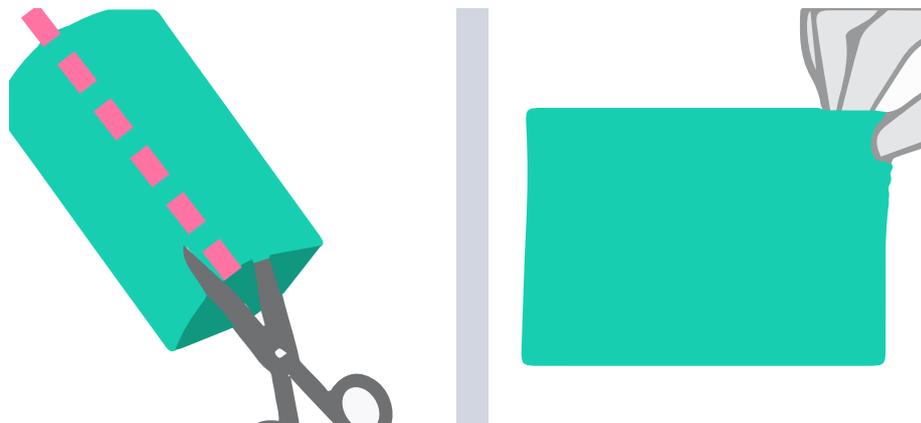
Step 1: Roll out the condom completely.



Step 2: Cut the "ring" and the tip off the condom.



Step 3: Cut along the length and then the dental dam is ready for use!



Source: http://www.sexualityandu.ca/stis-stds/how_do_i_protect_myself_from_stis_std/s/dental_dam.

How is a dental dam used?

When explaining how to use a dental dam, you may want to say: "First, check the dam to make sure there are no holes in it. The partner performing oral sex then holds the dam against the anus of the receiving partner. You can put some lubricant on the anus before using the dam, which can help increase the sensation for the receiving partner. Just make sure the lubricant is water-based because oil-based lubricants and lotions can degrade the latex and decrease the dam's effectiveness."

Then explain to your client: "When you use a dental dam, be sure to use only one side. Don't flip the dam over for another round because you will expose yourself to the very fluids you're trying to avoid! And do not re-use a dam on another body part because you can transfer germs from one body area to another. Do not re-use a dam for another act of oral sex later on, either. Dams, like condoms, are for one-time use only."⁵

How effective are (latex) condoms in preventing HIV and STIs?

Condoms are widely recommended for the prevention of STIs, including HIV. They have been shown to be effective in reducing infection rates in both men and women. While not perfect, the condom is effective at reducing the transmission of HIV, genital herpes, HPV, genital warts, syphilis, chlamydia, gonorrhoea and other diseases.

Although a condom is effective in limiting exposure, some disease transmission may occur even with a condom. Areas of the genitals exposed to or hosting an infection may not be covered by a condom and, as a result, some diseases, such as herpes and scabies, can be transmitted by direct skin-to-skin contact. The primary reason why people who use condoms regularly still get an STI is that they do not use them consistently.

According to a 2000 report by the US National Institutes of Health, correct and consistent use of latex condoms reduces the risk of HIV transmission by approximately 85%, relative to risk when unprotected. The same review also found condom use significantly reduces the risk of gonorrhoea for men. The US Centers for Disease Control and Prevention, however, recently lowered its estimate of the average protective effect of consistent condom use to 80%.

Proper condom use decreases the risk of transmission for HPV by approximately 70%; a 2012 review confirmed this.⁶ Another study found consistent condom use was effective at reducing transmission of herpes simplex virus-2, also known as genital herpes, in both men and women.

5 See http://www.brown.edu/Student_Services/Health_Services/Health_Education/sexual_health/ssc/dams.htm.

6 J. Lam et al., "Condom use in prevention of human papillomavirus infections and cervical neoplasia: systematic review of longitudinal studies", in *Journal of medical screening*, 21(1), 2014, pp. 38–50.

How do I deal with negative attitudes towards condom use?

Many men feel that condoms reduce the pleasure they get from inserting their partner's anus, mouth or vagina and therefore do not like to use condoms. When advising people on condom use, it is necessary and advisable to be open and honest about condoms. Do not tell friends or clients that condom use does not make any difference in terms of sexual pleasure, because that is simply not true. However, using a condom that fits well and using plenty of lubricant (including a drop of lubricant on the tip of the penis before wearing the condom) can greatly enhance pleasure while having sex. Ask men who refuse to use condoms for this reason whether those 10 minutes of heightened pleasure are worth the chance of getting a serious disease, along with the anguish and fear that possible exposure to HIV or the symptoms of STIs can bring.

If negative attitudes have to do with a perceived lack of intimacy, love and trust, you should try to explain how mechanisms of love and trust are contributing to the spread of HIV among men who have sex with men and among transgender people. True love has nothing to do with condom use! You could also turn the argument—that condoms are not used in love relationships—around by saying that if you truly love someone, your primary concern should be to protect that person from disease and thus you should use condoms.

Negative attitudes towards condoms can only be countered with arguments of reason. In an environment in which a significant number of sex partners have asymptomatic HIV or STI infections, it is the only way to go.



How can condom use be made fun?

You should remind clients that need to ensure that they can reach condoms and lubricant easily during sex, so that as little interruption as possible occurs. You can suggest to your clients or friends to practise putting a condom on their partner with their mouth or to make it into an erotic foreplay; this could include manual and oral stimulation of the penis or putting a bit of lubricant on the tip of the penis before putting the condom on.

What about men who say they cannot maintain an erection when using condoms?

Some men do not like to use condoms because they think it will diminish or totally end their erection. For these men, you should advise them to practise putting on condoms while in the privacy of their home. With a bit of practice, this "condom phobia" is easy to self-treat.

Why do condoms sometimes slip or break?

Condoms may slip off the penis after ejaculation, break due to faulty method of application or physical damage (such as tears caused when opening the package) or break or slip due to latex degradation (typically from being used with oil-based lubrication, being past the expiration date or being stored improperly).

It is important to advise people to store condoms properly and always check the expiration date before using them. Also, avoid carrying condoms together with sharp objects (keys, coins, pins, etc.) because they may pierce the package of the condom or the condom itself.

If condoms slip or break, do they still protect against HIV or STI?

Different types of condom failure result in different levels of exposure to semen (and potentially HIV or an STI). Failures that occur during application generally pose little risk to the user. One study found that semen exposure from a broken condom was about half that of unprotected intercourse; semen exposure from a slipped condom was about one fifth that of unprotected intercourse. This means that even if a condom slips or breaks, it still provides a level of protection.

What to do if a condom has broken or slipped inside the rectum?

Anal sex: For the insertive partner, try to urinate and then pull the foreskin back gently (if uncircumcised) and wash with mild soapy water only.

For the receptive partner (male or female), do not bare down and try to go to the toilet. Do not douche. Wash the outside of the anus only with mild soapy water.

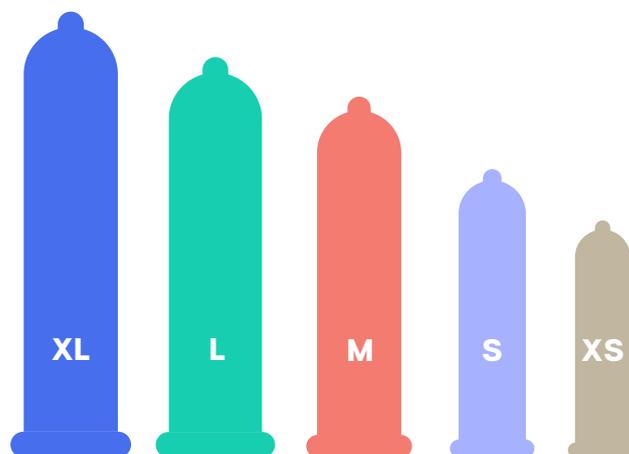
Vaginal sex: For the insertive partner, try to urinate and then pull foreskin back gently (if uncircumcised) and wash with mild soapy water only.

For the receptive partner, go to the toilet and try to urinate. But do not douche; just wash the perineum (outside genital area) with mild soapy water.

Oral sex: This information is only for people who have had somebody ejaculate into their mouth: Don't be too concerned because the risk, if there is any, is extremely small. If someone is concerned, they should rinse their mouth with water—but do not use Listerine or other harsh chemicals.⁷

Dr Bob's advice on TheBody.com: "Perhaps the best advice is to get rid of the [semen] in your mouth, either by spitting it out or swallowing it quickly. Is one method safer than the other? Most guides would recommend spitting over swallowing, but we really don't know for sure. Stomach acids would certainly quickly kill the virus very quickly. Theoretically, you don't want infected spunk to be in contact with mucous membranes (like the inside of your mouth and throat) for very long. Minimizing this contact decreases the risk that HIV will be absorbed. So spit when you can, swallow quickly when you must and do not use someone's [semen] as a trendy new mouthwash to gargle with, even if you do like the taste better than Listerine."⁸

Do condoms exist in different sizes?



Yes. In Asia, most condoms provided by health authorities have a diameter of 49 mm; commercially available condoms are 49–54 mm in diameter. Condoms are manufactured up to 57 mm in size, although these are not easy to find.

Source http://www.designersagainstaids.com/student_blog/item/customized_size_condoms_for_giant_and_tiny_penises.

7 From Dr Kathleen Casey, FHI 360.

8 See Dr Bob at <http://www.thebody.com/Forums/AIDS/SafeSex/Q209454.html>.

Does breakage and slippage of condoms decrease with increased experience?

Yes. Experienced condom users are significantly less likely to have a condom slip or break than less-frequent users, although users who experience one slippage or breakage are at increased risk of a second such failure, especially if the cause lies with the use of an inappropriately-sized or inferior quality condom.

Does condom education help to reduce the slipping or breaking of condoms?

Yes. A recent study suggested that education on condom use reduces behaviours or situations that increase the risk of breakage and slippage.

What other things can people do to prevent condom breakage or slippage?

You can advise friends and clients to consider several things:

- 1 "Experiment with condoms of different sizes and shapes and practise putting them on before intercourse."
- 2 "Practise talking with your partner about your desire and intention to use condoms."
- 3 "When using a condom, choose one that fits. Male condoms come in different sizes, shapes and styles, but most condoms will fit most men."
- 4 "Open and handle condoms carefully. Never use a condom that is in a damaged package or is past its expiration date. Condoms should be stored loosely in a cool, dry place (not in your wallet or the glove compartment of your car) and kept where you can easily reach them if you decide to have sex."
- 5 "To reduce friction that can cause breakage, use plenty of water-based lubricant on the outside of the male latex condom and a small amount on the inside, at the tip. Some condoms come with lubricant, but often there is not enough, especially for anal sex; additional lubricant is recommended."
- 6 "Never use oil-based lubricants like Vaseline, Nivea or antibiotic cream or any other oil-based cream with latex condoms. Oil-based lubricants can rapidly break down latex and allow the virus to pass through."
- 7 "Water-based lubricants include K-Y Jelly, Slippery Stuff, ForPlay, and most contraceptive jellies. These can be found next to the condoms in most pharmacy stores."

What is a female condom and can men who have sex with men or transgender people use it?

Female condoms are larger and wider than male condoms but equivalent in length. They have a flexible ring-shaped opening and are designed to be inserted into the vagina. They also contain an inner ring that helps insertion of the condom and helps keep the condom from sliding out of the vagina during sex. Recently,

in some countries, men who have sex with men and transgender people started using the female condom for anal sex. In this case, the ring that is inserted in the vagina is not used (it is taken out before use).

ADVANTAGES OF FEMALE CONDOMS	DISADVANTAGES OF FEMALE CONDOMS
They are not tight around the penis, providing a sense of freedom for the inserting partner.	They sometimes make a strange noise while having sex.
They can be used with oil-based lubricants (as well as with water-based lube).	They are large and may look off-putting at first.
They give the "power" of wearing a condom to the receptive partner instead of to the insertive partner, making condom negotiations for the receptive partner easier.	They are much more expensive than latex male condoms. They are not always easy to find or to buy.



Female condom image here



Here is a fun animation video on YouTube that demonstrates how two men can use the female condom for anal sex:

<http://www.impactprogram.org/uncategorized/how-two-guys-can-use-a-female-condom-for-safer-sex/#sthash.55jOJfib.dpbs>

Unit 6

Pre-exposure and post-exposure prophylaxis to prevent HIV infection

What is pre-exposure prophylaxis? What is PrEP?

PrEP stands for pre-exposure prophylaxis. The word “prophylaxis” means to prevent infection or disease. PrEP is a new way for people who do not have HIV to prevent themselves from becoming infected by taking a protective pill every day. This pill, called Truvada, contains two medicines that are also used to treat HIV. If someone takes PrEP and if they are exposed to HIV via unsafe sex (or unsafe needle use), these medicines can work to keep the virus from establishing itself inside their body. PrEP is an effective HIV-prevention strategy in populations in which HIV testing is common. This is important to remember when making recommendations for or against using PrEP: testing regularly is essential for its success.





Here is a fun educational video about PrEP:
<https://www.youtube.com/watch?v=-Xx92whZS0o>



Here are three videos that you can watch about Mr Vu, a young Vietnamese gay man who decided to go on PrEP, about his personal experiences:
<https://www.youtube.com/watch?v=heky48UAeXk>
<https://www.youtube.com/watch?v=zISCbOZQdD8>
<https://www.youtube.com/watch?v=DKm2F-VSHIE>

How effective is PrEP?

Recent studies have indicated that PrEP, if taken consistently, can prevent 92% of HIV infections.⁹ Other studies have shown that under ideal circumstances (if users absolutely never forget to take it), protection can be as high as 99%. Note that this is an even higher protective effect than using condoms (80%). Combining PrEP with condom use leads to a 99.2% level of protection, according to the US Centers for Disease Control and Prevention.

You should be a bit cautious when throwing about percentages with your clients, however, especially because we get conflicting percentages from different sources or different studies. It may just confuse your clients. The message to promote to clients is: If taken correctly, PrEP works.

Is PrEP a vaccine against HIV?

No. PrEP medicine is not injected into the body and does not work the same way as a vaccine. A vaccine teaches the body to fight off infection for several years. PrEP is taken in pill form every day by mouth, and it must be maintained on a daily basis for the protective effect to continue.

Can I also take PrEP now and then rather than every day?

Some studies have found that PrEP is, under certain specific circumstances, also effective if taken intermittently, such as only during periods of exposure. This is sometimes called “intermittent PrEP” or iPrEP. A 2014 study in France instructed gay men to take a double dose of Truvada (two pills) 2 to 24 hours before they anticipated having sex and then one pill the day after and another pill two days after having unprotected sex. For men who followed this regimen strictly, this reduced the incidence of HIV by 86% (with a 95% confidence interval of 40%–

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See <http://www.nejm.org/doi/full/10.1056/NEJMoal011205>.

99%). Although this is a smaller protective effect than taking PrEP every day, the result of the study is still impressive.¹⁰

The US Centers for Disease Control and Prevention, however, continues to recommend that people who take PrEP should do so continually (every day). This is the message you should give to your clients until better scientific evidence becomes available to promote PrEP via an intermittent regime.

Who should take PrEP?

The US Centers for Disease Control and Prevention recommends PrEP for people who are HIV-negative and at substantial risk for HIV infection. This includes HIV-negative people who are in an ongoing sexual relationship with someone who is living with HIV. The US Centers for Disease Control and Prevention also recommends PrEP for gay and bisexual men who have had sex without a condom or have been diagnosed with an STI within the past six months.¹¹ Based on existing epidemiological data from several Asian cities, a significant number of men who have sex with men and transgender people would qualify for PrEP based on this criteria. The US Centers for Disease Control and Prevention recommends that people on PrEP remain under medical supervision and test for HIV every three months. PrEP can affect the kidney function, so kidney function tests should be conducted for those on PrEP.

What do I say when someone asks, "If I start taking PrEP, must I take it for the rest of my life?"

No. People go in and out of periods in which they are at high risk for HIV infection—not everybody is equally at risk or equally sexually active all the time. You can advise friends or clients that if their risk declines or even disappears, they can stop taking PrEP; for example, if they get a boyfriend and enter into a monogamous relationship. However, if after a few years the relationship ends and they enter into a party mode once again, they can easily go back on PrEP.

How soon after starting PrEP does the protective effect begin?

According to the manufacturer of PrEP, it takes at least seven days for the medicine to reach a sufficiently high protective level in the body. However, recent French and British studies on intermittent use of PrEP (see previous references) showed that taking a double dose of PrEP 2 to 24 hours before sex, followed by one pill the day after and another two days after having sex had a protective effect of up to 86%. This would suggest that the protective effect of PrEP starts quicker if a double dose is taken.

¹⁰ See <http://betablog.org/demand-prep-shows-high-efficacy-ipergay-trial/>.

¹¹ See <https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/pre-exposure-prophylaxis/>.

Do PrEP medicines have side effects?

For the first few weeks of starting PrEP medication, a minority of users complain about nausea, vomiting, fatigue and dizziness. For most people, these symptoms eventually disappear once the body gets used to it. One potential danger when using the drug is developing kidney problems. Another study found that some people taking Truvada had a minor decrease in bone mineral density within the first month of taking it. Once Truvada was stopped, the bone density appeared to return to normal measures.¹² These are two reasons why it is recommended to be under medical supervision, with quarterly check-ups to ensure the kidneys and bones remain healthy.

Does PrEP medication change the way the body or face looks?

Truvada or other PrEP has not been associated with any redistribution of fat in the body or any deformation of the face.

Is PrEP expensive?

This depends on where you live. It also depends on whether someone buys the brand Truvada or one of its copied clones that are much cheaper. In Bangkok, taking PrEP costs a bit less than US\$30 per month and is available at the Thai Red Cross Clinic for anyone who wants to take it.

If someone starts using PrEP, can they stop using condoms?

Like condoms, PrEP is highly effective at preventing HIV when used consistently and correctly. Individuals need to figure out what works best for them and how comfortable they are with some degree of uncertainty. Some people will keep using condoms while on PrEP and others will decide to stop using them. If you are talking with someone who is already using condoms consistently and doing so makes them feel comfortable and protected, then tell them to keep doing what feels right to them. Many people struggle with using condoms consistently, which is one reason why PrEP was developed. But people must decide for themselves what level of protection feels right and gives them the peace of mind to lead a sexually fulfilling life.¹³

What is post-exposure prophylaxis? What is PEP?

Post-exposure prophylaxis, or PEP, is an anti-HIV medicine that is taken as soon as possible after someone has (or may have) been exposed to HIV to reduce the chance of becoming infected. Anyone who goes on PEP should continue to take the medicine for 28 days. Please note, however, that in many places PEP is available only for medical personnel who have been accidentally exposed to (potentially) infected blood, or for rape victims.

¹² See <http://www.aidsmap.com/iTruvadai-PrEP-causes-only-mild-loss-of-bone-mineral-density/page/2967903/>.

¹³ Excerpted from <http://men.prepfacts.org/the-questions/>.

Who should take PEP?

PEP should be taken only if there is a real and substantial risk that HIV infection might have occurred. For example, if a bottom who is HIV-negative had sex with a top who is living with HIV and the condom broke, slipped off or no condom was used. What is important to consider is also the HIV prevalence in the general men who have sex with men and the transgender population. For example, in a country with few HIV cases, the chance of encountering someone with HIV is much smaller than in a city like Bangkok, where in some saunas, up to 50% of patrons might have HIV. There is no golden yardstick according to which someone can decide whether to take PEP or not. It depends partly on how worried they are!

How soon after possibly having been exposed to HIV should someone take PEP?

The sooner, the better—but it should be within 72 hours after possible exposure to HIV. After that, the virus may have replicated itself too much for PEP to have an effect.

Is PEP like a morning-after pill?

In a way, yes. PEP can be used if someone has had an “accident”, or unsafe sex, with a person who has HIV or a person whose HIV status is unknown. Unlike a morning-after pill, however, it is not recommended to use PEP regularly. If it appears difficult for someone to use condoms consistently and if accidents keep happening, they should consider enrolling in PrEP instead.

Does the availability of PEP encourage risky behaviours?

Some people fear that having PEP as a back-up safety net may lead to people deliberately “forgetting” to use condoms. You should be certain to explain to your client that taking PEP is not fun, it is not a game! First, it can be a hassle to get them via particular channels that frown on using them for this purpose. Apart from that, side effects while taking it can make your client quite sick: note that PrEP and PEP are not the same drugs and that a person who thinks they may have had an HIV exposure should not use PrEP as PEP.

Unit 7

Sexual risk reduction, principles and practice of behaviour change

What is sexual risk?

Sexual risk is the chance of acquiring HIV or STI while having sex. Some sexual acts are riskier than others. Kissing and hugging, for example, constitute no sexual risk at all, whereas unprotected receptive anal sex has the highest sexual risk for HIV infection.



See **Unit 8** for a table of sexual behaviours and their risks.

What makes some people take risks when having sex?

There are several possible reasons why people take risks during sexual activity.

- 1 They may not know that the sex they engage in is a risk for HIV infection.
- 2 They don't mind taking a risk and find the pleasure the sex provides more important.
- 3 Sexual desire or passion may overshadow thoughts of potential risk when people have sex.
- 4 If people are drunk or high on drugs when having sex, they likely will take more risks than they would under normal circumstances.
- 5 Love and trust of a partner also lead many men who have sex with men and transgender people to stop using condoms. Many HIV infections occur within so-called 'long-term/steady' romantic love relationships that may, in reality, last only a few weeks or months.

- 6** Young people are often more likely to take risks than older people; young people like to experiment and try new things. They sometimes see themselves as invincible, see the sex (or even HIV) as inevitable or do not think deeply about what they are doing.
- 7** Persons with low self-esteem tend to take more risks as well; if they feel they are worthless, why should they take proper care of themselves? Self-esteem also reflects health-seeking behaviours; when persons have low self-esteem, they tend to ignore or not want to access information or go for HIV testing.
- 8** Some people may not worry about risk of HIV when they are faced with what they consider more pressing concerns, like acute poverty (feeding themselves or their family and covering other basic necessities), especially when offered more money not to use condoms, the threat of violence in their community or the presence of other life-threatening illnesses.
- 9** Some people may recognize risk in their lives but may not be able to reduce the risk (for example, they may not be able to negotiate condom use with their partners).
- 10** Some people may be worried about their risk, but they might be even more afraid of the consequences of talking about their sexuality (for example, men who have sex with men and transgender persons may fear getting treated for STIs because they do not want to admit they engage in homosexual acts).
- 11** Some people just do not realize or do not want to realize that they (or their sex partner) may have exposed themselves to HIV in the past.
- 12** Some people think condoms are not effective, or they downplay the risk of unprotected sex.
- 13** Many people find that condoms reduce the level of intimacy with their sex partner and therefore do not like to use condoms.
- 14** Many people think the risk is limited to certain types of people only—they assume only “other” people have HIV or are at risk of it, not people like themselves. For example, men who have sex with men may say only male sex workers or transgender people have HIV; injecting drug users or transgender people may say only female sex workers have HIV, etc.
- 15** Some people who are regular partners or in a relationship may decide to ditch using condoms after both of them test negative or both test positive.
- 16** If sero-discordant (meaning one person is negative and another is positive), the negative partner may be on PrEP and/or the positive partner may be on antiretroviral treatment and have an undetectable viral load.

What is barebacking?

Barebacking, or BB, is a term that originated in gay slang. It means “deliberately having unprotected anal sex”. This is different from having a condom break or slip off accidentally. Barebacking happens among certain groups of men who have sex with men and transgender people. Very young men who have sex with men and transgender people and who are not (yet) used to or skilled in using condoms often do not use condoms during their first sexual encounters, but this is usually not referred to as barebacking because the unsafe sex that they experience is often not deliberately planned. Or, at the least, it is not based on a deliberate choice or decision to have anal sex without using condoms.

Why do some men bareback?¹⁴

There are several possible reasons why some men like to bareback:

- Most often, these men may not imagine that their partner has HIV; they may also have misconceptions about what people with HIV and people who do not have HIV look like and, based on this misconception, they decide whether to use a condom or not. It is important to make clear to your clients that it is never possible to see from any outside features whether a person has HIV or not. People with HIV can be thin, fat, tall, short, rich, poor, high-class, low-class, white skinned or dark skinned; they can have an STI, they can have no STI, they may use condoms, they may not use condoms, etc.
- Apathy over the transmission of HIV. Many men who have sex with men and transgender people no longer fear the HIV virus. They believe that the virus is unavoidable, or they know that the virus can be controlled by provision of antiretroviral medicines, resulting in much longer lives for those infected than was the case in the past.
- Some men who have started using PrEP may no longer use condoms, in the knowledge that PrEP provides them with a certain level of protection against HIV that they find sufficient.
- Anxiety over contracting HIV. A tiny minority of men may be either deliberately transmitting the virus or willingly receiving the virus—in Western countries this is referred to as ‘gift giving’ and ‘bug chasing’, respectively. Men in the latter group have such high anxiety over catching the virus (believing it is just a matter of time before they become infected) that they would rather just get it so that they don’t have to fret about it any longer.
- Some HIV-positive men believe that because they already have the virus, there is no need to have protected sex with another HIV-positive man. In the case of positive men having unprotected sex with negative men, they believe that each

person makes their own choices when it comes to safe sex. So if another man wants to bareback with them, it's their decision.

- Some men live for the moment and accept whatever consequences result from their actions. They accept the risk of disease if barebacking feels like the right thing to do at that moment.
- Low self-esteem. Men with low self-esteem sometimes follow the direction of a more confident sex partner or friend and are not strong enough to insist on condom use or, in some cases, they do not care enough about themselves to insist on it.
- Alcohol and drug use. Using drugs like ecstasy or crystal methamphetamine or even alcohol can impair judgement and has been shown to strongly increase the chances of having unprotected sex.

Can people who are on antiretroviral treatment or on PrEP stop using condoms?

Antiretroviral treatment (for people who are living with HIV) and PrEP (for people who are HIV negative) are highly effective at preventing HIV, at least when the people taking it use the medication consistently and correctly. Can they therefore stop using condoms? This is not easy to answer. Every person has to decide what works best for him. This includes their willingness to take small, medium or big risks. Some people will keep using condoms while on antiretroviral treatment or PrEP; others will decide to stop using them. Each individual has to decide for themselves what level of protection feels right to lead a sexually fulfilling life, both for their partners and their own safety and peace of mind.¹⁵ If taken correctly, PrEP can reduce the risk of HIV infection by 96-99%. Combining PrEP with condom use increases that protection to 99.2%, according to the US Centers for Disease Control and Prevention.

It is also important to remember that antiretroviral treatment or PrEP do not protect against other STIs, such as syphilis, gonorrhoea, chlamydia, herpes and HPV.

What is behaviour change?

"Behaviour change" is a process through which people change their actions that are damaging or could damage them; it is their behaviour that puts them at risk of STI or HIV. Often, behaviour change is a gradual process, with progress made and progress lost (steps backward or relapses). The ease or success of behaviour change can differ from person to person. This may depend on their attitude, environment, social norms, etc.

What does “behaviour change is a gradual process” actually mean?

It is not realistic to assume that a person who wants to change their behaviour will be immediately and definitely successful, especially if the behaviour is partly “instinctive” (like sex). Behaviour change can be seen as a person’s process moving along a decreasing continuum of sexual risk, and this movement is gradual and sometimes cyclical; for instance, a person may relapse or move back towards less safe behaviours along the continuum, hopefully temporarily. For the continuum of risk, see [Table 1](#) in Unit 3, which lists sexual activities starting from “no risk” and moving to “high risk”. Men who have sex with men and transgender people can be at different stages in the behaviour change process (see Figure 4). It is useful for men who have sex with men and for transgender people who have decided they want to change their behaviour towards safer sex to set personal behaviour change objectives.

What are possible behaviour change objectives?

When you are discussing with your friends or clients about changing their risky behaviours, you can suggest they pick one or some of the following objectives to help guide their commitment:

- 1 Start to become aware of HIV as a serious problem that could affect them.
- 2 If HIV-negative, continue to have regular HIV tests (see [Unit 9](#)).
- 3 Have regular STI check-ups.
- 4 Start to realize the need to change their behaviour.
- 5 Try safer behaviours, like using condoms and lubricants with some partners.
- 6 Use condoms and lubricants during every sex act.
- 7 Reduce the number of sex partners.
- 8 Reduce anal sex in favour of oral or non-penetrative sex.
- 9 Reduce the frequency of sexual activity.
- 10 Avoid sharing needles.
- 11 Avoid having sex when drunk.
- 12 Reduce the consumption of alcohol or drugs.

What are the main stages of behaviour change?

There are several stages of behaviour change. People can move between different behaviour change stages.

- 1 Precontemplation stage (not yet acknowledging that there is a problem behaviour that needs to be changed).
- 2 Contemplation stage (acknowledging that there is a problem but not yet ready to make the change, or feels not yet certain if the behaviour should change).
- 3 Preparation or determination stage (getting interested and ready to change behaviour).
- 4 Action or willpower stage (starting to change the behaviour).
- 5 Maintenance stage (maintaining the behaviour change); during this stage the challenge is to prevent occasional relapse, which can happen between each of the stages).

FIGURE 4
Stages of behaviour change



Note The large arrow indicates the “tone” of outreach required to help a person move to the next stage of behaviour change.

Source <http://www.slideshare.net/abpascual/2013-behaviour-change>.

A change in behaviour typically occurs gradually, with a person moving from being uninterested, unaware or unwilling to make a change (precontemplation) to considering a change (contemplation) to deciding and preparing to make a change. Genuine, determined action is then taken and, over time, attempts to maintain the new behaviour then occur.

Relapses are almost inevitable and become part of the process of working towards lifelong change. Relapses can occur at every stage of behaviour change. Newer graphic depictions of the behaviour change process therefore allow for a “loop” back towards unsafe behaviours and thus present behaviour change not as a linear but as a cyclical process.

How can I tell which stage of behaviour change a person is at?

When talking to a friend or client, you must adapt your “message” to the stage the person is at. You can check if they are aware of HIV and or if they think that they are at risk or not and why, if they are concerned about HIV or STIs (precontemplation stage), if they are contemplating changing his behaviour and whether they know the different options to reduce risk (contemplation stage), if they have been experimenting with using condoms or reducing partners or reducing anal sex in favour of other forms of sex or whether they have started to adopt safer behaviours more frequently (action stage). You can also inquire about relapses—how and why and where they occur, and discuss strategies to prevent them—or talk about maintaining safer behaviours in all circumstances (maintenance stage). See [Table 2](#) for more information and tips.

With condom use as an example, the US Centers for Disease Control and Prevention developed a guide to assess where your friend or client is in the behaviour change process:

Precontemplation	Does not intend to start using condoms every time in the next six months
Contemplation	Intends to start using condoms every time in the next 30 days to six months
Preparation	Uses condoms sometimes or almost every time AND intends to start using condoms every time in the next 30 days
Action	Uses condoms every time he has sex AND has been using condoms every time for less than six months
Maintenance	Uses condoms every time he has sex AND has been using condoms every time for six months or longer

You want to emphasize that a person can be at different stages of readiness for change regarding different behaviours—at the same time. This guide is not an indication of a client's readiness to change generally (because that doesn't exist)—it's a measure of the client's readiness to change their condom-use behaviour specifically.

What should be discussed at each level of behaviour change?

See Table 2 for ideas about what to discuss with clients who are at different stages of behaviour change. The table reinforces that to be an effective outreach worker, it is important that you do not have a one-size-fits-all message for every client you encounter. You should do a bit of investigation with each client to assess what is the most appropriate advice you can provide for them.

What is a relapse?

"Relapse" is when your friend or client goes from a higher to a lower stage in the behaviour change continuum (moves backward). Most people have occasional relapses before the changed behaviour becomes permanent.

How can someone be supported to prevent relapse?

Try to talk about the circumstances in which relapse can occur. Often, there are clear "warning signs" before unsafe sex takes place. For example, your (in this case male) client may have gone out without taking condoms and lubricant; he may have drunk too much and planned to go to a park or may be making arrangements to go out to meet someone he was chatting with online; he may have assumed that the partner he was going to meet would have condoms. Discuss these warning signs and discuss how they can be anticipated in the future; this will help your client recognize the situation next time and increase his risk-reduction options. Different options for risk reduction might be discussed, thus giving him choices.

You should also encourage your friends or clients to share their experiences with safe sex with other friends; this will encourage both the person who is changing his behaviour and may also have an impact on nudging his social network towards behaviour change.

TABLE 2
Stages of behaviour change¹⁶

STAGE	THOUGHTS AND LEVEL OF AWARENESS OR RESOLVE	WHAT TO SAY OR ADVISE A PERSON IN THIS STAGE
Precontemplation stage	Clients do not know about HIV and do not consider changing—they feel that HIV has nothing to do with them.	Focus on raising awareness and knowledge about HIV and STIs and their spread in the community or a group, about the risk of transmission and the possibilities to prevent it. Focus on how prevention applies to them personally. And focus on the importance of HIV testing.
Contemplation stage	Clients are ambivalent about changing. Giving up an enjoyed behaviour (sex without using condoms) causes them to feel a sense of loss, despite the perceived gain of more safety and avoidance of disease or death. During this stage, clients assess barriers (time, expense, hassle or fear: “I know I need to, but...”) as well as the benefits of change. They may not yet relate the threat of HIV or STIs to themselves.	Help them clarify that the benefits of change eventually will be bigger than the disadvantages. For those who are worried or scared to get an HIV test, focus on the peace of mind that comes with knowing that one is safe and the benefits of going on treatment if there is an HIV-positive outcome. It is important to talk about persons close to you who may have HIV or know people with HIV personally to bring the issue closer to the person in the contemplation stage. Of course, you should maintain the principle of confidentiality when you talk about others (Unit 1).
Preparation stage	Clients prepare to make a specific change; they may experiment with small changes in their behaviour as their determination to change increases. For example, by trying out a condom in anal sex with a particular person shows that this person is contemplating making a change towards consistent condom use.	Encourage the experimentation by stressing the benefits of the new behaviour and facilitate the change by pointing out different options for condom use, in terms of size and shape (see Unit 5). The client may need ideas about how to discuss using condoms with partners, how to deal with resistance on behalf of partners, what arguments to use in case a partner refuses, etc. The client may also need encouragement and praise if the initial experiences with safer sex have occurred.
Action stage	Client adopts the safer behaviour they have been contemplating and preparing for.	You should encourage the decision to change behaviour by affirming the changes the client is making and reiterating the benefits of these changes. You can give examples of these benefits and share your experiences from when you changed your own behaviour. If the client relapses—has unsafe sex—ensure that the client understands that this does not necessarily mean that the battle is lost; provide encouragement, saying that relapses are part of the process and that they will disappear over time.
Maintenance stage	Incorporating the new behaviour over the long term. Discouragement over occasional slips may halt the change process and result in the client giving up.	You should congratulate the client and provide encouragement to continue. Provide advice on how to make the changes stick; warn the client about relapse by giving strategic advice to avoid situations in which relapse can occur—for example, warn against becoming drunk or using drugs, which is known to cause relapse in individuals who would under normal circumstances have only safe sex.

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See G. Zimmermann et al., “A ‘stages of change’ approach to helping patients change behavior”, in *American Family Physician*, 61(5), 2000, pp. 1409–1416, <http://www.aafp.org/afp/20000301/1409.html>.

Unit 8

Dealing with accidental exposure to HIV

What do I say when someone asks, “Help! I had unprotected sex last night! Do I have HIV now?”

This is a question you may encounter in your work. It is important to encourage your friends or clients to always engage in safe sex. But sometimes people may put themselves at risk: they may be drunk or high (under the influence of drugs), they may be offered a lot of money to have sex without a condom or they may just have been too “hot” while having sex. Sometimes, people are unable to negotiate safe sex with a more powerful person; sometimes rape occurs. Make sure you understand why the condom was not used or why it broke to help prevent it from happening again by giving appropriate information. Did the client use the wrong type of lubricant? Did he use a condom that was too old—past its expiration date? Was the condom too small or too big?

You should sit with your client and explain that having unprotected sex means giving HIV a chance to enter their body. It is a **chance**, not a **certainty**.

- First, of course it depends on whether the sex partner had HIV or not. This is almost always impossible to confirm, unless the sex partner explicitly told your client.
- Second, if the sex partner had HIV, the chance of transmission partly depends on how high their viral load was, which depends on how long they had been infected already and on whether they were on HIV treatment or not (see [Units 2 and 3](#)).
- Third, it depends on whether your client was taking PrEP or not.
- Fourth, it depends on whether one or both of the partners had another STI, which may make HIV transmission more likely.
- Fifth, it will depend on the sexual behaviour the client had last night—for example, whether they had anal or only oral sex, whether your client was receptive or insertive when having anal sex and whether ejaculation took place inside the rectum.

- Sixth, it will depend on whether sufficient lubricant was used, which decreases the chance of bleeding or tears.
- Finally, it may also depend on physical features of the sex organs, such as the size of the penis or the width or flexibility of the rectum (which partly depends on experience and on sexual skills).

Taking all these factors into consideration, reliable sources (see footnote on the next page) estimate that if 10,000 people have unprotected receptive anal sex with an HIV-infected man, 138 of them will also become infected with HIV (a transmission efficiency of 1.38% per sex act).

This means that being unsafe with a person with HIV does not necessarily mean that someone will become immediately infected. It means there is a chance that the person has been infected.

See **Table 3** for transmission probabilities—for each situation, there is an assumption that 10,000 people have the behaviour with an infected source, and the number in the right column is an estimation of the number that, on average, will become infected as a result. Be aware that despite these perhaps surprisingly small chances, people tend to a good deal of sexual activity, and these small chances have resulted in HIV prevalence of 10%–30% in some Asian cities. Just to give an example, winning the lottery is also a small chance, but hundreds of people win it every week!



Warning: The following information is considered to be very sensitive. Public health professionals usually do not provide it to the public because there is a fear that people may start “gambling” with risks. They may think: “Oh, only 0.11% chance? I will just take that risk.” Please use this information only to help people who had unsafe sex put their risk into perspective—do not use this knowledge as a prevention strategy for yourself or your partners!

Also note that these are chances per each sex act. If someone has sex several times per week or month, these chances really add up!

Around 30% of men having sex with men frequenting entertainment venues in Bangkok were found living with HIV in 2013; in several other Asian cities, percentages of more than 10% were found.

It should always be emphasized that if a person has an STI, the chances for HIV infection become greater. Also, if a person is in the acute phase or late phase of HIV infection, when viral load is high, the chances of infection also increase dramatically.

TABLE 3

Estimated per act risk for infection of HIV, by exposure route

EXPOSURE ROUTE	ESTIMATED INFECTIONS PER 10,000 EXPOSURES TO AN INFECTED SOURCE
Blood transfusion	9,250
Needle-sharing injection drug use	63
Receptive anal intercourse*	138
Needle stick	23
Receptive vaginal intercourse*	8
Insertive anal intercourse*	11
Insertive vaginal intercourse*	4
Receptive oral intercourse*	Low
Insertive oral intercourse*	Low

**Note
Source**

*=assuming no condom use.
<http://www.cdc.gov/hiv/policies/law/risk.html>; see also
<http://www.catie.ca/en/pif/summer-2012/putting-number-it-risk-exposure-hiv>.

What do I say when someone asks, “Help! I had unsafe sex! What do I do now?”

If a client calls you with this message, you can advise them to stay calm. As discussed previously, possible exposure to HIV does not always lead to transmission.

You can then advise the client: “If you were the insertive partner, wash your penis; pull back the foreskin (if you have one) and rinse thoroughly. If semen entered your rectum, sit on the toilet and try to let it drip out. Do not use a showerhead or douche to clean yourself inside: this has been associated with increased infection risk.”

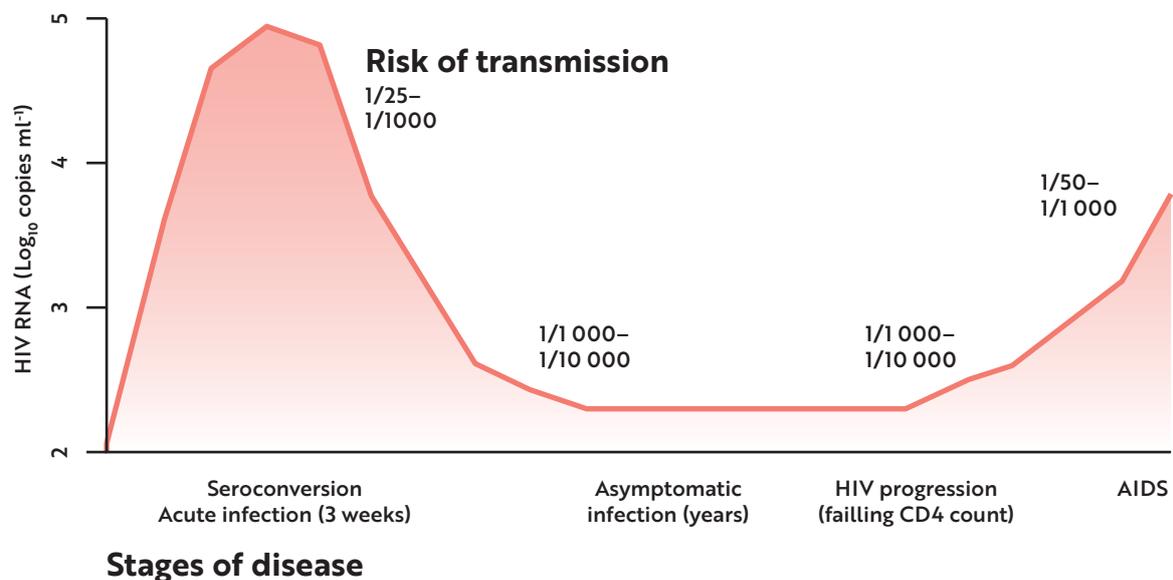
You can then advise: “If you had oral sex, you can either spit out or swallow the semen that has entered your mouth. You can rinse your mouth with a Betadine solution to clean; do not brush your teeth, and do not floss for at least two hours because of the chance that your gums may bleed, providing a potential entry point for HIV.”

If there is a big chance that your client was exposed to HIV (if they know that the sex partner is HIV-positive), and if Post-Exposure Prophylaxis (PEP) treatment is available in your country, you suggest that client begin the course (see [Unit 6](#)). Stress to your client that the treatment requires the anti-HIV drugs be taken at full strength for one month. In most countries, only a doctor can prescribe this medicine. If your client believes they have been exposed to HIV, this treatment must be started as soon as possible (within 72 hours, but preferably earlier) and continued until it is completed.

Is a person with HIV who does not use condoms or is not on treatment always equally likely to transmit HIV to others?

No. A person with HIV who does not use condoms and is not on treatment is more infectious during the phase of acute HIV infection (two to six weeks after infection) and at the stage in which his viral load increases and he is becoming symptomatic (Figure 5).

FIGURE 5
Stages of HIV infection



Source S.R. Galvin and M.S. Cohen, "The role of sexually transmitted diseases in HIV transmission", in *Nature Reviews Microbiology*, 2(1), 2004, pp. 33–42.

What should be done after accidental exposure to HIV?

After accidental exposure to HIV, it is important to keep in touch with your client and advise him to undergo an HIV test (see [Unit 9](#)). In the few cities tests are offered that measure HIV RNA in the blood are offered, rather than HIV antibodies that take several weeks to emerge in the blood (Bangkok and Singapore are among them), this can be done as soon as a week after possible exposure. In other places, the client will need to wait for at least six weeks before doing a test.

Unit 9

HIV counselling and testing

Why is HIV counselling and testing important?

In more and more countries and cities, increasing the uptake of HIV testing among men who have sex with men and transgender people is becoming the top priority for HIV outreach. This is because life-prolonging HIV treatment is now available in most countries. It is best for every man who has sex with men or for every transgender person who is sexually active to get tested for HIV regularly (at least every six months). Apart from the health benefits for individuals who have HIV, this is also important because if we identify an undiagnosed person and help them access antiretroviral treatment, the chance that they will pass on their HIV infection eventually drops by 96%.

Many people believe that finding undiagnosed HIV cases and putting them on HIV treatment is the best chance for slowing and eventually eradicating the HIV epidemic—although most infections among men who have sex with men and transgender women appear to happen during the acute infection phase, meaning these onward infections could not have been prevented by putting people on treatment earlier.

Should outreach workers stop seeing clients after referring them to testing services?

Outreach workers should help clients access HIV testing services. But it is important that clients are not scared away after receiving an HIV-positive test result. In some cases, it may be desirable for an outreach worker to accompany a client to a testing service; in other cases, it might be unnecessary. This depends on the number of unreached men who have sex with men and unreached transgender people as well as the efficiency and quality of the testing service, and especially on the quality of the post-test counselling. In some countries, if required accompanied referral is the standard, outreach workers may be forced to wait around until after the client is tested every time, and the result may be

that programme reach plummets because outreach workers may spend too much of their time hanging out at the clinic waiting room rather than reaching out to new clients. Outreach workers could also hand over a client to a special HIV case manager who accompanies the client to the facility where the test takes place and who makes sure that the client has access to follow-up tests and antiretroviral treatment after receiving a test result.

Why should your client be tested for HIV?

It is important that everybody who is at risk for HIV infection is tested. If they are found HIV-positive, knowing it will help them (i) access medical services, anti-retroviral treatment and social support services, which will enable them to live longer; and (ii) avoid unwittingly infecting other people with HIV. If they are found HIV-negative, knowing this will strengthen their commitment to “stay safe” and use condoms consistently.

How is HIV infection discovered?

HIV infection is usually confirmed with tests that determine whether antibodies (the proteins that the body creates to fight an infection) to HIV are present in the blood or in oral fluids.

If the first test is positive, people are commonly tested a second time to reduce the likelihood of a false result (the second test is done to confirm the result). False test results can be false-positive (this is when the test suggests that a person is infected with HIV but in reality they are not) or false-negative (this is when the test suggests that a person is not infected with HIV but in reality they are). False-negative tests can also occur during the “window period” (see the explanation further on).

What different types of HIV tests exist?

The most common HIV test is the antibody screening test (also called immunoassay), which tests for the antibodies that the body creates in response to its infection with HIV. This test can be taken from blood or from oral fluid (but not saliva). Tests that use blood tend to find HIV infections quicker than oral-fluid-tests because the level of antibodies in blood is higher. The rapid test is one kind of immunoassay test and produces a result within 30 minutes. This test, using either blood or oral fluid to look for antibodies to HIV, is often used in non-clinic-settings. All immunoassays that are positive need to be confirmed with a follow-up lab-based test.

Follow-up diagnostic testing is performed in a lab if the first immunoassay result is positive. The types of tests used differ per country and even city.

RNA tests detect the virus directly rather than the antibodies to HIV. Therefore, RNA tests can detect HIV much earlier, at about 10 days after infection or as soon as it appears in the bloodstream and long before the body develops antibodies. These tests cost much more than antibody-based tests.

In an increasing number of countries, **home-based HIV testing** is currently allowed.

What is (pre- and post-test) counselling and why is it important?

Counselling before testing (pre-test counselling) and after testing (post-test counselling) is an important and standard part of HIV-testing procedures. Pre-test counselling means preparing a person who is going to have an HIV test for the possibility of a positive test result, including a risk assessment. This person should be prepared to get bad news. If they are unable to handle this, perhaps they should wait to have the test until they are mentally better prepared. This is very important because suicide or other self-destructive behaviours have been reported after positive test results were given to individuals who did not receive pre- and/or post-test counselling. Sometimes, it is better for persons who think they may become upset or unstable to go and have a test in the company of a trusted friend, a case manager or an outreach worker.

During post-test counselling, vital information is provided to the person who was tested. For those who test negative, counselling information can help to prevent infection in the future—remember that most people who go for a test have reason to do so; they may have exposed themselves to HIV. Those who test positive are referred to a case worker or case manager who will help them access a confirmation HIV test (if needed), CD4 tests and other baseline tests, and then accompany them and facilitate their access to care and support services. The case manager will also provide guidance for maintaining their general health.

Testing combined with counselling can make a critical difference in the lives of those who test positive; knowing that they have HIV can empower them to take appropriate action in planning their lives and in getting the services they need. However, many people in Asian cities have been found to disappear after receiving a positive HIV test result. They sometimes disappear for many years and only reappear in the health system when they show symptoms of advanced HIV infection or even AIDS. It is of critical importance that a proper case-management system is put in place that works to prevent newly diagnosed people from dropping out of or missing the services that are available for them.



See Annex 1 for a list of HIV services available in your country.

What is peer-initiated or peer-delivered HIV testing?

In some countries, such as Cambodia, Lao PDR and Thailand, experimental programmes have been conducted in recent years in which outreach workers were trained to become lay counsellors. This has included training to conduct HIV tests among their peers in the field. Such programmes help normalize HIV testing and improve access to it among people who may otherwise be hesitant to access mainstream HIV counselling and testing services, which is important. The lay counsellor conducts a screening test and then refers (or, ideally, accompanies) the client to an HIV counselling and testing centre for follow-up or confirmation testing if the initial screening test is reactive. Confidentiality can be a problem with such programmes because outreach workers may not always be equally able to keep the news of a community member's sero-conversion to themselves. It is therefore utterly important to have reliable and professional outreach workers in place and to reinforce their training on the importance of confidentiality. It is also important to cultivate outreach workers with strong post-test counselling skills, which are necessary to ensure that the client understands the result of the test and what he should do next. This can prevent clients from becoming scared and disappearing after testing positive in the screening test. The outreach worker must make sure that after receiving a positive test result, the client has access to case management services that can help them access follow-up tests and antiretroviral treatment.



Why are anonymity and confidentiality important?

Anonymity and confidentiality are crucial—nobody will use an HIV testing service if the result is not kept a secret. This is one of the first principles for HIV health care providers and social workers. Unfortunately, it is sometimes not respected. In many countries in the region, HIV testing is impossible to be done anonymously, with positive cases finding their way into government records.

Discussing intimate information with your clients also needs to be in a confidential way. Always be professional and respect each person's right to anonymity and confidentiality. It will encourage your clients to trust you and give you more information about their feelings and behaviours, enabling you to help them progress towards engaging in safer behaviours.

What is the window period?

Most HIV tests check the blood for antibodies (which are proteins produced by the body and released into the bloodstream to fight infection) rather than for the actual HIV virus. After infection with HIV, it takes a few weeks for the body to create these HIV antibodies. In other words, it is possible that during the time between when infection occurs and when antibody levels are high enough to be detected by the test, an HIV test result may show as negative, even if the person was recently infected with HIV. This gap is called the "window period".

How long is the window period?

The length of the window period varies from one person to the next and depends on the type of test that is used. It is as little as a few days for the RNA tests (which measures the presence of HIV itself, not of antibodies against HIV) but four weeks for the latest (4th-generation) HIV antibody-based test. Therefore, people should be tested regularly, if they can—possibly every six months if they or their sexual partners have experienced risky behaviours.

Why is the window period important?

It is important because it is a period of time during which a person has a negative test result but in fact is HIV-positive and already infectious. Because of the window period, we can never be 100% sure that we are really free of HIV when the test is negative—unless we had absolutely no risk behaviour in the period before the negative test result.



In some countries, such as the Philippines, a national HIV testing day is organized every year to normalize and de-stigmatize HIV testing.

Is there a treatment or cure for HIV infection or AIDS?

Currently, there is no cure for HIV infection or AIDS. However, with the combined use of antiretroviral drugs (see [Unit 11](#)) and the drugs to prevent opportunistic infections, many people with HIV infection and AIDS have improved the quality of their lives and delayed or reversed the progression of HIV infection to AIDS. However, these drugs can cause a number of side effects that may require that a person switch to other medication or stop taking them. In addition, recent research has shown that over time, HIV may become resistant to certain drugs (another reason why a person living with HIV or AIDS may have to switch to a different drug).

How can I best approach clients who resist HIV testing?

Many men who have sex with men and many transgender people are afraid to access HIV counselling and testing services. [Table 4](#) lists some common reasons that are used to rationalize the decision not to take an HIV test and possible responses to these arguments. It is important not to use any of these answers to stop the conversation or to provide a final answer. Rather, it is important to engage in discussion with your clients to find out what it is that stops them from having an HIV test. Between cities and countries, the reasons for not getting tested may be quite different. (Keep in mind, [Table 4](#) is meant as an illustration or source of inspiration only.)

TABLE 4

Common reasons for not having an HIV test and possible responses

REASON NOT TO TEST	POSSIBLE RESPONSE
"I have no money."	"HIV testing is usually free."
"I have no time."	"HIV testing does not take a long time. The whole process usually takes less than 90 minutes. There are different opening hours for clinics in the city, and there also are possibilities to test outside of office hours."
"I don't know where to do an HIV test."	"I can take you to a safe and confidential location where you can get an HIV test, which is quick and free."
"People like me don't get HIV." "I am only 'top', so I can't get HIV." "I choose my partners carefully, so I won't have HIV."	"HIV does not choose people based on certain characteristics. It is transmitted via certain behaviours. If you have engaged in such behaviours, there is a chance you have HIV, regardless of the type of person you are or the type of person you had sex with."
"I don't think I need an HIV test."	"Have you ever had anal sex without a condom with someone whose HIV status you were not sure about? Have you had an STI? Have you had tuberculosis or hepatitis? Have you ever shared needles when injecting drugs? If you can answer YES to any of these questions, you should get tested."
"God (or fate) will decide if I live or die."	"That may be true, but God also has given you the capacity to think and decide about your own life and your health. Plus, if you have HIV and unwittingly spread it to others, God would probably not approve. It is better to know your status."
"Why should I know whether I have HIV or not? You have to die of something!"	"If you know you have HIV, it is not a death sentence. There is free treatment available, and if you take it as prescribed, you will likely die of old age, not of AIDS."
"I am afraid people will know it if I have HIV and will start gossiping. Better not to test."	[This is an important and valid reason for refusing a test in some cities! Ensure that you take your client to a safe and confidential clinic. If you are not convinced of the standards of confidentiality in a clinic, do not take your clients there.]
"I don't know what will happen if I test positive for HIV. I prefer not to know."	[Here you have to discuss with your client why he prefers not to know; try to discuss the future with your client if he remains healthy versus when he gets sick or even dies. Discuss the impact this may have on himself and his family.]
"I cannot afford HIV treatment if I test positive for HIV, so I might as well not know it."	"Antiretroviral treatment for HIV is free."
"I am shy and I am worried that staff at the clinic will look down on me."	"I can accompany you to support you and help you deal with this, if you wish."

What are arguments to encourage HIV testing?

There are several reasons for why people particularly at risk should have an HIV test (and regularly if they are negative). First, HIV testing is important because finding out whether people have HIV will enable them to access antiretroviral treatment. This will keep them alive and healthy. The earlier a person starts with this treatment, the better the long-term effects of the treatment and the fewer the long-term detrimental effects of HIV will be.

Second, it is important to find out whether a person has HIV to avoid passing it on to others. People who are diagnosed with HIV are often extra careful and extra safe when having sex to ensure that their partners do not get exposed. Getting on antiretroviral treatment is in itself an effective way to avoid transmitting HIV to others.

Third, testing is a good way to reduce anxiety about HIV or STIs. Walking out of the testing centre with a negative result is a great feeling, and it can strengthen a person's resolve to remain free of HIV and be safe when having sex.

Fourth, both HIV testing as well as antiretroviral treatment are free. You can stress to a client: "Why not make sure you access these services and stay in control of your health?"

The fifth reason you can give your client: "If it is not for yourself, you might consider getting tested to ensure you stay healthy for your family and friends or, if you have a partner, for your partner!"

And a sixth reason to cite: "If you decide to settle down with somebody special, you may discuss together to start having sex without condoms. To do so, both of you should get tested to ensure you have the same serostatus."

It should be emphasized that there are certain groups of men who have sex with men who may have difficulty accessing HIV counselling and testing. These groups include people from ethnic minority populations who may not have citizenship in their country of residence and may have difficulty communicating with health care providers. The same may be an issue for migrants who wish to be tested. Another group that often faces difficulties accessing HIV testing services are adolescents under the age of 15 (or 18), who may need parental consent to access medical services.

Unit 10

Sexually transmitted infections and how they can or cannot be transmitted

What is a sexually transmitted infection?

A sexually transmitted infection (STI) is a disease or infection transferred between humans, usually by means of sexual contact (vaginal, oral or anal sex). Some STIs can also be transmitted from mother to baby and through the sharing of injecting-drug equipment. STIs overlap with a broader group of infections known as “reproductive tract infections”.



For more details, see [Table 5](#) and [Annex 2](#).

What are the symptoms of STIs?

Symptoms may differ from one STI to another. STIs may lead to symptoms in the reproductive organs as well as in the skin around the vagina, penis or anus. Some STIs also cause systemic symptoms that cause problems in other parts of the body. **Other STIs (such as chlamydia, gonorrhoea, HPV, hepatitis B and genital herpes) often cause no symptoms at all.** Thus, although the person has an infection, they may have no symptoms and may not realize that they are infected. Despite being asymptomatic, they may still be infectious (see [Annex 2](#)). It is therefore important for clients who are sexually active to frequently test for STIs, even if they have no (clear) symptoms.

Symptoms of STI can include:

- 1 Having to go to the toilet very often to pee. This can also be a symptom of bladder infection.
- 2 An ulcer or sore on the penis or anus.
- 3 Itching around the groin or between the buttocks.
- 4 Pus coming from the penis and/or pain during urination.
- 5 Other (see the STIs listed in [Annex 2](#) for details).

Why should someone bother about STIs that are asymptomatic?

STIs without symptoms can be transferred to others and can cause serious complications, especially if they are not treated.

Why are STIs relevant to HIV prevention?

Because STIs are transferred in much the same way as HIV is, it is also important to prevent their occurrence. People who have untreated STIs are more likely to become infected with HIV and to transmit HIV to others.

Why are people with STIs more likely to get or transmit HIV?

STIs often result in open sores, lesions or abrasions on the anus or penis (or mouth), which provide convenient entry points for HIV infection. In short, someone with an STI is more likely to become infected with HIV if exposed. STIs can also cause inflammation in the genitals, producing a discharge. In people who also have HIV infection, the large number of HIV-infected cells in the discharge makes it easier to transmit HIV.

What are the differences between HIV and STIs?

HIV is often sexually transmitted but can be transferred in other ways (through the sharing of needles or injecting equipment, through a blood transfusion with HIV-infected blood or from an HIV-infected mother to her baby). Therefore, HIV is different from most STIs, which are generally transmitted only through sex.

TABLE 5

Overview of sexually transmitted infections

DISEASE	TRANSMISSION	TYPE OF GERM	MAIN SYMPTOMS	TREATABLE?
Chlamydia	Vaginal, anal and oral sex; hand to eye; mother to baby	Bacterium	Often none; however, it can include discharge from penis or anus, burning urination and swollen, painful testicles	Curable with antibiotics
Gonorrhoea	Vaginal, anal and oral sex; hand to eye; mother to baby	Bacterium	Often none; however, it can include dripping penis or rectal discharge, painful urination, throat infection and swollen, painful testicles	Curable with antibiotics—but resistant strains are very common
Syphilis	Sexual contact with sore; mother to baby	Bacterium	Painless sore near genitals, body rash with severe symptoms later	Curable with antibiotics
Herpes	Sex; skin to skin; mother to baby	Virus	Often no symptoms; however, can include flu-like symptoms or painful blisters around genital area or mouth	No cure, but infection and symptoms are treatable
HPV	Sex; skin to skin; mother to baby	Virus	Usually no symptoms, but infectious; however, can include genital warts or ano-genital cancer	No cure for infection, but warts can be removed—also preventable by vaccine
Hepatitis B	Sex; sharing needles; blood; mother to baby	Virus	Several, including flu-like symptoms, dark urine and light stools and jaundice	No cure for infection but preventable by vaccine
Scabies	Skin to skin	Parasite	Itching, rash	Curable, with insecticide
Lice	Skin to skin	Parasite	Itching	Curable, with insecticide



All these diseases are discussed in more detail in [Annex 2](#).

Can an STI be cured?

All STIs except for viral STIs, such as HIV, HPV and herpes, can be cured with medicines—usually antibiotics under medical follow-up.

Can STIs be cured at home by buying drugs from a pharmacy?

No! It is impossible for an untrained person to know the diagnosis (which STI a person has) and what the latest recommended treatment for that STI is. Therefore, it is essential that your client seeks treatment from a qualified medical service provider. This will also allow for proper testing for possible other STIs that may not be showing any symptoms.

Can STIs be prevented?

The chance of becoming infected with an STI can be reduced by avoiding risky sexual behaviours. To reduce the risk, you should advise your clients:

- Use condoms during oral, anal and vaginal sex.
- Use water-based lubricants with condoms, especially during anal sex.
- Limit the number of sex partners.
- If they have recently been treated or are being treated for an STI, they must make sure their sex partners also receive treatment to prevent getting infected again and infecting other people. Sex partners should receive treatment even if they do not have any symptoms.
- Don't share sex toys—if they do, they should cover them with a new condom every time they are used with a different partner.
- Maintain good genital hygiene (see the discussion further on).

Some STIs can be transferred via skin-to-skin contact—see [Annex 2](#).

How can someone know if they have an STI?

STIs can be symptomatic or non-symptomatic. If there are no obvious symptoms, the only way that a person can find out whether they are infected is by testing at an STI clinic.



See [Annex 1](#) for an overview of STI testing and treatment services in your country.

How can I tell clients to check themselves for STIs?

You can start by explaining: “Regularly examining the genitals and anal area for signs of STIs can be done in less than one minute. This examination is also useful for detecting other uncomfortable problems, like skin rashes and in-grown hairs. Here’s how you do it:”

- 1 "Grab a small mirror. Find a private place and get naked."
- 2 "Examine your body, especially areas of sexual contact. Do you see any sores, blisters, rashes, itchy areas, redness, swollen bits or fluid discharge or smell an unusual odour on or around your penis, anus or testicles?
 - Lift and look under the balls.
 - If you are uncircumcised, pull back the foreskin and look at the skin under the foreskin.
 - Look at the area between your anus and your testicles.
 - Check your pubic hair closely for small eggs, lumps or lice (or crabs).
 - Gently squeeze your penis along the shaft to check for any unusual discharge that is smelly or creamy in colour (remember, it is common for men to find some fluid when doing this but it doesn't mean you have an STI)."

"If you detect signs of an STI, it is time to go to an STI clinic for treatment!" Tell your client that there are friendly and confidential STI services available in your city and give the locations.

You should then emphasize: "If you want to be sure that you do not have an STI, you should get tested at a clinic because many STIs do not have the symptoms that you can discover yourself."

Some notes on genital hygiene

- Keeping the genitals clean and healthy is very important, particularly for uncircumcised men and transgender women with a neovagina.
- Genitals should be washed every day with mild soap and water.
- Avoid the use of harsh or perfumed soaps because they can irritate the penis, neovagina and anus.
- After washing, it is important to gently dry. It's not good to leave the genital area moist because this provides conditions in which bacteria can flourish.
- For those with a penis, pass urine before and after sex. This can help keep infections from travelling further up the penis.
- Perform regular self-examination of the genitals for any sores, lumps, discharges or parasites.
- If condoms are causing friction problems around the head, try a bit of lubricant inside the condom. Don't use too much or the condom may slip off.

Source SQWISI PowerPoint presentation, 2005.

What should I do when I think my client may have an STI?

Ask friends or other outreach workers about services for diagnosis and treatment of STIs in your neighbourhood. It is important that services that you recommend are friendly to men who have sex with men and to transgender clients. This allows for your client to be open and honest towards health care staff at such services. After the client has been at the service, ensure that you ask the client how the experience was. If health care staff treat clients in an inappropriate or insensitive manner, it is important that this is reported to the management of your organization and that steps are taken to offer coaching or training to the workers at this facility or, alternatively, that you start referring clients to another STI service.

Unit 11

Supporting people who are living with HIV to stay healthy and happy

What should I tell someone who has just been diagnosed with HIV?

The most important first thing to say is to reassure your client that they are okay and will be okay. Your client should be told that it is lucky to receive an HIV diagnosis in an age when excellent medical treatment is available. People who have been diagnosed with HIV have a good chance to live and die of old age rather than of AIDS. Even so, it is normal that your client will feel a lot of different emotions in coming to accept the idea of living with HIV. Whatever the feelings, it is really important to say that it's okay. It's a good idea to let these feelings out—be angry, be sad, be confident, be calm, be afraid, be numb. If your client becomes overwhelmed by these feelings, tell him to try to be careful not to self-harm or harm anyone else. Consider getting help from professional counsellors, from friends and family and especially from other people living with HIV. Tell the person that talking about their feelings can help significantly.¹⁷



There is an online e-course for people who have just found out they are HIV positive. It can be found here (in English): http://video.catie.ca/myh_01/sco_frameset.htm

What do I say when someone asks, “I almost feel I am sorry I did the test and found out I was positive. Is that normal?”

Your HIV-positive clients might find themselves wishing they had never found out about their status. It is hard to hear at first. But the fact that a client has been diagnosed means that they can take steps to take care of themselves. Knowledge

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See <http://www.catie.ca/en/practical-guides/managing-your-health/1>.

is power. It's a cliché, but with HIV it's true. You should tell your clients: "By knowing your status, you can decide how you want to live with the virus." Maybe some of your clients won't want to know too much at first, but as time goes by, have confidence that they will learn what needs to be done and will find their own way of living with HIV.¹⁸

Can HIV be treated? How?

Yes. HIV is treated with two groups of medicines. One group of medicines is used to slow or even reduce the spread of the virus within the body. These are called antiretroviral medicines (see the explanation further on). The other group of medicines is used to fight illnesses that are caused by a weakened immune system. These are called medicines to cure or prevent opportunistic infections (see the explanation further on).¹⁹ People who begin HIV treatment on time will most likely never need to use the second group of medicines because their immune system is and will remain strong enough to fight off possible opportunistic infections before they take hold.

Can HIV be cured?

The medicines mentioned previously cannot cure either HIV or AIDS, but they do help people live a healthier and therefore a higher-quality life for a longer period of time than if they did not take any medicine.

What happens if people with HIV do not get treated?

If people who need treatment do not receive it, they will gradually get sicker and sicker, and eventually they may die. People who are on treatment and under medical supervision, on the other hand, can live long and healthy lives.

What are ARV and ART?

ART stands for antiretroviral treatment (or therapy)—the term covers the provision of medicines and professional medical care and refers to medications for the treatment of infection by retroviruses, primarily HIV. ARV stands for antiretroviral medicines, which work against retroviruses. HIV is a retrovirus.

What types of antiretroviral treatment exist?

Different classes of antiretroviral drugs act at different stages of the HIV life cycle. Antiretroviral drugs are broadly classified by the phase of the retrovirus life cycle (see [Unit 2](#)) that the drug attacks.

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ibid.

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Much of the information in this unit was taken from <http://www.thebody.com/content/treat/art32195.html>.

There are six types:

- 1 **Entry inhibitors** interfere with the virus' ability to bind to receptors on the outer surface of the cell it tries to enter. When binding with the cell receptor fails, HIV cannot infect the cell.
- 2 **Fusion inhibitors** interfere with the virus' ability to fuse with a cellular membrane, also preventing HIV from entering a cell.
- 3 **Reverse transcriptase** inhibitors prevent the HIV enzyme reverse transcriptase (RT) from converting single-stranded HIV RNA into double-stranded HIV DNA. The process is called "reverse transcription".
- 4 **Integrase** inhibitors block the HIV enzyme integrase, which the virus uses to integrate its genetic material into the DNA of the cell it has infected.
- 5 **Protease** inhibitors interfere with the HIV enzyme called protease, which normally cuts long chains of HIV proteins into smaller individual proteins. When protease does not work properly, new virus particles cannot be assembled.
- 6 **Multi-class** combination products combine HIV drugs from two or more classes, or types, into a single product.

To prevent strains of HIV from becoming resistant to a type of antiretroviral drug, health care providers recommend that people infected with HIV take a combination of antiretroviral drugs in an approach called "highly active antiretroviral therapy" (HAART).²⁰

What is CD4 and what does it have to do with HIV or AIDS?

CD4 cells are a subgroup of white blood cells and are the part of the immune system responsible for fighting infections and are the cells directly targeted by HIV. The "absolute CD4 count" refers to the number of CD4 cells available in the immune system. As HIV progresses, it takes over the CD4 cells, using the cells to replicate itself, killing off the original CD4 cell in the process. This is why a CD4 count is a useful indicator of immune system health—the more CD4 a person has, the stronger the immune system is.

What is a CD4 test and what does it do?

The CD4 count test measures how many CD4 (white blood) cells are in the body, reflecting the health of the immune system. The focus of this test is to measure the absolute CD4 count. The more CD4 cells there are, the stronger the immune system is. A person without HIV usually has a CD4 count between 500 and 1,600.

How often should someone do a CD4 test?

The recommended routine for a CD4 test is as soon as someone tests positive for HIV, then follow up every six months. The result can be obtained within the same day in case a rapid CD4 test is used, or it can take up to two weeks if older CD4 tests are in use.



For more information about the CD4 test, see:
<http://www.thebody.com/content/art58838.html>

When should a person living with HIV start antiretroviral treatment?

There is now strong evidence that from an individual's perspective, there is no good reason to postpone treatment with antiretroviral medicines after being diagnosed. In many cities, treatment only commences when a person's CD4 count drops to below 500. In some cities (Bangkok, Manila and Jakarta, for instance), people at high risk (including men who have sex with men and transgender people) are enrolled into an antiretroviral treatment programme as soon as they are diagnosed, regardless of their CD4 count. This has two distinct advantages: it avoids newly infected people from dropping out or disappearing, and it avoids infections to other people by the newly diagnosed person due to the protective effect and the reduced viral load obtained when on antiretroviral treatment.

How can a person living with HIV monitor their physical health?

There are several laboratory tests that can be used to monitor HIV. The four common tests are viral load, CD4 count, complete blood count (CBC) and blood chemistry tests. These four blood tests are the most comprehensive tests available to monitor the health of individuals living with HIV. Depending on each person's health and whether they are on a treatment regimen, most doctors will run these tests every three to six months. Because these tests are used to monitor a person's overall health through comparisons of tests over time, it is important when people are first diagnosed or when they start their first treatment regimen to get their lab work done to provide a baseline for future comparisons.

What does a lab report look like and what does it mean?

To read a lab report, you will find listed on the summary the names of the tests performed, the results of the tests and the reference ranges. The results are typically reported as absolute numbers measured per a specified unit or as percentages, which can then be compared with the reference ranges provided

for those particular tests. Reference ranges are determined by sampling a large population of healthy individuals to determine a range of averages. A person's test results should fall within those averages to be considered in a "normal" range.

What is a viral load test, and what does it measure?²¹

The viral load test measures the amount of HIV in a body's bloodstream (number of copies per millilitre of blood). There are two tests to do this—the results cannot be compared, so it is important to always take the same test type so that trends can be measured. The viral load test is often seen as less essential than the CD4 test and is sometimes omitted altogether, especially if the CD4 count is extremely low. However, in the near future it is likely that HIV service providers may increasingly move away from CD4 tests towards viral load testing as a means of monitoring success in achieving viral suppression. This will become the case once new rapid viral load tests, which are currently in the development pipeline, become commercially available.

What does it mean if a person is said to have an undetectable viral load?

For the polymerase chain reaction (PCR) viral load test, fewer than 50 copies of HIV in the bloodstream is considered undetectable, and for the branched DNA (B-DNA) viral load test, fewer than 400 copies of HIV in the bloodstream is considered undetectable. If one is undetectable, it means HIV is not making progress to attack the immune system, and this is a good sign. It is also a signal that the treatment with antiretroviral medicines is doing a good job and that the client is adhering to the treatment.

If a person's viral load is undetectable, can they stop using condoms with their partner?

If a person with HIV has an undetectable viral load, this means they have an extremely low chance of transmitting the virus to another person. It is thus less problematic if condoms are not (always) used than when a person's viral load is still detectable. Being undetectable, however, does not mean that a person does not have HIV. There will still be HIV in their blood and sperm (in men), and viral levels can fluctuate for a host of reasons. Therefore, it is better if condoms continue to be used. Again, it depends on how certain a person with HIV and their sexual partners want to be about the possibility of potentially transmitting HIV to others.

While having an undetectable viral load protects against an HIV-positive person transmitting infection, it does nothing to protect the positive person from becoming infected with other diseases. Even with an undetectable viral load, it is still important that an HIV-positive person takes steps to protect their own health!

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See <http://www.thebody.com/content/treat/art32195.html>.

How often does a person with HIV need to do a viral load test?²²

After someone is diagnosed with HIV, the health care provider will conduct or refer them to do a viral load test. After that, they should have a viral load test every six months before they start taking a new HIV medicine and two to eight weeks after starting or changing HIV medicines until their viral load is suppressed.

What is an opportunistic infection?

Opportunistic infections are brought on by organisms that usually do not cause disease in a person with a healthy immune system but affect people with a poorly functioning or suppressed immune system, such as people with HIV or AIDS. These organisms need an “opportunity” to infect a person, and HIV immune suppression provides the opportunity (see Table 6).

Can opportunistic infections be treated?

Opportunistic infections can be treated and prevented; when a person is on antiretroviral treatment and under regular medical supervision, such infections are unlikely to occur.²³ Treatment depends on the type of infection.

TABLE 6

Opportunistic infections occurring at different levels of CD4 count

CD4 COUNT	DISEASE
200–500/ μ L	Pneumonia (usually caused by bacteria)
	Tuberculosis in the lungs
	Oral or vaginal yeast infections
	Shingles (viral skin infection)
	Oral hairy leukoplakia
	Kaposi’s sarcoma
100–200/ μ L	All of the above plus:
	Pneumonia due to <i>Pneumocystis Pneumonia</i> (PCP)
	Chronic diarrhoea
50–100/ μ L	All of the above, plus:
	Encephalitis (usually due to toxoplasmosis)
	Esophagitis due to yeast infection or a virus
	Meningitis (usually due to <i>Cryptococcus</i>)
	Tuberculosis outside the lungs
	Chronic herpes simplex virus infection
	Primary brain lymphoma
<50/ μ L	All of the above, plus:
	Widespread infection due to <i>Mycobacterium avium</i> complex
	Retinitis, diarrhoea and encephalitis due to cytomegalovirus

22 Taken from <https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/viral-load/>.

23 For information on prevention of opportunistic infections, see <http://www.thebody.com/content/treat/art13054.html>.



See also: <https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/potential-related-health-problems/opportunistic-infections/>.

What is a complete blood count test?

The complete blood count (CBC) test is a measure of all the components that make up blood. The test is important because some drugs can cause low red or white blood cell counts, which can lead to anaemia or other blood disorders. This test measures the amount of white blood cells, haemoglobin, haematocrit and platelets in the bloodstream. With this test, a high white blood cell count can suggest that the body is fighting an infection that may be undetectable; a low red blood cell count with the haemoglobin and haematocrit could be the result of anaemia from the HIV medications; and a low platelet count could affect blood clotting.

How often should a complete blood count test be done?

This test is different from the viral load test or the CD4 count because it doesn't show a direct progression related to HIV. But it does help determine the overall health of the individual. It is recommended that someone taking antiretroviral medicines should do a complete blood count test every three months. This test takes one day for the laboratory to process.



See **Annex 1** for details on the services available in your area.

Apart from adhering to antiretroviral treatment, how can people living with HIV stay healthy?

You can tell your clients that there are many things people can do to feel healthier and better about living with HIV. One of the best ways to cope with HIV—other than taking anti-HIV drugs—is to work towards achieving a healthy, happy and relaxed life. You should emphasize that they have to work towards getting and staying healthy, reducing harm to themselves and others and taking control of their personal well-being. Finding the right balance for their body and lifestyle can make living well with HIV a reality.

This includes:²⁴

- 1 Eat a balanced diet based on fresh and unprocessed foods, with lots of vegetables and fruits.
- 2 Be extra aware of hygiene and food safety; people with HIV may be more susceptible to disease-causing bacteria. Wash hands frequently; ensure meat and fish are thoroughly cooked; carefully wash or peel fruits and vegetables; avoid foods that are past their best-by date and pay attention to warnings about food contamination.
- 3 Some foods can interfere with HIV treatments. Your clients should ask their doctor if there are any specific foods that they should avoid.
- 4 Get sufficient minerals and vitamins; some people with HIV have been found to have difficulty extracting minerals and vitamins from food, so vitamin supplements might be a good idea.
- 5 Maintain a healthy weight. Many people believe people with HIV lose weight easily, but many people with HIV actually have trouble keeping their weight down.
- 6 Recommend to your clients that they consume a sufficient level of antioxidants. Antioxidants are important because they neutralize molecules called “free radicals” inside the body. Free radicals start a process called oxidation, which damages healthy cells in the body. HIV can intensify this process of cell damage. Antioxidants protect against cell damage. The body makes antioxidants, but it can be helped by consuming foods that are rich in antioxidants. These include blueberries, red peppers, spinach, black and green tea, red wine and dark chocolate. Antioxidants also can be taken in supplement form.
- 7 Exercise can lead to a stronger body, higher self-esteem, less stress, better sleep, better heart and lung function and fewer mental problems, such as anxiety and depression.

What kind of support do people living with HIV need?

Apart from the medical support and treatment discussed previously, people who are diagnosed with HIV need social and psychological support. Many of them are devastated when they are diagnosed and need counselling and information about how to live their life with this new reality. Case managers are tasked with looking after newly diagnosed people and helping them stay or get back on their feet. In some countries, workshops are regularly organized for newly diagnosed men who have sex with men and for transgender people to help them share their experiences and learn how to remain healthy.

What can people living with HIV do to reduce their sense of stress and anxiety?

A certain level of stress and anxiety is quite normal if someone has just been diagnosed with HIV. You might suggest to clients that they consider learning how to meditate or take classes in yoga or tai chi. Having massages helps some people de-stress as well. At the least, clients should be encouraged to do more of what they like to do or to explore something they have always wanted to do, such as travel or learn a new skill or language.

What do I say when someone asks, “Can I still consume alcohol?”

You might consider saying something like: “Having a few drinks can relieve stress and give you a chance to catch up with friends. However, excessive alcohol consumption can be dangerous. It can deplete important vitamins and minerals from your body. It also can be hard on your liver. Too much alcohol can lead you to make errors in judgement, and because sex and alcohol often go together, alcohol can lead you to make choices you may regret, like not having safer sex and not telling your sex partners about your HIV status.”

Alcohol is a well-known depressant, and depression is an issue with which many people with HIV struggle. You should also warn your clients: “Proceed with caution when it comes to alcohol; if you feel that alcohol is affecting your decision-making and your quality of life, speak to your doctor about ways that you can regain control of your alcohol use.”²⁵

What do I say when someone asks, “Can I still smoke tobacco?”

You can remind your clients: “Smoking tobacco has been shown to lead to heart disease and cancer and can make breathing-related conditions, including asthma and emphysema, much worse. The nicotine in cigarettes is highly addictive. If you smoke, quitting may be the single best thing you can do for your health and well-being.”²⁶

What do I say when someone asks, “Can I still have sex?”

You should say: “Yes, of course! But in the context of HIV, it’s important to think about the health of your partner, too. Because sex is, for the most part, a social act that takes place between or among people, your own sexual health is inescapably linked to the sexual health of your partners. It is therefore important to take measures to prevent transmitting your HIV infection to a lover or sex partner. There are several ways of doing this; the most important one is to take

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Taken from <http://www.catie.ca/en/practical-guides/managing-your-health/4>.

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ibid.

your antiretroviral treatment faithfully, which will radically reduce the chance you transmit HIV to others.”

For your clients who are HIV-positive, remind them that using condoms during anal sex is another important way to reduce the risk of HIV transmission. If they are in a committed relationship, they should discuss with their partner whether they would be willing to go on antiretroviral medication as well (such as PrEP) to prevent infection.

How can an HIV-positive person make sex safer?

This question is covered throughout the manual, but to reiterate, sexual contact with another person can be made safer in the following ways:

- 1 Take antiretroviral medicines faithfully to keep the viral load low or undetectable.
- 2 If your client is in a steady relationship with someone who is HIV-negative, they should consider suggesting that their partner enrol in PrEP (see [Unit 6](#)).
- 3 Use a latex condom with a water-based lubricant and use a new condom with each new partner and with each new act of oral, anal or vaginal sex.
- 4 If your client likes both the insertive and receptive roles in anal sex, you can suggest they consider sticking to the receptive role only because this greatly reduces the chance of virus transmission to sex partners.
- 5 Use a dental dam (see [Unit 7](#)) for oral sex on a woman or oral-to-anal sex. Use an intact male condom for oral sex on a man’s penis.
- 6 Use a latex glove and, if necessary, a water-based lubricant when engaging in other penetrative sex (fisting or fingering).
- 7 Clean sex toys with soap and water after each person uses them.

Several research studies have shown that the viral load found in the bloodstream is often different from the viral load in sperm and vaginal fluids. Often, the latter is higher. Therefore, it is still important that a person living with HIV always practises safe sex with sexual partners. A low or undetectable viral load (measured in the bloodstream) is just another layer of protection for sexual partners that reduces the risk of transmission.

What are barriers to prevention for people living with HIV?

The following are major barriers to preventing HIV transmission (either re-infection or transmission to others) for people living with HIV.

First, disclosure (telling others about HIV status) is a major barrier for prevention among people living with HIV. People who were recently diagnosed with HIV should get advice on whether and how to disclose their HIV status from other people living with HIV (such as support groups or services) or from HIV

counsellors or other health care providers (see Annex 1 for details of service providers in your area).

Second, some people with HIV have no or limited access to antiretroviral treatment. This means they are unable to suppress the viral load in their blood, semen and rectal fluids. Enrolling in HIV treatment is the single best way for newly diagnosed people living with HIV to reduce the risk of onward transmission. It is particularly important for people who prefer to not disclose their HIV status to others.

Third, access to condoms, dental dams and/or lubricants can be problematic. Condoms may be difficult for individuals to find in the “heat of the moment”, so stress to friends and clients that they should always be prepared by having condoms with them at all times.

What do I say when someone asks, “What if my HIV-negative partner is accidentally exposed to my HIV?”

In 2005, the US Centers for Disease Control and Prevention recommended that PEP be offered to individuals who have been accidentally exposed to HIV in non-work-related situations (PEP for work-related exposures, such as a needle-stick injury in a health care worker, has been recommended for several years) (see Unit 6).

PEP is simply HIV therapy taken by an HIV-negative person who has been (or might have been—often it is not known for sure) exposed to HIV. If taken soon enough, PEP may prevent that person from getting HIV. PEP requires that a person start taking HIV medications within 72 hours (three days) after possible exposure to the virus. PEP therapy should always be prescribed and closely monitored by health care professionals. Tell your clients: “Do not start PEP by yourself!” A person on PEP must take HIV medications for at least one month. These HIV medications often have side effects that might make it difficult to continue therapy. However, a person should always check with their health care provider before starting or stopping PEP therapy.

To get PEP, it is probably easiest for a person to visit their local emergency hospital; however, some clinics or health care providers are now also offering PEP. It may not be available in all cities or countries in the region (see [Unit 6](#)).

What do I say when someone asks, “If I am on antiretroviral treatment, can I stop using condoms?”

You must stress that no, they can’t stop using condoms. You can say to your clients that even though the treatment may make their body so healthy that it becomes difficult or impossible to detect HIV in the bloodstream, HIV is still there. And there is still a small possibility that they might infect others with HIV. It is recommended to continue using condoms with all sex partners. Condoms will also

provide protection against other STIs, which people living with HIV are more at risk of contracting and which can have stronger symptoms in their system. Inform your clients living with HIV that other STIs can weaken their immune system.

What is the role of social support for people living with HIV?

People with HIV have been found to benefit from social and psychological support, where it is available, especially from support groups of people who are also living with HIV. Not all places have social support services for people with HIV, let alone for men who have sex with men and for transgender people. Look at Annex 1 to see what services are available in your area.

People living with HIV often benefit from small group discussions and skills-building exercises that are combined with individual counselling. Support combined with health care provider-delivered prevention messages is also useful. In other words, these three directions for behaviour change also reinforce each other.

Unit 12

Sexuality and sexual identities

What is sexuality?

Sexuality is a set of ideas, knowledge and practices related to the expression of sexual desire between human beings. It can include sexual acts, sexual identities, sexual meanings, norms and values related to sex and sexual relationships.

What is sexual orientation?

Sexual orientation refers to the direction of sexual attraction or desire. It refers to the type of sex and the type of person that an individual is attracted to. The most commonly understood sexual orientations are heterosexuality (being attracted to members of the opposite sex), homosexuality (being attracted to members of the same sex) and bisexuality (being attracted to members of either sex).

What is sexual identity?

If people relate their sexuality to “who they are” rather than to “what they do”, they may adopt a label that describes their identity linked to their sexuality. Examples may include self-identifying as a gay man, transwoman, homosexual, heterosexual or bisexual. Many cultures and societies have special words to describe sexual identities.

Usually, this self-view is linked to a person’s sexual orientation. In other words, a man who is attracted to women will call himself a “real man” or “straight” or “heterosexual”. But sometimes a sexual identity is not related to a person’s sexual behaviour. For example, a gay man who occasionally has sex with a woman may still call himself “gay” or “homosexual” because he or his friends may dislike the label “bisexual”. Likewise, many men who have sex with men prefer the “straight” label when interacting with their friends and family because they feel less stigmatized by it and can retain their status as “real men”.

It is important to remember that our sexual identity (who we say we are), our sexual orientation (who we are sexually attracted to) and our sexual behaviour (what we do sexually) can be quite different things!

What do I say when someone asks, “What is my sexual identity?”

You should say: “That depends entirely on you!” You can further explain that it usually relates to sexual orientation but not necessarily so. Many people also derive their sense of identity from something other than their sexual orientation or sexuality, such as nationality, position in the family (son, brother, father) or profession or religion.

What is heterosexuality?

Heterosexuality refers to sexual attraction or sexual activity between men and women.

What is homosexuality?

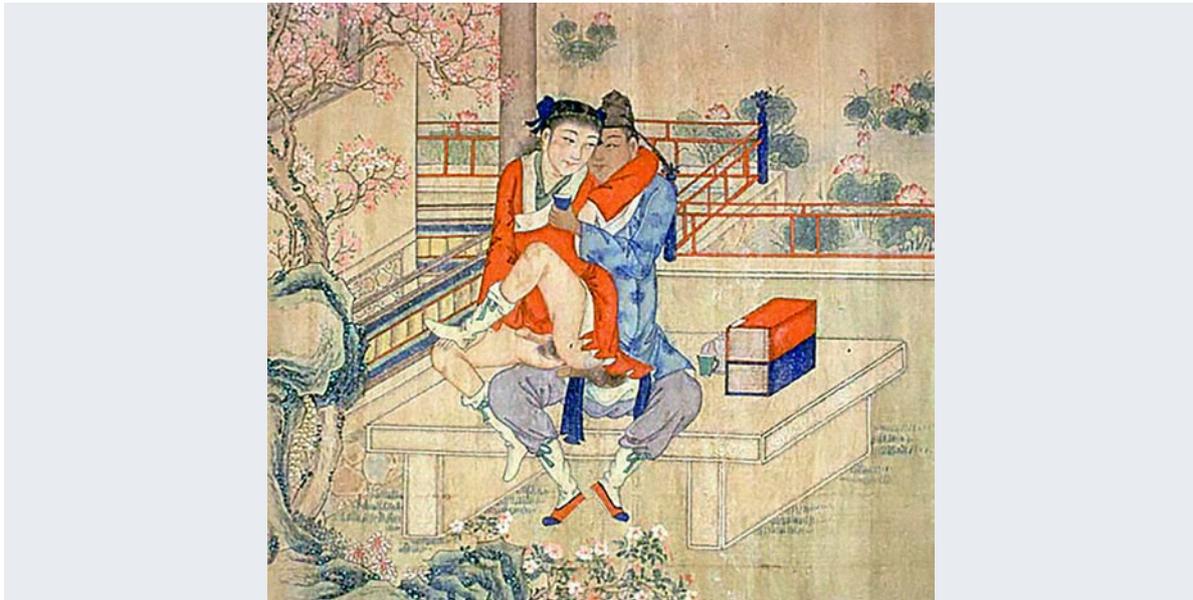
Homosexuality refers to sexual attraction or activity between men and men or between women and women.

What is bisexuality?

Bisexuality refers to attraction to individuals of both sexes.

Is homosexuality unnatural?

No. Homosexuality has been part of all human societies, on all continents and in all cultures for thousands of years. If homosexuality were uncommon or unnatural, there would not be so many of us! Homosexuality has also been reported between animals. It was only relatively recent that scientists started to realize that homosexuality is not a “mental disorder”, as some of them had thought before—the World Health Organization has officially declassified homosexuality as such, for instance.



Two men making love on a terrace, Qing Dynasty painting on silk (18th-19th century)

How many men who have sex with men are there?

International organizations assume that between 3% and 5% of men have sex with other men regularly and that up to 15% have experience with other men at least once in their lifetime, though not frequently.²⁷ These figures have been confirmed for nearly all countries in the Mekong region. But the number of “open” or self-identified men who have sex with men is much smaller. It partly depends on the level of stigma and/or openness that exists in different societies.

Is it true that the number of gay or homosexual men is growing?

In most countries, due to urbanization and globalization, there is a trend towards growing numbers of men who are open about their sexuality, along with increased organization and participation in communities. This gives the impression that the number is actually growing, whereas the total number of men who have sex with men is probably stable.

Are all men who have sex with men part of a gay community?

No. Whereas most outreach workers will have been recruited from a gay or other sexual minority community, it is important to realize that in most countries there is probably a large majority of men who have sex with men who see their sexual behaviour as a pleasurable activity or hobby, but it is not something to organize their life around. For that reason, it is important not to package all HIV services around the idea of a community because this might scare away significant numbers of men who have sex with men who choose to lead a more hidden, discreet sexual life, often in combination with having a family (marriage to a woman) and children.

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C. Caceres et al., “Estimating the number of men who have sex with men in low and middle income countries”, in STI, 82(Suppl III), 2006, pp. iii3–iii9.

Why do some men have sex with men and others do not?

It is not known exactly why some men like sex with men and others do not. It is partly caused by genes and by physical or mental characteristics that are there at birth. Some men like both men and women, and whether they become sexually active with men can partly depend on their environment and on the opportunity.

Some men are attracted to a particular sexual behaviour; for example, they like to penetrate and they do not care whether they penetrate a woman or another man. It depends on their mood and their desire or on the situation. Some men have sex with men in all-male environments only, like jails, marine ships, fishing ships or boarding schools, because there are no women available there. Such men prefer women, but they do not have a girlfriend and no access to women, so they have sex with men instead. Some men do have sex with other men because they need money, and they can earn money engaging in such relationships.

Some adolescent boys have sex with each other to learn about their bodies and explore their emerging sexual sensations, especially in societies where they cannot experiment freely with girls (i.e. most Muslim societies). As soon as they are adults and/or have access to women, they may (or may not) stop having sex with other males.

Why do some men who have sex with men also have sex with women?

Some men who have sex with men prefer women, or they like both men and women. As previously mentioned, some men are attracted to a particular sexual behaviour; for example, they like to penetrate and they do not care whether they penetrate a woman or another man. Some men who like other men want to have a family and get married. Or sometimes they are forced to marry and likely feel forced to have sex with women due to family or social pressure.

Do homosexuals lack male hormones?

No. Although many people believe this, hormones have nothing to do with sexual orientation or behaviour. Hormone treatment will therefore not “cure” homosexuality, although it may influence sexual appetite.

What do I say when someone asks, “I am a man who likes sex with other men but I want to change. Can I be treated or cured?”

Because homosexuality is not a disease, it cannot be treated or cured. Homosexuality is part of the natural variety in human sexuality. You should explain to your clients that they need to learn to accept themselves as they are and live their life with this reality. However, some men who have sex with men also have sexual desire for women and manage to live a married life in addition to their

sexual relations with other men. There are many ways to live with homosexuality, either in the open or in secret. It might be possible to change sexual practices (or stop having sex, for a while at least), but emotionally it is unlikely that anyone can forget their desires for other men or their love for transgender persons.

Many men who “discover” their feelings of homosexuality later in life are initially shocked. They might hate themselves and blame themselves for these feelings. This period is one of great vulnerability to HIV, because men who dislike themselves are less likely to protect their health than men who feel comfortable with who they are. Sometimes, people around a man who has just discovered that he is not heterosexual try to treat or cure him while he is in a period of great turmoil and despair. Such “conversion therapy” has rightfully been outlawed in many Western countries because it is not only totally ineffective but also unethical and hurtful towards the persons being forced to undergo it.

Can homosexuality be temporary?

Sometimes, adolescent boys are attracted or in love with male friends, but once they grow older, their attractions shift to women. This is especially common in countries in which boys and girls are strictly separated from each other, such as some Muslim societies. So yes, homosexual orientation can be temporary, but this is more likely only at a young age (12–17 years old). If a person is sexually attracted to men after that age, it is not likely to change, although exceptions to this rule have been reported.

Are men who have sex with men and transgender people bad people?

Of course not. Men who have sex with men and people who are transgender are no better or worse than men who have sex with women. People should never be judged by their sexual orientation or identity because this is something they cannot choose or change. Goodness or badness of an individual is (and should) be determined by how someone treats others in society. Someone’s sexuality or gender orientation is not related to this.

Why do so many people dislike men who have sex with men and transgender people?

Men who have sex with men and transgender people are often discriminated against by society because they are different. For many people, being different is strange or bad. People who are different are also often blamed for bad things, for example, for moral decay in society or for diseases like STIs and HIV. Some religious or political leaders see themselves as “defenders” of morality, and they often take negative views

of homosexuality. In recent years, a surprising number of such defenders have been outed in media reports for being homosexual themselves.



See **Unit 18** on stigma for more on this issue.

Why is it important to feel good about yourself—and shake off possible stigma and negative attitudes by society?

Being discriminated against or laughed at may lead some men who have sex with men and transgender people to feel guilty, bad or dirty. They may have heard negative things about men who have sex with men and about transgender people since the time they were children. You should tell your clients: “It is important to realize the health consequences of feeling bad about yourself. There is strong scientific proof that it is less likely that you will protect your health if you feel you don’t have any value.”

Negative self-esteem and feelings of guilt are seen as important obstacles to behaviour change, and it is important that religious leaders who express negative views about homosexuality are confronted and corrected, and that men who feel bad or guilty about their sexuality are supported to change this around.

Is homosexuality caused by karma?

Some people think karma has brought on homosexuality and others disagree. It is important to realize the consequences of thinking of homosexuality as a “punishment”, however. It may lead people to have low self-esteem, and this will make the process of behaviour change more challenging or even impossible in some cases. Homosexuality is common in nature, and it is caused by genetic, biological and possibly social factors only—not moral ones.

Is homosexuality caused by growing up around too many females?

Some people believe this, but there is no scientific evidence for it. Many men who have sex with men and many transgender people did not grow up around females and still ended up as men who have sex with men or as transgender people.

Unit 13

Basic health issues for transgender people

What is transgender?

Most people are comfortable with being male or female. Most people typically never give it a thought. But there are some people who feel they were born with (or inside) the wrong body or who otherwise feel their assigned sex at birth is not correct. If such persons want to adapt physically to another sex as completely as possible, these people are considered to have a medical condition known as "gender dysphoria" (meaning discontent and discomfort about one's gender) and are generally referred to as "transgender". A person born as male who transitions to a woman is called a "transgender woman" or a "trans woman". A person born as female who transitions to a man is called a "transgender man" or a "trans man".

Transgender is a term describing the crossing of gender boundaries. This can be done for a variety of reasons and motives by women and men (though predominantly men), on a part-time or full-time, temporary or permanent basis, with or without the use of cross-sex hormones and with or without a sex change operation. This unit focuses on people who cross more or less permanently from the male into the female gender.

How many transgender people are there?

This is not known. Because of the social stigma attached to being transgender, it is something that is often kept hidden. Some scientists have estimated that 1 in 12,000 men and 1 in 25,000 women are transgender by nature, but not all of them will follow their desire to be different by crossing the gender divide. Doing so depends on the possibilities and opportunities in the environment in which they live and other factors.

What is the medical treatment for gender dysphoria?

The currently accepted and effective model of treatment for the condition of gender dysphoria uses hormone therapy and surgical reconstruction and may include counselling and other psychotherapeutic approaches. The male-to-female transgender will typically take courses of female hormones (oestrogen) similar to those used in the contraceptive pill and hormone replacement therapy (HRT). Some transgender women have access to speech therapy and facial surgery to make their appearance more feminine. Hairy men may undergo treatment to remove beard growth and other body hair. In all cases, the length and kind of treatment provided will depend on the individual needs of the client and on whether the person has money for medical treatment and/or surgery.

How is gender dysphoria diagnosed?

Usually people with gender dysphoria have a clear picture of what their problem is and what the solution should be. In the Western world, the diagnosis is verified by a mental health professional. In Asian countries, no such diagnosis occurs because there is no medical procedure or test for proving it. In many countries, with few or no specialized mental health professionals, people will often start hormone treatment themselves and find a surgeon to perform the sex change at a later stage. For many young and starting transgender people, the role of senior or older transgender people in their circle of friends is important.

What are the effects of taking hormones or birth control pills?

Many transgender women take hormones (including birth control pills) to become more feminine in appearance. Most clients experience noticeable changes within two to three months, with irreversible effects after 12 months. The main effects of feminizing hormones are as follows:

- 1** Fertility and sexual arousal drop rapidly. The most important aspect is that erections become infrequent or unobtainable, and this may become permanent after a few months.
- 2** Breasts develop, the nipples expand, and the area around the nipples darkens to some extent. The final breast size is usually smaller than that of a natural-born woman, hence some people will seek a surgical breast augmentation.
- 3** Body and facial fat is redistributed. The face becomes more typically feminine, with fuller cheeks and less angularity. In the longer term, fat tends to migrate away from the waist to be re-deposited at the hips and buttocks, giving a more feminine figure.
- 4** Body hair growth often reduces, and body hair may lighten in both texture and colour. There is seldom any major effect on facial hair, although if the client is undergoing electrolysis or laser treatment, hormone treatment does noticeably reduce the strength and amount of re-growth. Scalp hair often improves in texture and thickness, and male-pattern baldness generally stops progressing.

- 5 Some people report sensory and emotional changes. Heightened senses of touch and smell are common, along with generally feeling more emotional. Mood swings are common for a while following commencement of hormone therapy or any change in the regime.²⁸



Warning: You should make clear to your clients that taking hormone treatment without proper medical supervision can be dangerous. Hormones affect many different parts of the body and bodily functions. Some medical tests may be necessary to ensure that the body can handle the treatment well or which types of treatment will work best for you. Advise your clients to always obtain advice from a trained specialist or medical doctor, if they have access to one.

What happens during sex-change surgery?

Many transgender women will aim to undergo an operation to change their sex organs. The most frequent form of surgery for transgender women is creation of a vagina (called “neovagina”) with a technique known as “penile inversion”. When carried out by a skilled and experienced gender-reassignment surgeon, the results look almost indistinguishable from the external genitals of a woman.

Of course, because a transgender woman does not have ovaries and a womb, she is not able to conceive and does not have monthly menstrual periods. During the operation, tissue and skin from the penis and scrotum are relocated to form a vagina and clitoris. Following surgery, the transgender woman will need to keep her newly formed vagina from closing up by performing regular dilation. She should also not have sexual intercourse until two months after the operation.

Why are transgender people often at increased risk for HIV?

Because of their involvement in unprotected anal sex with multiple partners as well as limited access to HIV services due to their often marginalized position in society, transgender people are perceived as at increased risk for HIV. Health care professionals may not know how to deal with transgender people; they may stigmatize or discriminate against them or even refuse them services. Many transgender people need to get by in life by selling sex because other forms of employment (or access to education) are often blocked due to societal stigma and discrimination as well as rejection by their families, leading them to have greater exposure to HIV risk than many other people.

Unit 14

Dealing with love, sex and friendship

Why do some men who have sex with men and some transgender women have many sex partners?

Although not all men who have sex with men or transgender people have more sex partners than other men, many do, including (perhaps especially) those that you are likely to meet during your work at cruising venues.

There are several reasons for some men who have sex with men and transgender people to be more sexually active than heterosexual (married) men or than women. First, whether this is caused by biological factors or has been societally sanctioned, boys and men may have a stronger sex drive than girls and women, and men may be more likely to aim for more sex partners than women. Many men must reduce their sexual exploits after they find a wife. But for men who have sex with men and for transgender people, this is not an issue. Many of them continue to have multiple partners throughout life. For some men, this lifestyle is part of their sexual liberation, an answer to their previously (or sometimes continued) repressed sexuality. Social support or finding activities that use energy in other ways (sports, for instance) may help people who want to reduce their sexual activity level.

Some men agree that they should limit their sexual exploits, but they may not see sex with a man as real sex but just as play, and therefore they may not feel they should restrain themselves when it comes to sex with men.

Sexual relationships between men often take place in secret—hidden from society. Social control to limit a man's sexuality (which would control married men) is avoided this way.

Why do so few men who have sex with men and transgender people have long-term relationships, like men and women do?

First of all, many men who have sex with men and some transgender people do have long-term relationships with one person, just like heterosexual couples. But there are many factors for why many people do not or cannot have such relationships.

Many societies do not allow same-sex couples to live their relationship openly or to openly build a life together. In some places, such a life is illegal or prohibited. In such circumstances, it is difficult for many same-sex sexual relationships between men to be long-lasting.

And oftentimes, relationships between two men are not taken seriously or even respected by friends or by family or by society; thus, these men do not receive encouragement to maintain a relationship when they experience problems, the way people in a heterosexual relationship might experience.

An impact of this can be that some men who have sex with men and some transgender people may be afraid or may not take their relationships seriously, thinking these relationships are not as valuable as those between men and women. The male partners of transgender persons often see their relationship as temporary and aimed at fulfilling sexual desire and not as a long-term commitment. This also partly relates to the reality that transgender persons cannot give birth. The desire to have children is often a reason for men and women to marry and stay together, which is a factor that is lacking for male–male relationships in many places, although in more and more countries same-sex couples are legally allowed to adopt children.

Should men who have sex with men and transgender people be allowed to marry?

According to universal human rights, everyone should have the right to marry. But various cultures have a different regard for who can marry and who can marry who. Therefore, there is no true or false answer to this question. It depends on each individual whether you agree or not.

Some people believe marriage would make relationships between men more stable, more official, more accepted and therefore more sustainable. And for that reason, they argue that men should be allowed to marry each other. There are other reasons also, such as the advantages that married couples have in terms of pensions, insurance and tax benefits that single people, or unmarried couples, do not have.

Other people believe that marriage should be between a man and a woman only, partly because marriage is often used as a means for procreation and raising children. Fortunately, more and more Asian governments appear to recognize civil partnerships between men, between women and between transgender women and men, and others are even moving towards equal marriage rights.

Can men who have sex with men and transgender people be good parents?

In the United States and Europe, gay and lesbian parenting enjoys broad support from medical experts. According to the American Psychological Association, "There is no scientific evidence that parenting effectiveness is related to parental sexual orientation: Lesbian and gay parents are as likely as heterosexual parents to provide supportive and healthy environments for their children" and that "research has shown that the adjustment, development, and psychological well-being of children is unrelated to parental sexual orientation and that the children of lesbian and gay parents are as likely as those of heterosexual parents to flourish."

Are the children of homosexual partners more likely to be or become homosexual?

Extensive scientific research has proven that children of same-sex partners are not more likely to become homosexual, as is sometimes believed.²⁹

How can men who have sex with men or transgender people become parents?

Many men who have sex with men or transgender people would like to have children. Common methods to become a parent are adoption, donor insemination, foster parenting and surrogacy.

Another possible way is to become a sperm donor for a heterosexual couple or a single woman and arrange for a role in bringing up the child. Or a man can find a lesbian friend who wants to have and jointly raise children. It is important to think about such arrangements long and hard and to make clear agreements between the future father and mother, taking all future scenarios into consideration.

Why are friendships so important for many men who have sex with men and for transgender people?

Friendships are important for all of us, regardless of our sexuality. However, many men who have sex with men and transgender people, especially those who are more or less openly gay, often have little social support from their family and therefore rely heavily on their friends for many things, including social, financial and emotional support.

29

R.U. Paige, "Proceedings of the American Psychological Association, Incorporated, for the legislative year 2004", Minutes of the meeting of the Council of Representatives 28 and 30 July, 2004, Honolulu, in *American Psychologist*, 60(5), 2005, <http://www.apa.org/governance/>.

What do I say when someone asks, “I have a boyfriend, should I be monogamous now?”

You should explain that this depends on their situation. But your client should discuss this together with his boyfriend. Does the partner want to be monogamous? Does your client want it? You could advise the client and his partner to make clear rules for their relationship and be open with each other about it. There are many possibilities that can be included here, and each couple must decide and agree what is best for their relationship. Some people agree that they will remain monogamous. Others agree that they can have only anal sex between the two of them and that they can have non-anal sex with others. It is important that partners agree on what each means by “sex”—does it include oral sex? Masturbation?

What is an open relationship?

Some people choose to have an open relationship, meaning that both partners can have sex with others. The idea is that “sex is sex, love is love”—having sex with others does not have relevance for the love relationship between two people in an agreed open relationship. You can tell a client: “In practice, it may happen that a sex partner becomes a person whom you love or who loves you, and this could create problems with your boyfriend. Also, having sex with others may lead to jealousy and competition between the two of you. On the other hand, sometimes by giving each other sexual liberty, a relationship may last longer than would otherwise be the case.”

You should also point out that people in an open relationship usually continue to use condoms with each other, whereas people in a monogamous relationship often stop using condoms. This can create situations of risk if one or both of the partners continues (secretly) to have (unprotected) sex outside their relationship.

There is no single suggestion for whether a relationship should be open or not. It depends on the persons involved, what they want and expect from each other and from life.

Can a straight man have a healthy, long-lasting relationship with a transgender person?

There have been examples of marriages between transgender women with straight men. In Asian countries, one of the reasons for heterosexual marriages is to have children. That is why many men do not consider transgender women to be serious marriage candidates, unless they agree on adoption or some other way to have and raise children or unless both partners are not interested in starting a family. The social stigma that transgender women experience may also be an important reason for why men do not often choose them as long-term partners.

What do I say when someone asks, “I cannot be monogamous, but I love my boyfriend. What should I say to him?”

You could advise that your client be honest about this with himself and with his boyfriend. They should talk about what they each likes and what each needs. If sex outside of their relationship is something that your client cannot do without, he should discuss that with his boyfriend and find a way forward that is good for him and his boyfriend (see the previous discussion on open relationships).

What do I say when someone asks, “I have a boyfriend now, and I love him so much. Can I stop using condoms?”

It is probably best to advise that it is better to continue being safe. You could also say: “You could decide to stop using condoms if you both tested HIV-negative twice in a 4-6 week-time period and have not exposed yourselves to any HIV risk in that same time. This means you need to trust each other fully. You need to have clear agreement between you both to be absolutely honest with each other, in case one of you has unprotected sex with somebody else. Some people find it so difficult to be honest that they prefer to keep using condoms (or both take PrEP) within their relationship.”

What do I say when someone asks, “My boyfriend has cheated on me. What should I do?”

One approach to this situation would be to advise: “Maybe you feel upset or angry. Wait till you are calmer, and then you should talk to him about it. Find out why he cheated on you. Is he in love with someone else? Perhaps it was just something that happened to him because he was drunk or confused, or maybe he was seduced. Maybe he feels bad about it, too. Or perhaps the two of you have been in a monogamous relationship for a long time, and your partner may want to have an open relationship now.” You should also advise your client to find out whether his boyfriend has exposed himself to HIV during his cheating-episode, especially if the partners were not using condoms; perhaps they need to re-start using condoms until both can get tested for HIV again.

When can love relationships be a risk for HIV and STI?

Some men who have sex with men and transgender people have boyfriends who are much older or much richer or more powerful than themselves. This may lead them to feel junior, weaker and less in control of themselves. They may enjoy being taken care of by a strong and caring boyfriend. However, in these situations the younger person tends to leave decisions about safer sex and condom use entirely to their partner. This is something outreach workers should warn their younger friends or clients about. Deciding to stop using condoms should never happen without discussion or mutual agreement, let alone without prior HIV testing.

Unit 15

Dealing with the family, marriage and girlfriends

What do I say when someone asks, “Should I tell my parents that I am gay or a man who has sex with men?”

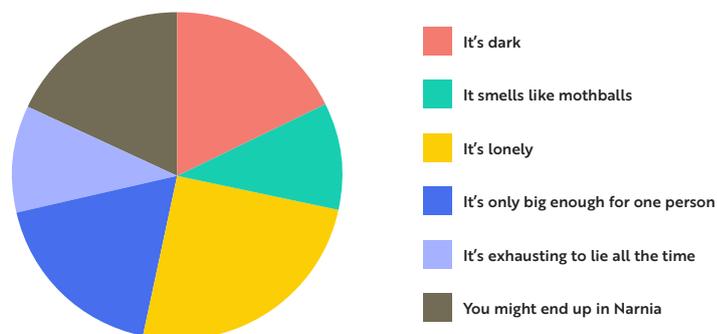
You could start your response by explaining: “This is a personal choice. Some people decide to tell their parents because they want to be honest with their parents. Sometimes they want to prevent their parents from arranging marriage to a woman, or they are fed up with questions about when they will have a girlfriend or a wife.”

You could then say: “Other people do not want to confront their parents and are worried that the parents will be shocked, will be unable to accept it or will be hostile or violent when they find out. It partly depends to the extent to which they feel comfortable leading a double life—one of (presumed) heterosexuality in public and a secret life as a man who has sex with men.”

Part of the decision to be open also has to do with how financially independent an individual is. It is difficult to risk cutting off all ties with their family if a person is still dependent on them for tuition fees and living expenses, for example.

“The choice is up to you,” you must remind your client.

Reasons not to stay in The Closet



Source <http://queerious.com/2011/06/10/gay-at-work-should-i-tell-a-potential-employer-im-gay/> (this is not serious research but a joke!).

What do I say when someone asks, “How can I tell my parents, siblings and friends?”

The following is a list of tips you can use to help people “expose” themselves to loved ones. All may be useful to each person who consults you.

- 1 “Consider your exposure process as a circle: There is only you in the circle of people who know you. Consider who you want to gradually add to this circle.”
- 2 “Practise first. Tell yourself the news that you want to expose in front of a mirror. Think about what you will say and how you will bring it up. Think about what people will say in response and how you will react to each statement.”
- 3 “Go slow. Start with one person who you trust and/or who you can reasonably expect to be understanding and compassionate.”
- 4 “Consider a worst-case scenario. What will you do if you are told to move out of the house? Should you confide and/or prepare with a friend first?
- 5 “Is there a telephone hotline where you can ask for advice?”
- 6 “Once you have confided in a sibling, you can discuss together if and how to tell your parents and/or other persons.”
- 7 “Choose a good time. If you want to give the person time to think about what you tell them, you may tell them during the morning and then leave and come back in the afternoon to continue.”
- 8 “Be prepared for “blaming” reactions or for shock reactions (crying, shouting and fainting), and understand that these have more to do with the news you have conveyed than with you as a person!”
- 9 “To avoid shock reactions, or if you prefer not to witness them, it may be good to tell a loved one the news by letter. This will give them a chance to process the news you tell them alone and not have a shock reaction that they may regret in the future. It will give them some time in private to get used to the idea.”
- 10 “Make sure that you can take care of yourself financially and emotionally before coming out to your family.”
- 11 “Give your family some time to realize and accept that their son is a man who has sex with men. This process may take a long time.”

These tips are also useful when someone wants to tell loved ones that they have HIV.

How should education be provided to parents on behalf of clients?

If one of your male friends or clients decides to tell his parents that he is gay or a man who has sex with men, you may discuss with him whether it is a good idea for you as the outreach worker or another friend to join him to provide support and

to possibly help explain to the parents about homosexuality. In that explanation, you would tell them that homosexuality is not a disease, not a fashion and not a temporary thing and that it has nothing to do with the way their son was raised. And that it is impossible to change.

How does someone deal with the situation of being outed or accidentally discovered as a man who has sex with men?

You can explain that being “outed” is possibly one of the most painful things that can happen. And then you can say something like: “If it is not you who tells people of your choice that you are gay or a man who has sex with men, being outed occurs when other people talk about it or betray your secret or, worse, if an unsuspecting parent or a sibling enters a room (without knocking) where you and your male lover are having sex. It is difficult to give general advice on how to deal with such a situation. The best course of action, probably, is to give it some time so you cool off and think about how to proceed. Probably the person who discovered you is as shocked as you are and may even decide to ignore what was seen, at least for a while. If the situation becomes nasty or violent, perhaps you should find refuge at a good friend’s place for a while, meanwhile communicating with your parents or family by phone or mail.”

What do I say when someone asks, “I have a girlfriend, but I prefer men. Should I break up with her?”

One approach for response would be to say: “If you have a girlfriend because you think this is what society expects from you or because this is what your parents want for you, you should consider whether you may cause grief and suffering to her in the future, especially if you are unable to stop having sex with men.”

Many men who have sex with men get married and manage to combine a sex life with men with their life as a family man. Some are happy doing so; others end up divorced with many problems, especially if they have children.

You can advise your client to consider his options: “Can you choose to remain single? Can you choose a male partner? Could you talk to that partner about your sexual orientation? Is it possible not to get married to a woman at all?” You might add that there is not a single best way forward here.

What do I say when someone asks, “My wife [or girlfriend] does not know I like men. Should I tell her?”

Again, one approach to this type of question is to advise: “If you have unsafe sex with men, you might expose your wife (or girlfriend) to STIs, including HIV, if you have sex with her. This is one reason why some men who have sex with men feel they have to tell their wife (or girlfriend) that they are unfaithful. They may not tell

her that the extramarital partners are men rather than women, which is what your wife may assume.”

If the client has safe sex with men and if he feels his wife would be unhappy knowing that he has sex with men, you perhaps might suggest that it is better not to tell her. But you must make clear that it is a decision only he can make.

And remember, that as with most questions in this section, these are individual choices. They in no way are one-size-fits-all responses.

What do I say when someone asks, “I want to have children, but I do not like women. What can I do?”

Some men who have sex with men get married to a woman just because they want to have children. It may work, but in many cases, the urge to continue having sex with other men can lead to tensions between the husband and the wife. If the wife finds out about the other life, the relationship might end in divorce.

In some countries, men who have sex with men have been found to link up for marriage with lesbian women who face the same problems. They establish a public family, with mother, father and children, while at the same time maintaining a sex life outside the family.

Men who have sex with men and transgender people have adopted children and raised them as their own.

Unit 16

Dealing with drugs and addiction

What is addiction?

Addiction is characterized by the compulsive use of substances or engagement in harmful behaviours, often despite evidence to the user of their negative effects, which could be disease or even death. Addiction to drugs or alcohol has been found to be an important predictor for HIV infection or risk (see [Unit 19](#) on syndemic conditions). Addiction is a chronic or recurrent condition that can be caused by genetic, biological, pharmacological and/or social factors.

What types of addiction are problems among men who have sex with men and transgender people?

In some countries, some groups of men who have sex with men or transgender people use heroin and other drugs. In some instances, men sell sex to pay for their addiction. More common addictions among men who have sex with men and transgender people are cigarette smoking and alcoholism.

Some men who have sex with men and transgender people are addicted to gambling.

Some men who have sex with men and transgender people are compulsive sex addicts who feel they cannot sleep or eat until they have had sex with another man. Extreme cases of this addiction have been recorded, in which men had five or more sex partners every day. The health dangers of this are obvious.



See [Unit 7](#) for more information on behaviour change.

What does addiction have to do with HIV and STI?

Addicted people may not take decisions that are in the best interest of their own health. For instance, a heroin addict who sells sex and is offered money in exchange for unprotected anal intercourse is much more likely to agree than a male sex worker who has no addictions. Also, outside the context of sex work, people who are a bit drunk tend to have poorer judgement when it comes to sex. When people get drunk, everybody suddenly seems to be sexier, and condom use is conveniently forgotten.

Many men who have sex with men and many transgender people and who have unsafe sex in some settings do so under the influence of alcohol, for example, in late night saunas or in parks, especially after having gone out to drink at entertainment venues (see Unit 19).

What do I say when someone asks, “How can I deal with addiction?”

Professional counsellors can help an addicted person deal with acknowledging, analysing and rectifying addictive behaviours or habits. Most people who are addicted can be helped to reduce the impact of the addiction on their health or to kick their addictive habit altogether. You may be able to refer clients with addictions to health providers; sometimes religious counsellors may help. Or techniques like acupuncture and meditation may be useful. For any addiction, it is important that the direct social network is mobilized to provide support in the period after quitting; if this is not done, relapse is common.



See **Annex 1** for a list of providers of counselling to deal with addiction in your country.

Unit 17

Tips for handling stigma and harassment in everyday life

What is stigma?

“Social stigma” is social disapproval of personal characteristics or beliefs of a person or a group of persons who are considered to be in opposition to the dominant cultural norms. Social stigma often leads to marginalization. This means that people who are different from the “mainstream” way of doing things are ignored. It may mean that they have less access to education or health care or that they live in the least desirable neighbourhoods.

Examples of social stigmas include attitudes to physical or mental disabilities and disorders as well as not knowing who one’s father is, homosexuality or affiliation with a specific nationality, religion or ethnicity. Past or present involvement in crime also carries a strong social stigma in most societies.

In what forms does stigma exist?

Stigma comes in four forms:

- 1 Stigma based on outside signs of disease or disability, such as being very thin or fat or having leprosy or being in a wheelchair. This can include people with AIDS who are showing symptoms of disease.
- 2 Stigma based on personal traits or behaviours that are undesirable in the eyes of the dominant culture. This includes criminals, sex workers, homosexuals, transgender people and drug addicts.
- 3 Stigma based on membership in a certain group (this is also called “tribal stigma”) and is based on a race, nationality or religion that is different from the dominant race, nationality or religion.
- 4 Self-stigma. Some people (from any of the three groups above) withdraw from mainstream life because they stigmatize themselves; they may expect a negative reaction from society about a particular characteristic, such as homosexuality, and withdraw in anticipation of it.

What forms of stigma do men who have sex with men and transgender people face?

Stigma from outsiders against men who have sex with men and against transgender people comes in five forms:

- 1 Stigma due to their sexual orientation (such as “you are bad because you are gay / a man who has sex with other men”).
- 2 Stigma due to their sexual behaviour (such as “you are bad because you have many sex partners”; or “you are bad because you have anal sex”).
- 3 Stigma due to engagement in sex work (such as “you are bad because you are a prostitute”).
- 4 Stigma due to disease (such as “you are bad because you have HIV or STIs”).
- 5 Stigma due to social behaviour or self-presentation (such as “you are bad because you overact or overreact or you act too feminine”).

Many men who have sex with men and transgender people typically experience more than one form of stigma.

Do men who have sex with men and transgender people also stigmatize each other? How?

Yes, just as in many other social groups and populations, sometimes men who have sex with men and transgender people stigmatize within their own group. Forms of stigma include:

- 1 Stigma based on ethnicity.
- 2 Stigma based on their rural background or religion or their (perceived) socioeconomic status.
- 3 Stigma based on their (perceived) engagement in sex work.
- 4 Stigma based on their (perceived) promiscuity.
- 5 Stigma based on their HIV status.
- 6 Stigma based on their identity (for example, some transgender people are discriminated against by other men who have sex with men, and bisexuals may be discriminated against by men who have sex with men, by transgender people and by straight people).
- 7 Stigma based on social behaviour or overacting.

What is HIV-related stigma about?

HIV-related stigma is a set of ideas and beliefs that links HIV and AIDS to negatively defined behaviours or groups. This is sometimes called “negative social baggage”. HIV is, for example, often linked with having many sex partners (also called “promiscuity”), commercial sex or injecting-drug use. To understand this better, try to think about the flu. Nobody is ashamed or worried to admit that they have the flu because there is no negative social baggage associated with it. If you could only get the flu by having oral sex, people would find it much more difficult to admit to having the flu.

How can stigma be reduced?

The best way to fight stigma is through openness and reducing ignorance, making sure people can see HIV as part of their community and not something that only affects “others”. Openness about HIV—think of the UNAIDS slogan: “Break the Silence”—will help people understand that there are many people with the virus who are not part of what they perceive as “bad” groups or who engage in what they perceive as bad behaviours. Openness will help others to see that people with HIV engage in the same behaviours as other people, they have just been less lucky in terms of remaining HIV-negative.

Improving social awareness of the development-, exploitation-, marginalization- and poverty-related roots of HIV transmission will help reduce stigmatizing attitudes within the population. Training of influential people in a community—journalists, religious leaders, teachers, medical doctors—can help.

Stigma is also often rooted in fear of something unknown, beyond our control. Therefore, improving knowledge about how HIV can be transmitted, and especially how it will not be transmitted, will reduce fear and therefore stigma and discrimination, especially of people with HIV.

What can be done to reduce stigma in our own environment?

At the community level, you could think about engaging the abbot of the temple, the village or district chief, the director of the secondary school or university or other influential people in supporting more openness and awareness about HIV in the population. A popular medical doctor may be engaged in assuring people that homosexuality is not a disease or a disorder but a perfectly natural behaviour.

What do I say when someone asks, “What can I do, at a personal level, when faced with stigma?”

There are several strategies when confronted with stigma that you can suggest to friends or clients:

- 1 “You can ignore it and carry on.”
- 2 “You can avoid further discussion by making a joke about it.”
- 3 “You can confide in a friend, a mentor or someone who gives you spiritual support.”
- 4 “You can keep a diary and write down what you experience and how you feel about it.”
- 5 “You can join a support group.”
- 6 “You can confront it. Do this only if there is no danger to your physical health—don’t get beaten up! You can confront by:
 - giving facts to contradict what the person said;
 - appealing for understanding and compassion;
 - discuss what the person said; and
 - in some countries you can go to the police or take legal steps to protect yourself.”

What do I say when someone asks, “How can I build my self-esteem?”

You can explain to a friend or client that we can change the way we feel about ourselves and develop confidence and self-esteem in several ways:

- 1 “Encourage people to praise us by praising them. Tell others what they have done well, the things we like about them and their strengths.”
- 2 “Give ourselves positive messages. Sometimes, we say good things about ourselves and sometimes we say bad things. Sometimes our conscience tells us we have done wrong. Sometimes we are too hard on ourselves.”
- 3 “We all make mistakes—that’s how we learn. Learning is good; we don’t need to feel bad every time we make a mistake.”
- 4 “Being good at something helps us gain confidence, so focus on your strengths. Then when you are feeling bad, say to yourself, ‘Yes, but I’m very good at’”³⁰

Unit 18

Using social media and the internet for outreach

What is online outreach or cyber outreach?

Many outreach workers use the internet to find prospective clients. This is called "online outreach" or "cyber outreach". Online outreach is a way to explore online venues where men who have sex with men or transgender people go to find friends, boyfriends or casual sex dates. Most prospective clients who visit such venues, however, are not there to be approached about HIV testing or about safer sex. Although an online user is not at direct risk of physical attack by others while online, you should realize that the online and offline worlds are not entirely separate universes, and you should take certain safety precautions. This unit tries to establish some rules and advice on how to deal with this problem.



What are the benefits of online outreach over real-world outreach?

Online outreach and outreach in physical venues should not be seen as separate, but they must complement each other. The advantages of online outreach are manifold. First, it is a convenient form of outreach from the perspective of

the outreach worker. In most countries, there is virtually no chance of police harassment, and there is no chance of being robbed or raped with online work. In some contexts, being linked to an online cruising site (and particularly one using geolocation functions, such as Grindr and Jack'D) could lead to police harassment or even criminal penalties.

There is also no time limit: Most cyber locations for dating can be accessed around the clock, in contrast with real-time venues, which often have specific hours of operation. Another advantage is the sheer number of men who can be accessed online. It is important, however, to carefully assess when each of the online venues is typically busiest, for planning purposes.

It is easier to communicate about sensitive issues when online. In the real world, there may be embarrassment discussing sensitive (sexual) issues, but when typing in a chat this shyness may disappear. The time lapses between chats to and from a client also allows for more careful consideration and editing of a response—time that a person may not have when put on the spot in the field during face-to-face contact. Online outreach also gives the outreach worker the opportunity to compile a prepared list of topics or frequently asked questions (such as the questions presented in this manual) that are factually accurate, in line with the sponsoring organization's goals and communications approach and that can include links to additional online or offline resources.

Are online outreach and outreach in physical locations mutually exclusive?

Online and real-world outreach should be seen as complementary. Online outreach is often used as a way to establish an initial contact with a potential client, which can be followed by a face-to-face meeting for the provision of follow-up services. Sometimes it is the other way around: A client may be encountered at a physical venue and after exchanging social media or other contact information, follow-up support may be provided online. The fact that online and offline settings are not mutually exclusive is also the reason why online outreach should use some of the same safety precautions as offline research, especially when it comes to vulnerability to violence or blackmail.

What are the disadvantages of online outreach versus outreach at cruising venues?

There are several disadvantages: Clients can suddenly cut off the conversation and/or block the outreach worker; clients can pretend to be somebody who they are not, or potential clients could become upset when finding out that the outreach worker is not a potential sex date but a professional health worker. Another important disadvantage is that the boundary between dating, flirting, romance and professional outreach may be blurred, especially if the outreach worker uses the same online ID for their work as they do in their personal or

sexual life. For this reason, it is recommended that an outreach worker use a different ID or Facebook page for their personal and professional lives. In developing countries, another disadvantage of online outreach might be power outages or an unreliable internet connection, which can disturb the flow of communication and can make proper planning for online outreach difficult.

How can I find potential clients online?

It is best if the management of the organization you work for tries to come to an agreement with the owner or manager of online dating venues or telephone applications about the planned outreach. This may prevent you from being banned as a member, for example, if they find out that you have more than one user account (which is usually not allowed under user agreements).

You may already know where men who have sex with men or transgender people tend to go when they are online, looking for friends, long-term partners or casual sex dates. If you do not know, ask your friends or clients that you have met in real-world venues. If the platform or website you are using is new to you, consider creating an ID or identity that reveals your purpose, for example: "HIVOutreach2015", "GetTested2014" or "StaySafe".

It is important for the organization you work for to do a space and time mapping to determine which applications or chat rooms are busy during which hours. It is also important for clients to have an idea when you or one of your colleagues are available for online chats. This can be done by including operating hours in your user profile.

How can I start a conversation with a stranger to make them my client?

If your organization has decided to engage in cyber outreach and you have created a profile that reflects the fact that you are interested to meet people from the perspective of an outreach worker rather than meeting friends, boyfriends or casual sex partners, you can approach people with a short statement about yourself. For example: "Hello! My name is XXX. I work for an organization that promotes the sexual health of gay, men who have sex with men and transgender people. Would you mind to have a chat with me?"

Should I use my own Facebook, Jack'd, Hornet, Grindr, Manhunt or Gayromeo account when doing outreach?

Even though this is usually not in line with the service agreement that you have to sign when opening an account, from a safety perspective it is essential to use a different user ID or account name when you work in professional outreach. You should never use the same account name or user ID that you use in your private life. This is important because your supervisor may request your user name and

your password to look at the chats you have conducted with (potential) clients to give you feedback on how to further improve your performance. You would not want your supervisor to have access to your personal chats!



Source http://www.huffingtonpost.com/david-toussaint/everything-thats-wrong-wi_2_b_4926121.html

Is it okay to flirt with potential clients as a way of making contact with them?

No. It is okay to joke or make fun with a person to keep or attract their attention, but you should not deceive a client by making them think that you could be their next sex date or boyfriend. That is not ethical. It is important that the client knows who you are and what you are interested in, which is providing information, answering questions and promoting HIV testing and safer sex. It is important to establish and maintain clear and professional boundaries with users.

A prospective online client has suggested sex (or a relationship) with me. What should I do?

Because the online dating platforms you likely will focus on are primarily intended for men to meet each other, it will be most likely just a matter of time before you are approached for a sex date or a relationship while doing your online outreach. You should kindly decline and explain to your contact that you are not online in order to date or find sex or friends but to do a job, which is to help improve the sexual health and well-being of the men who are dating or cruising online.

What are the safety concerns about online outreach?

While there are several advantages to online engagement compared to offline, online work is certainly not without risk. Outreach workers operating online must be aware of the possibility of cyber-bullying, trolling and violence. The location-based functionality of the mobile apps poses some security risks, especially in settings in which homosexuality is criminalized. Police in many countries are becoming more adept at monitoring these online spaces, and there are anecdotal reports of entrapment, especially in relation to anti-drug police tactics. Training and security protocols to mitigate the risk of hacking and security breaches are important for any organization that is considering doing online engagement. If your organization does not have such protocols, this should be raised with the management before the onset of online outreach.

What is online harassment?

Online harassment is when someone is bothering you online. It can be in sexual, verbal and psychological forms.

What should I do when someone harasses me online?

First, you can try to remind the user who is harassing you about the code of conduct of the online platform or website that you are using, by issuing them a warning. In this code of conduct, harassment is specifically mentioned as something that is strictly forbidden. If the code of conduct is breached and if this is reported to the website or application management, that user may be banned from the platform.

Apart from possibly reporting online harassment to the website for application manager, ongoing online harassment should be reported to your supervisor. Before doing so, record all evidence and activities related to the harassment (for example, screen capture, data logs, etc.).

How can I present myself in an ethical and safe way so that there are no incorrect assumptions about my motives?

It is not okay to have a love or sexual relationship with a client under any circumstances. You have to maintain a professional boundary between your clients and yourself. It is important to avoid the impression that you are doing two things at the same time: working and cruising or flirting. Giving this impression hurts your personal image and the image of the organization you are working for.

Of course, we are all human. If it happens that a client falls in love with you and/or the other way around, you should refer your client to another outreach worker for follow-up services, inform your supervisor and only then share your personal contact details with the client so that your conversations or romance become

part of your personal domain. You should then block or remove your new friend or lover from the friend list or contact list of your outreach account to avoid confusion.

A client of mine who has HIV is now dating a friend of mine. Should I warn my friend?

Absolutely not. The confidentiality of your client goes above everything. What you can do is to remind your client about their ethical responsibility for the health and well-being of their sexual partners. Disclosure of HIV status can never be decided upon by outsiders: Only a person living with HIV can disclose their status to others. If an outreach worker discloses the HIV status of a client against their will, the worker will be fired.

How can I avoid my family and friends from finding out I am working for a gay organization while doing online outreach?

If you share your computer, tablet or phone with other people in your family, make sure you delete your bookmarks or history in your internet browser (this you can do under the File menu and under Preferences. If you use your own computer, tablet or phone, make sure there is a passcode to protect your privacy so that other people cannot access your device when you are not present. In case someone catches you, you can always explain that you work in an HIV service organization and that this requires you to study and explore certain websites that are important to your clients, without disclosing your own HIV status or sexual orientation.

Unit 19

Syndemic conditions: Understanding the context of HIV transmission

What is a syndemic?

A “syndemic” is a set of health problems or social conditions that strengthen and are linked to each other. HIV is often mentioned in relation to other health problems, such as tuberculosis, STIs, the use of or addiction to alcohol or drugs, violence and mental health problems. Syndemics often occur under situations of poverty, stigma and discrimination or among populations with limited or no access to health care or other services. Seeing HIV as a component in a wider set of syndemic conditions helps explain why focusing only on HIV, while ignoring other pressing social and health problems of the people we are trying to reach, is often not successful.

Most of us will intuitively understand the link between, for example, being drunk and having unsafe sex. Rather than only talking about condoms and testing, for a person who is always drunk while having sex, addressing alcohol addiction might be a much better way to prevent HIV infection.

What are syndemic conditions to be addressed in tandem with HIV prevention?

According to the latest research, conditions that decrease the likelihood that a client uses condoms or accesses HIV counselling and testing services might include:

- 1 binge drinking or heavy alcohol use or addiction;
- 2 drug use (especially crystal meth or ice);
- 3 depression, severe loneliness or other mental health issues;
- 4 being sexually compulsive, such as addicted to sex;
- 5 having a history of sexual abuse during childhood;

- 6 having a violent boyfriend or intimate partner;
- 7 having considered suicide or having tried to commit suicide;
- 8 having a history or current involvement in sex work; and
- 9 poverty and homelessness.

If a person had one of the above conditions, researchers found that condom use was generally higher and HIV prevalence lower than if a person had two or more conditions. In other words, at the population level, reducing HIV transmission would be much more successful if alcoholism, drug abuse, mental health issues and poverty among men who have sex with men and among transgender people were addressed at the same time.

It needs to be stressed that the importance of these factors can differ strongly between men who have sex with men and transgender people, and their importance also differs between countries and cities.

How are syndemic conditions important for my work?

It is important to assess if your client has one or more of these conditions. It is more likely that your client will achieve sexual behaviour change goals or access HIV services if these conditions are also addressed. For example, a person who regularly has unsafe anal sex while high on crystal meth would be more likely to achieve safer sex if they dealt with their drug habit. Endlessly talking about condoms would not have much of an effect on a client who really needs to understand the link between their drug use and HIV risk.

What should I do if my client has one or more syndemic conditions?

It is important that your client understand that there are links between these syndemic conditions and HIV risks. As discussed, helping clients address one or more syndemic conditions will increase the likelihood that they can also prevent HIV infection or, if already infected, access HIV treatment, care and support services.

Because providing counselling and support for many of these problems is challenging and requires much training and experience, it is beyond the scope of outreach workers and case managers to provide services to deal with these syndemic conditions. It is important to refer clients to appropriate professional services.

Where can I refer my client who has one or more syndemic conditions?

Unfortunately in most Asian cities, mental health care services needed to address many of these problems are either non-existent or they are not friendly or adapted to provide services to men who have sex with men or to transgender people. In some cities, there are at least programmes to deal with alcohol and drug addiction, which are two important factors.

Table 7 contains information on services dealing with different syndemic conditions. It can be used to refer clients; if possible, it would be best if you accompany your client there, at least for the first visit, to provide support.

TABLE 7

Services for dealing with syndemic conditions

CONDITION OR PROBLEM	SERVICE, CONTACT OR WEBSITE
Alcohol addiction	
Drug addiction	
Sexual violence and abuse hotlines	
Social services	
Mental health care	
Suicide hotline or prevention services	
Support for homeless people	
Support for male or transgender sex work	

Unit 20

Gender-based violence



This unit was authored by Maryce Ramsey of FHI360, email: mramsey@fhi360.org

What is gender-based violence?

Gender-based violence is an abuse of power and a violation of basic human rights. It can be physical, sexual or emotional violence that is directed at women or men because they are women or men or because of their gender identify or because they do not appear or behave in ways that their community expects a man or woman to behave. Men who have sex with men and transgender men and women are often targeted because they may not conform to ideas for “acceptable” gender and sexuality norms and identities. Transgender women can be especially vulnerable.

Gender-based violence can be carried out by someone known or not known to the victim, including a parent or other family member, a neighbour, someone in the community, a health care worker, teacher, student, employer or the police, to name a few. When a current or former spouse or partner is the abuser, this is called “intimate partner violence”.

What forms can gender-based violence take?

Gender-based violence can take many forms:

- It can be physical, such as hitting, slapping, kicking, punching or anything that results in physical harm.
- It can be verbal, such as bullying, name calling, threats (including threats to “out” someone) or anything that results in someone feeling worthless or humiliated.

- It can be sexual, such as being raped or forced to perform any kind of sex act against a person's will or forced to have sex without a condom.
- It can be economic, including being thrown out of the family home, having money or resources, such as food, withheld or used to manipulate a person.
- It can include a partner who is overly jealous or who follows or monitors their partner at all times, causing them to be nervous or fearful.
- Some of the worst types of gender-based violence against men who have sex with men and transgender individuals are carried out by the police, including sexual coercion, abuse, gang rape, physical abuse, torture, extortion and arbitrary detention.

How common is gender-based or intimate-partner violence against men who have sex with men or transgender women and men?

It is hard to know how common gender-based or intimate-partner violence is among men who have sex with men and transgender individuals because there has not been much research on this issue, and most studies are quite small. Men who have sex with men seem to experience violence within their intimate relationships at about the same level as heterosexual couples. And men who have sex with men, transgender men and women and those who exchange sex are among those most affected by gender-based violence in the broader community. Their risk for gender-based violence is higher due to widespread homophobia, transphobia, discrimination, stigma, marginalization and low self-esteem while little gender-based violence prevention is targeted to them. And they have little to no access to justice, especially when laws exist that criminalize their status and behaviour.

What does gender-based violence have to do with HIV?

Gender-based violence is both a cause and consequence of HIV transmission. For example, having previously experienced violence, currently living in a violent relationship or being faced with imminent violence can make it difficult to decide if or when to have sex or to negotiate for condom use. And living with HIV or being associated with the illness can also cause men who have sex with men or transgender individuals to be targeted for violence. Gender-based or intimate-partner violence affect men who have sex with men and transgender women's and men's ability to protect themselves from HIV and to access necessary support and services.

All of the same things that cause men who have sex with men and transgender people to be at risk of HIV also put them at risk of gender-based violence, including stigma, marginalization and disempowerment. That is why gender-based or intimate-partner violence as well as some of their consequences, such

as alcohol or drug abuse, depression, suicide attempts and sex work, are listed as syndemic conditions that must be addressed along with HIV risks.

Some of the ways that gender-based violence is related to HIV risk:

- direct transmission through rape, coerced sex, refusal to use condoms or allow condom use;
- having a violent intimate partner who makes condom negotiation difficult;
- a man who has sex with men or a transgender woman or man fears accessing HIV services because it may expose their sexual identity to the police, their family or others who will harass or reject them;
- a health care worker who refuses to provide HIV or STI services to men who have sex with men, transgender women or men or to sex workers because they don't like them or disapprove of them;
- police officers using their power to demand, force or coerce sex from a man who has sex with men or from a transgender person; this can happen especially to men who have sex with men or transgender women or men who sell or exchange sex;
- a family forcing an man who has sex with men or transgender woman or man out of the family home and onto the street, leaving them economically vulnerable;
- verbal abuse from the family or the community that causes someone to feel so badly about themselves that they take unnecessary risks with their health, such as sex work, multiple partners or not using a condom;
- an abusive partner who intentionally infects their partner with HIV;
- being in an abusive relationship can make it difficult to test, disclose or adhere to HIV treatment if someone fears that doing so will put themselves at risk;
- HIV-positive men who have sex with men and transgender individuals can be targeted for verbal and physical abuse by the community, their families or partners because they are HIV-positive;
- all men who have sex with men, transgender men and women and those who engage in sex work can be targeted for verbal and physical abuse if the community has associated HIV with them;
- men who have sex with men and transgender outreach workers may be harassed for carrying condoms or doing HIV outreach to marginalized communities, especially in countries where homosexual sex or prostitution are illegal.

What is my role in violence prevention or response as an outreach worker?

As an outreach worker, you have two important gender-based violence functions: to educate everyone you speak with about violence and to refer anyone who discloses violence to available services. One of the important things that you can do is make sure that everyone you speak with knows that they have rights just like everyone else. These rights include the right to life—to live a life free from fear and violence. You can also tell everyone about what gender-based violence is, how it can affect their health, the benefits to seeking help and where they can get help. Many men who have sex with men and transgender women and men think that violence in their lives is normal or that they deserve to have bad things happen to them. Many have experienced a lifetime of hearing that they are bad or not normal from their families, communities and even sometimes their partners, so they expect to be abused. You can make sure that they know that abuse is not normal and that they deserve to be treated better.

What is not part of my job?

You are not a trained gender-based violence service provider. It is not your job to identify violence survivors or to provide them with gender-based violence services. If someone tells you they have experienced violence, then you should connect them with those who are trained to provide gender-based violence services. You are an important link between violence survivors in your community and essential gender-based violence services. It is not your job to ask people to analyse or give detailed descriptions of their incident or events. It is not your job to pressure someone into talking about something they don't want to. And it is not your job to determine fault by interrogating the survivor.

What if I suspect someone is experiencing gender-based violence, what should I do?

The first thing you should do is ensure that you are in a private place where no one can overhear a conversation. If you think that someone you are talking with has experienced gender-based or intimate-partner violence, then you should first discuss what gender-based violence is, how it can affect their health and the benefits of seeking help. Then you can say that many people in the community experience violence and that it is very common. It is nothing to be ashamed of, and it is never a person's fault. And most of all, no one ever deserves to be hurt. Then leave a little time for the person to decide if they want to share. If the person discloses that they have experienced violence, then talk about what they can do (see the discussion on how to respond when someone discloses violence).

It is not unusual that a person may choose not to share their experience with gender-based violence with you or not to share it with you at first and then later disclose their experience with violence. This is normal. They may not recognize

their experience as gender-based violence but just view it as normal life. They may be used to denying their violence experiences as a protective measure. They may need time to become comfortable with you before opening up about their experience of violence. You should not pressure anyone to share their experience but wait until they are ready. Every person has a right to make decisions for themselves.

If a person does not disclose that they have experienced violence but you suspect that they have, then make sure that you explain where they can seek help if they ever need it by providing them with a referral card with the necessary gender-based violence services information.

How do I know where to refer someone?

Because gender-based or intimate-partner violence are so common, it is certain that once you start to talk with people about it that you will come across someone who you think has experienced violence or someone will tell you that they have experienced violence. Before starting to talk to people in your community about gender-based and intimate partner violence, you need to find out where you can refer people for support. Support includes places where a survivor can go for medical, counselling, shelter and legal support.

What do I do if someone discloses gender-based violence to me?

If a client discloses gender-based violence in the presence of others, such as a partner, friends or family members, take the client aside to see whether they feel safe discussing with others in the room or nearby. Then begin psychological first-aid. The three basic action principles of psychological first-aid are:³¹

- 1 Look:** Identify any immediate needs.
- 2 Listen:** Follow what you have learned already in basic listening skills. Listen with your eyes, ears and heart.
- 3 Link:** Connect the violence survivor to necessary services through referral.

Begin by telling the person, "It is good that you have shared this information. I am so sorry to hear about your experience. Please know that you are not alone. Mistreatment and abuse are quite common. No one deserves to be abused, and you have the right to live a life free of violence. I can help you access services that can help you. Everything that happens next is your choice. I can provide you with information and then you decide what you want to do."

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The section on psychological first-aid is adapted from World Health Organization, War Trauma Foundation and World Vision International, Psychological first aid: Guide for field workers. Geneva, WHO, 2011, http://www.who.int/mental_health/publications/guide_field_workers/en/.

The most important thing is to help the survivor begin the healing process by supporting their right to make their own decisions. They must feel in control throughout the entire process!

Look

- The first thing to do is to assess whether the person is safe. Has the perpetrator followed the survivor? Does the survivor have any urgent medical needs? Is the person showing signs of serious distress, such as talking about hurting themselves or others, unable to care for themselves, in shock or in distress and asking for help? If the answer is yes to any of these questions, then ask the survivor if they would be willing to seek help immediately. Offer to go with them to the nearest gender-based violence one-stop shop or service provider.

Listen

By listening you can better understand a person's situation and needs, help them to feel calm and better link them to appropriate help. Remember to listen with your eyes, ears and heart. Use your:

- eyes to give the person your undivided attention;
- ears to truly hear their concerns; and
- heart to show your care and respect for them.
- Once the person has told you that they've experienced violence, ask about their needs and concerns. Find out what is most important to them, and help them work out what their priorities are.
- Listen to the survivor, and help them feel calm by staying close to the person (but not too close). Listen to the survivor if they want to talk about what happened, but do not pressure the person to talk about it if they do not want to.
- Remember to:
 - be non-judgmental and do not engage in victim blaming;
 - help the survivor recognize their strengths;
 - help the survivor feel calm, safe and in control; and
 - help the survivor assess needs, risks and their concerns.

Link

- One of the most important things that you can do is to link a survivor to practical support. This will assist survivors to begin to feel more in control of their situation.
- Provide accurate information but don't overwhelm the person with information. Encourage the survivor to ask questions. Information is different from advice. Remember that the survivor needs to be empowered to make their own decisions and not be told what they should do.
- Make sure that the survivor has information on the benefits of seeking support, such as:
 - If the survivor is a biological female who has not transitioned and has experienced unprotected vaginal sex, she can **access emergency contraception to prevent pregnancy**. It is most effective if it is taken **within 72 hours**, but it can be taken up to 120 hours (five days) after unprotected vaginal sex. But from 72–120 hours, the effectiveness is reduced to less than 50%.
 - If the survivor is a biological female who has not transitioned and is already pregnant as a result of rape, she may be able **to access safe medical termination of pregnancy**, depending on the law in your country.
 - All survivors of unprotected sexual violence can **access prevention or treatment for STIs**, such as chlamydia, gonorrhoea, syphilis and trichomoniasis.
 - All survivors of unprotected sexual violence can **access PEP within 72 hours to help prevent HIV infection**. They must begin PEP within 72 hours of being sexually assaulted.
 - All survivors of sexual violence can **access HIV counselling and testing to learn their status**. If the survivor presents shortly after the incident and is too traumatized for counselling and testing, there is no need to do it in this first encounter. PEP can be started without the test.
 - All survivors who experienced unprotected sexual violence or exposure to the attacker's blood **can access antiretroviral treatment if they test HIV-positive** (see Unit 11 for more information on antiretroviral treatment).
 - All survivors of sexual and physical violence can access **vaccinations for prevention of hepatitis B and tetanus**.
 - If the survivor is in a relationship in which intimate partner violence makes it difficult or impossible to practise safe sex, especially if the partner is HIV-positive, then the survivor may want to access **PrEP to prevent HIV infection** by taking a protective pill every day (see Units 4 and 6 for more information on PrEP.)

- All survivors of gender-based or intimate partner violence may benefit from **counselling** to deal with their trauma, explore causes and consequences of such violence in their lives and make short- and long-term safety plans.
- All survivors may need to **access temporary shelter**, especially if they have been thrown out of their home or if it is unsafe to go home.
- All survivors may benefit from **access to legal justice and protection**. This may include access to police, legal representation, formal and informal justice systems or to human rights protection and advocacy. Before referring anyone to the police or formal justice system, first identify if there are laws that criminalize sex between men, transgender individuals or sex workers' status or behaviour. If such laws exist or if police are known to engage in violence against men who have sex with men, transgender people or sex workers, do not refer to them. Remember to **do no harm**.
- Once you have listened to the survivor's story, heard what their priorities are and shared the benefits of seeking support, then you can help them to address basic needs and access multisector services. A survivor may feel overwhelmed and need your help to identify and prioritize their most urgent needs. What do they want to do now versus what can wait until later? If they have medical needs, particularly ones that are time sensitive, like PEP and emergency contraception, then help them to prioritize medical services and provide referral information to the nearest one-stop shop or medical facility receiving gender-based violence survivors. Also provide them with the information for other gender-based violence services that they might need after seeking medical services. If they have needs other than medical, then provide them with the referral information for all gender-based violence services. Violence survivors are more likely to complete or reach their referral point if someone goes with them. Consider offering to go with the survivor to the referral point. Remember that the decision to seek gender-based violence services is entirely up to the survivor to make. Your job is to provide the information, make the referral and offer to accompany them if you can.
- Before the survivor leaves, help them to identify their own strengths or support that they can draw on to help them cope with their situation. Encourage them to consider friends, family or loved ones who can help them. Ask the survivor to think about how they coped with difficult situations in the past. Remind them that they can do so again. Ask the survivor what typically helps them to feel better. Encourage the survivor to use positive coping strategies, such as exercise or reaching out to friends, and to avoid negative coping strategies, such as drugs, alcohol or sex.

What if the survivor refuses to take the referral information or to go to the referred service?

The choice to seek help is entirely up to the survivor. Do not make the survivor feel bad about not seeking help. Let the person know that you and the services will be there whenever they are ready. In the meantime, encourage the survivor to identify their own strengths and support system. Ask the person to consider developing a safety plan. Tell the survivor that a safety plan is best if it is developed with the help of a skilled professional, such as someone at a referral site. Once again, encourage the person to access these specialized services. Their safety plan should take into account the type of violence the person has experienced—gender-based or intimate partner violence, whether it was a one-time thing or it happens regularly, who the perpetrator was and where it took place.

Annex 1

A referral list to available health and social support services

unaids-ap.org/hiv_services/

This website has the most up-to-date information on health and social support services in your area.

Annex 2

Overview of common sexually transmitted infections among men who have sex with men and transgender people

GONORRHOEA³²

What is gonorrhoea?

Gonorrhoea is an infection caused by a bacterium. Gonorrhoea can lead to infection of the penis, rectum, and throat.

How does someone get gonorrhoea?

Gonorrhoea is transmitted through unprotected sexual contact (vaginal, anal or oral sex) with an infected person and also from mother to baby.

What are some symptoms of gonorrhoea?

Gonorrhoea may affect the genitals, rectum or throat. Many women and men with gonorrhoea have no noticeable symptoms, especially with infection of the rectum or throat.

- In men, symptoms of gonorrhoea, when they do appear, may include:
- discharge from the penis;
- pain or burning with urination or increased frequency of urination;
- swollen and/or painful testicles;
- infection of the rectum can occur from having unprotected receptive anal sex; although often there are no symptoms of rectal infection when they do occur, they may include rectal discomfort, anal itching, pain, discharge or bleeding; and
- infection of the throat can occur following unprotected oral-genital sex with an infected partner, resulting in a sore throat.

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The information below was taken and slightly adapted from the website <http://www.engenderhealth.org/wh/inf/index.html>.

How do people protect themselves from getting gonorrhoea?

The chance of becoming infected with gonorrhoea can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- use latex or polyurethane condoms during sex;
- limit the number of sex partners and sexual acts;
- a person who has recently been treated or is being treated for gonorrhoea must make sure their sex partners also receive treatment to prevent getting infected again and infecting other people; sex partners should receive treatment even if they do not have any symptoms; and
- it's best to not share sex toys, but if it is done, cover them with a new condom every time they are used with different partners.

Can infection with gonorrhoea lead to other health problems?

When left untreated, gonorrhoea can increase the risk of acquiring or transmitting HIV. In addition, gonorrhoea can enter the bloodstream, leading to an infection throughout the body, often causing pain and swelling in the joints.

In men, untreated gonorrhoea can affect the testicles, leading to swelling and pain. Related complications can lead to infertility.

How is gonorrhoea diagnosed?

A variety of laboratory tests can be used to diagnose gonorrhoea. Tests are done with either a urine sample or a sample obtained from a woman's cervix or a man's urethra, using a cotton swab. If rectal or throat infection is suspected, samples may also be taken from those areas.

These tests are usually not available in Asia, and clients are treated syndromically (without waiting for a test result) for both gonorrhoea and chlamydia at the same time.

Is there a treatment or cure for gonorrhoea?

Gonorrhoea can be easily treated and cured with antibiotics. Many men self-treat by buying antibiotics at a pharmacy. This is not recommended and has resulted in gonorrhoea becoming resistant to almost all useful drugs in many places. Therefore, anyone who has gonorrhoea (or any other STI) should see their doctor. The doctor will know the latest and most effective drugs to treat it. Because men and women infected with gonorrhoea often also have chlamydia, treatment for chlamydia is usually provided as well. It is important to make sure the sex partners also receive treatment to prevent getting infected again and infecting other

people. Avoid having sex while being treated, to reduce the chances of getting the infection again or transmitting it to someone else.

CHLAMYDIA

What is chlamydia?

Chlamydia trachomatis is a bacterium that can cause an STI. Chlamydial infection is common among young adults and teenagers. However, many people do not know that they have chlamydia because they may not have any symptoms.

How does someone get chlamydia?

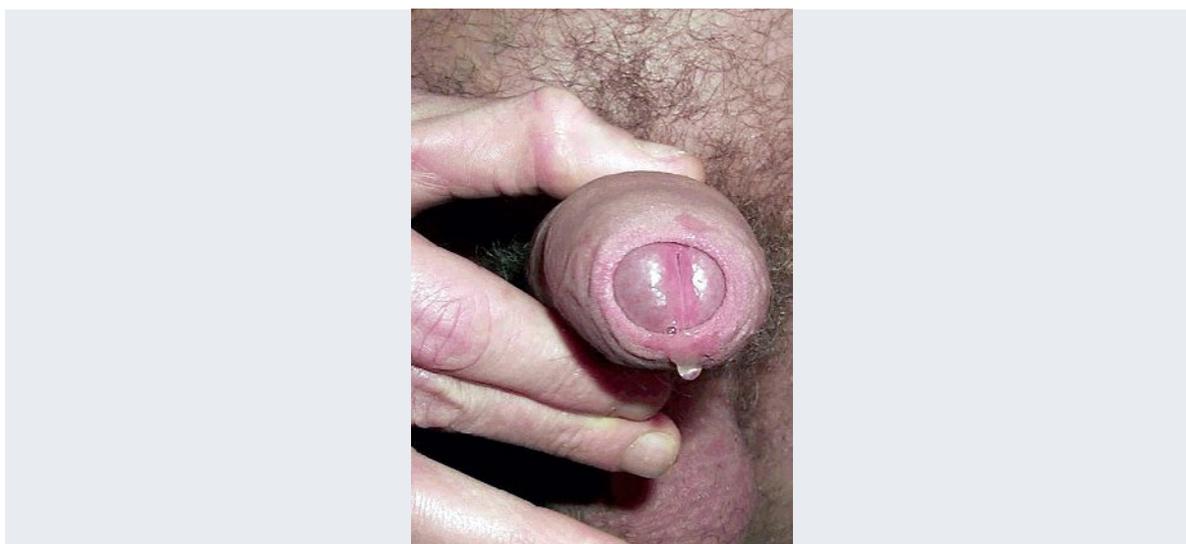
Chlamydia is transmitted through unprotected sexual contact (primarily vaginal, oral or anal) with an infected person and from mother to baby.

What are some symptoms of chlamydia?

About 75% of women and 50% of men with chlamydia **have no symptoms of infection.**

In men, symptoms of chlamydia, when they do appear, may include:

- discharge from the penis;
- burning with urination; and
- swollen and/or painful testicles.



Discharge from the penis can be white, transparent, or something in between

Source <http://studentaffairs.case.edu/health/sexual/male/std/chlamydia.html>

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- use latex or polyurethane condoms during sex;
- limit the number of sex partners or sexual acts;
- if a person has recently been treated or is being treated for chlamydia infection, they must make sure their sex partners also receive treatment in order to prevent getting infected again or infecting other people; sex partners should receive treatment even if they do not have any symptoms; and
- it's best to not share sex toys, but if it is done, cover them with a new condom every time they are used with different partners.

How is chlamydia diagnosed?

A variety of laboratory tests can be used to diagnose chlamydia infection. Tests are done with either a urine sample or a sample obtained from a woman's cervix or a man's urethra, using a cotton swab.

Usually, these tests are not available in Asia, and clients are treated syndromically for both gonorrhoea and chlamydia at the same time.

Is there a treatment or cure for chlamydia?

Chlamydia can be easily treated and cured with antibiotics. Because men and women infected with chlamydia often also have gonorrhoea, treatment for gonorrhoea is usually provided as well. It is important to make sure sex partners also receive treatment to prevent getting infected again or infecting other people. People being treated should avoid having sex to reduce the chances of getting the infection again or transmitting it to someone else.

HUMAN PAPILLOMAVIRUS

What is human papillomavirus?

Human papillomavirus (HPV) is a virus with more than 100 subtypes that can cause a range of disease that includes warts (or papillomas) and ano-genital cancer. Although some types of HPV cause common warts on hands and feet, genital HPVs are sexually transmitted and can cause warts in the genital and anal area of both men and women. HPV causes almost all cases of cervical cancer in women.

How does someone get HPV?

The virus is passed by direct contact during sex with a wart or skin that is infected with the virus and from mother to baby. It is possible to get the warts on hands and in the mouth through contact during foreplay or oral sex. About 50% of individuals who are infected with HPV never develop genital warts but are still capable of transmitting the virus to others.

What are some symptoms of HPV?

HPV may cause warts with many different characteristics. They may appear small or large, flat or raised, single or multiple; sometimes the warts may not even be visible. The most common places to notice warts are outside the vagina, on the penis and around the anus. In women, HPV can lead to the development of warts inside the vagina and on the cervix as well. In about half of all cases, persons infected with HPV do not have any warts.

How do people protect themselves from getting HPV?

The chance of becoming infected with HPV can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- use latex or polyurethane condoms during sex (this may help reduce the risk of transmission, but transmission may still occur if warts are on parts of the body not covered by the condom); and
- limit the number of sex partners and sexual activities.



A severe case of genital warts around the anus

Source CC BY-SA 3.0, <https://commons.wikimedia.org/w/index.php?curid=45743>

How can someone tell the difference between anal warts and haemorrhoids?

Sometimes people are not sure whether they are suffering from anal warts (caused by HPV) or whether they have a problem with haemorrhoids. When you see them, genital or anal warts cannot easily be mistaken for haemorrhoids. Anal warts are white or pink, haemorrhoids are blue-red-purple in colour; warts have a cauliflower-like surface, first soft, later more firm or hard; haemorrhoids have a smooth surface and are soft; anal warts can be single or in groups, especially when growing larger, and both can cause some itching or burning. Warts are not painful but haemorrhoids can become very painful when a blood clot and inflammation develop. Haemorrhoids can cause some bleeding in the poo. It is best to have a medical professional assess the situation so proper treatment can be provided. Anal warts can grow to a large size if left untreated. Some anal lumps will turn out to be cancer, so a medical assessment is essential.

How is HPV diagnosed?

Many people who have HPV show no obvious signs of infection. However, if warts are present, a doctor can diagnose HPV infection by their characteristic appearance and the history of how they developed. In women, to look for warts on the cervix or in the vagina, a doctor may use a colposcope, which is like a microscope. In addition, Pap smear results may be suggestive of HPV infection. There are now a number of tests that can detect high-risk subtypes of HPV, but they are expensive. Cheaper versions are currently in development.

Is there a treatment or cure for HPV?

There is currently no cure for HPV infection. Once an individual is infected, they can carry the virus for life, even if the genital warts are removed. Some people, however, can clear the virus from their body. Vaccines against HPV have now been developed, but these are either unavailable and or unaffordable in developing countries at this time.

If left untreated, some genital warts may disappear. There are a number of effective treatments for removing genital warts. According the US Centers for Disease Control and Prevention, none of the following treatments is better than the others, and more than one treatment may be needed to effectively remove warts. These include:

- podofilox gel, which is a client-applied treatment for external genital warts;
- imiquimod cream, which is a client-applied treatment for external genital warts and perianal warts;
- chemical treatments (including trichloroacetic acid and podophyllin), which must be applied by a trained health care provider to destroy the warts;

- cryotherapy, which uses liquid nitrogen to freeze off the warts;
- laser therapy, which uses a laser beam to destroy the warts;
- electrosurgery, which uses an electric current to burn off the warts;
- surgery, which can cut away the wart in one office visit; and
- interferon, an antiviral drug, which can be injected directly into warts.

Each of these treatments has advantages and disadvantages that should be discussed with a health care provider.

SYPHILIS

What is syphilis?

Syphilis is caused by a bacterium. It is a complex disease that causes various symptoms at different stages of infection. If left untreated, syphilis can have many serious complications. Fortunately, it is easy to treat once diagnosed.

How does someone get syphilis?

Syphilis is transmitted through unprotected sexual contact (vaginal, anal or oral) with an infected person and from mother to baby. In particular, the syphilis bacterium is transmitted through direct contact with syphilis sores, which mainly occur in the genital area of both men and women. Because the sores are usually painless, people may not know they are infected.

What are some symptoms of syphilis?

Primary or early symptoms: The first symptom of syphilis infection is usually a small painless sore (chancre) in the area of sexual contact (penis, vagina, anus, rectum, or mouth). The sore usually appears about two to six weeks after exposure and disappears within a few weeks.

Secondary symptoms: Shortly after the sore heals, a rash all over the body (including the palms of the hands and soles of the feet), swollen lymph nodes, fever, or tiredness may be noticed. These symptoms also disappear within a few weeks. Even though the initial symptoms of syphilis clear up on their own, the syphilis bacterium will remain in the body if not treated.

Latent syphilis: During the latent stage of syphilis, there are no symptoms, but the bacterium is still in the body. This stage can be detected only through the use of a blood test.

Late syphilis: Many years after infection, syphilis can produce symptoms related to the severe damage that it can cause to the heart, brain and other organs of the body.

How do people protect themselves from getting syphilis?

The chance of becoming infected with syphilis can be reduced by avoiding risky sexual behaviours. To reduce the risk:

use latex or polyurethane condoms during sex;

limit the number of sex partners and sexual activities; and

if a person has symptoms suggestive of syphilis or thinks they may have been exposed to it, they should seek medical attention immediately.

If someone has recently been treated or is being treated for syphilis, they must make sure their sex partners also receive treatment in order to prevent getting infected again or infecting other people. Sex partners should receive treatment even if they do not have any symptoms.



A penis with symptoms of syphilis

Source <https://en.wikipedia.org/wiki/Syphilis>.

Can infection with syphilis lead to other health problems?

Syphilis is a very serious infection for both men and women. It spreads through the whole body. Without proper antibiotic treatment, the disease can cause heart disease, dementia, paralysis and death. Infection with syphilis also increases the risk for transmitting or acquiring HIV infection.

How is syphilis diagnosed?

Syphilis can be diagnosed in several ways. A sample from a syphilis sore can be examined under a special microscope. Usually syphilis is diagnosed with a simple blood test.

Is there a treatment or cure for syphilis?

Syphilis is treated and cured with the antibiotic penicillin. People who have had syphilis for less than one year can be cured with one dose of penicillin. For people who have had syphilis longer, more doses of penicillin are required.

It is important to make sure sex partners also receive treatment to prevent getting infected again or infecting other people. People who are being treated should avoid having sex to reduce the chances of getting the infection again or transmitting it to someone else.

Return for follow-up testing at three and six months after treatment for early syphilis, and at six and 12 months after treatment for secondary syphilis.

HERPES

What is herpes?

Herpes is a common, often recurrent infection caused by the herpes simplex virus (HSV), discussed previously and of which there are two subtypes: HSV-1 and HSV-2. Both HSV-1 and HSV-2 can cause blisters and ulcers on the mouth, face and genitals or around the anus. Once a person is infected with herpes, they remain infected for life. However, the virus often remains latent and does not cause symptoms for long periods of time.



A cold sore on the lips; cold sores are a symptom of Herpes infection

Source <http://www.webmd.com/skin-problems-and-treatments/ss/slideshow-cold-sores>.

How does someone get herpes?

Herpes spreads through intimate skin contact with an infected individual and from mother to baby. Although the virus can be spread through contact with lesions or secretions, most transmission occurs from unrecognized lesions or asymptomatic shedding of the virus. Transmission of the virus can occur when the infected

partner does not have an active outbreak of blisters, ulcers or other symptoms. Some individuals may never have any symptoms and may not know that they are infected with the herpes virus. However, they can still transmit the virus to others. Oral herpes (mostly caused by HSV-1) can be spread through kissing. Genital herpes (mostly caused by HSV-2) is transmitted through sexual contact (vaginal, anal and oral). The virus (HSV-1 or HSV-2) can be transmitted from oral to genital regions and vice versa during oral sex.

What are some symptoms of herpes?

Many individuals infected with herpes never have any symptoms and do not know they are infected. The initial herpes infection may be accompanied by flu-like symptoms, such as fever, fatigue, headaches, muscle aches and swollen glands (lymph nodes), in addition to blisters and ulcers on and around the genitals, thighs, buttocks and anus or on the lips, mouth, throat, tongue and gums. Lesions may also be found within the vagina and on the cervix. In the case of genital infection, there may also be pain and itching where the sore is located or burning with urination. These blisters eventually crust over, form a scab and heal, usually within one to three weeks.

Once the initial infection has resolved, some people experience outbreaks of genital blisters, ulcers or small sores, which can occur on the penis, vulva, anus, buttocks and/or thighs. Itching and tingling in the genitals are often an early warning sign that an outbreak is soon to occur. The frequency and severity of outbreaks varies from one person to the next. Sores that occur during recurrent episodes generally last three to seven days and are not as painful as those of the initial infection, and systemic symptoms are rare. However, some people may experience recurrent, painful genital ulcers. In addition, people with suppressed immune system (with HIV infection) may experience severe, persistent ulcers.

How do people protect themselves from getting herpes?

The chance of becoming infected with herpes can be reduced by avoiding risky sexual behaviours. To reduce the risk:

- Use latex or polyurethane condoms during sex. While this may help reduce the risk of transmission, transmission may still occur if herpes lesions are on parts of the body not covered by the condom.
- Limit the number of sex partners and sexual activities.
- Avoid any sexual contact with a partner who has sores until the sores are completely healed.
- Avoid having sex just before or during a herpes episode, since the risk for transmission is highest at that time. If possible, people should encourage their

partner to let them know at the first sign of any recurrence so that they both can avoid sex then.

- If possible, ask any potential sexual partners if they have ever had a herpes episode, and encourage them to see a health care provider or clinic for more information, even if they do not have any symptoms.

What triggers a herpes episode?

Once infected with HSV, recurrent episodes of herpes symptoms can be triggered by a number of factors, including:

- stress;
- sunlight; or
- sickness or fever.

Can infection with herpes lead to other health problems?

Although genital herpes usually causes mild symptoms, some people may experience recurrent painful genital ulcers, which can be especially severe in people with a suppressed immune system. As with other STIs, herpes may also increase the risk for transmitting or acquiring HIV infection.

How is herpes diagnosed?

Herpes can be diagnosed by testing a sample taken from an ulcer or blister. There is no readily available and useful diagnostic blood test for the virus, and there is no certain diagnosis for individuals who are asymptomatic.

Is there a treatment or cure for herpes?

There is no cure for herpes. Once an individual is infected with herpes, they carry the virus in their body for life. This does not mean that the person will have herpes trouble for the rest of their life: Symptoms may or may never come back. Certain antiviral drugs and creams (such as acyclovir) may be used to decrease the severity of the symptoms, the duration of and the frequency of recurrences. Infected individuals can also avoid some of the known causes of recurrences. During an episode, symptomatic relief may be obtained by keeping the area clean and dry, taking pain relievers (such as aspirin, acetaminophen, paracetamol or ibuprofen) and, for genital herpes, by taking baths (sitting in a tub with warm water covering the hips).

HEPATITIS B

What is hepatitis B?

Hepatitis B is a serious liver disease that is caused by the hepatitis B virus (HBV). It is very infectious and can be transmitted sexually or from contact with infected blood or body fluids and from mother to baby. Although HBV can infect people of all ages, young adults and adolescents are at greatest risk. HBV directly attacks the liver and can lead to severe illness (both as an acute illness and also chronic long-term liver damage, including cancer) and, in some cases, death. Although there is no cure for hepatitis B, there is a safe and effective vaccine that can prevent the infection.

How does someone get hepatitis B?

HBV is very infectious and is spread through contact with the blood and other body fluids (including semen, vaginal secretions, and breast milk) of infected individuals. It can be transmitted through:

- sexual contact (vaginal, anal or oral) with an infected person;
- sharing needles and other drug injecting equipment;
- use of contaminated razors or tattooing needles;
- pregnancy and/or birth resulting in perinatal exposure (exposure of the baby to the virus);
- occupational exposure to blood or other body fluids of an infected person (needle-stick injuries); and
- hepatitis B can also be transmitted by other means, such as blood transfusion, intranasal cocaine use with shared straws, shared items, such as toothbrushes, and use of unclean skin-cutting tools or surgical equipment.

Although it is rare, household transmission (transmission without recognized blood, sexual or perinatal exposure) of hepatitis B has been documented, primarily among young children who live with family members who are hepatitis B carriers. It is believed that the virus is most likely transmitted by unrecognized exposure to mucous membranes or minor cuts in the skin.

Unlike hepatitis A, hepatitis B is not spread through food or water.

What are some symptoms of hepatitis B?

Many people with hepatitis B have no or only mild symptoms. However, some people experience flu-like symptoms or may develop jaundice (yellowing of the skin). Symptoms of hepatitis B include:

- fatigue;
- nausea or vomiting;
- fever and chills;
- dark urine;
- light stools (poo);
- yellowing of the eyes and skin (jaundice); and
- pain in the right side, which may radiate to the back.

What are the risk factors for hepatitis B?

The primary risk factors for hepatitis B include:

- engaging in unsafe sex, particularly unprotected receptive anal sex;
- having sex with more than one partner or with a partner who has or has had more than one partner or who has injected drugs;
- sharing needles and injecting drug equipment;
- recent history of STI;
- having a blood transfusion or treatment with infected blood products
- getting a tattoo or piercing;
- having a job (such as a health care worker) that exposes people to blood or other body fluids; and
- traveling or living in areas with high rates of HBV infection (including South-East Asia).

How do people protect themselves from getting hepatitis B?

Although there is no cure for the HBV, there is a safe and effective vaccine that can prevent hepatitis B. This vaccine has been available since 1982 and is given in a series of three shots. It provides protection against hepatitis B in 90–95% of those vaccinated. Getting vaccinated is the best way to reduce the risk of getting hepatitis B. The vaccine is usually given by means of injection, which has to be repeated one month and six months after the first shot. The vaccine protects for many years; after that, it can be repeated if need be.

It is recommended the vaccine be administered to:

- individuals who engage in high-risk behaviours (including unprotected sex, sex with multiple partners and sharing injecting equipment);
- all babies;
- adolescents;
- individuals who live with people infected with HBV; and
- individuals who live in areas with high rates of HBV infection.

In addition, other ways to reduce the risk include:

- using latex or polyurethane condoms during sex (whenever there is a chance that a sex partner is susceptible to HBV, including unvaccinated or previously uninfected regular partners);
- limiting the number of sex partners;
- avoiding sharing needles and injecting-drug equipment;
- avoiding skin-piercing or tattoos;
- practising universal precautions by health care workers; and
- using care when handling any items that may have HBV-infected blood on them (such as razors, toothbrushes, nail clippers, sanitary napkins and tampons).

Can infection with hepatitis B lead to other health problems?

The majority of individuals have self-limited infections, experience complete resolution and develop protective levels of antibodies. A small number of individuals (5–10%) are unable to clear the infection and become chronic carriers. Of the chronic carriers, 10–30% will develop chronic liver disease or cirrhosis. In addition, chronic carriers can infect others throughout their life, and their risk for developing liver cancer is 200 times greater.

How is hepatitis B diagnosed?

Hepatitis B can be diagnosed by a blood test. Routine blood tests that include testing for liver function may indicate infection. In addition, a specific blood test for the virus can give a definitive diagnosis of hepatitis B.

Is there a treatment or cure for hepatitis B?

There is no specific treatment or cure for acute hepatitis B, and no drugs have been shown to alter the course of infection once someone becomes ill. However, for individuals with chronic hepatitis B, interferon therapy and some newer and very expensive drugs may help. In addition, the US Food and Drug Administration

approved the use of lamivudine in late 1998, which is an oral antiviral drug for the treatment of chronic hepatitis B infection. Sometimes, liver transplantation is necessary for severe cases.

Symptoms of hepatitis B can be treated. For example, restricting fat consumption and drinking clear liquids can help relieve symptoms, such as nausea, vomiting and diarrhoea. In addition, it is recommended that individuals with hepatitis B:

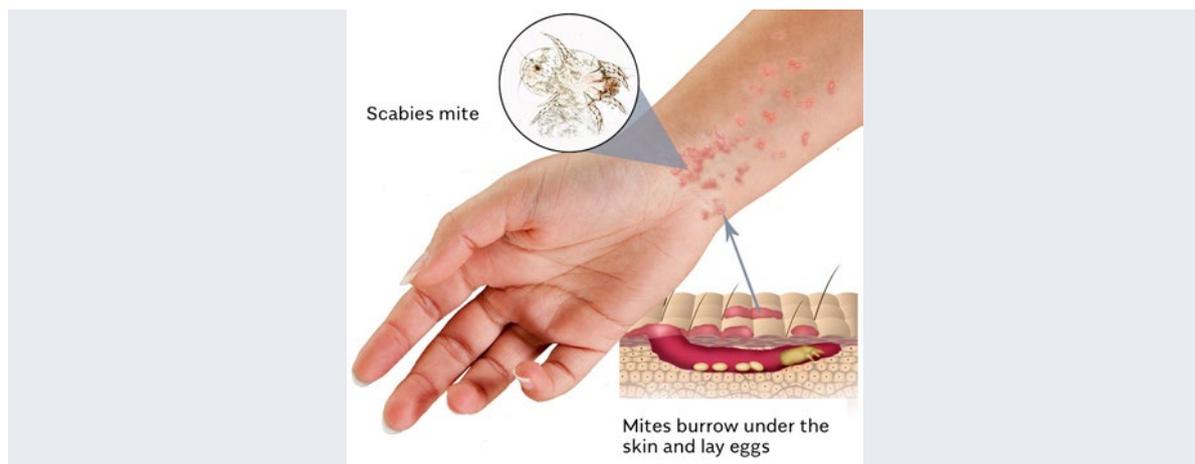
- get plenty of rest;
- drink plenty of fluids;
- eat a high-protein diet to repair damaged cells;
- eat a high-carbohydrate diet to protect the liver; and
- avoid alcohol.

Keep in mind that HBV can be transmitted to others via sex or contact with items that are contaminated with blood (such as razors, toothbrushes, nail clippers, sanitary napkins and tampons). Remember that most infections are self-limiting and that the virus is cleared from the body. A blood test can confirm if the virus has been cleared from the body.

SCABIES³³

What is scabies?

Scabies is caused by a mite (a tiny insect). The female mite tunnels into the skin and lays eggs. The eggs hatch into mites after a few days, causing itches and a rash.



Source <http://www.naturasil.com/what-are-scabies/>.

33 Text slightly adapted from <http://www.leeds.ac.uk/lsmph/healthadvice/scabies/scabies.html>.

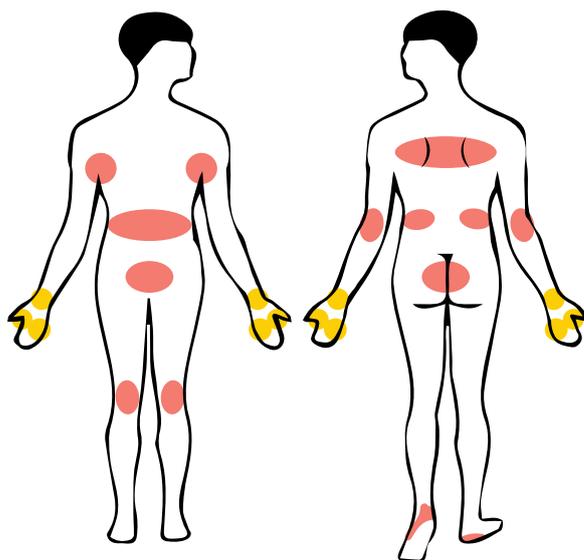
How does someone get scabies?

Close skin-to-skin contact with an infected person causes scabies transmission. The mites live in skin but die after a short time if they are away from the skin. Most cases are probably caught from holding hands with an infected person. The hand is the most common site to be first affected. Sleeping in the same bed and sexual contact are other common ways of passing on the mites.

What are the symptoms of scabies?

Itching is often severe. Itchy skin tends to be in one area at first (often the hands) and then spreads to other parts of the body. The itch tends to be worse at night and after a hot bath. A rash usually appears soon after the itch starts. It is typically a blotchy red rash that can appear anywhere on the body. It is often most obvious on the inside of the thighs, parts of the abdomen and the ankles. Mite tunnels may be seen on the skin as fine, dark or silvery lines about 2–10 mm long. The most common areas where they occur are the loose skin between the fingers, the front of wrists and elbows, groin, armpits, under breasts, scrotum and penis. The itch and rash of scabies are due to an allergy to the mites.

These symptoms usually take two to six weeks to occur after a person is infected (as the allergy develops). Some people may not know that they are infected, and they may pass the mite on to others before they have any symptoms. Some people believe that they are covered in mites. This is usually not so. Commonly, there are just a few mites on the skin. But the allergy to mites can cause someone to itch all over and for a rash to appear in many parts of the body. The rash and itch can be extreme in people who also have HIV infection.



Human scabies mites are often found between the fingers and on the wrists (areas highlighted in yellow).

Highlighted areas in red represent the most common sites where rashes may occur.

Source

<https://en.wikipedia.org/wiki/Scabies>.

Who should be treated?

The affected person and all household members and sexual partners of the affected person, even if they have no symptoms, should be treated. This is because it can take up to six weeks to develop symptoms after someone becomes infected. Close contacts may be infected but have no symptoms and may pass on the mites. Note: Everyone who is treated should be treated at the same time.

What is the treatment for scabies?

The usual treatment is a cream or lotion that kills the mites. This can be bought at a pharmacy. It can also be obtained with a prescription. It is easy to apply and normally works well if used properly. Re-apply the same treatment seven days after the first application. This helps to make sure that all the mites are killed. Follow the instructions on the packet.

Clothes, towels and bed linen should be machine washed (at 50°C or above) after the first application of treatment. This is to prevent re-infestation and transmission to others. Items that cannot be washed can be kept in plastic bags for at least 72 hours to contain the mites until they die.

An infected person will still be itchy for a while after successful treatment. It is normal to take up to two or three weeks for the itch to disappear after the mites have been killed by treatment. A soothing cream, such as crotamiton, may help until the itch eases. An antihistamine medicine, such as chlorpheniramine, may also be useful to help people sleep if itching is a problem at night (particularly for children).

Annex 3

Substances that may be used by men who have sex with men and transgender people

Alcohol

Alternative names:	Drink, booze
Forms:	Liquid
Effects:	Relaxation, increased confidence, loosening of inhibitions
Risks:	Headache, vomiting, loss of coordination, slurred speech, impaired judgement Heavy drinking can cause alcohol poisoning, and liver, heart and stomach problems
Legality	Usually illegal to sell to anyone younger than 18

Amphetamines

Alternative names:	Speed, ya ba
Forms:	Usually comes as a grey or white powder or as tablets
Effects:	Increased energy and confidence, suppressed appetite, rapid heart rate
Risks:	Coming down (tiredness and depression), possible anxiety, panic and hallucinations
Legality	Usually illegal

Cannabis

Alternative names:	Marijuana, pot, dope, grass, hash, ganja, weed, puff
Forms:	Usually smoked with tobacco or eaten in a cooked dish or cake ("skunk" is a very potent form of cannabis)
Effects:	Relaxation and talkativeness ("getting stoned"), heightening of senses, painkilling effects
Risks:	Tiredness, lethargy, paranoia, effects on short-term memory and ability to concentrate
Legality	Usually illegal but softer punishment than other drugs

Cocaine

Alternative names:	Coke, crack, charlie, candy, snow, rock, wash, stone
Forms:	Powder that can be snorted or injected. Crack is the smokeable form of cocaine
Effects:	Feelings of alertness, well-being and confidence (the effects of smoking crack are more intense)
Risks:	Coming down (tiredness and depression), paranoia, confusion, nausea. Heavy use can cause heart or lung problems and convulsions
Legality	Illegal

Ecstasy

Alternative names:	E, ya E, fantasy (chemical name is MDMA)
Forms:	Usually comes as small tablets
Effects:	Increased energy and confidence, heightened senses and awareness
Risks:	Coming down (tiredness and depression), possible liver and kidney problems; can sometimes be fatal
Legality	Illegal

GHB

Alternative names:	GBH (chemical name is gamma hydroxybutyrate)
Forms:	Colourless, odourless liquid in small bottles or capsules
Effects:	Sedative effects, euphoria
Risks:	Illness, collapse, can be slipped into drinks and used to aid "date rape", can be fatal when mixed with other drugs or alcohol
Legality	Possession of GHB without a prescription is not illegal, but supply is against the law

Heroin

Alternative names:	Smack, junk, skag, gear, brown, horse, H, jack
Forms:	Powder that can be snorted, smoked or injected
Effects:	Sense of warmth and well-being or relaxation and drowsiness
Risks:	Dizziness and vomiting, long-lasting destructive addiction, overdosing can cause coma and death
Legality	Illegal

Ketamine

Alternative names:	K, special K, vitamin K.
Forms:	Usually powder to be snorted or tablets
Effects:	Out-of-body experiences and hallucinations (being in a K-hole), anaesthetic and painkilling effects
Risks:	Inability to move, very dangerous when mixed with other drugs or alcohol, heavy doses carry risk of breathing problems and heart failure
Legality	Ketamine is a prescription-only medicine (possession without a prescription is not illegal but supply is against the law)

LSD

Alternative names:	Acid, trips, tabs, microdots, (chemical name: lysergic acid diethylamide)
Forms:	Usually comes in tiny squares of paper, sometimes with a picture on one side
Effects:	Hallucinations, changes to the perception of time, objects, colour and sound ("tripping")
Risks:	Bad trips, paranoia, anxiety or fear
Legality	Illegal

Methamphetamine

Alternative names:	Ice, crystal, crystal meth, Tina, crank, ya ba
Forms:	Powder that can be snorted or injected, the crystal form (ice) is smoked in a pipe
Effects:	Exhilaration, sharpened focus, increased sexual desire
Risks:	Paranoia, mood swings, short-term memory loss, difficulty eating or sleeping, large doses can cause coma and death
Legality	Illegal

Poppers

Alternative names:	Numerous trade names (chemical names: amyl nitrite, butyl nitrite, isobutyl nitrite)
Forms:	Liquid in a small bottle that is inhaled
Effects:	Brief but intense head rush, increased heart rate, often used as an aid to anal sex
Risks:	Headache, nausea, dangerous for those with anaemia, breathing or heart problems
Legality	Poppers are a prescription-only medicine (possession without a prescription is not illegal but supplying it can be)

Solvents

Alternative names:	Glue, gas, aerosols, various trade names
Forms:	Inhalation of the fumes from ordinary household products (especially those found in lighter refills, hairsprays, deodorants, air fresheners, glues, paints, thinners and correcting fluids)
Effects:	Hallucinations, thick-headedness, dreamy or giggly feeling
Risks:	Drowsiness, headache, vomiting, nausea, long-term use can damage the brain, liver and kidneys, can cause instant death (even on first use)
Legality	It is illegal for retailers to sell these products to people younger than 18 or if they suspect the product is intended for abuse

Tobacco

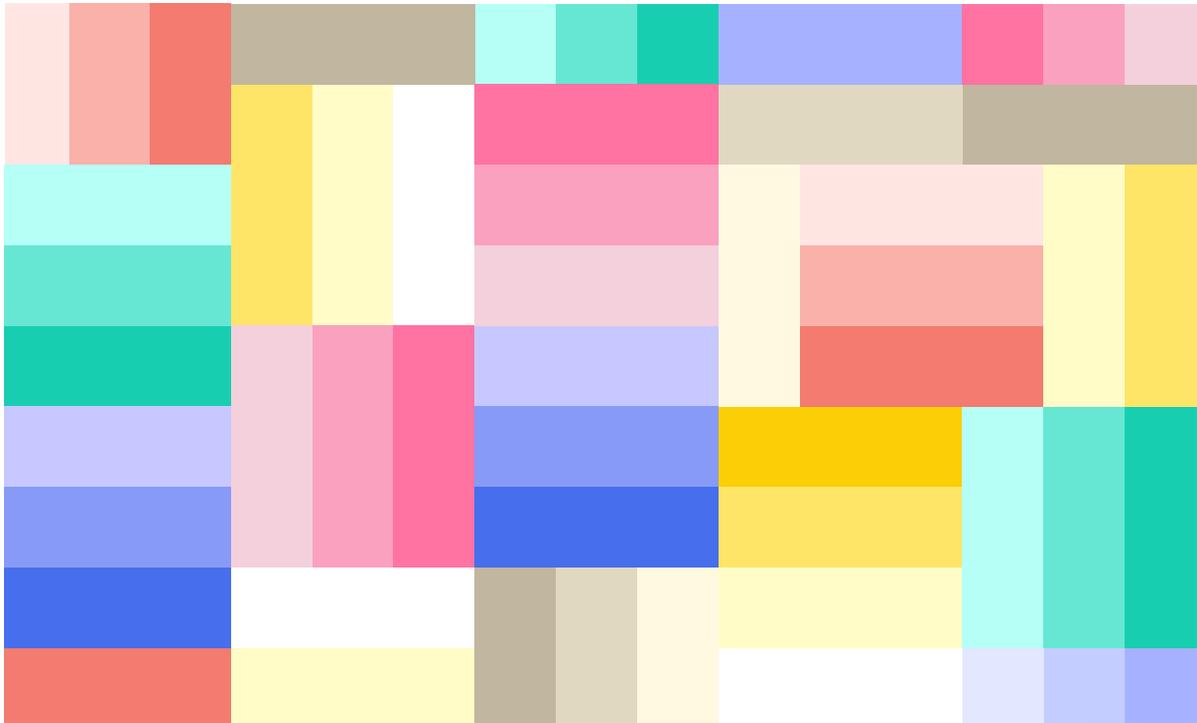
Alternative names:	Cigarettes, cigars, ciggies, rollies, straights
Forms:	Plant that is smoked
Effects:	Relaxation, relief from nervousness
Risks:	Nausea, addiction, causes cancer, respiratory problems and heart disease
Legality	Illegal for retailers to sell tobacco products to people younger than 16 or 18

Tranquilizers

Alternative names:	Tranks, numerous trade names (chemical names include diazepam and temazepam)
Forms:	Usually tablets or capsules
Effects:	Relief from anxiety, depression or sleep problems
Risks:	Addiction, slowed reactions, dangerous if mixed with alcohol
Legality	Possession without a prescription usually is not illegal but supply is against the law



See also <http://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts-0>



For more information, please contact:

UNAIDS

Regional Support for Asia and the Pacific
9th floor, Block A
United Nations Building
Rajadamnern Nok Avenue
Bangkok 10200
Thailand

unaids.org