Reducing the Burden of HIV on
Men who have Sex with Men
and Transgender People in Asia

A self-study and reference manual

for outreach workers, case workers and other HIV service providers

FINAL FULLY UPDATED AND REVISED DRAFT – APRIL 2016

ACKNOWLEDGEMENTS FOR THE 2007 VERSION: The initial draft of this manual was compiled by Jan W de Lind van Wijngaarden, consultant to Family Health International/Asia Regional Program (FHI/ARP), and MSM and HIV advisor to the United Nations Educational, Scientific, and Cultural Organization (UNESCO). Important comments and suggestions for improvement were provided by Graham Neilsen, Celine Daly and Philippe Girault (FHI/Asia Pacific Regional Office), Harry Walsh (International HIV/AIDS Alliance), Clive Wing and Simon Baker (UNESCO) and Prof Louis Gooren of the Free University of Amsterdam (Unit on transgender health).

Elden Chamberlain (International HIV/AIDS Alliance), Rakdaow Pritchard (Population Services International (PSI)), Clifton Cortez (United States Agency for International Development/RDMA), Dr Rutt Chuachuwong (Centers for Disease Control / Thailand–US Collaboration (CDC/TUC)) and Xavier Alterescu (Pact) helped facilitate the regional workshop at which this manual was finalized, and provided important inputs and suggestions for improvement. Srisuman Sartsara and Marisa of UNESCO, Chutima Chomsookprakit of FHI, Edmund Settle of UNDP China and Jack Arayawongchai of the Purple Sky Network helped in the logistics and organization of the workshop. Renata Zanetti of UNESCO is thanked for meticulously recording all suggested changes and providing invaluable editorial support to the draft. Dr Rutt Chuachuwong (CDC/TUC) has been an important source for verification and clarification of medical information in this document during the workshop.

Last but not least, all peer and outreach workers who so enthusiastically and thoroughly went through the entire document and suggested many improvements that were incorporated in this version must be deeply thanked – without them this document would not be as user-friendly and comprehensive as it is. A list with their names is included in Annex 5.

ACKNOWLEDGEMENTS FOR THE UPDATED 2015 version: This entirely updated version of the manual was again prepared by Jan W. de Lind van Wijngaarden, PhD, this time as a consultant to UNAIDS Regional Support Team in Bangkok, Thailand. Matt Avery of FHI 360 re-wrote Unit 1 and he and Justine Sass of UNESCO Bangkok provided helpful comments and suggestions for improvement of the entire manual. Dr. Graham Neilsen (Australia, formerly FHI 360 in Bangkok) reviewed the STI sections (Unit 10 and Annex 2); several people, including Rob Oostvogels (Netherlands) and Jamie Uhrich (Thailand) advised on the section on testing and counselling. Prempreeda Pramoj Na Ayudhya (UNESCO Bangkok) reviewed the section on transgender health. Matthew Vaughan (APCOM), Laurindo Garcia (B-Change Group) reviewed the new section on internet dating and social media. Dr Bas van Loon (Amsterdam) provided advice on a section on rectal health.

Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CBC	Complete Blood Count
CD4	Cluster of Deviation 4 (marker on white blood cells)
CCR5	Chemokine Receptor 5 (used by HIV to enter target cells)
DNA	Deoxyribonucleic acid - a nucleic acid molecule (genetic material in cells)
ELISA	Enzyme Linked ImmunoSorbent Assay (Diagnostic Medical Tool)
FHI	Family Health International
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSV 1-2	Herpes, types 1 and 2
HCT	HIV Counselling and Testing
IEC	Information, Education and Communication
KY	KY™ Jelly (water-based lubricant)
MSM	Men who have sex with men
OI	Opportunistic Infection
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
RTI	Reverse Transcriptase Inhibitor
STI	Sexually Transmitted Infection
T-Cell	Sub-group of White Blood Cells
TG	Transgender

Introduction – what is this reference manual about?

What is this reference manual about and what are its aims?

This manual helps people who work in HIV service organizations, including peer educators and outreach workers, who are working with men who have sex with men and transgender people[1] sustain and update their knowledge about HIV/STI and sexual health issues. It provides detailed information about everything an HIV service worker or outreach worker may be asked about during their work. It aims to improve the scope and accuracy of information that peer and outreach workers provide to their target audience.

How should this manual be used?

The manual consists of different parts, which can be put in or taken out of the ring binder, allowing each user to choose the materials he needs. In addition, updates will be provided when needed, for example when new HIV prevention technologies (i.e. vaccines, circumcision, and microbicides) or treatments become available (see e-mail address and website below).

Users of this manual can access a website to discuss its use, ask additional questions on a web-board or provide feedback – please contact the author at jwdlvw@gmail.com

The information in this manual is presented in a Question and Answer format, to enable users to find answers to questions asked in the field.

Where does the information in this manual come from?

Information was collected from existing documents used by Family Health International, the HIV alliance and other organizations, as well as scientific information and the internet, with many entries adapted from:

www.cdc.gov
www.thebody.com
www.wikipedia.com
www.engenderhealth.com

Other sources are mentioned throughout the text; see also Annex 4.

A draft of the 2007 version of this manual was reviewed by experts from different international organizations, and was reviewed by English speaking peer and outreach workers from Thailand, Lao PDR, China, Viet Nam, Cambodia and Myanmar at a regional workshop in Chiang Mai, Thailand in June 2007.

The new version of the manual was reviewed using an online peer-review process.

[1] In this manual the focus is mainly on transgender people who cross more or less permanently from the male into the female gender.

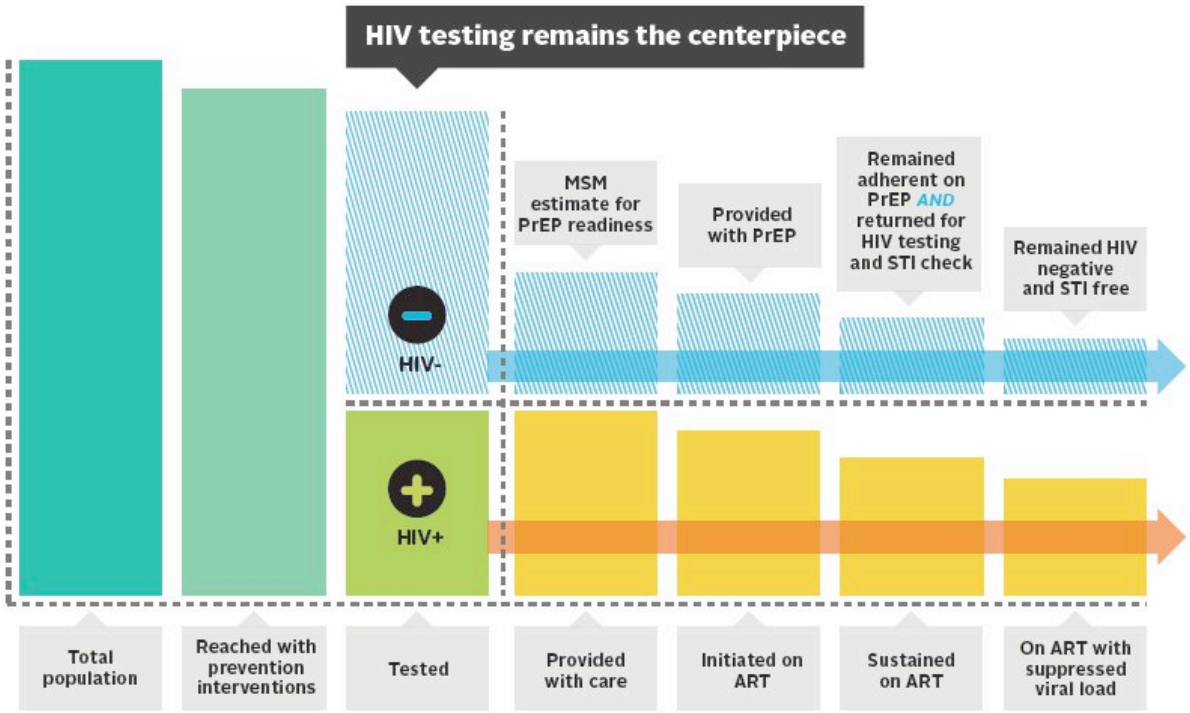
Unit 1: Outreach and the HIV Cascade

What is the role of the peer 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, a key reason is that many MSM 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 MSM and TG avoid HIV testing services even when such services are available, mainly because of (actual or perceived) stigma by health care providers and inconvenient locations or opening hours, meaning they are unaware of their HIV status, cannot access life-saving antiretroviral treatment (ART), and may be continuing to spread infection to their partners, perpetuating the HIV epidemic.

Outreach workers have for many years played a key role in disseminating HIV prevention information and commodities (condoms and lube), identifying undiagnosed HIV infection among MSM and TG people and in facilitating access to HIV counseling and testing services. However, in recent years a consensus has emerged that preventing HIV will require not only strong prevention services, but strong linkages across an entire continuum of HIV prevention, care and treatment services, as illustrated below.



Evidence has shown that the linkages between programs and client flow through them have been woefully inadequate at every stage of this “HIV cascade.” Outreach programs often reach high-risk individuals and refer them to HIV testing services, but a huge segment of those reached never go for an actual HIV test. If people who receive an HIV test are diagnosed HIV+, they often leave without the medical or

social support to start early ART. Many seek treatment very late, when they have multiple health problems.

In short, loss to follow up is rampant across the continuum in many settings, with HIV infection remaining unacceptably high and access to ARV treatment for people living with HIV unacceptably low, both leading to unnecessary HIV-related deaths. Trained and well-supported peer staff such as yourself can play a critical role in identifying and plugging these "leaks" across the HIV cascade so that MSM and TG clients, once engaged, are effectively supported and retained within the system and access the services they need to safeguard their own health and to prevent the further spread of infection. Below we will discuss the varying roles that a peer worker can play across the HIV cascade.

How can we reach potential clients?

As described above, one critical role of peer 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 MSM and TG gather, so-called "cyber outreach" via Internet and social media platforms, and peer-driven recruitment models wherein our own clients help us to identify and recruit additional members of our target audiences.
Whatever the "reach" model, these activities have traditionally focused on provision of correct information about HIV transmission and prevention, promotion and provision of condoms, and referral to MSM- and TG-friendly STI and HCT services. There has been less focus on building clients' motivation and skills for behavior change (safer sex, HIV testing etc.) or on providing specific information or assistance to access testing services. Outreach workers have also been less likely to address alternative sexual risk reduction strategies (including PrEP or other sexual behaviors) or to discuss more entrenched issues such as managing drug use and HIV risk; dealing with sexual or gender identity issues; or handling stigma, discrimination and/or gender-based violence based on one's sexual or gender identity or preference, HIV status, or involvement in sex work.
It is expected that this manual will help peer 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, peer 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 programing for MSM and TG is recognizing the potential for "task shifting" – that is, shifting the responsibility for some services, previously solely the domain of the formal healthcare sector, onto lay health workers, including peer workers. There are a number of models by which this can be accomplished, including HIV testing services delivered through community-based drop-in centers or mobile clinics, outreach-based rapid testing delivered by a peer outreach worker (what the WHO 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, peer workers are increasingly being responsible for not only referral to testing, but for the actual delivery of high-quality, MSM- and TG-friendly HCT services.

What happens if a client tests positive?

The role of the peer worker does not necessarily stop when a client tests HIV positive. One of the biggest "leaks" in the HIV cascade is among individuals who test positive but do not initiate treatment. There are numerous reasons for this, including clients' own (often outdated) beliefs about HIV treatment, including 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. Peer workers can give up-to-date and accurate information about treatment, work with clients to build motivation and provide emotional support, and assist in overcoming structural barriers to treatment, such as confusing clinic processes or regulatory issues. There are various models by which this might be accomplished – in some programs this might be the role of the peer outreach workers themselves, in others it might be the responsibility of a specialized worker called a "case manager" or a "clinic navigator." It is not necessarily a requirement that the person fulfilling this role be a peer (or be a person living with HIV) but peer workers who fulfill these roles can speak with additional experience when supporting a newly diagnosed client.

If your role as a peer worker includes these responsibilities, we must emphasize the importance of keeping in 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 when a client has been recently diagnosed or recently started treatment.

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

Another key "leak" in the cascade is among clients who start ART but drop-out, perhaps because they cannot make their appointment schedule, or they are having issues handling treatment side effects, or in some cases because they feel better and believe that treatment is no longer necessary! Stopping treatment threatens the health of the individual HIV-positive client; in addition, 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, peer workers have a role to play. Case managers or clinic navigators may follow-up with ART patients over time – via telephone, home visits, or other activities, and provide both practical and psychosocial support to help clients stick to their treatment. Peer outreach workers can also help, by identifying ART patients who are lost-to-follow-up through their outreach work, and by assisting them to reconnect with healthcare services. This may be an especially critical role as treatment initiation guidelines change. Previously, HIV-positive clients usually did not start treatment until they reached a certain stage of infection (often determined by their CD4 count). The WHO 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 ART under the previous guidelines who would now be eligible – peer outreach workers can play a role in identifying these individuals in the community and helping them access treatment.

What about clients who test negative?

The HIV cascade has typically focused on service uptake and retention for people who test HIV-positive; many people test HIV-negative and are then never seen again. This is another leak in the cascade – people at high risk of infection (such as sexually active MSM and TG) should receive a regular HIV test. This way, if they do become infected, they can start treatment as soon as possible. And with the growing availability of PrEP, regular HIV testing can be a way for our clients to access new options for HIV prevention. Peer 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 peer workers for all kinds of reasons:

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

What do I say when people ask me: “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 questions 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; therefore 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 of 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 it will keep you and your partner/s 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 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 Peer/Outreach and HIV Service Workers?

1. Confidentiality: Personal issues raised by your client should remain a secret. You can use examples about people that you know in your work or from your social network, but make sure they can never be identified by the person you are talking with. You need to keep confidentiality to keep the trust of your friends; without trust you will not be able to do your work. This principle is especially critical as healthcare tasks are shifting to peer 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 (i.e. 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 his name or age or other personal information, that is fine. Respect and honor it!
4. Benevolence: Always speak to your client from the perspective that you have his best interest in mind.
5. Reducing harm: Your aim is to reduce your client's exposure to HIV or other STIs and to avoid him from exposing others to HIV or STIs. Do not expect him 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 according to the need of your client. Many outreach workers tend to always 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 you are sexually attracted to, refer him to a fellow outreach worker. It is not appropriate to flirt or date with (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 what you do 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 his question and come back to him later. Keep yourself updated with new information from your supervisor, from the internet and from this manual.
9. Diffuse information through your client's networks: Encourage clients and peers to take a proactive role in informing and educating and influencing their own friends to get tested for HIV regularly and to have safer sex.
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 risky behaviors. Then, help your client analyze and overcome these challenges together. 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, by keeping records and using monitoring tools. This will help you as well as the organization you work for to improve the program over the long term.

Unit 2: Basic information about HIV

HIV is a virus.

A virus is a small organism, so small that it is invisible to the human eye. There are many different 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 make our stomach upset. The Human Immune Deficiency Virus (HIV) is also a virus, which can lead to AIDS (Acquired Immune Deficiency Syndrome), which is a serious disease. If HIV is not treated, it usually leads to death. HIV is transmitted via blood, semen, breast milk and vaginal fluids. Fortunately HIV is not as easy to transmit as the flu, and its transmission can be prevented relatively easily.

What is HIV and what does it do?

The Human Immuno-deficiency Virus (HIV) is a virus, which slowly weakens the ability of the human body to fight off diseases. The body's ability to fight off disease is called the 'immune response' and is managed by the body's 'immune system'. It consists, among other things, of 'defense-cells' in our blood, which are called '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 our body. HIV attacks the body's 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 and less effective. As a result, diseases and infections, some of which normally have little success in attacking the body, may now get a chance. People infected with HIV can die after their immune system is brought completely 'down'. This stage in the disease progression is called 'Acquired Immune Deficiency Syndrome', or AIDS. 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?

AIDS stands for Acquired Immune Deficiency Syndrome. A syndrome is a set of different symptoms of disease that often occur together, and in the case of AIDS these symptoms are a result of severe damage to the immune system. When the immune system is seriously damaged by HIV (i.e. there are not enough CD4 cells left), it becomes unable to defend the body against certain specific 'opportunistic' infections and tumors. These are also known as HIV-related diseases. The person is now more vulnerable to a wider range of possible diseases, including tuberculosis, pneumonia and types of 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, but can only be confirmed by a doctor.

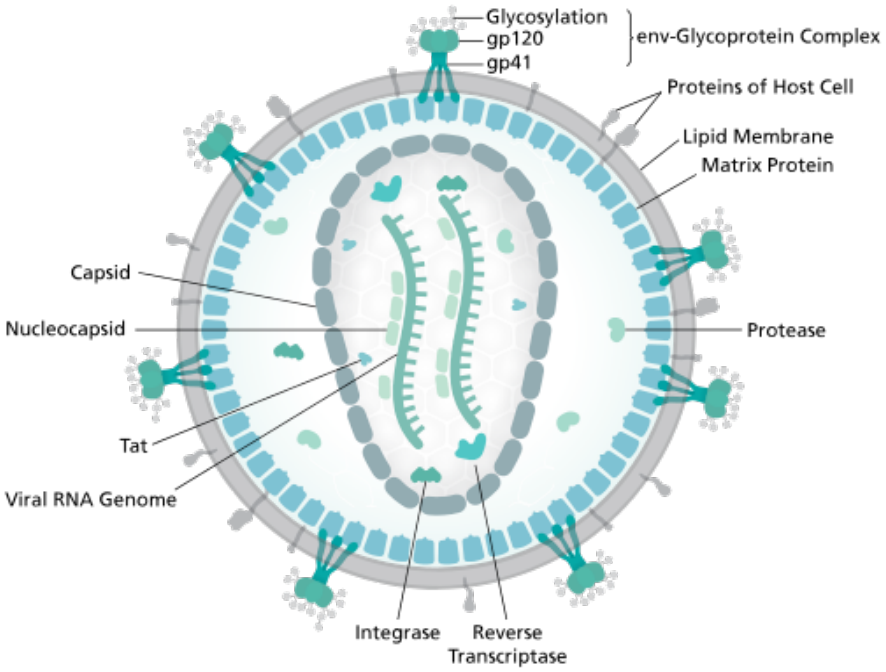


Figure: a diagram of an HIV virus particle. Source: http://en.wikipedia.org/wiki/HIV

What is the difference between HIV and AIDS?

When a person is infected with the virus called HIV, they may look well and feel healthy like any other person. Without treatment and after continued attacks by HIV on the immune system, the person may develop other illnesses and symptoms and get seriously weaker; HIV infection has then progressed into the stage called 'AIDS'. This process can take between 3 and 10 years from the moment of initial infection with HIV, depending on several factors.

You cannot see or 'feel' from the outside whether a person has HIV. 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 in gradually destroying 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 the person will most likely eventually die of his illness.

A person can often lead a normal life without knowing that they are HIV-infected. It is therefore easy to understand how he may, without knowing, transmit HIV to others. HIV also makes a person more vulnerable to other sexually transmitted infections.

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

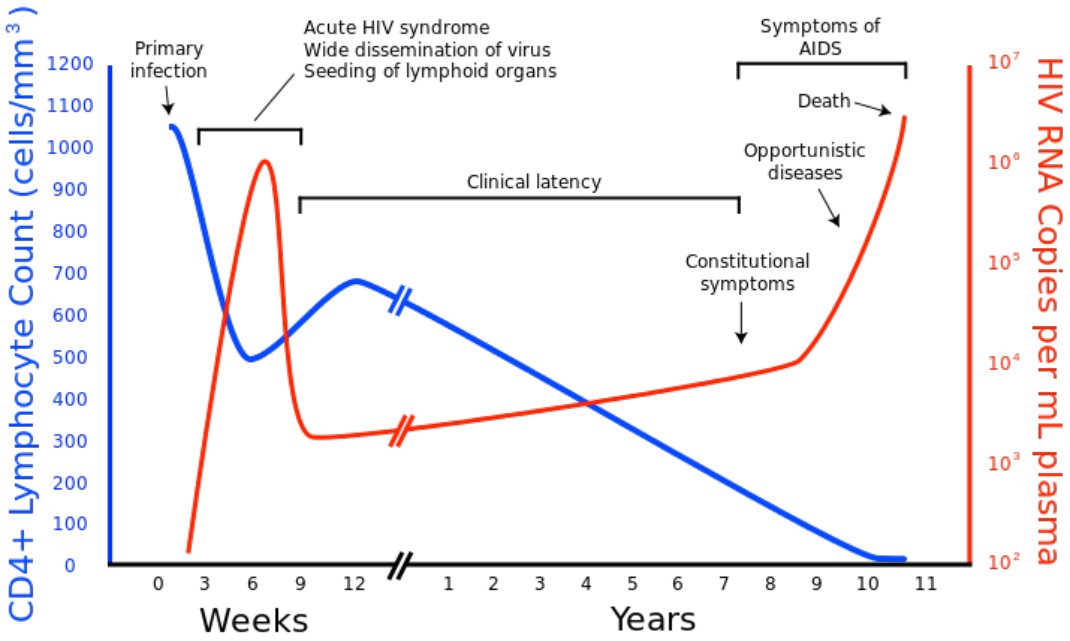
Depending on a person's physical and mental health as well as other factors, including the extent to which a person with HIV has support and a healthy lifestyle with plenty of rest, sports, proper nutrition, and peace of mind, this can be many years; between 5 to 10 years after infection with HIV – most often it is 9 to 10 years. It should be noted that scientists have recently discovered a new sub-type of HIV, called 'CRF19', which develops from HIV into AIDS three times faster, i.e. around 3

years after infection. However, with increased availability of HIV treatment, if a person with HIV is under medical supervision and starts treatment with antiretroviral medicines (see Unit 11) a person living with HIV may live a healthy and fulfilling life. A recent study conducted in the US showed 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 (Source: http://pag.ias2013.org/Abstracts.aspx?AID=2451).

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 anti-retroviral medicines (see Unit 11), his life and health can be extended for many years; many people will die of old age rather than of complications of HIV or AIDS. With increasing access to antiretroviral medication more people with AIDS are successful in bringing down HIV levels and recovering their immune system, returning to the asymptomatic stage of their HIV infection and living long and healthy lives.

Figure: Progress of HIV disease without treatment



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

Can you see whether a person has HIV?

You can never see from outside characteristics or symptoms whether a person has HIV. Many people have misconceptions about this. They think people with HIV are particularly thin/skinny, or that their skin looks different. This is nonsense. The only way to know whether you have HIV is by doing a clinical test (e.g., blood or saliva test) to find out.

☞ See Unit 12 and Annex 1.

Who gets HIV?

Anybody who has engaged in risk behaviors and has been exposed to the virus can become infected! Many people believe that people who look fat, healthy or are of a higher social class do not have HIV, or that only poor people, sex workers or drug users get HIV. This is not true. A virus cannot know whether a person is of high class or not, or whether they are fat or thin. HIV is transmitted by behaviors, and people who engage in these behaviors can be exposed to HIV and become infected. It is not related to class, looks, age, educational level, profession, ethnicity or anything else. The only exception to this are babies, who can become infected from their HIV positive mothers without engaging in any behavior.

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

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

1. Blood
2. Semen / sperm
3. Fluids that exist in the female vagina
4. Fluids that are secreted in the rectum
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, i.e. blood, semen, 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 (see table below).

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

HIV can also be transmitted from an HIV-infected woman to her child, either during pregnancy, during childbirth or through breast feeding.

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

No. Of course, 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. Since anal sex is the most effective way of sexually transmitting HIV, men who have sex with men and transgender people who would like to reduce their risk can enjoy sex with each other in other ways that do not involve penetration or ejaculation inside the partner's body. Hugging, body rubbing and erotic massage, kissing, licking and thigh sex are examples.

Many men, however, enjoy anal sex and find it difficult or impossible to stop. Fortunately, where one partner is HIV-positive, the chances of infecting the negative partner are very low if condoms and water-based lube are used correctly and consistently in anal sex. The chances are even lower if the infected partner is on treatment and is taking their 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 HIV pre-exposure prophylaxis or PrEP. (See Unit 6).

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

Which sexual behaviors are no risk/low risk/medium risk/high risk?

In the table below, a wide range of sexual behaviors are mentioned, and the possibility of HIV transmission is defined as 'no risk' for HIV transmission (safe sex), 'low risk' (a extremely small chance for HIV transmission that you could decide to ignore), medium risk (a small chance for HIV transmission) and 'high risk' (the highest chance for HIV transmission).

As well as always promoting condoms to make penetrative sex safer, as a peer / 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 below may help you think of suggestions to make during your work.

PRACTICE	RISK	NOTES
Abstinence	No risk	
Masturbation	No risk	
Unshared sex toys	No risk	If there is no exchange of bodily fluids between different users.
Phone sex	No risk	
Cyber / webcam sex	No risk	
Hugging	No risk	
Massaging each other	No risk	
Telling each other sexual fantasies	No risk	
Watching pornographic movies	No risk	
Rubbing genitals together fully clothed	No risk	
Rubbing genitals together without penetration, unclothed	No risk	Provided there are no lesions on the genitals and no exchanges of body fluids.
Manual sexual stimulation of the genitals	No risk	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	No risk	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	No risk	Clean sex toys with soap and water after each use. It is even better if you use a condom on the sex toy, and remove it after use.
Rubbing sweaty bodies together	No risk	No HIV transmission risk, although some STIs (e.g. herpes and scabies) can be transmitted through contact with skin not covered by a barrier if there are lesions.
Biting as part of sexual play	No risk	It is no risk if there are no lesions/open sores/cuts in the mouth and provided that the biting does not cause the person to bleed.
Deep (tongue) kissing	No risk	There is no risk if there are no sores or

PRACTICE	RISK	NOTES
		cuts in the mouth, or bleeding gums. Also no risk due to saliva itself; saliva can contain antibodies to HIV but not the virus itself.
Oral sex on a man with a condom	No risk	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 you pick a condom that has a nice flavor! (Unit 7)
Oral sex on a man without a condom	Low risk	STIs can be transmitted through oral sex from the person receiving it to the person 'giving' oral sex (i.e. the person who does the sucking). However risk for HIV transmission in oral sex is extremely low, and much lower than that of anal or vaginal sex. It is even safer if no ejaculation in the mouth occurs.
Fingering or fisting	Low risk	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)
Anal sex with a condom	Low risk	The risk of condom breakage is greater than for vaginal sex. 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	Low risk	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/oral sex. However, you can get parasites too, which can be particularly unhealthy for HIV infected people. If you use a dental dam, there is no risk.
Anal sex with multiple partners; condom use every time	Medium risk	Multiple 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 increase STI risk.
Withdrawal of the penis before ejaculating while having anal sex without a condom	Medium risk / high risk	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	High risk	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

PRACTICE	RISK	NOTES
		unsafe sex with many partners.
Sex with a circumcised man without a condom	High risk	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/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 practice safer sexual behaviors.
Anal/vaginal intercourse using oil-based lubricants and condoms	High risk	Oil-based lubricants can seriously damage condoms and increase the likelihood of condom breakage during intercourse.
Using the same condom twice	High risk	Condoms should not be re-used, as re-use is not hygienic and increases the likelihood of breakages and slippage.
Using more than one condom at the same time	High risk	Using more than one condom increases the likelihood that the condoms will break or slip off during sex.

Adapted from *FHI Vietnam MSM Outreach Training Manual*

Can HIV be transmitted through anal sex?

Yes. The tissue inside the rectum is very 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 to happen is significant if intercourse is without condoms, if an HIV positive partner is not using antiretroviral treatment and/or if the HIV negative person is not using pre-exposure prophylaxis (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 reduce transmission risks even further).

Transmission chances are close to zero if the infected 'insertor' is on antiretroviral treatment and has an undetectable HIV viral load. An infected 'bottom' can infect a 'top' 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, as well as other rectal secretions manages to enter, via the penis, the bloodstream of the penetrating partner. In terms of sexual transmission, anal sex remains the most-high risk activity for STI and HIV infection.

Does it matter whether you are 'top' or 'bottom' 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 each 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 just 0.11% per each sexual act (source:

http://www.cdc.gov/hiv/policies/law/risk.html). It is important to note 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 are population-based estimates, which can vary widely per each individual.

If you are HIV negative and if you are going to have unprotected sex with a person of whom you are not sure or know he is HIV positive, it is therefore a sensible HIV prevention strategy to be the 'inserter' in anal intercourse, i.e. to not let the person with HIV or of unknown HIV status penetrate you! This can reduce the chance of HIV transmission by a factor of 12.5.

Picture: An Ottoman drawing depicting to men having anal sex, 19th 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 are 0.08% per sex act; the other way around it is 0.04%. It is important to note that 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 HIV viral load is high and infectiousness increases. The percentages provided are population-based estimates, which can vary widely per each individual.

Can HIV be transmitted through oral sex?

It is assumed that in theory, HIV can be transmitted through oral sex; however the chance of transmission is extremely small. It is assumed that transmission is theoretically 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. However, other STIs, including chlamydia, gonorrhea, 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).

Picture: A 19th-century picture during the Qing dynasty (China), depicting men engaging in oral and anal sex.
Source: http://commons.wikimedia.org/wiki/File:ChinaScrollPN3.jpg

Why is it so difficult to transmit HIV orally?

HIV needs to enter the body of an uninfected individual for infection to take place through one of the body fluids mentioned (i.e. blood, semen, vaginal fluids, rectal secretions or breast milk). During oral sex, it is difficult for HIV to enter another person's body since the virus is likely to be in the mouth for only a short time and then is likely to be killed by the acid in the stomach. Just to be safe, it is advised not to let semen of a man come into the mouth (see for the latest updates on oral sex transmission risk: http://www.cdc.gov/hiv/risk/behavior/oralsex.html).

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 inject silicone, penicillin or some type of oil (such as olive oil) in the penis, which sometimes has very serious medical consequences. Some people also use type of "modified" condoms that are not authorized for sale, e.g. hairy condoms or condoms with plastic pieces embedded in them. These condoms are dangerous for both partners since the condom is not effective to prevent HIV or STI. It can cause

irritations or lesions to the inner surface of the rectum or vagina that ease the transmission of HIV to the receptive partner.

If your friend or client is contemplating doing this, you should warn them about the negative consequences this can have for themselves and their sexual partner(s). There are many unauthorized so-called 'doctors' who do this kind of operation, 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 'dying' of the skin or parts of the penis, or cancer.

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

Does circumcision protect against HIV?

Studies have proven that among heterosexual men having vaginal sex with women, circumcised men had a much lower risk to get HIV from an infected woman compared to those who are uncircumcised. This is because the inner surface of the foreskin of the penis provides an opportunity for access for the HIV virus. After it 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. Since there is still a risk for HIV transmission, circumcised men, like those who uncircumcised, must therefore continue to use condoms.

For men practicing anal sex, there is some evidence that circumcision has a protective effect, but of course this is only the case if a man is top (insertive) and if he is never, ever the bottom in unprotected anal sex! Since many men have experience being bottom as well as top during their lifetime, circumcision is not generally a recommended prevention strategy for MSM and TG.

Is group sex more risky than sex with only one partner?

In principle, the more partners one has, the more risk for HIV infection there is; and this is true whether one has a different partner per week or two people at the same time every two weeks. However, if having sex with 2 or more partners at the same time, it is important to note 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. STI can be transmitted in this way, too! 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 different 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. However, other infections can be transmitted, especially those transmitted via human excrement: Hepatitis A and B and certain parasites and bacteria are the most common.

Picture: ‘Rimming’ or anilingus is a relatively safe sex act in terms of HIV transmission, but under unhygienic circumstances the person performing it can get Hepatitis A, B or other bacteria or parasites from the person being pleasured...

Can HIV be transmitted by kissing or hugging?

No, because 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. HIV can not survive for long outside the human body. Besides, 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 a 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 in to the body of an uninfected family member; 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 shared with 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: The prevention of HIV infection

How can I prevent myself from getting HIV?

While HIV infection can now be treated, it cannot yet be cured. 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 this is not a realistic choice. Sex is part of our life and we enjoy it, and that is fine.

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

The most common option—which is not easy or possible to implement for everybody—is to **use a condom and water-based lubricants** every time you have anal or vaginal sex with anybody (see Unit 5). The latest CDC 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. If you find a well-fitting condom and you 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 (antiretroviral drugs) consistently**, which can reduce your chance of infection by up to 96% (see Unit 6). If you use both condoms and PrEP, your risk is reduced by 99.2%.

If you have sex with more than one person, strategies to reduce your risk can be to **reduce the number of partners and sexual encounters** you have. You can do this, for example, by masturbating more, which is a safe (and fun) way of reducing your urge and desire to have sex (see Unit 7).

You can also choose to not reduce the number of sex partners or encounters, but to shift away from anal sex. By having **more oral sex and less anal sex** you can reduce your risk for getting (or transmitting) HIV dramatically. Instead of oral sex, you can also have mutual masturbation, thigh sex, rubbing and hugging. Other super-safe options include web-cam-sex or phone sex (see Unit 7).

You can read more about HIV prevention techniques at:
https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/sexual-risk-factors/

Can I reduce my risk of HIV without bothering with condoms or PrEP?

A study from Sydney, Australia (Source: http://europepmc.org/articles/pmc2768371) found that even when men do not use condoms or PrEP, or even when none of the partners is taking 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). Three of these strategies were found to reduce the chance of getting HIV significantly, compared to men who did not use any strategy (and no condoms). These strategies are not as effective and not as safe as always using condoms or enrolling in pre-exposure prophylaxis, but nevertheless, they may offer some limited protection again HIV infection.

Please note that these strategies help reduce some infection risk but only for people who get tested very regularly, which is not the case in many Asian settings. These strategies are definitely not as safe as using condoms, lubricants and PrEP consistently. It has also been shown that men who practice the below strategies had higher levels sexually transmitted infections other than HIV.

What can I do to reduce my risk of HIV without using condoms?

First, there is what the researchers call **strategic positioning**. This means that if a person living with HIV has sex without condoms with a partner who is HIV negative, or who is not sure what he is, that only the person living with HIV is the receptive partner in anal intercourse. This is because, as discussed above, the receptive partner is up to ten 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 practice unsafe sex, while they promise each other that when having sex with others, they will always be safe - if an 'accident' happens, 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.

In the Sydney study, both these strategies reduced HIV infection risk to a similar degree as consistent condom use.

A third strategy is called **sero-sorting**. This means that HIV negative men only have (condom-less) sex with HIV negative men, and men living with HIV 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 two above mentioned strategies, but lower than having unprotected sex indiscriminately, without exchanging information about one's presumed serostatus. Sero-sorting is usually not recommended, as 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 HIV tests yet. The period where 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 in fact have become infected already, but is still relying on his last (negative) test result. Even so, sero-sorting also 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 as consistent condom use.

See for more information in non-scientific language: http://www.fridae.asia/gay-news/2009/04/29/2269.alternatives-to-condom-use-can-help-reduce-hiv-transmission-among-gay-men#sthash.Oha5TG4Y.dpuf

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

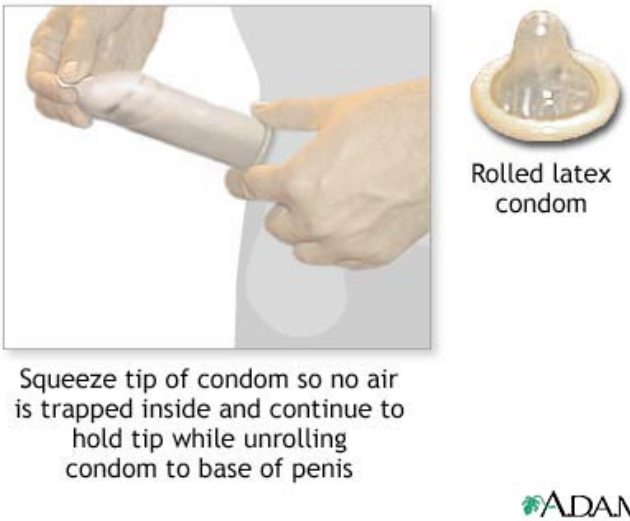
No. This is due to the infectiousness of pre-cum of the insertive partner, and the risk of transmission from an infected 'bottom' to an uninfected 'top', which does not have anything to do with the moment of ejaculation.

Unit 5: Basic information about condoms and lubricants

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 sexually transmitted infections (such as gonorrhea, syphilis, Hepatitis B and C, and HIV).

Latex condoms are the most common condoms in Asia; they 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 put off. It is very explicit, i.e. a real person is demonstrating it, 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 simply 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 them in penetrative sex, especially when applied to a condom. This enhances sexual pleasure, enables penetration of the rectum (which can be very narrow) and prevents latex condoms from tearing or breaking. Many condoms are packed 'lubricated', but for anal sex the amount of lubricant inside a condom package is not enough, and additional lubricant should be applied. Lubricant is sold in tubes or in plastic containers (see picture below), and sometimes in handy pocket-sized sachets.

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, KY 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).

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

There are several sub-types of water-based lubricants – some include smells or odors, some are edible and some give a special effect (i.e. they cause a tingling or warm sensation when applied).

What if I want to have sex and I do not have water-based lubricants?

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

If you do want to have anal sex in this situation, or if you have no choice, use saliva (spit). Saliva is a natural, water-based substance that can be applied to the condom before having sex. Use your own saliva if you are the receptive partner. You 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 higher. You should be careful if you re-apply saliva to a condom after it already has been inside the rectum; make sure you do not get bacteria from the gut inside your mouth. Spit on your hands from a distance, do not touch your mouth or tongue with fingers that have already touched a condom that has been inside the anus.

For what types of sex should one use water-based lubricants?

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

How to have safe oral-vaginal or oral-anal sex?

'Dental dams' are used to have safe oral-anal and oral-vaginal sex (see below).

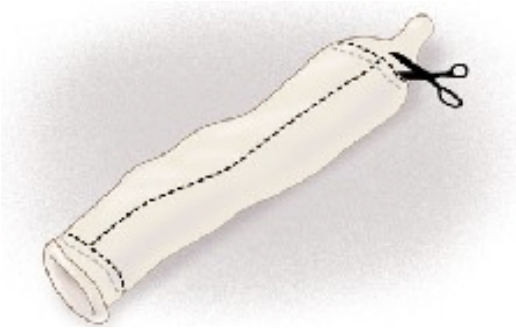
What is a dental dam?

Dental dams are small, thin, square pieces of latex that are placed between the mouth / 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 can I make a dental dam myself?

You can make a dental dam easily from a male latex condom:

Step 1: roll out the condom completely.



Step 2: cut the 'ring' and the tip off the condom, and cut it open along its length.

Step 3: the dental dam is ready for use!

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

How can I use a dental dam?

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 a water-based lube because oil-based lubes and lotions can degrade the latex and decrease the dam's effectiveness.

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[2].

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

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, gonorrhea, 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 Institute 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 gonorrhea for men. The US CDC recently lowered its estimate of the average protective effect of consistent condom use to 80%.

Proper condom use decreases the risk of transmission for human papillomavirus by approximately 70%; a 2012 review[3] confirmed this. 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.

Dealing with negative attitudes towards condoms

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

[2] http://www.brown.edu/Student_Services/Health_Services/Health_Education/sexual_health/ssc/dams.htm

[3] Lam, Janni Uyen Hoa, et al. "Condom use in prevention of human papillomavirus infections and cervical neoplasia: systematic review of longitudinal studies." *Journal of medical screening* 21.1 (2014): 38-50.

honest about condoms. Do not tell them 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 lube 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, and 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 transgender people. 'True love' has nothing to do with condom use! You could turn the argument that condoms are not used in love relationship around by saying that if you truly love someone, your primary concern should be to protect this person from disease, and use condoms.

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

Read more about this in this column, written in a fun way:
http://www.fridae.asia/gay-news/2009/09/04/8915.condoms-in-defence-of-our-unliked-friends

How to make condom use 'fun'?

Ensure that you can reach condoms and lubricant easily during sex, so that as little interruption as possible occurs. You can suggest to your clients / friends to practice putting on the 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.

"I can not maintain an erection when using condoms…"

Some men do not like to use condoms as they say it will diminish or totally end their erections. For these men, you should advice them to practice 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 methods of application or physical damage (such as tears caused when opening the package), or breakage or slippage 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 of condoms before using them. Also, avoid carrying condoms together with sharp objects (keys, coins, pins, etc) as 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/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 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.

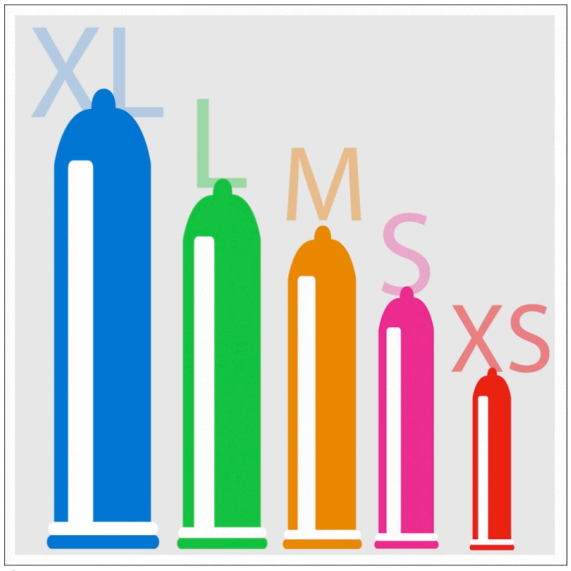
Vaginal sex:
Insertive partner: try to urinate, and then pull foreskin back gently (if uncircumcised) and wash with mild soapy water only.
Receptive partner: go to the toilet and try to urinate – do not douche, and just wash to perineum (outside genital area) with mild soapy water.

Oral sex:
This information is only for people have somebody who ejaculate into their mouth. This is moderate risk. Don't be too concerned… But if you are, rinse your mouth with water – do not use Lysterine or other harsh chemicals.

Source: Dr Kathleen Casey, FHI360

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 – however, these are not easy to find.



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

Does breakage and slippage decrease with increased experience?

Yes - experienced condom users are significantly less likely to have a condom slip or break compared to less-frequent users, although users who experience one slippage or breakage are at increased risk of a second such failure.

Does condom education help to reduce slipping or breaking condoms?

Yes – a recent study indeed suggests that education on condom use reduces behaviors or situations that increase the risk of breakage and slippage.

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

1. Experiment with condoms of different sizes and shapes and practice putting them on before intercourse.
2. Practice 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 get 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 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.

Read more about this in this column, written in a fun way:
http://www.fridae.asia/gay-news/2009/09/04/8915.condoms-in-defence-of-our-unliked-friends

What is a female condom and can men who have sex with men and 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 which 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 have started using the female condom for anal sex. In this case, the ring that is inserted in the vagina is not used, i.e. 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

Here is a fun cartoon-style 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 you take PrEP and are exposed to HIV via unsafe sex (or unsafe needle use) these medicines can work to keep the virus from establishing itself inside your body. PrEP is an effective HIV prevention strategy in populations where 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 has decided to go on PrEP, about his personal experiences:
https://www.youtube.com/watch?v=heky48UAeXk;
the second one: https://www.youtube.com/watch?v=zISCbOZQdD8 and
the third one: 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 (Source: http://www.nejm.org/doi/full/10.1056/NEJMoa1011205). Other studies have shown that under ideal circumstances (i.e. if one absolutely never forgets 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 condoms leads to a 99.2% level of protection, according to the US CDC.

You should be a bit cautious about throwing about percentages with your clients, especially when we get conflicting percentages from different sources or different studies. This may just confuse them. The message to promote to clients is: PrEP works, if you take it correctly.

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 your body to fight off infection for several years. For PrEP, you take a pill every day by mouth, and you have to continue doing it 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, i.e. only during periods of exposure. This is sometimes called 'intermittent PrEP' or 'iPrEP'. A 2014 study in France gave gay men the instruction to take a double dose of Truvada (2 pills) two 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 40-99%). Although this is a smaller protective effect than taking PrEP every day, the result of the studies is still impressive (Source: http://betablog.org/demand-prep-shows-high-efficacy-ipergay-trial/).

The US CDC, however, continues to recommend that people who are interested to take PrEP should do so continually, i.e. every day. This is the message you should provide to your clients until better scientific evidence becomes available to promote PrEP via an intermittent regime.

Can everybody take PrEP?

The US CDC 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 CDC also recommends PrEP for 'gay and bisexual men who have had sex without a condom or been diagnosed with an STI within the past 6 months'. (Source: https://www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/pre-exposure-prophylaxis/). Based on existing epidemiological data from several Asian cities, a significant number of MSM and TG would qualify for PrEP based on these criteria. The CDC recommends that people on PrEP remain under quarterly medical supervision, and test for HIV every three months. PrEP can affect the kidney function too, so kidney function tests should be conducted for those on PrEP.

If I start taking PrEP, should I take it for the rest of my life?

No. People go in and out of periods that they are at high risk for HIV, i.e. not everybody is equally at risk and equally sexually active all the time. If your risk declines or even disappears, you can stop taking PrEP. For example, you might get a boyfriend and enter into a monogamous relationship. But if, after a few years, the relationship ends, and you enter into a 'party mode' once again, you can easily get back on PrEP.

How soon after starting PrEP does the protective effect begin?

It is estimated that it takes at least seven days for the medicine to reach a sufficiently high protective level in the body. However, the recent French and UK studies on intermittent use of PrEP (see above) showed that taking a double dose of PrEP two to 24 hours before sex, followed by 1 pill the day after and another 2

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.

Do PrEP medicines have side effects?

For the first few weeks of starting PrEP medication, a minority of people taking it complain about nausea, vomiting, fatigue and dizziness. For most people, these symptoms eventually disappear once the body gets used to it. One potential danger of using the drug is 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 normal[4]. These are two reasons why it is recommended to be under medical supervision, with quarterly check-ups, to ensure your kidneys and bones remain healthy.

Will PrEP medication change the way my body or face looks?

Truvada or 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 you buy the brand Truvada itself, or one of its copied 'clones' that are much cheaper. In Bangkok (Thailand), taking PrEP costs a bit less than 30 US$ per month and it is available for whoever feels the need to take it at the Thai Red Cross Clinic.

If I start using PrEP, can I stop using condoms?

Like condoms, PrEP is highly effective at preventing HIV when used consistently and correctly. You have to figure out what works best for you, and how comfortable you 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 already using condoms consistently, and doing so makes you feel comfortable and protected, then keep doing what feels right to you. Many people struggle with using condoms consistently, which one reason why PrEP was developed. You have to decide for yourself what level of protection feels right and gives you the peace of mind to lead a sexually fulfilling life (Quoted from http://men.prepfacts.org/the-questions/).

Where can I get PrEP?

THIS INFO SHOULD BE ADDED FOR EACH CITY/COUNTRY

[4] http://www.aidsmap.com/iTruvadai-PrEP-causes-only-mild-loss-of-bone-mineral-density/page/2967903/

Source: www.thebody.com

What is Post-Exposure Prophylaxis? What is PEP?

Post-exposure Prophylaxis (PEP) involves taking anti-HIV medicines as soon as possible after you have (or may have) been exposed to HIV, in order to reduce the chance of becoming infected. If you go on PEP, you should continue to take these medicines for 28 days. Please note that PEP is not available for men who have sex with men or transgender women in many places. [Pls update according to your local situation!]

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 MSM/TG population. For example, in a country with very 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 one can decide whether to take PEP or not. It depends partly on how worried you are!

How soon after possibly having exposed myself to HIV should I 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 you have had an 'accident', i.e. after having unsafe sex with a person who has HIV or a person of whom you do not know his HIV status. Unlike a morning after pill, however, it is not recommended to use PEP regularly. If it appears difficult for you to use condoms consistently, and if 'accidents' keep happening, you 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 who might 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. It remains 'better to be safe than to be sorry!'

Where can I get PEP?
THIS INFO SHOULD BE ADDED FOR EACH CITY/COUNTRY

Unit 7: Sexual risk reduction and principles and practice of behavior change

What is sexual risk?

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

☞ See Unit 8 for a table of sexual behaviors and their risks

What makes some people take risks when having sex?

1. They may not know that the sex they engage in is a risk for HIV.
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. Often people are drunk or high on drugs when having sex, which leads them to 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 romantic love relationships that often 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 behaviors, when persons have low self esteem they tend to ignore or not want to access information or go for HIV testing.
8. Some may not worry about risk for HIV when they are faced with what they consider more pressing concerns like acute poverty, feeding themselves and family, 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 (e.g. 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 (e.g. men who have sex with men and those of us who are transgender 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 in 'risk groups' – assuming only other people have HIV or are at risk of it. For example, men who have sex with men may say only male sex workers or transgender people have HIV; injecting drug users or transgenders may say only female sex workers have HIV etc.

What is bare-backing ('BB')?

Bare-backing is a term that originated in gay slang. It means 'deliberately having unprotected anal sex'. This is different from having a condom breaking or slipping off accidentally. Bare-backing is 'fashionable' among certain groups of men who have sex with men and transgender people. While very young men who have sex with men and transgender people, who are not (yet) used or skilled in using condoms, also often do not use condoms during their first sexual encounters, this is usually not referred to as 'bare-backing' since the unsafe sex that they experience is often not deliberately planned, or at least it is not based on a deliberate choice or decision to have anal sex without using condoms.

Why do some men bareback[5]?

There are several possible reasons:

- Most often, men may simply not imagine that their partner may have HIV; they may also have misconceptions about what people with HIV and people who do not have HIV look like, and decide based on this misconception 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, dark-skinned, they can have an STI, they can have no STI, they may use condoms, they may not use condoms, et cetera.
- 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 been 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, feeling that PrEP provides them with sufficient protection against HIV.
- Anxiety over contracting HIV. Some men are either deliberately transmitting the virus or willingly receiving the virus. These men 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 they don't have to fret about it any longer.
- Some HIV-positive men believe that since they already have the virus there is no need to have protected sex with another HIV-positive man. In the case of a positive men having unprotected sex with a 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 bare-backing 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 alcohol, ecstasy or crystal meth can impair judgment and has been shown to strongly increase the chances of having unprotected sex.

[5] Adapted from http://www.queerid.com/html/articles_support.asp

Can people who are on ART or on PrEP stop using condoms?

ART (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 an easy question 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 ART or PrEP; others will decide to stop using them. You have to decide for yourself what level of protection feels right, both for your partner and his/her safety and for your own peace of mind, to lead a sexually fulfilling life. (See also http://men.prepfacts.org/the-questions/). PrEP, if taken correctly, can reduce the risk of HIV infection by 96%. Combining PrEP with condoms increases the protection to 99.3%, according to the US CDC.

It is also important to remember that ART or PrEP do not protect against other STIs, such as Syphilis, Gonorrhea, Chlamydia, Herpes, and Human Papillomavirus (HPV).

What is 'behavior change'?

'Behavior change' is a process through which people change a behavior that is damaging or could damage them; in our case it is their behavior that puts them at risk for STI or HIV. Often, behavior change is a gradual process, with progress and steps back. The ease or success of behavior change can differ from person to person. This may depend on their attitudes, environment, social norms, etc.

What is meant by 'behavior change is a gradual process'?

It is not realistic to assume that a person who wants to change his behavior will be immediately and definitely successful, especially if the behavior is partly 'instinctive' (like sex). Behavior 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, i.e. a person may relapse or move back towards less safe behaviors along the continuum, hopefully temporarily. See for the continuum of risk the table in Unit 3, which lists sexual activities starting from 'no risk' to 'high risk'. Men who have sex with men and transgender people can be at different stages in the behavior change process (see below). It is key for men who have sex with men and transgender people who have decided they want to change their behavior towards safer sex to set personal 'behavior change objectives'.

What are possible behavior change objectives?

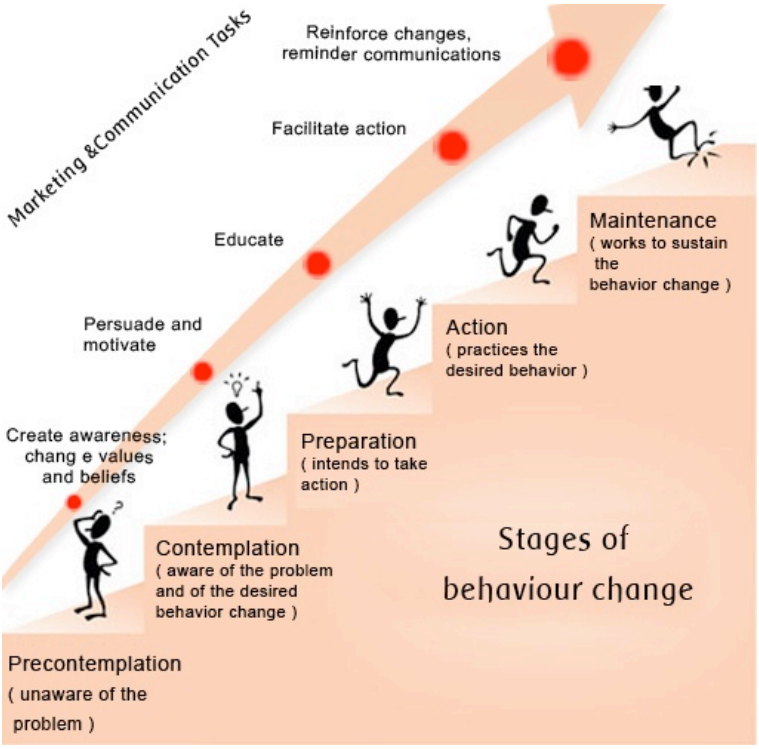
1. Start to become aware of HIV as a serious problem which could affect us;
2. Have regular HIV tests (see Unit 9);
3. Start to realize the need to change one's behavior;
4. Try safer behaviors, like using condoms and lubricants with some partners;
5. Using condoms and lubricants during every sex act;
6. Reducing the number of sex partners;
7. Reducing anal sex in favor of oral or non-penetrative sex;
8. Reducing the frequency of sex/sexual activity;
9. Avoiding needle sharing;
10. Avoiding having sex when drunk;
11. Reduce the consumption of alcohol or drugs;

12. Having regular STI check-ups.

What are the main stages of behavior change?

Persons can move between different behavior change 'stages'. The stages of change are:

1. Pre-contemplation stage (Not yet acknowledging that there is a problem behavior that needs to be changed)
2. Contemplation stage (Acknowledging that there is a problem but not yet ready or sure if the person wants to make a change)
3. Preparation/Determination stage (Getting interested and ready to change behavior)
4. Action/Willpower stage (Starting to change the behavior)
5. Maintenance stage (Maintaining the behavior change); during this stage the challenge is to prevent occasional relapse, which can happen between each of the stages)



Picture: Stages of behaviour change- model. Note that the large arrow indicates the 'tone' of outreach required to help a person move to the next stage of behavior change. *Source*: http://www.slideshare.net/abpascual/2013-behavior-change

For most persons a change in behavior occurs gradually, with the 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 behavior occur.

Relapses are almost inevitable and become part of the process of working toward life-long change. Relapses can occur at every stage of behavior change. Newer

graphic depictions of the behavior change process therefore allow for a 'loop' back towards unsafer behaviors, and present behavior change not as a linear but as a cyclical process.

How can we tell which stage of behavior change a person is at?

When talking to your friend or client you must adapt your 'message' to the stage he is at. You can check if he is aware of HIV and or if he thinks that he is at risk or not and why, if he is concerned about HIV/STI (precontemplation stage), if he is contemplating changing his behavior and whether he knows the different options to reduce risk (contemplation stage), if he has been experimenting with using condoms or reducing partners or reducing anal sex in favor of other forms of sex, or whether he has started to adopt safer behaviors more and more frequently (action stage). You can also inquire about relapses – how and why and where they occur, and discuss strategies to prevent this – or talk about maintaining safer behaviors in all circumstances (maintenance stage). See the table below for more info and tips.

It should be noted that a person can be at different stages of readiness for change regarding different behaviors, at the same time. So the example below 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 behavior specifically.

CDC has developed a table to assess where your friend or client is in the behavior change process, by using condom use as an example:

Pre-contemplation	Does not intend to start using condoms every time in the next 6 months
Contemplation	Intends to start using condoms every time in the next 30 days – 6 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 6 months
Maintenance	Uses condoms every time he has sex AND has been using condoms every time for 6 months or longer

What to discuss at each level of behavior change?

See the Table on the next page to gain some ideas about what to discuss with clients who are at different stages of behavior change. The table shows that in order to be an effective outreach worker, it is important that you don't have a 'one-size-fits-all' message for every client you encounter. You should do a bit of research to assess what is the most appropriate advice you can provide.

What is 'relapse'?

Relapse is if your friend or client goes back from a higher to a lower stage in the behavior change continuum. Most people have occasional relapses before the changed behavior becomes permanent.

How to help a person prevent relapse?

Try to talk about the circumstances in which relapse can occur. Often there are very clear 'warning signs' before unsafe sex happens. For example, your client may have gone out without bringing condoms and lube along; he may have drunk too much and plan 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 future; this will help your client recognize this situation next time, and increase their risk-reduction options. Different options for risk reduction might be discussed, giving him a choice.

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

Table: Stages of behavior change[6]

Stage	Thoughts and level of awareness/resolve:	What to say / advice a person in this stage:
Pre-contemplation stage	Clients do not know about HIV and do not consider changing – they feel as if HIV has nothing to do with them.	Focus on raising awareness and knowledge about HIV and STI and its spread in the community/groups, about the risk of transmission and the possibilities to prevent it, and on how this applies to them personally. Focus on the importance of HIV testing.
Contemplation stage	Here clients are ambivalent about changing. Giving up an enjoyed behavior (i.e. 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, patients assess barriers (e.g., time, expense, hassle, fear, "I know I need to, but ...") as well as the benefits of change. They may not yet relate the threat of HIV/STI to himself.	Help them clarify that the benefits of change will eventually 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 one has HIV. It is important to talk about persons close to us who may have HIV or know people with HIV personally, to bring the issue closer to the person in the contemplation stage. Of course, we should retain our principle of confidentiality (Unit 1).
Preparation stage	Client prepares to make a specific change; he may experiment with small changes in their behavior, 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 behavior 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 partner/s, how to deal with resistance on behalf of partner/s, what arguments to use in case a partner refuses, et cetera. The client may also need encouragement and praise if the initial experiences with safer sex have occurred.
Action stage	Client adopts the safer behavior they have been contemplating and preparing for.	You should encourage the decision to change behavior 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 own experiences when you changed your own behavior. If the client relapses – i.e. has unsafe sex –

[6] See Zimmermann et al (2000) at http://www.aafp.org/afp/20000301/1409.html

		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 these will disappear over time.
Maintenance stage	Incorporating the new behavior "over the long haul." 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.

Unit 8: Dealing with accidental exposure to HIV

"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 have safe sex, always. 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 were 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 or skills. Did the client use the wrong type of lubricant? Did he use a condom that was too old – i.e. 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 his viral load was, which depends on the time he has been infected already and it depends on whether he was on HIV treatment or not (see Unit 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 behavior 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 – i.e. 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 one becomes immediately infected. It means there is a CHANCE that one has become infected.

See the table below for transmission probabilities – each time we assume 10,000 people have the behavior with an infected source, and the number in the right column is an estimation of the number that will become infected as a result. Realize that despite these perhaps surprisingly small chances, people tend to have a lot of sex 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, as 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 – but do not use this knowledge as a prevention strategy for yourself or your partners!

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 a 2013; in several other Asian cities percentages of more than 10% have been found.

It should always be noted that if a person has an STI, these chances become higher. 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: Estimated per act risk for acquisition 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
* assuming no condom use	

Source: 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

"Help!! The condom broke! What do I do now?"

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

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.

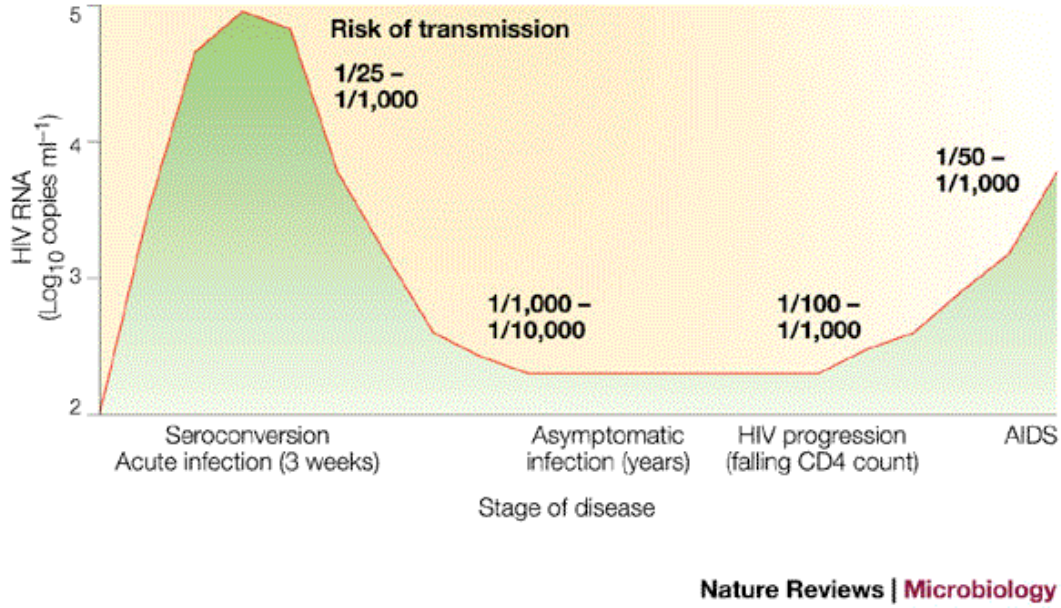
If you had oral sex, you can either spit out or swallow the semen that has entered your mouth. You can rinse your mouth with a Betadine solution to clean; do NOT

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 you exposed yourself to HIV (i.e. if you know that your partner is HIV-positive), PEP treatment (means Post Exposure Prophylaxis), when available in your country, can be taken (see Unit 6 towards the end). It means that anti-HIV drugs are taken full-strength for one month. In most countries, only a doctor can prescribe these. If you feel you have exposed yourself 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 (2-6 weeks after infection) and at the stage in which his viral load increases and he is becoming symptomatic. See the figure below:



Source: Galvin, S. R., & Cohen, M. S. (2004). The role of sexually transmitted diseases in HIV transmission. Nature Reviews Microbiology, 2(1), 33-42.

What to do 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 where RNA-tests for HIV are offered (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 6 weeks before doing a test.

Unit 9: HIV Counselling and Testing (HCT)

Why is HIV counselling and testing important?

In more and more countries and cities, increasing rates of HIV testing among MSM and TG is becoming the top priority for HIV outreach. This is, first of all, because in most countries life-prolonging HIV treatment is now available. It is best for every man who has sex with men or transgender person who is sexually active to get tested for HIV regularly (at least every 6 months). Apart from the health benefits for individuals who have HIV, this is also important because if we identify an undiagnosed person and help him access antiretroviral treatment, the chance that he will pass on his HIV infection drops by 96%.

Many people believe, therefore, that finding undiagnosed HIV cases and putting them on HIV treatment is our best chance for slowing and eventually eradicating the HIV epidemic.

Should outreach workers only refer clients to testing services?

Outreach workers should help clients access HIV testing services. But it is key that clients are not scared away after receiving an HIV positive test result. It may in some cases 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 MSM and TG as well as the efficiency of the testing service. In some countries, if required accompanied referral is the standard, outreach workers may be forced to wait around until after the client gets tested every time, and the result may be that program reach plummeted because outreach workers may spend too much of their time hanging out around the clinic waiting room rather than reaching out to new clients. Outreach workers could also 'hand over' a client to a special 'case manager' (see below) accompanies the client to the facility where the test takes pace and who makes sure that after receiving a test result, the client has access to follow-up tests and antiretroviral treatment.

Why should you / your client get an HIV test?

It is important that everybody who is at risk for HIV infection is tested. If they are found HIV-positive, knowing this will help them a) access medical services, anti-retroviral treatment and as well as social support services, which will enable them to live longer, and b) 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 tested?

There are tests that are used to determine if a person is infected with HIV. HIV infection is usually confirmed with tests that determine whether antibodies (the proteins that your 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 (i.e. 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 he is not) or false-negative (this is when the test

suggests that a person is not infected with HIV but in reality he is). False-negative tests can also occur during the “window period” – see below.

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 (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, which produces a test 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 test based in a lab.

Follow-up diagnostic testing is performed in a lab if the first immunoassay result is positive. The types of tests used differ per country/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, as soon as it appears in the bloodstream, long before the body develops antibodies. These tests cost much more than antibody-based tests. [ADD INFO ABOUT WHETHER THIS IS AVAILABLE IN YOUR COUNTRY]

In an increasing number of countries, home-based HIV testing is currently allowed. [ADD INFO ABOUT WHETHER THIS IS AVAILABLE IN YOUR COUNTRY]

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

Counseling before (‘pre-test counseling’) and after testing (‘post-test counseling’) is an important and standard part of HIV-testing procedures. Pre-test counseling 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 he is unable to handle this, perhaps he should wait with the test until he is mentally better prepared. This is very important, because suicide or other self-destructive behaviors have been reported after positive test results were given to individuals who did not receive pre- and / or post-test counseling. Sometimes it is better for persons who think they may become upset or instable to go and have a test in the company of a trusted friend, a case manager or an outreach worker.

During post-test counseling, vital information is provided to the person who was tested. For those who test negative, counseling 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/case manager who will help them access a confirmation HIV test (if needed), CD4-tests, other baselines tests, and accompany them and facilitate their access to care and support services. The case manager will also provide guidance for maintaining their general health.

Testing with counseling can make a critical difference in the lives of those who test positive, as 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 system is put in place that avoids newly-diagnosed people from dropping out of the services that are available for them.

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

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

In some countries, such as Cambodia and Thailand, experimental programs have been conducted in recent years in which outreach workers were trained to become 'lay counselors'; this would also include training to conduct HIV tests among their peers 'in the field'. Such programs help 'normalise' HIV testing and improve access to HIV testing among people who may otherwise be hesitant to access mainstream HCT services, which is very important. The lay counselor conducts a screening test, and then refers (or, ideally, accompanies) the client to an HCT centre for follow-up/confirmation testing if the initial test is positive. Confidentiality can be a problem with such programs, as outreach workers may not always be equally able to keep the news of a community member sero-converting to themselves. It is therefore utterly important to have very reliable and professional outreach workers in place and to reinforce their training about the importance of confidentiality. It is also important to provide outreach workers with strong(er) post-test counselling skills, which are necessary to ensure 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 the client access follow-up tests and antiretroviral treatment.

Why are confidentiality and anonymity important?

Confidentiality and anonymity are crucial; nobody will use a testing service if the results are not kept as a secret. This is one of the first principles for health care providers and social workers. Unfortunately, it is sometimes not respected and in many countries in the region, HIV testing is impossible 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 behaviors, enabling you to help them progress towards safer behaviors.

What is the ‘window period’?

Most HIV tests check the blood for antibodies (proteins produced by the body and released into the blood) rather than for the actual HIV virus itself, and 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, 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 also depends on the type of test that is used. It is as little as 9-10 days for the RNA tests but 6 weeks to 3 months for 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 behaviors.

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 is in fact HIV-infected and already infectious. Because of the window period, we can never be 100% sure that we are really HIV-uninfected when the test is negative – unless we had absolutely no risk behavior in the period before the negative test result.

Picture: In some countries, including The Philippines, a ‘national HIV testing day’ is organized every year in order to ‘normalise’ and de-stigmatise 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), as well as the use of 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).

Is treatment for people with HIV available in our country? Is it free?

[THIS INFORMATION SHOULD BE INCLUDED SPECIFICALLY FOR EACH COUNTRY OR CITY]

How to deal with resistance against HIV testing?
Many men who have sex with men and transgender people are afraid to access HIV counselling and testing services. In the table below, there are some common reasons that are used to rationalize the decision not to take an HIV test, and possible replies/responses to these arguments. It is important not to provide these answers to stop the conversation, or to provide a 'final answer'. It is important to engage in discussion with your client, to find out what it is that stops him from having an HIV test. Between cities and countries, the reasons for not getting tested may be quite different. The below table is meant as an illustration or source of inspiration only—

[it is important to 'localise' this table, making it suitable and correct for each of the cultural and societal settings in which this manual is used.]

Reason not to test	**Possible response/reply**
"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, i.e. there also are possibilities to test outside 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 don'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 behaviors. If you engaged in such behaviors, 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 TB or hepatitis? Have you ever shared needles when

	injecting drugs? If you answer is 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. Besides, 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 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 / I am worried that staff at the clinic will look down on me’.	[This may also be a very valid reason in some cities/countries]

What are ways or arguments with which to ‘sell’ HIV testing?

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 one starts with this treatment, the better the long-term effects of the treatment, and the fewer long-term detrimental effects of HIV will be.

Second, it is important to find out whether one 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, ensuring their partners do not get exposed. Getting on antiretroviral treatment is in itself a very 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 HCT center with a negative test result in your pocket is a great feeling, and it can strengthen your resolve to remain free of HIV and be safe when having sex.

Fourth, HIV testing as well as antiretroviral treatment are both free. Why not make sure you access these services and stay in control of your health?

Fifth, 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!

Sixth, if you decide to settle down with somebody special, you may discuss together to start having sex without condoms. In order to do so, both of you should get tested to ensure you have the same sero-status.

It should be noted that there are certain groups of MSM and TG who may have difficulty accessing HIV testing and counseling: people from ethnic minority populations, who may not have citizenship in their country of residence; migrants, and, importantly, adolescent and young MSM and TG who may need parental consent in order to access medical services.

Unit 10: Sexually Transmitted Infections and how they can or cannot be transmitted

What is a Sexually Transmitted Infection (STI)?

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

☞ For more details see the table below 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 themselves, 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, for example chlamydia, gonorrhea, human papillomavirus [HPV], hepatitis B, and genital herpes) often cause no symptoms at all. Therefore, although the person has an infection, he or she may have no symptoms and may not realize that he or she is infected; despite being asymptomatic, he may still be infectious for others (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 we bother about STIs that are asymptomatic?

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

Why are STIs relevant to HIV prevention?

First of all, because STIs are transmitted in much the same way as HIV is. But people who have untreated STIs are also more likely both 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 also makes it easier to transmit HIV.

What are the differences between HIV and STIs?

HIV is often sexually transmitted, but can also be transmitted in other ways (i.e. through sharing 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: Short overview of main STIs – more detail in Annex 2

Disease	Trans-mission	Type of Germ	Main symptoms	Treatable?
Chlamydia	Vaginal and anal, and oral sex, hand to eye, mother-to-baby	Bacterium	Often none; however can include discharge from penis or anus, burning urination, swollen, painful testicles	Curable with antibiotics
Gonorrhea	Vaginal, anal, oral sex, hand to eye, mother-to-baby	Bacterium	Often none, however can include dripping penis or rectal discharge, painful urination, throat infection, 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, later severe symptoms	Curable with antibiotics
Herpes	Sex and skin to skin, mother-to-baby	Virus	Often no symptoms; however can include flu-like symptoms, painful blisters around genital area or mouth	No cure, but infection and symptoms are treatable
HPV	Sex and skin to skin, mother-to-baby	Virus	Usually no symptoms, but infectious; however can include genital warts, ano-genital cancer	No cure for infection, but warts can be removed – also preventable by vaccine
Hepatitis B	Sexual, sharing needles, blood, mother-to-baby	Virus	Several, including flu-like symptoms, dark urine and light stools, and jaundice	No cure for infection, – also 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 I cure STIs myself by buying drugs from a pharmacy?

No! It is impossible for an untrained person to know the diagnosis (which STI you might have) 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 behaviors. To reduce your risk:

- Use condoms during oral, anal and vaginal sex.
- Use water-based lubricants with condoms, especially during anal sex.
- Limit your number of sex partners.
- If you have recently been treated or are being treated for a STI, you must make sure your sex partner(s) 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 you do, cover them with a new condom every time you use them with different partners.
- Keep good genital hygiene (see below).

Some STIs can be transmitted via skin to skin contact – See Annex 2.

How can you know whether you have an STI?

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

☞ See Annex 1 for an overview of STI testing and treatment services.

How to check for STIs yourself?

Regularly examining your 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, unusual odor or fluid discharge on or around your penis, anus or balls?
    - 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 balls.
    - Check your pubic hair closely for small eggs, lumps, or lice (e.g. crabs)
    - Gently squeeze your penis along the shaft to check for any unusual discharge that is smelly or creamy in color (remember that

it is common for men to find some fluid when doing this, but it doesn't mean you have an STI).

3. If you detect signs of STIs, it is time to go to an STI clinic for treatment! There are friendly and confidential STI services available in most cities.

If you want to be sure that you do not have an STI, you should get tested at a clinic – since 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 neo-vagina.
- Genitals should be washed every day with mild soap and water.
- Avoid the use of harsh or perfumed soaps as they can irritate the penis, neovagina and anus.
- After washing, it is important to gently dry. It's not good to leave it moist as this provides conditions in which bacteria can flourish.
- For those with a penis, pass urine before and after sex. This can avoid infections 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 lube inside the condom. Don't use too much or the condom may slip off.

Source: SQWISI PowerPoint presentation, 2005

<u>What should I do when I think my client could have an STI?</u>

Ask friends or other outreach workers about services for diagnosis and treatment of STIs in your neighborhood. It is important that services that you recommend are friendly to MSM and TG clients. This allows for your client to be open and honest towards healthcare staff at such services. After the client has been at the service, ensure you ask the client how the experience was. If health care staff treat patients in an inappropriate or insensitive manner, it is important that this is reported to the management of your organization and that steps are undertaken 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 stay healthy and happy

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

The most important thing is that you say to your client that he/she is OK, and will be OK. Your client should be told that it is lucky to receive an HIV diagnosis in an age where 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 coming to accept the idea of living with HIV. Whatever the feeling, it is really important to say that it's OK. 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 them to try to be careful not to self-harm or harm those around him/her. Consider getting help from professional counsellors, from friends and family, and especially from other people living with HIV. Talking about your feelings can help a lot.

Source: http://www.catie.ca/en/practical-guides/managing-your-health/1

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

"I almost feel I am sorry I did the test and found out I was positive. Is that normal?"

Your client might find him/herself wishing they had never found out about this diagnosis. It's true that it is hard to hear at first. But the fact that the client has been diagnosed means that they can take steps to take care of themselves. Knowledge is power. It's a cliché, but with HIV it's true. By knowing your status, you can decide how you want to live with the virus. Maybe your client won't want to know too much at first, but as time goes by, have confidence that the client will learn what needs to be done, and will find his/her own way of living with HIV.

Source: http://www.catie.ca/en/practical-guides/managing-your-health/1

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 below). 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 below)[7]. People who begin HIV treatment on time will most likely never need to use the second group of medicines, as 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 above cannot cure either HIV or AIDS, but they do help people live a healthier and therefore higher quality life for a longer period of time than if they did not take any medicine.

[7] Much of the information in this Unit was taken from http://www.thebody.com/content/treat/art32195.html

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 ART and ARV?

ARV stands for 'Antiretroviral'. This means that they work against retro-viruses—HIV is a retrovirus. ART stands for Anti-retroviral 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.

What types of ART exist?

Different classes of antiretroviral drugs act at different stages of the HIV life cycle. Anti-retroviral drugs are broadly classified by the phase of the retrovirus life cycle (see Unit 2) that the drug attacks. 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's 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—a process 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, healthcare providers recommend that people infected with HIV take a combination of antiretroviral drugs in an approach called highly active antiretroviral therapy (HAART).

Source:
http://www.niaid.nih.gov/topics/HIVAIDS/Understanding/Treatment/pages/arvdrugclasses.aspx

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

CD4 cells 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, they take over the CD4 cells, using the cells to replicate HIV, 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 you have, the stronger the immune system is.

What is a CD4 test and what does it do?

The CD4 or CD4 count test measures how many CD4 cells (one sub-group of 'white blood cells') are in your body, reflecting the health of your 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 1600.

How often should one do a CD4 test?

It is recommended that you have a CD4 test as soon as you test 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 [PLEASE UPDATE ACCORDING TO THE SITUATION IN YOUR CITY/COUNTRY].

See for more information about the CD4 test:
http://www.thebody.com/content/art58838.html

When should a person with HIV start treatment?

There is now strong evidence that from the patient/individual's perspective, there is no good reason to postpone treatment with ARV after being diagnosed. In many cities, treatment is only commenced when a person's CD4 count drops under 500. In some cities (Bangkok, Manila, Jakarta), people at high risk (including men who have sex with men and transgender people) are enrolled on ARV treatment as soon as they are diagnosed, i.e. regardless of the level of their CD4. 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 ARV treatment.

How can a person with HIV monitor his physical health?

There are several different types of 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 your health and whether you are on a treatment regimen, most doctors will run these tests every three to six months. Since these tests are used to monitor your overall health through comparisons of tests over time, it is important when you are first diagnosed or when you start your first treatment regimen to get your lab work done to provide a baseline for future comparisons.

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

To read your 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 in order to determine a range of averages. A person's test results should fall within those averages in order to be considered in a "normal" range.

What is a viral load test and what does it measure?[8]

The viral load test is responsible for measuring the amount of HIV in the blood (number of copies per milliliter of blood). There are two different 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 toward viral load testing as a means of monitoring success in achieving viral suppression. This will particularly 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 PCR viral load test, fewer than 50 copies of HIV in the blood is considered undetectable, and for the b-DNA viral load test, fewer than 400 copies of HIV in the blood 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 well.

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

Undetectable viral load means that the chance a person with HIV transmits HIV to another person is extremely low. Therefore, it is less problematic if condoms are not (always) used than when a person is not undetectable. Being undetectable does not mean that a person does not have HIV. There will still be HIV in his blood and sperm, and viral levels can fluctuate for a host of reasons. Therefore, it is better if condoms continue to be used, even when an infected person's viral load is undetectable. Again, it depends on how certain a person with HIV and his sexual partner(s) want to be about 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 a positive person take steps to protect their own health!

How often does a person with HIV need to do a viral load test?[9]

After you are diagnosed with HIV, your health care provider will conduct or refer you to do a viral load test. After that, you should have a viral load test every 6 months before you start taking a new HIV medicine, and 2 to 8 weeks after starting or changing HIV medicines until your viral load is suppressed.

What is an Opportunistic Infection (OI)?

Opportunistic infections are infections caused by organisms that usually do not cause disease in a person with a healthy immune system, but can affect people with

[8] See http://www.thebody.com/content/treat/art32195.html
[9] Taken from https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/viral-load/

a poorly functioning or suppressed immune system – for example those with HIV or AIDS. These organisms need an "opportunity" to infect a person and HIV immune suppression provides the opportunity – see the tables below.

Can opportunistic infections be treated?

Opportunistic infections can be treated and prevented; when a person is on antiretroviral treatment and under regular medical supervision, opportunistic infections are unlikely to occur.[10] Treatment for opportunistic infections depends on the type of opportunistic infection.

Table: Opportunistic infections occurring at different levels of CD4 count

CD4 Count	Disease
200-500/µL	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/µL	All of the above plus:
	Pneumonia due to *Pneumocystis carinii* (PCP)
	Chronic diarrhea
50-100/µL	All of the above, plus:
	Encephalitis (usually due to toxoplasmosis)
	Esophagitis due to yeast or viruses
	Meningitis (usually due to cryptococcus)
	Tuberculosis outside the lungs
	Chronic herpes simplex virus (HSV infection
	Primary brain lymphoma
<50/µL	All of the above, plus:
	Widespread infection due to *Mycobacterium avium* complex
	Retinitis, diarrhea, encephalitis due to cytomegalovirus

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 (CBC) test?

The CBC test is a measure of all the components that make up blood. CBCs are important because some drugs can cause low red or white blood cell counts, which can lead to anemia or other blood disorders. This test measures the amount of white blood cells, hemoglobin, hematocrit and platelets in the blood. 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 hemoglobin and hematocrit could be the result of anemia from the HIV medications; and a low platelet count could affect blood clotting.

[10] See for information on OI prevention http://www.thebody.com/content/treat/art13054.html

How often should you do a CBC test?

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 to do a CBC every three months if one is taking ARV drugs. This test takes one day for the laboratory to process.

What kind of support do people living with HIV need?

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

☞ See Annex 1

"Apart from adhering to antiretroviral treatment, what can I do to stay healthy?"

There are many things you 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 toward achieving a healthy, happy and relaxed life. You have to work towards getting and staying healthy, reducing harm and taking control of your personal well-being. Finding the right balance for your body and lifestyle can make living well with HIV a reality. This includes:

1. Eating a balanced diet based on fresh and unprocessed foods, with lots of vegetables and fruits.
2. Be extra aware of hygiene and food safety, as people with HIV may be more susceptible to disease-causing bacteria. Wash your 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 interact with HIV treatments. Ask your doctor if there are any specific foods you 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 are in fact having trouble keeping their weight down.
6. Ensure your body has sufficient antioxidants. Antioxidants are important because they neutralize molecules called free radicals inside your 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. Your body makes antioxidants, but you can help it by consuming foods that are rich in antioxidants. These include blueberries, red peppers and spinach, as well as black and green tea, red wine and dark chocolate. You can also find antioxidants in supplements.

7. Exercise. Exercise can lead to a stronger body, higher self-esteem, less stress, better sleep, a better heart- and lung function, and fewer mental problems such as anxiety and depression.

Source: http://www.catie.ca/en/practical-guides/managing-your-health/4

What can I do to reduce my sense of stress and anxiety?

A certain level of stress and anxiety are quite normal if you have just been diagnosed with HIV. You could consider learning how to meditate, or take classes in yoga or tai-chi. Taking massages helps some people de-stress as well. You can also try to do more of what you like to do, or to explore something you have always wanted to do, for example travel or learn a new skill or language.

Can I still take alcohol?

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 can also be very hard on your liver. Too much alcohol can lead you to make errors in judgment, and since 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 also a well-known depressant and depression is an issue with which many people with HIV struggle. Proceed with caution when it comes to alcohol and 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.

Source: http://www.catie.ca/en/practical-guides/managing-your-health/4

Can I still smoke tobacco?

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.

Source: http://www.catie.ca/en/practical-guides/managing-your-health/4

Can I still have sex?

Yes, of course! But in the context of HIV, it's important to think about the health of your partner too. Since 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 your lover(s) or sex partner(s). There are several ways of doing this; the most important one is to take your antiretroviral treatment faithfully, which will radically reduce the chance you transmit HIV to others. If you have HIV, using condoms during anal sex is another important way to reduce the risk of HIV transmission. If you are in a committed 'steady' relationship, you should discuss with your partner whether he would be willing to go ARV medication as well (i.e. PrEP, see Unit 6), to prevent him from getting infected.

How can an HIV-positive person make sex "safer"?

Sexual contact with another person can be made safer in the following ways:

1. Take your antiretroviral medicines faithfully, ensuring you keep your viral load low or undetectable
2. If you are in a 'steady' relationship with someone who is HIV negative, consider suggesting to your partner that he enrolls in PrEP (See Unit 6)
3. Anal and vaginal sex – correctly using a latex condom with a water-based lubricant and using a new condom with each new partner and with each new act of oral, anal or vaginal sex.
4. Anal sex – if you like both the insertive and receptive roles, you should consider sticking to the receptive role only, as this greatly reduces the chance of transmission to your partner(s).
5. Oral sex – using 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. Other penetrative sex (fisting or fingering) – Using a latex glove and, if necessary, a water-based lubricant.
7. Sex toys – cleaning sex toys with soap and water after each person uses them.

Other research studies have shown that the viral load found in the blood 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 with HIV always practices safe sex with his or her partner(s). Low or "undetectable" viral load (measured in blood!) is just another layer of protecting sexual partners by reducing risk of transmission.

What are barriers to prevention for people living with HIV?

The following are major barriers to preventing HIV transmission (i.e. 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 (i.e. support groups/services) or from HIV counselors or other health care providers (see Annex 1).

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/lubricants can be problematic. Condoms may be difficult for individuals to find in the "heat of the moment" so ALWAYS BE PREPARED by having condoms with you at all times.

What if my HIV-negative partner is accidentally exposed to my HIV?

In 2005, the US Centers for Disease Control and Prevention (CDC) recommended that "post-exposure prophylaxis" or 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 healthcare worker, has been already 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 (3 days) after the possible exposure to HIV. PEP therapy should always be prescribed and closely monitored by health care professionals. Do not start PEP by yourself! A person on PEP must take HIV medications for at least 1 month. These HIV medications often have side effects that might make it difficult to continue therapy. However, a person should always check with his or her healthcare provider before starting or stopping PEP therapy.

To get PEP, it is probably easiest for a person to visit his or her local emergency center; however some clinics or healthcare providers are now also offering PEP. It may not be available in all cities or countries in the region (see Unit 6).

In our city, you can get PEP at …….. [fill in for each city/country]

If I am on antiretroviral treatment, can I stop to use condoms?

No. Despite the fact that the treatment may make your body so healthy that it becomes difficult or impossible to detect HIV in your blood, HIV is still there, and there is still a small possibility that you might infect others with HIV. Therefore 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, which can have stronger symptoms in people living with HIV and which could weaken the immune system.

Social support for people living with HIV

People with HIV have been found to benefit from social and psychological support, where these were 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 transgender people. Look at Annex 1 to see what services are available in your country / city.

People living with HIV often benefit from small group discussions and skills building exercises combined with individual level counseling and support combined with health care provider-delivered prevention messages – in other words, three ‘directions’ for behavior change which 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 your sexual attraction or desire. It refers to the type of sex and the type of person that you are 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 calling yourself a gay man, transwoman, homosexual, heterosexual or bisexual. Many cultures and societies have special words to describe sexual identities, for example [INSERT country-specific examples in the table below].

Word / term:	Description:	Remark:

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 behavior. For example, a 'gay' man who occasionally has sex with a woman may still call himself 'gay' or 'homosexual' because he himself 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 behavior (what we do sexually) can be quite different things!

What is my sexual identity?

That depends entirely on you! It is usually related to your sexual orientation, but not necessarily so. Many people also derive their sense of identity from other things than their sexual orientation or sexuality, for instance, on nationality, on position in the family (i.e. son, brother, father) or on their 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, all continents and 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 has been 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 now officially declassified homosexuality as such.

Figure: Chinese silk painting depicting homosexual behavior, 18th or 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, but not frequently[11]. These figures have been confirmed for nearly all countries in the Mekong region. [RECOMMENDED to include figures from your own country here!] But the number of 'open' or self-identified men who have

[11] Caceres C, Konda K, Pecheny M, Chatterjee A, Lyerla R, Estimating the number of men who have sex with men in low and middle income countries. In STI, 82(Suppl III):iii3-iii9., 2006

sex with men is much smaller – this partly depends on the level of stigma and / or openness that exists in different societies.

Is it true that the number of gay men / 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, and increased organization and participation in communities. This gives the impression that the number is actually growing, whereas in fact probably the total number of men who have sex with men is stable but the share of men who are more or less open about it is growing.

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 probably a large majority of men who have sex with men see their sexual behavior as a pleasurable activity or hobby, but not something to organize (part of) their life around. For that reason, it is important not to 'package' all our HIV services around the idea of a community, as this would 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.

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

It is not known exactly why some men like sex with men and others don't. It is partly caused by genes and by physical or mental characteristics that were given to us 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 behavior – 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, fishery ships, 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 doing so.

Some adolescent boys have sex with each other to learn about their bodies and their emerging sexual sensations; as soon as they are adults and / or gain access to women they may (or may not) stop having sex with other males.

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

Some men who have sex with men prefer women, or they like both men and women. Some men are attracted to a particular sexual behavior – 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 – sometimes they are forced to, and therefore forced to have sex with women, due to family or social pressure.

Do homosexuals have a lack of male hormones?

No. Although many people believe in this, hormones in fact have nothing to do with sexual orientation or behavior. Hormone treatment will therefore not 'cure' homosexuality – it may, however, influence sexual appetite.

I am a man who likes sex with other men but I want to change. Can I be 'treated' or 'cured'?

Since homosexuality is not a disease, it cannot be treated or cured. Homosexuality is part of the natural variety in human sexuality. You will need to learn to accept yourself as you are and live your life with it. However, some men who have sex with men also can have sexual desires for women, and manage to live a married life besides their sexual relations with other men. There are many ways to live with homosexuality – either in the open or in secret. Maybe it is possible to change your sexual practices (or stop having sex, for a while at least), but emotionally it is unlikely you can 'forget' about your desires for other men (or transgender persons).

Many men who just find out about their feelings of homosexuality are initially shocked and they might hate themselves and blame themselves for these feelings. This period is one of great vulnerability to HIV, as men who dislike themselves are less likely to protect their health than men who feel comfortable with whom they are. Sometimes people around a person who has just discovered that he is not heterosexual try to 'treat' or 'cure' this person in his/her period of greatest turmoil and despair. Such 'conversion therapy' has rightfully been outlawed in many Western countries, as 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 they start becoming attracted to women. This is especially common in countries where boys and girls are strictly separated from each other, for instance in 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?

No. Men who have sex with men and transgender people are not better or worse than men who have sex with women. People should never be judged based on their sexual orientation or identity, as this is something they cannot choose or change. Goodness or badness of an individual is (and should) determined by how someone treats others in society, and 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, and for many people, being different equals being 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. It should be noted that in recent years, a surprising number of such ‘defenders’ are outed in newspaper and media report 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 transgender people since the time they were children. 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. Therefore negative self-esteem and feelings of guilt are seen as important obstacles to behavior 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 so, 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 behavior 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 transgender people did NOT grow up around females and still ended up as men who have sex with men and transgender people.

Unit 13: Basic health issues for transgender people

What is transgender?

Most people are perfectly comfortable with the fact that they are male or female. In fact most people normally 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 wish to adapt physically to the new 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 become a woman is called a 'transgender woman' or a 'trans woman'. A person born as female who transitions to become 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 by women and men, though predominantly men; part-time or full time, temporary or permanently; with or without use of cross-sex hormone and with or without a sex change operation, and for a variety of reasons and motives. In this unit, we focus 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' – this depends on the possibilities and opportunities for doing so in the environment where 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 counseling and other psychotherapeutic approaches. The male-to-female transgender will typically take courses of female hormones (estrogens) 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 patient 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 will be verified by a mental health professional; in Asian countries no such 'diagnosis' is usually set. 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/older transgender people in their circle of friends is important in this regard.

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

Many transgender women take hormones (including birth control pills) to become more feminine in appearance. Most patients experience noticeable changes within 2-3 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 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 and 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 color. There is seldom any major effect on facial hair, although if the patient 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.

See www.tsroadmap.com for more details.

WARNING – taking hormone treatment without proper medical supervision can be dangerous. Hormones affect many different parts of our body and bodily functions. Some medical tests may be necessary to ensure that your body can handle the treatment well, or which types of treatment will work best for you. Always obtain advice from a trained specialist or medical doctor, if you 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 ‘neo-vagina’) with a technique known as penile inversion. When carried out by a skilled and experienced gender surgeon the results look almost indistinguishable from the external genitals of a woman.

Of course, since a transgender woman does not have ovaries and a womb, she is not able to conceive and does not have monthly periods. During the operation, tissue and skin from the penis and scrotum is 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. They normally should also not have sexual intercourse until two months after the operation.

Unit 14: Dealing with love, sex and friendship

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

Whilst not all men who have sex with men and 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, biologically men may have a stronger sex drive than 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 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.

Sex between men often happens in secret and is therefore hidden from society – therefore, 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, some men who have sex with men and transgender people do have long-term relationships with one other man, just like heterosexual couples. However, for many other men who have sex with men and transgender people this is not the case, as there are many factors at play here.

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.

Related to this is the fact that often relationships between two men are not taken seriously or even respected by friends or by family or by society, so that these men do not receive encouragement to maintain their relationship when they experience problems, the way heterosexual relationships might.

An effect of this can be that some men who have sex with men and 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.
Especially the male partners of transgenders often see these relationships as temporary and aimed at fulfilling sexual desire, not as a long-term commitment. This has partly to do with the fact that transgenders can not have children: the desire to

have children is often a reason for men and women to marry and to stay together, which is a factor that is lacking for male – male relationships in many places.

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

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 men should be allowed to marry each other. There are also other reasons – for example, married couples have advantages 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, in recent years 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 US and Europe, gay and lesbian parenting enjoys broad support from medical experts. The American Psychological Association states: "*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[12].

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

Many men who have sex with men and 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 to find a lesbian friend who wishes to have and jointly raise children. It is important to think about

[12] Paige, R. U. (2005). Proceedings of the American Psychological Association, Incorporated, for the legislative year 2004. Minutes of the meeting of the Council of Representatives July 28 & 30, 2004, Honolulu, HI. Retrieved November 18, 2004, from the World Wide Web http://www.apa.org/governance/ , published in Volume 60, Issue Number 5 of the American Psychologist.

such arrangements long and hard, and to make very 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 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 families, and therefore rely heavily on their friends for many things, including social and financial and emotional support.

I have a boyfriend. Should I be monogamous now?

This depends on your situation. You should discuss this together. Does he want to be monogamous? Do you want to? You should make clear rules for your relationship, and be open with each other about this. 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 you agree on what the two of you mean by 'sex' – does it include oral sex? Masturbation?

What is an open relationship?

Some people choose for an open relationship, meaning that both partners can have sex with others. The idea is that 'sex is sex, love is love' – or that having sex with others does not have relevance for the love relationship between you and your boyfriend. But in practice it may happen, of course, 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 liberty sexually, a relationship may last longer than would otherwise be the case.

Also, 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. However, often at least one of the objectives of a heterosexual marriage in Asian countries 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 another way to have and raise children, or unless both partners are not interested in starting a family. Social stigma of transgender women may also be an important reason why men do not often chose them as long-term partners.

I cannot be monogamous, but I love my boyfriend. What should I say to him?

You should be honest about this to yourself and to your boyfriend too. You should talk about what you like and what you need, and if 'sex outside your relationship' is something you can not do without, you should discuss with your boyfriend and find a way forward that is good for him and for you too. See under Open Relationship above.

I have a boyfriend now. I love him so much. Can I stop using condoms now?

It is better to continue being safe. You could decide to stop using condoms if you both tested HIV-negative twice covering the past 3 months window period and have not exposed yourself to any HIV risk in this period. This means you need to be anle to trust each other fully. You need to have a clear agreement among yourself to be absolutely honest to 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 within their relationship. Another way you could decide to stop using condoms is by taking pre-exposure prophylaxis, reducing the chance that you might infect each other by as much as 96%. Note that there remains a small chance you could infect each other!

My boyfriend has cheated on me! What should I do?

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 somebody 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.

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 much junior, weaker and less in control of themselves. They may enjoy 'being taken care of' by a strong and caring boyfriend. However, this often leads these often young men who have sex with men and transgender people to leave decisions about safer sex and condom use entirely to their partner. This is something peer educators and outreach workers should warn their 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, girlfriends, etc

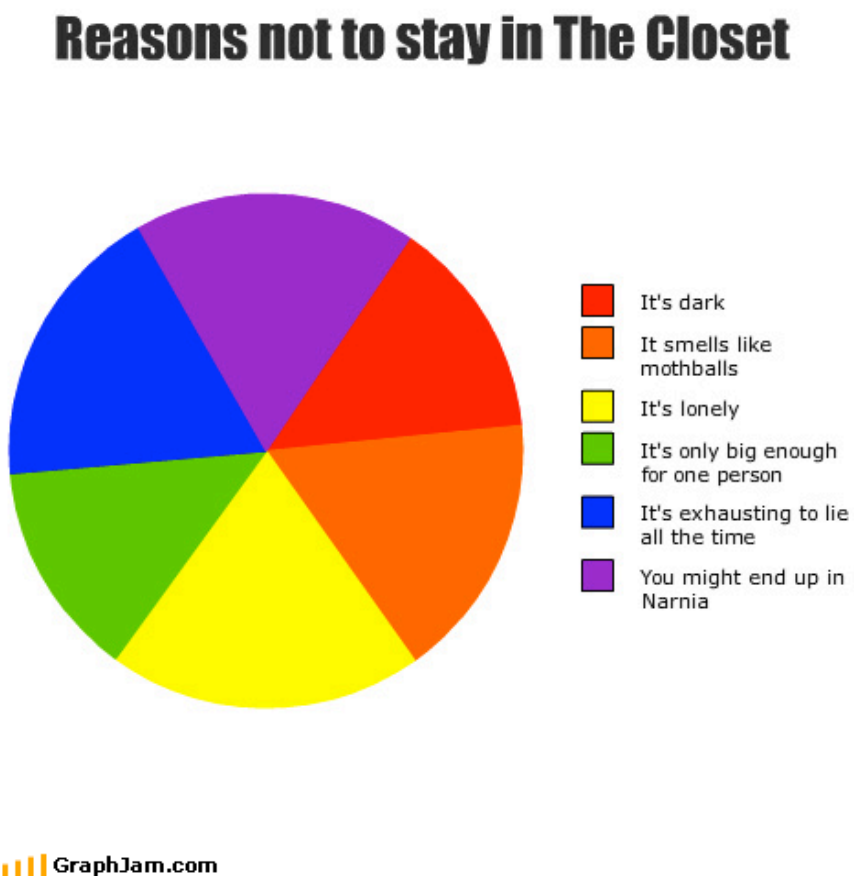
Should I tell my parents that I am a man who has sex with men?

This is a personal choice. Some people decide to tell their parents, because they dislike the fact that their parents do not know; sometimes they want to prevent their parents from arranging marriage to a woman, or they are fed up with questions about 'when will you have a girlfriend' or 'when will you find a wife' …

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 even be hostile or violent when they find out. Many feel comfortable leading a double life – one of (presumed) heterosexuality in public, and a secret life as a man who have sex with men.

Part of the decision also has to do with how financially independent you are. It is difficult to risk cutting off all ties with your family if you still depend on them for your tuition fees and cost of living, for example.

The choice is up to you.



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!)

How can I tell my parents, siblings and friends?

1. Consider your exposure process as a circle – first there is only you in the circle of people who know – consider who you want to gradually add to this circle.
2. Practice 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. Think about what they may respond, and how you will react to it.
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 to do if you are thrown 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 bring than with you as a person!
9. To avoid these shock reactions – or if you do 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 by themselves, 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 for 'exposing yourself' – can also be useful to tell loved ones if you have HIV.

Providing education to parents on behalf of clients

If one of your friends or clients decides to tell his parents that he is a man who has sex with men, you may discuss with him whether it is a good idea for you as the peer/outreach worker or another friend to join him, to provide support and to possibly help explain to the parents about homosexuality – that it is not a disease, not a fashion, not a temporary thing, that it has nothing to do with the way you were raised, and that it is impossible to change.

How do I deal with the situation of being 'outed' or accidentally discovered as a man who has sex with men?

This is possibly one of the most painful things that can happen – if it is not you who tells people of your choice that you are a man who has sex with men, but if 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 very difficult to give general advice on how to deal with this situation. The best way, probably, is to give it some time to 'cool off' and to think about how to proceed. Probably the person who discovered you is as shocked as you are, and may even decide to ignore what he/she just saw, 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 talking to your parents or family by phone or mail.

I have a girlfriend, but I prefer men. Should I break up with her?

If you have a girlfriend because you feel 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 your girlfriend 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 a life as a family man. Some are happy doing so; others end up divorced with many problems, especially if they have children.

You should consider your options. Can you choose to remain single? Can you choose a male partner? Can I talk to her about my sexual orientation? Is it possible not to get married to a woman at all? Again, there is not a single 'best way forward' here.

My girlfriend or wife does not know I like men. Should I tell her? What should I do?

If you have unsafe sex with men, you might expose your girlfriend or your wife 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 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 you always have safe sex with men, and if you feel your wife would be unhappy knowing that you are a man who has sex with men, perhaps it is better not to tell her.

As with most questions in this section, these are individual choices, not 'one size fits all' recipes.

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 of men who have sex with men to continue to have sex with other men can lead to tensions between the husband and the wife; if the wife finds out it often leads to 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 and father and children, while at the same time having a sex life outside the family.

Other 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 a chronic or recurrent condition, which can be caused by genetic, biological, pharmacological and social factors. Addiction is characterized by the compulsive use of substances or engagement in behaviors, often despite clear evidence to the user of their harmful 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).

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 and transgender people use heroin and other drugs; in some instances men sell sex in order to pay for their addiction. More common addictions among men who have sex with men and transgender people are cigarettes and alcohol.

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, where men have 5 or more sex partners every day. The health dangers of this are obvious.

☞See Unit 7 for more information on behavior 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. Therefore, a heroin addict who sells sex and is offered money in exchange for unprotected anal intercourse is usually much more likely to agree than a male sex worker who is not addicted. Also, outside the context of sex work, people who are a bit drunk tend to have poorer judgment when it comes to sex; when one gets drunk, everybody suddenly seems to be sexier, and condom use all of a sudden is conveniently ‘forgotten’.

Many men who have sex with men and 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).

How can I deal with addiction?

Professional counselors can help an addicted person deal with acknowledging, analyzing and rectifying addictive behaviors 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 counselors may help, or techniques like acupuncture and meditation. For any addiction, it is key 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 counseling 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 that are considered to be against dominant cultural norms. Social stigma often leads to marginalization (Source: Wikipedia) – this means that people who are different from the mainstream are 'pushed out'. It may mean that they have less access to education, health care, or that they live in the least desirable neighborhoods.

Examples of social stigmas include attitudes to physical or mental disabilities and disorders, as well as illegitimacy, homosexuality or affiliation with a specific nationality, religion or ethnicity. Likewise, past or present involvement in crime carries a strong social stigma.

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 wheel chair. This can include people with AIDS who are showing symptoms of disease.
2. Stigma based on personal traits or behaviors 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', - i.e. based on race, nation, or religion that are different from the dominant race, nationality or religion.
4. Self-stigma – some people (from any of the three groups above) withdraw from 'mainstream life' due to the fact that they stigmatize themselves; they may expect a negative reaction from society about a particular characteristic, such as homosexuality, and withdraw in anticipation of that.

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 transgender people comes in five forms:

1. Stigma due to their sexual orientation (i.e. 'you are bad because you are a man who has sex with other men')
2. Stigma due to their sexual behavior (i.e. '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 (i.e. 'you are bad because you are a prostitute')
4. Stigma due to disease (i.e. 'you are bad because you have HIV or STIs')
5. Stigma due to social behavior or self presentation (i.e. 'you are bad because you over-act or over-react or you act too feminine')

Many men who have sex with men and transgender people face 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 too. 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 (i.e. some transgenders are discriminated against by other men who have sex with men, and bisexuals may be discriminated against by both men who have sex with men and transgender people and 'straight' people)
7. Stigma based on social behavior / 'over acting'

What is HIV-related stigma about?

HIV-related stigma is a set of ideas and beliefs that links HIV and AIDS to negatively-defined behaviors 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 drugs. To understand this better, try to think about the flu. Nobody is ashamed or worried to admit that he or she has 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 openness and reducing ignorance, making sure people can see HIV as part of their community, and not something that affects only 'others'. Openness about HIV – think of the UNAIDS slogan 'Break the Silence' – will help people understand that there are many people with HIV who are not part of what they perceive as 'bad groups' or engaging in what they perceive as 'bad behaviors', or that, in effect, 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 also help reduce stigmatizing attitudes among the population. Training of key people in a community – journalists, religious leaders, teachers, medical doctors – can help.

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

What can we do 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 perfectly natural.

What can I do, at a personal level, when faced with stigma?

There are several strategies:

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 – i.e. don't get beaten up! You can confront by:
    a. Giving facts to contradict what the person said
    b. Appealing for understanding and compassion
    c. You can discuss about what the person said
    d. In some countries you can go to the police or take legal steps to protect yourself

How can I build my self-esteem?

We can change the way we feel about ourselves and develop confidence and self-esteem in the following ways:

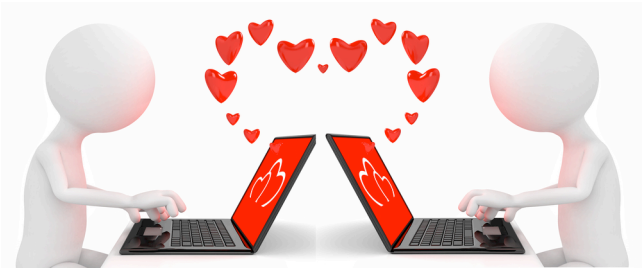
1. Encourage people to praise us by praising them. Tell others what they have done well, the things we like about them, their strengths.
2. Give ourselves positive messages. Sometimes we say good things about ourselves and sometimes bad. Sometimes our conscience tells us we have done wrong. Sometimes 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 ..."[13]

[13] Adapted from: Gordon, Gill (1999) Choices: A Guide for Young People. Macmillan Education, MFEMFE, 1999. Page 29

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 and transgender people go in order to find friends, boyfriends or casual sex dates. On the other hand, most prospective clients who visit such venues are not there to be approached about HIV testing or about safer sex. While you are 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 word'-outreach?

First, it should be noted that online outreach and outreach in physical venues should not be seen as separate, but must complement each other. The advantages of online outreach offline outreach are manifold. First, it is a convenient form of outreach from the perspective of the outreach worker. Whereas in most countries, there is virtually no chance of police harassment and there is no chance of being robbed or raped, 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. [this section should be edited differently in each city/country where the manual is adapted]

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 that can be accessed online. It is important, however, to carefully assess when each of the online venues is most busy, 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 the 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 a face-to-face contact. Online outreach also gives the outreach worker the opportunity to compile a pre-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 which can include linkages to additional online or offline resources.

Are online outreach and outreach in physical locations mutually exclusive?

They 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 in fact 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 his work as he does in his personal/sexual life. For this reason, it is recommended that an outreach worker uses a different ID or Facebook page for his personal and professional life. 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/manager of online dating venues or apps about the planned outreach. This may avoid 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 their user agreement.

You may know yourself 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, try to ask your friends or clients that you have met on other ‘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/time mapping to determine which apps or chat rooms are busy during which hours. At the same time, it is 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 in order to make him my client?

If your organization has decided to engage in cyber outreach, and once 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

works to promote the sexual health of gay/MSM/TG people. Would you mind to have a chat with me?"

Should I use my own Facebook / Jack'd / Hornet / Grindr / Manhunt / 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 personal/private life. This is important, since your supervisor may request your user name/ID and your password to look at the chats you have conducted with (potential) clients, in order 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 OK to flirt with a potential client in order to get in contact with him?

No. It is OK to joke or make fun with a person in order to keep or attract his attention, but you should not deceive a client by making him think that you could be his 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, i.e. 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/a relationship with me. What should I do?

Since online dating platforms are, of course, primarily intended for men to meet each other, it will most likely be 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/friends, but to do a job, which is to help improve the sexual health and wellbeing

of the men who are dating/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. Peer educators working 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 where 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 who 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 form.

What should I do when someone harasses me online?

First, you can try to remind the user who is harassing you to the Code of Conduct of the online platform or website that you are using, by issuing him a warning. In this Code of Conduct, harassment is specifically mentioned as something which is strictly forbidden. If the Code of Conduct is breached and if this is reported to the website/app management, this may result in that user being banned from using the platform.

Apart from possibly reporting online harassment to the app/website manager, ongoing online harassment should also be reported to your manager/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 OK to have a love or sexual relationship with a client under any circumstances. You have to maintain a professional boundary between your client and yourself. It is important to avoid the impression that you are doing two things at the same time: working and cruising/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/romance become part of your personal domain. You should then block/remove your new friend/lover from the friend list / contact list of your outreach account to avoid confusion.

A client of mine of whom I know he has HIV is now starting to date 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 his ethical responsibility for the health and wellbeing of his sexual partners. Disclosure of HIV status can never be decided upon by outsiders: only a person living with HIV can disclose his/her status to others. Be reminded that if an outreach worker discloses the HIV status of a client against his/her will, he will be fired.

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

If you share your computer/tablet/phone with other people in your family, make sure you delete your bookmarks/history in your internet browser (this you can do under the ‘File’ menu, and ‘Preferences’. If you use your own computer/tablet/phone, make sure there is a passcode to protect your privacy, so 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 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- 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 very 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.

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

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

1. Binge drinking / 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, i.e. 'addicted to sex'
5. Having a history of sexual abuse during childhood
6. Having a violent boyfriend/intimate partner
7. Having considered suicide or having tried to commit suicide
8. Having a history or current involvement in sex work
9. Poverty and homelessness

If a person has 1 of the above list of conditions, researchers found that condom use was generally higher and HIV prevalence lower than if a person has 2 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 transgender people were addressed at the same time.

It should be noted 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 behavior 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 he dealt with his drug habit. Endlessly talking about condoms

would not have much of an effect on a client who really needs to understand the link between his 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 linkages between these syndemic conditions and HIV. As discussed above, helping clients address one or more syndemic conditions will increase the likelihood that he can also prevent HIV infection or, if already infected, access HIV treatment, care and support services.

Since providing counselling and support for many of these problems is challenging and requires a lot of 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 / adapted to provide services to men who have sex with men or transgender people. In some cities, there are at least programs to deal with alcohol and drug addiction, which are two important factors.

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

[This information should be added specifically for each city/country]

Condition / problem	**Service/contact/website:**
Alcohol addiction	
Drug addiction	
Sexual violence/abuse hotline	
Social services	
Mental health care	
Suicide hotline / prevention services	
Support for homeless people	
Support for male / TG sex work	

ANNEX 1: A referral list to available health- and social support services

To be completed for each city where the manual is used

ANNEX 2: OVERVIEW of common STIs among men who have sex with men and transgender people

GONORRHEA[14]

What is gonorrhea?

Gonorrhea is an infection caused by a bacterium. Gonorrhea can lead to infection of the penis, rectum, and throat. However, many people do not know they have gonorrhea, because although they are infected, they do not have any symptoms.

How does someone get gonorrhea?

Gonorrhea 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 gonorrhea?

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

In men, symptoms of gonorrhea 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, they may include rectal discomfort, anal itching, pain, discharge, or bleeding.
- Infection of the throat can occur following unprotected oral-genital sex with an infected partner, resulting in a sore throat.

How can you protect yourself from getting gonorrhea?

The chance of becoming infected with gonorrhea can be reduced by avoiding risky sexual behaviors. To reduce your risk:

- Use latex or polyurethane condoms during sex
- Limit your number of sex partners and sexual acts
- If you have recently been treated or are being treated for gonorrhea, you must make sure your sex partner(s) 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 you do, cover them with a new condom every time you use them with different partners

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

Can infection with gonorrhea lead to other health problems?

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

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

How is gonorrhea diagnosed?

A variety of laboratory tests can be used to diagnose gonorrhea. 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 these sites.

Usually, these tests are not available in Asia and patients are treated syndromically (i.e. without waiting for a test result) for both gonorrhea and chlamydia at the same time.

Is there a treatment or cure for gonorrhea?

Gonorrhea 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 Gonorrhea becoming resistant to almost all useful drugs in many places. Therefore you should see your doctor if you have gonorrhea (or any other STI) as he or she will know the latest and most effective drugs to treat it. Because men and women infected with gonorrhea often also have chlamydia, treatment for chlamydia is usually provided as well. It is important to make sure your sex partner(s) 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. About 75% of infected women and half of infected men have no symptoms of chlamydia.

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 may include:

- Discharge from the penis

- Burning with urination
- Swollen and/or painful testicles

Picture taken from
http://studentaffairs.case.edu/health/sexual/male/std/chlamydia.html

How can you protect yourself from getting chlamydia?

The chance of becoming infected with chlamydia can be reduced by avoiding risky sexual behaviors.

To reduce your risk:

- Use latex or polyurethane condoms during sex
- Limit your number of sex partners or sexual acts
- If you have recently been treated or are being treated for chlamydia infection, you must make sure your sex partner(s) also receives 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.
- Do not share sex toys, and if you do, cover it with a new condom for each sex partner

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 patients are treated syndromically for both gonorrhea 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 gonorrhea, treatment for gonorrhea is usually provided as well. It is important to make sure your sex partner(s) also receive treatment, in order to prevent getting infected again or infecting other

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

HUMAN PAPILLOMAVIRUS (HPV)

What is human papillomavirus (HPV)?

Human papillomavirus (HPV) is a virus with more than 100 sub-types 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 human papillomavirus?

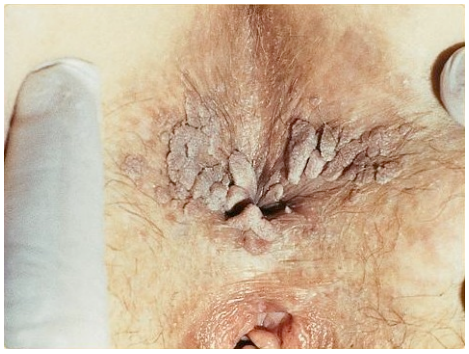
HPV may cause warts with many different characteristics. They may appear small or large, flat or raised, single or multiple; sometimes the warts may not even be visible. The most common places to notice warts are outside the vagina, on the penis, and around the anus. In women, HPV can lead to the development 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 can you protect yourself from getting HPV?

The chance of becoming infected with human papillomavirus can be reduced by avoiding risky sexual behaviors.

To reduce your risk:

- Using 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)
- Limiting your number of sex partners and sexual activities



A severe case of genital warts around the anus
Source: https://en.wikipedia.org/wiki/Genital_wart

How can you tell the difference between anal warts and hemorrhoids?

Sometimes people are not sure whether they are suffering from anal warts (caused by the HPV virus) or whether they have a problem with hemorrhoids. When you see them, genital/anal warts cannot easily be mistaken for hemorrhoids. Anal warts are white or pink, hemorrhoids are blue-red-purple in color; warts have a cauliflower-like surface, first soft, later more firm/hard; hemorrhoids 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 hemorrhoids can become very painful when a blood clot and inflammation develop. Hemorrhoids can cause some bleeding in your 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 cancers so a medical assessment is essential.

How is HPV diagnosed?

Many people who have HPV infection 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 sub-types 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, he or she can carry the virus for life, even if genital warts are removed but many people 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 U.S. 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 patient-applied treatment for external genital warts
- Imiquimod cream, which is a patient-applied treatment for external genital warts and perianal warts
- Chemical treatments (including trichloracetic acid and podophyllin), which must be applied by a trained health care provider to destroy 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
- Interferon, an antiviral drug, which can be injected directly into warts

Each of these treatments has advantages and disadvantages that you should discuss with your 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 (see below). 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 2-6 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 can you protect yourself from getting syphilis?

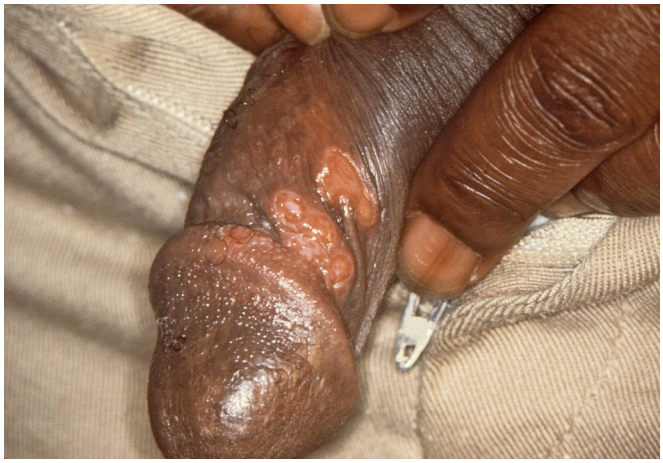
The chance of becoming infected with syphilis can be reduced by avoiding risky sexual behaviors.

To reduce your risk:

- Use latex or polyurethane condoms during sex
- Limit the number of your sex partners and sexual activities
- If you have symptoms suggestive of syphilis or think you may have been exposed to it, you should seek medical attention immediately.

If you have recently been treated or are being treated for syphilis, you must make sure your sex partner(s) also receives 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.



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 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 your sex partner(s) also receives treatment, in order to prevent getting infected again or infecting other people. Avoid having sex while being treated, to reduce the chances of getting the infection again or transmitting it to someone else.

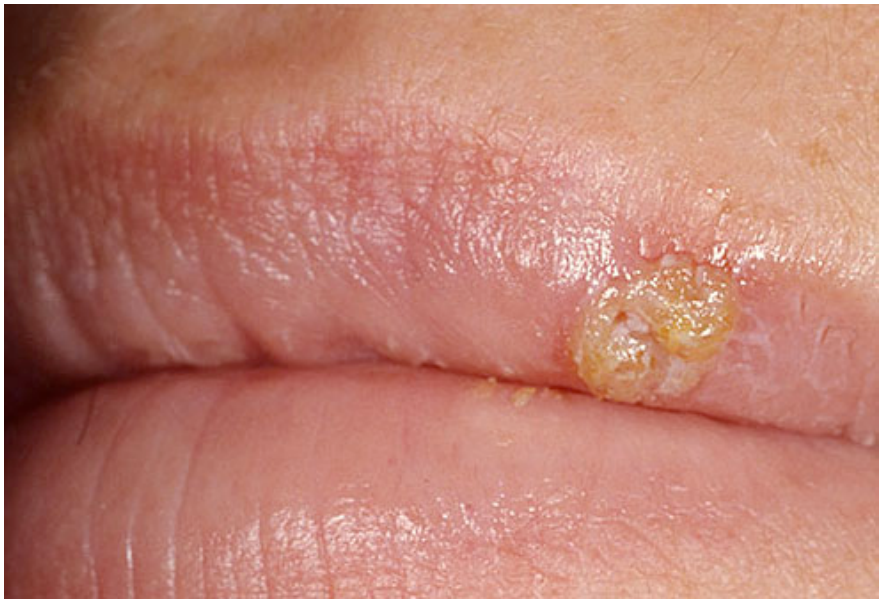
Return for follow-up testing at three and six months after treatment for early syphilis, and at six and 12 months after treatment for secondary syphilis.

HERPES

What is herpes?

Herpes is a common, often recurrent infection caused by the herpes simplex virus (HSV), discussed above, 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, he or she remains infected

for life. However, the virus often remains "latent" and does not cause symptoms for long periods of time.



See: 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 1-3 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 3-7 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 systems (e.g., with HIV disease) may experience severe, persistent ulcers.

How can you protect yourself from getting herpes?

The chance of becoming infected with herpes can be reduced by avoiding risky sexual behaviors.

To reduce your 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 your 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, encourage your partner to let you know at the first sign(s) of any recurrence so that you 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
- 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 suppressed immune systems. 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.

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

Is there a treatment or cure for herpes?

There is no cure for herpes. Once an individual is infected with herpes, he or she carries the virus in his or her body for life. This does NOT mean that the person will have herpes trouble for the rest of his/her 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 or 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 (e.g. needlestick injuries)
- 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)
- 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 one to blood or other body fluids
- Traveling or living in areas with high rates of HBV infection (including Southeast Asia)

How can you protect yourself 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 your risk of getting hepatitis B. The vaccine is usually given by means of injection which has to be repeated one and six months after the first shot. The vaccine protects for many years – after that, one can repeat it if needed.

It is recommended the vaccine be administered to:

- Individuals who engage in high-risk behaviors (including unprotected sex, sex with multiple partners, and sharing injecting equipment)
- All babies
- Adolescents
- Individuals who live with people infected with HBV
- Individuals who live in areas with high rates of HBV infection

In addition, other ways to reduce your 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 your number of sex partners

- Avoiding sharing needles, and injecting drug equipment
- Avoiding skin-piercing or tattoos
- Practicing universal precautions if you are a health care worker
- 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 lives, and their risk for developing liver cancer is 200 times higher.

How is hepatitis B diagnosed?

Hepatitis B can be diagnosed by blood tests. 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, in late 1998, the U.S. Food and Drug Administration approved the use of lamivudine, 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 diarrhea. In addition, it is recommended that individuals with hepatitis B:

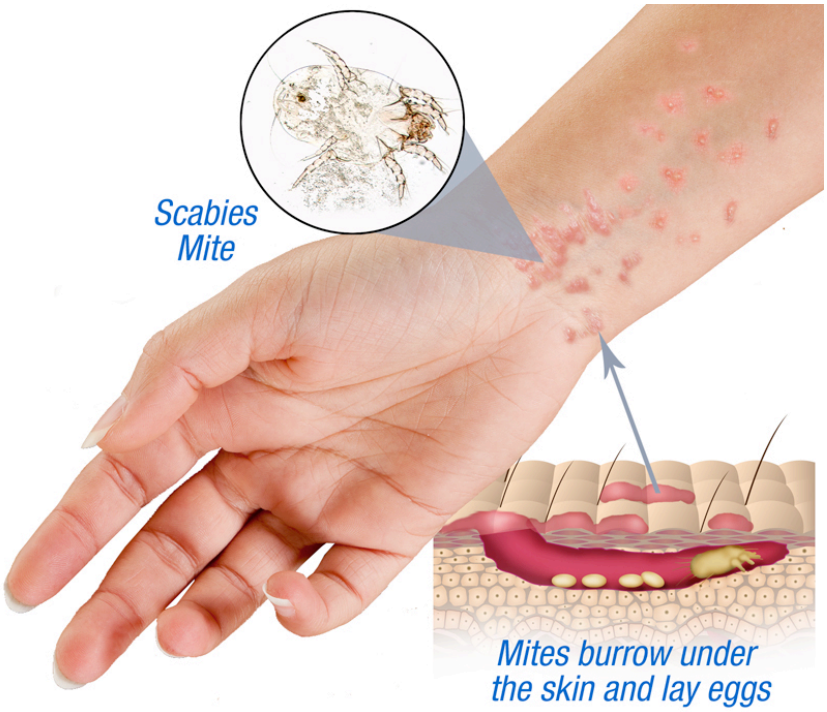
- Get plenty of rest
- Drink plenty of fluids
- Eat a high-protein diet to repair damaged cells
- Eat a high-carbohydrate diet to protect the liver
- Avoid alcohol

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 one's body.

SCABIES[15]

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 itch and a rash.



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

How do you get scabies?

You need close skin-to-skin contact with an infected person to catch scabies. 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 mite.

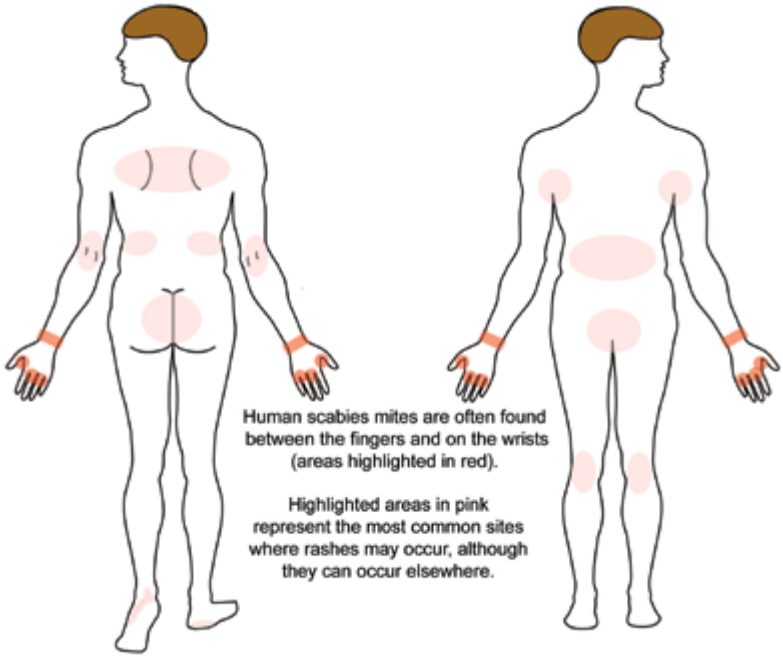
What are the symptoms of scabies?

Itch 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

[15] Text slightly adapted from
http://www.leeds.ac.uk/lsmp/healthadvice/scabies/scabies.html

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 2-6 weeks to occur after you are infected (as the allergy develops). So you may not know that you are infected, and you may pass the mite on to others before you 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 you 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.



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 6 weeks to develop symptoms after you become infected. Close contacts may be infected, but have no symptoms, and may pass on the mite. 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 mite. You can buy them from pharmacies. You can also get them on prescription. They are easy to apply and normally work 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 degree Celsius 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.

You will still be itchy for a while after successful treatment. It is normal to take up to 2-3 weeks for the itch to go completely 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 you sleep if itching is a problem at night (particularly for children).

ANNEX 3: List of drugs that may be used by some men who have sex with men and transgender people

Alcohol

Alternative names:	Drink, booze, etc.
Forms:	Liquid
Effects:	Relaxation, increased confidence, loosening of inhibitions
Risks:	Headache, vomiting, loss of co-ordination, slurred speech, impaired judgment. Heavy drinking can cause alcohol poisoning, and liver, heart and stomach problems.
Legality	Usually illegal to sell to under-18s

Amphetamines

Alternative names:	Speed, 'Ya Ba'
Forms:	Usually comes as a grey/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 cooking/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, 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, wellbeing 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: 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. Ecstasy can sometimes be fatal
Legality	Illegal

GHB

Alternative names:	GBH (chemical name: gammahydroxybutrate)
Forms:	Colorless, odorless 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:	Senses of warmth and wellbeing, 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'), anesthetic 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 in 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, color and sound ('trip')
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 supply can be)

Solvents

Alternative names:	Glue, gas, aerosols, various trade names
Forms:	Inhalation of the fumes in 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 to brain, liver and kidneys, can cause instant death (even on first use)
Legality	It is illegal for retailers to sell these products to under-18s, 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 under-16 or under 18s

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

ANNEX 4: Useful websites, hotlines and other resources for MSM and TG

To be completed in each specific country