



Health Care Provision for men who have sex with men, sex workers, and people who use drugs

An Introductory Manual for
Health Care Workers in South Africa

1st Edition 2013

Editors: Ben Brown, Zoe Duby & Delene Van Dyk



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



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DEDICATION

This manual is dedicated to any individual who has experienced discrimination when seeking health care or who has been denied the care and support they deserve.

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GLOSSARY

Abstinence

Abstinence in the context of drug-taking behaviour refers to abstaining or not using drugs.

Acquired Immunodeficiency Syndrome (AIDS)

A fatal disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy. The cause is a virus (the human immunodeficiency virus, or HIV) transmitted in blood, sexual fluids and breast milk. HIV destroys the body's ability to fight off infection and disease.

Addiction

A condition in which a physical or mental dependence exists for a particular substance, without which adverse effects occur. The use and abuse of a chemical marked by increased tolerance, craving, preoccupation, withdrawal when the substance is not available, and failed efforts to stop or reduce intake despite recurring problems in major life areas.

Aftercare

A type of follow-up care that supports people who use drugs to maintain sobriety or abstinence, continue their personal growth, and reintegrate into the community/family.

Alcohol

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

Amphetamine

A synthetic, addictive, and mood-altering drug, used illegally and legally as a prescription drug, which acts as a central nervous system stimulant. Amphetamines are usually ingested orally but can also be snorted, smoked, injected or inserted anally.

Anxiety

Anxiety can be described as worrying about issues or situations over which a person has no control. It affects how individuals feel and behave and can manifest physical symptoms.

Anal sex

Sex which usually involves the insertion of the penis into the anus (penile-anal penetrative sex).

Anal taboo

A general avoidance of any reference to the anus because of complex social constructs that associate the anus with shame, guilt and even dirt.

Analingus

The oral stimulation (licking) of the anus. Also known as anal rimming.

Antiretrovirals (ARVs)

Medication used to inhibit HIV at specific phases of its life cycle.

Anus

The region of the bowels which opens onto the skin.

Androgyny

Not having clear masculine or feminine physical characteristics or appearance.

Assessment/Evaluation

The systematic identification of a patient's/client's condition and needs within a framework based on professionally accepted best-practice guidelines.

Asexual

Lack of sexual attraction, and interest in and desire for sex.

Backloading

Sometimes referred to as piggybacking. Backloading refers to a single syringe which is used to draw up equal amounts of the liquid drug (e.g. heroin), which can then be carefully squirted into the back of each person's syringe after the plunger has been removed.

Barebacking

Anal penetration without use of any barrier method. It is usually used in the context of making a conscious decision not to use condoms.

Bipolar disorder

A mood disorder characterised by alternating episodes of depression and mania or hypomania.

Bisexual

It refers to both a sexual orientation and identity. Bisexual people have an attraction to people of the same and opposite sex on various levels (emotionally, physically, intellectually, spiritually and sexually), though not

necessarily at the same time and there is not necessarily an equal amount of attraction.

Bottom

A slang term referring to the receptive partner during anal sex, the opposite of a 'Top'.

Business

The act of exchanging sex for money, goods, or favours.

Cannabis

Known as marijuana or dagga. This substance acts as a central nervous system depressant and hallucinogen. Cannabis is usually inhaled by smoking but can also be ingested orally.

Chlamydia

A sexually transmitted infection caused by a group of bacteria, commonly responsible for 'the drop'/urethritis/proctitis.

Chipping

This term refers to heroin users who stick to very strict rules, such as only using on weekends, using once a week, and so forth. They are considered to be not (yet) addicted to heroin.

Crystal meth

See Methamphetamine.

Cisgender

Refers to people whose gender identity matches their sex at birth. The Latin prefix 'cis' stands for 'on the same side,' while the prefix 'trans' stands for 'on the opposite side.' This has a more positive connotation than 'normal' or 'non-transgender'.

Client

The person with whom a sex worker exchanges money or goods for sexual activity.

Coming out

A term describing the complex process where an individual realises that they are not heterosexual and they resolve conflicts related to heteronormativity (where heterosexuality is being internalised and viewed as the norm). Coming out is a process of how one wants to be identified. When an individual chooses not to come out (which is their right too), the colloquial term used is 'to be in the closet'.

Comorbidity

See Dual diagnosis.

Condom-compatible lubricants

Water and silicon-based lubrications which do not increase the risk of a condom tearing during sexual intercourse.

Cocaine/Crack cocaine

Substances derived from the coca plant that act as a central nervous system stimulant. Cocaine can be snorted and injected while crack cocaine can be smoked or injected.

Concurrent partners

Having more than one sexual partner at the same time.

Cooker

A term used to describe any variety of containers used to heat or dissolve drugs in solid form into liquids to prepare them for injection.

Craving

Strong desires that are linked to the effect of drugs on the brain and can cause strong physiological effects.

Depression

Depression can be described as a low or depressed mood with loss of interest or pleasure in life and activities that lasts for a period of two weeks or more and is disruptive to everyday functioning. It is characterised by sadness, inactivity, difficulty concentrating and thinking, significant increase or decrease in appetite, difficulty sleeping and suicidal thoughts.

Dental dams

A latex sheath (square) that serves as a barrier of protection against the transmission of sexually transmitted infections (STIs) during oral sex, frottage or tribadism (where genitals rub directly against each other). Also called vaginal dams.

Detoxification

Detoxification, or detox, is a process in which the body is allowed to free itself of a drug. During this period, the symptoms of withdrawal are also treated. Detoxification is included in many drug treatment programmes and can be used in treating addictions to alcohol, heroin, inhalants, sedatives and hypnotics. The goal of detoxification is to clear the toxins out of the body so that the body can adjust and heal itself after being dependent on a substance.

Discharge

Fluid oozing from an area of inflammation, which includes cells aimed at fighting infection and the infectious agent. Discharge may be seen coming from the penis, anus, vagina or throat as a result of selected sexually transmitted infections.

Discrimination

The unjust or prejudicial treatment of different categories of people on the grounds of race, age, sex, sexual orientation, gender and gender identity and presentation.

Downer

Downer refers to a type of depressant or tranquilising drug.

Drug

A drug is a substance that influences the normal functioning of the central nervous system and results in both physical and mental effects.

Drug dependence/Substance dependence

Drug dependence occurs when an individual has a physical dependence on a drug and becomes dependent on it for normal physiological functioning of the body. (See page 101 for a detailed definition of Dependence.)

Dual diagnosis

This is given when an individual presents with signs and symptoms for two co-occurring conditions, each requiring treatment and management.

Ejaculation fluid (Cum)

Fluid released from the penis during ejaculation ('cumming'); many viruses and bacteria which are responsible for sexually transmitted infections can be present in this fluid.

Ecstasy

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

Fingering

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

Frontloading

Frontloading refers to when the liquid drug (e.g. heroin) is carefully squirted into the front of each person's syringe, which still has the plunger in it but from which the detachable needle has been removed.

Female condom

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

Flashback

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

Frottage

Rubbing penises together for sexual stimulation.

FTM/Transman

A transman, or female-to-male transsexual, starts his life with a female body, but his gender identity is male. Always use male pronouns in reference.

Gear

See 'Paraphernalia'.

Genital

Related to sexual organs.

Gay man

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

Gonorrhoea

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

Gender

Socially-constructed characteristics assigned to or learned by women and men, that may vary according to the times and the society or group one belongs to. It is a broader concept than the mere biological differences between men and women, and includes masculine and feminine traits. Unequal power is afforded to males.

Gender-based violence (GBV)

GBV encompasses various forms of violence directed at women, because they are women, and men, because they are men, depending on the expectations of each in a given community. For MSM and Transgender individuals, the violence is directed towards them because of their challenging notions of sexuality and gender identity and expression.

Gender identity

Refers to a person's persistent and consistent sense of being male, female or androgynous. An internalised representation of gender roles and an awareness from infancy which is reinforced during adolescence.

Genderqueer

An umbrella term for gender identities other than man and woman that are outside of the gender binary (male and female) and heteronormative outlook. Genderqueer people may think of themselves as both man and woman (bigender), neither man nor woman (agender), moving between genders (genderfluid), and/or third gendered.

Gender role

Socially-constructed or learned behaviours that condition activities, tasks, and responsibilities viewed within a given society as 'masculine' or 'feminine'.

Hallucination

A common side effect of some drugs that causes individuals to perceive objects that are not present in reality.

Harm reduction

Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.

Hepatitis

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

Heterosexuality

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

Heroin

This substance belongs to the class of drugs known as opiates. It acts as a central nervous system depressant and analgesic. It is usually injected but can also be smoked. Also known as H, horse or smack.

Herpes

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

Homophobia

Discrimination, stigma, fear or hatred based on homosexuality, directed at gays, lesbians, bisexuals and transgendered people.

Homosexuality

Refers to the sexual orientation in which an individual has romantic or sexual feelings toward members of the same sex.

Hotspot

Refers to a community space that is commonly understood to be affiliated with certain key populations, such as sex workers, MSM, and people who use drugs.

Heteronormative

A social construct that views all human beings as either male or female with the associated behaviour and gender roles assigned, both in sex and gender, where sexual and romantic thoughts and relations are viewed as normal only between people of opposite sexes. All other behaviour is viewed as 'abnormal'.

Homo-prejudice

Prejudice against people of diverse sexual identities, all non-heterosexual.

Homosexual

Attraction between two people of the same sex on various levels: emotionally, physically, intellectually, spiritually and, most prominently, sexually.

Human rights

The basic rights and freedoms that all people are entitled to regardless of nationality, sex, age, nationality or ethnic origin, race, religion, language, or other status. The other status refers to, for example, a person's HIV status. Freedoms around sexual orientation and gender identity are also basic human rights.

Human Immunodeficiency Virus (HIV)

The Human Immunodeficiency Virus is a retrovirus that causes AIDS by infecting helper T cells of the immune system. The most common serotype, HIV-1, is distributed worldwide, while HIV-2 is primarily confined to West Africa. It is one of many sexually transmitted infections.

Human Papilloma Virus (HPV)

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

Incarcerated

Being in prison.

Injecting drug user (IDU)

See PWID.

Incidence

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

Insertive partner (Top')

In anal sex, the partner who is penetrating the other partner's anus.

Intersexed people

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

Internalised Homophobia

When a homosexual individual internalises (makes their own) the shame and hatred projected onto gays and lesbians by a homophobic society.

Junkie

A stigmatising term used to refer to people who use drugs.

Key Populations

'The term "key populations" or "key populations at higher risk of HIV exposure" refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response, i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.'⁽¹⁾

Khat/Cat

This substance belongs to the class of drugs known as methcathinone. It acts as a central nervous system stimulant. It is usually snorted but can also be taken orally, injected and smoked.

Lubricant

Substance which reduces friction during sexual intercourse. Lubricants can be water-based (e.g. KY Jelly®) or oil-based (e.g. Vaseline®, body cream, cooking oil). Latex male condoms should only be used with water-based lubricants, as oil-based lubricants deteriorate latex.

Lesbian

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

LGBTI

Abbreviation for 'lesbian, gay, bisexual, transgender, intersex'.

Lymph nodes

Glands which form part of the immune system and are involved in fighting infection. Major groups of glands exist in the inner thigh, in the armpits and in the neck.

Male condom

Sheath placed over the erect penis before sexual intercourse. It prevents pregnancy and HIV/STIs by blocking the exchange of sexual fluids.

Methamphetamine

This includes crystal meth, or tik which act as a central nervous system stimulant. It can be snorted, ingested orally, injected or smoked.

Mandrax

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

Methadone maintenance therapy (MMT)

The most widely known and well-researched treatment for opioid dependence. Goals of therapy are to prevent abstinence syndrome (withdrawal), reduce narcotic cravings and block the euphoric effects of illicit opioid use.

Morphine

This substance belongs to the class of drugs known as opiates. It acts as a central nervous system depressant and analgesic. It is a powerful narcotic analgesic and its primary clinical use is in the management of moderately severe to severe pain. After heroin, morphine has the greatest potential for dependence of all narcotic analgesics.

MTF / Transwoman

A transwoman, or male-to-female transsexual individual, starts her life with a male body, but her gender identity is female. Always use female pronouns in reference.

Marijuana

Also known as 'dagga' or 'weed' comes from the cannabis plant and is usually smoked, but can also be ingested orally. It acts as a central nervous system depressant and hallucinogen.

MSM

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

Multiple stigma

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

Needle (syringe)

A medical tool used to deliver liquids into the blood stream that is commonly used among PWID to inject drugs.

Needle syringe programmes (NSP)

Needle and syringe exchange programmes provide sterile syringes and needles in exchange for used syringes and needles to reduce transmission of HIV and other blood-borne infections associated with re-use of contaminated syringes and needles by PWID. The programmes can help to prevent blood-borne pathogen transmission by increasing access to sterile injecting equipment and enabling safe disposal of used syringes and needles. Often, programmes also provide other public health services, such as HIV testing, risk-reduction education and referrals for substance-abuse treatment. Also referred to as needle and syringe exchange (NSE).

Oral sex

Contact between the mouth and tongue and genitals (penis, testicles, anus, vagina). Includes licking, sucking, kissing.

Opioid dependence

Opioid dependence is a medical diagnosis of a chronic brain disease characterised by an individual's inability to stop using opioids (e.g. morphine, heroin, codeine, oxycodone, hydrocodone) even when it is in his or her best interest to do so. This physical, psychological and behavioural need for an opioid drug is unrelated to medical necessity for pain relief. 'Opioid dependence develops after a period of regular use of opioids. The time required for dependence to occur in a person varies according to the quantity, frequency, and route of administration, as well as factors such as individual vulnerability and the context in which drug use occurs. Opioid dependence is not just a heavy use of opioids, but a complex health condition that has social, psychological, and biological determinants and consequences. It is not a weakness of character or will' (World Health Organisation definition).

Opioid substitution therapy (OST)

An evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates such as buprenorphine and methadone. OST reduces HIV risk behaviours and harms associated with injecting (such as abscesses, septicaemia, and endocarditis), overdose and participation in criminal activity, thereby improving the quality of life and health of PWID. It is endorsed by UNAIDS, UNODC and WHO as part of a comprehensive package of nine core interventions for PWID programmes that collectively maximise impact for HIV prevention and treatment.

Oro-anal sex

Contact between mouth, tongue and anus, including licking (rimming) and kissing the area around the anus and rectum.

Patient

An individual who is engaged in some type of medical or health care service.

Phobia

Excessive anxiety or fear about a specific object or situation.

Post-exposure prophylaxis (PEP)

The use of medication to prevent infection after exposure to an infectious agent. Preventive treatment (anti-retroviral drugs typically taken for 4 weeks) started immediately (within 72 hours) after exposure to the HIV virus in order to prevent the virus from developing inside the body.

Pre-exposure prophylaxis (PreP)

A strategy of using combinations of anti-retroviral medications long term in HIV negative individuals to lower their risk of becoming HIV positive if they are exposed to the virus.

Paraphernalia

Paraphernalia, or gear, refers to any assorted collection of tools that are used to facilitate drug use or drug-taking behaviour. This can include such items as spoons, bottle top, filters, needles, syringes, etc.

Popping

A process called popping or skin popping refers to injecting heroin right under the skin.

Post-traumatic stress disorder (PTSD)

A disorder that develops after exposure to a highly stressful event (e.g. threats to one's life, rape, war, natural disasters, being robbed). Symptoms include flashbacks of the incident, difficulty sleeping, recurrent nightmares about the incident and avoiding reminders of the incident.

Psychosis

A mental disorder characterised by delusional thinking, disorientation, detachment from reality and hallucinations.

PWID (People who inject drugs)

This refers to people who inject drugs or a person who injects drugs.

PWUD (People who use drugs)

This refers to people who use drugs or a person who uses drugs.

Penetrative penile-anal sex

Sex act describing the positioning or role of the 'active' partner or 'top' whose penis is being inserted into the anus of his sexual partner.

Physiological

Relating to processes in the physical body.

Prevalence

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

Prostate

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

Prejudice

It is an irrational, preconceived opinion, not based on reality or actual experience. It often results in dislike, hostility and unjust behaviour.

Rectum

The lower region of the bowels linking the descending colon to the anus. Also referred to as the rectal passage.

Relapse

Relapse refers to a period of substance use following a period of no substance use. The term relapse usually refers to drinking or using drugs again after a period of abstinence, or trying to quit drinking or using and not being able to do so. Sometimes it is used interchangeably with the terms slipping or falling off the wagon. Many alcohol- and drug-abuse clinicians differentiate between a slip and a relapse by defining a slip as a one-time, isolated mistake followed by a renewed commitment to and effort at treatment and abstinence. A slip may be seen by the recovering person as a wake-up call regarding how much more effort will be required to achieve lasting, continuous abstinence.

Receptive anal sex

Sex act describing the positioning or role of the 'passive', 'receptive', 'bottom' whose anus is being entered.

Receptive partner ('Bottom')

In anal sex, refers to the partner whose anus is being penetrated.

Rimming

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

Re-infection

Acquiring a second strain of the HI virus in someone who is already HIV positive. This may have a negative consequence on the long-term treatment of HIV.

Responsible sex

A sex-positive way of looking at prevention. It emphasizes the prevention of STIs, including HIV, through consistent condom use, with condom-compatible / water-based lubrication and the reduction in the numbers of sexual partners.

Sero-conversion

The time when an infectious agent is present in the body.

Sero-discordant relationship

A romantic or sexual relationship between two people of differing HIV status.

Sero-sorting

This is a risk-reduction strategy used by a subset of MSM and transgender individuals to prevent HIV transmission, dependent on being able to identify sexual partners with the same HIV status.

Service providers

In this manual, service providers refers to anyone who could come into contact with sexual minorities accessing services for prevention, treatment and care. This could include nurses, doctors, counsellors and community health workers providing voluntary counselling and testing (VCT) and HIV counselling and testing (HCT) or supportive services. It also includes the management staff responsible for designing and monitoring the services.

Sex

A biological construct of a human being. 'What's in the pants?' Male genitals – penis, testes, testosterone and genetic make-up – and for females – breasts, vagina, oestrogen, progesterone and genetic make-up.

Sexual behaviour

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

Sexual identity

The overall sexual self-identity, which includes how the person identifies as male, female, masculine, feminine, or some combination of these, and the person's sexual orientation.

Sexual minority

A group whose sexual identity, orientation, and gender identity, expression or practices, differ from the majority of the surrounding society.

Sexual orientation

The term used to describe the set of emotional, physical and romantic feelings an individual has towards others. These feelings and behaviours are usually directed towards men or women, or both men and women.

Sexuality

How people experience and express themselves as sexual beings, within the concepts of biological sex, gender identity and presentation, attractions and practices. Culture and religion have a huge impact on how individuals see themselves as sexual beings, especially within relations of power.

Sexually transmitted infection (STI)

Infection transmitted and acquired through sexual contact.

Sex work

'Any agreement between two or more adult persons in which the objective is limited to a consenting sexual act, and which involves preliminary negotiations for a price. Hence there is a distinction from marriage contracts, sexual patronage and agreements concluded between lovers that could include presents in kind or money, but its value has no connection with the price of the sexual act and the agreement does not depend exclusively on sexual services.'⁽²⁾

Sex worker

Sex workers include consenting female, male and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Acceptable alternative formulations for the term 'sex worker' are 'women/men/people who sell sex'. The term 'commercial sex worker' is not used because it says the same thing but in different words. Children selling sex under the age of 18 are considered to be victims of commercial sexual exploitation, unless otherwise determined (USAID definition). The term 'sex worker' is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold and is preferred to 'prostitute' which has negative connotations.

Slip

See Relapse.

Sobriety

Sobriety refers to the moderation of or abstinence from consumption of alcoholic liquor or use of drugs.

Substance dependence

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

Stereotype

An oversimplified characteristic of a person or group that is usually driven by stigma.

Stigma

Shame or disgrace that is directed toward something regarded as socially unacceptable.

Stigmatise

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

Street work

Refers to sex work that takes place in/on the streets. Known colloquially as outdoor sex.

Symptom

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

Syphilis

A sexually transmitted infection caused by *Treponema pallidum*, one of the 'genital ulcer diseases'.

Transgender

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

Transman

A transgender person who was born female but identifies as male.

Transphobia

The fear of, and/or hostility towards, people who are transgender or who otherwise transgress traditional gender norms. The most direct victims of transphobia are people who are transsexual. Because our culture is often very transphobic, transgender people can often have internalised transphobia and experience feelings of insignificance and self-prejudice.

Transsexual

A transgender person in the process of seeking or undergoing some form of medical treatment to bring their body and gender identity into closer alignment. Not all transgender people undergo reassignment surgery.

Transitioning

The process of changing one's gender presentation to align with the internal sense of one's gender. For transgender people this may sometimes include sexual reassignment surgery, but not always.

Transvestite

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

Transwoman

A transgender person who was born male but identifies as female.

Top

A colloquial term referring to the penetrating partner during anal sex.

Thigh sex

The act of rubbing the penis between the partner's thighs.

Transactional sex

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

Tourniquet

This is a tool that may, but not always, be used during injecting drug use. A tourniquet is usually a piece of elastic or other material that may be tied around the arm in order to cause blood veins to become more prominent and accessible.

Ulcer

A sore which involves a break in the protective covering provided by skin.

Unprotected anal intercourse

Anal sex, penis in anus, which occurs without the protection provided by a condom.

Upper

These are stimulants designed to make the user feel energised, excited, and capable of doing anything. Cocaine, ecstasy, methamphetamine [tik], and crack cocaine.

Urethritis

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

Venue-based sex work

Refers to sex work that takes place within an established structure as opposed to street-based sex work. Known colloquially as indoor sex.

Vaginal sex

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

Versatile

A colloquial term referring to being both a 'Bottom' and a 'Top'.

Warts

Growths on the skin, caused by a virus; human papilloma virus is responsible for warts in the genital area.

WSW

Women who have sex with women. This term includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women as well as women who self-identify as heterosexual but have sex with other women. This term is more technical and is not necessarily an identity.

Withdrawal

Withdrawal refers to the group of symptoms that occurs upon the abrupt discontinuation of or decrease in intake of drugs and/or alcohol. (Also referred to as abstinence syndrome.)

HEALTH CARE PROVISION

PRE-COURSE EVALUATION AND QUESTIONNAIRE

Before using this manual or participating in a related training programme, please complete the following questions.

A post-course evaluation is available at the end of this manual on page 205.

SW/PWUD/MSM PRE-COURSE EVALUATION

SECTION A: Training details

A1	Training Date:	_____ (Day) / _____ (Month) / (Year)
A2	Training Venue:	
A3	City/District:	
A4	Province:	

SECTION B: Trainee details

B1	Gender:	
B2	Age:	
B3	Job title:	
B4	Employer:	

SECTION C: Trainee experience

Guide: 1. Yes 2. No 3. Don't know (Numerical Answer)

	Question	Response 1. Yes 2. No 3. Don't know (Numerical answer)
C1	Do you have experience providing health care?	
C2	If yes, how long have you been providing health care?	
C3	Have you ever received sensitisation training for Sex Workers before?	
C4	Have you ever received sensitisation training for Men who have sex with Men (MSM) before?	
C5	Have you ever received sensitisation training for People who Use Drugs (PWUD) before?	
C6	In the past 3 months, have you provided health services to any clients who disclosed selling sex?	
C7	In the past 3 months, have you provided health services to any clients who disclosed taking drugs?	

	Question	Response
C8	In the past 3 months, have you provided health services to any Male clients who disclosed having sex with other men?	
C9	In your career, have you provided health services to any clients who disclosed selling sex?	
C10	In your career, have you provided health services to any clients who disclosed taking drugs?	
C11	In your career, have you provided health services to any Male clients who disclosed having sex with other men?	
C12	In your career, have you discussed anal sex with any of your Male clients?	
C13	In your career, have you discussed anal sex with any of your Female clients?	
C14	Have you ever provided a client with risk reduction counselling?	
C15	Have you ever provided a client with counselling or information on anal sex?	
C16	Have you ever provided a client with water+based lubricants for anal sex?	
C17	Have you ever provided a client with counselling on safe drug injecting practice?	
C18	Have you ever provided a client with clean needles to inject drugs with?	

SECTION D: Knowledge assessment

	Question	Answers: tick all that apply	
D1	SW, PWUD and MSM are at higher risk for HIV and STIs than the general community because:	a. They may have unprotected sex	<input type="checkbox"/>
		b. They may share contaminated needles to inject drugs	<input type="checkbox"/>
		c. They are more likely to be exposed to violence or sexual assault	<input type="checkbox"/>
		d. They often do not get effective health care because of stigma or discrimination	<input type="checkbox"/>
		e. They often do not have the correct information about their own level of risk	<input type="checkbox"/>

D2	Sex workers are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They are dirty or smell bad	<input type="checkbox"/>
		c. They engage in an illegal activity	<input type="checkbox"/>
		d. They are dishonest and untrustworthy	<input type="checkbox"/>
		e. They never adhere to treatment	<input type="checkbox"/>
		f. They are rude	<input type="checkbox"/>
		g. They are responsible for spreading HIV	<input type="checkbox"/>
D3	People who use drugs are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They are dirty or smell bad	<input type="checkbox"/>
		c. They engage in an illegal activity	<input type="checkbox"/>
		d. They are dishonest and untrustworthy	<input type="checkbox"/>
		e. They never adhere to treatment	<input type="checkbox"/>
		f. They are thieves	<input type="checkbox"/>
D4	Men who have sex with men are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They engage in unnatural behaviour	<input type="checkbox"/>
		c. They are mentally ill	<input type="checkbox"/>
		d. Homosexuality is a sickness	<input type="checkbox"/>
		e. They are rude	<input type="checkbox"/>
		f. They engage in disgusting behaviour	<input type="checkbox"/>
D5	Stigma towards SW, PWUD and MSM can be reduced in a health care setting by:	a. Ensuring that inappropriate language and behaviour are not tolerated in health facilities	<input type="checkbox"/>
		b. Encouraging the police to visit the clinic regularly	<input type="checkbox"/>
		c. Having separate queues for SW, PWUD and MSM away from the other clients	<input type="checkbox"/>
		d. Refusing to provide SW, PWUD and MSM the same services as other clients	<input type="checkbox"/>

D6	Sex workers, PWUD and MSM find it hard to access health services because:	a. They often face unfair treatment and discrimination from health care staff	<input type="checkbox"/>
		b. Many don't have money for transport	<input type="checkbox"/>
		c. They worry about the lack of confidentiality	<input type="checkbox"/>
		d. They cannot disclose their behaviour to health workers for fear of judgement	<input type="checkbox"/>
		e. They worry that they will be refused services	<input type="checkbox"/>
		f. They don't believe they deserve treatment	<input type="checkbox"/>
		g. They worry that they will be abused by clinic staff	<input type="checkbox"/>
D7	Risk-reduction counselling is a behavioural technique meant to reduce HIV risk by:	a. Telling the client that they are engaging in dangerous and immoral behaviour and that they should stop these behaviours immediately	<input type="checkbox"/>
		b. Discussing ways they could reduce their risk and practise safer behaviour	<input type="checkbox"/>
		c. Telling the client that you will not provide them with health care until they stop their risky behaviour	<input type="checkbox"/>
D8	Which of the following factors affects the mental health of SW, PWUD and MSM?	a. High levels of stigma and discrimination	<input type="checkbox"/>
		b. They spend time in dangerous places and environments	<input type="checkbox"/>
		c. They are vulnerable to high levels of physical and emotional abuse	<input type="checkbox"/>
		d. They face rejection from family and friends	<input type="checkbox"/>
		e. They worry that they will be caught or discovered doing something that is not generally accepted in their community or family	<input type="checkbox"/>
		f. They face police harassment	<input type="checkbox"/>
		g. The behaviour they engage in is judged to be immoral	<input type="checkbox"/>
		h. They engage in risky behaviours	<input type="checkbox"/>

D9	To provide better services for SW, PWUD and MSM, health care services should:	a. Provide risk-reduction counselling	<input type="checkbox"/>
		b. Provide information and advice on anal sex	<input type="checkbox"/>
		c. Provide information and advice on how to inject drugs safely	<input type="checkbox"/>
		d. Provide moral and religious guidance	<input type="checkbox"/>
		e. Provide clean needles for injecting drug users	<input type="checkbox"/>
		f. Include input from Sex workers, PWUD and MSM in the design of relevant services	<input type="checkbox"/>
		g. Provide a range of combined HIV prevention and safer sex strategies for clients to use e.g., condom negotiation skills)	<input type="checkbox"/>

SECTION E:

	Question	Response guide 1. Strongly disagree 2. Disagree 3. Don't know 4. Agree 5. Strongly agree
E1	Sex workers, PWUD and MSM do not visit my clinic.	
E2	Selling sex is immoral	
E3	Using an illegal drug is immoral	
E4	Having sex with someone of the same sex is immoral	
E5	Sex workers deserve to get HIV because of the behaviour that they engage in.	
E6	People who use drugs deserve to get HIV because of the behaviour that they engage in.	
E7	Men who have sex with men deserve to get HIV because of the behaviour that they engage in.	

E8	If a sex worker came to my clinic, I would provide him/her services just like anyone else.	
E9	If a person who uses drugs came to my clinic, I would provide him/her services just like anyone else.	
E10	If a man who has sex with other men came to my clinic, I would provide him with services just like anyone else.	
E11	If a sex worker wanted treatment for an STI, I would not provide it because he or she will just get infected again.	
E12	I feel comfortable providing health care services to sex workers	
E13	I feel comfortable providing health care services to people who Use drugs.	
E14	I feel comfortable providing health care services to men who have sex with men.	
E15	Sex workers, PWUD and MSM should be offered services tailored to their needs because they are more vulnerable than other people and may need specific treatment.	

THANK YOU FOR COMPLETING THIS EVALUATION

OVERVIEW

Why was this manual developed?

This manual was developed in order to support the sensitisation of health care workers who are providing services to key populations. The National Strategic Plan on HIV, STIs and TB 2012–2016 (NSP) identifies key populations as those individuals who are at greater risk for being infected by or transmitting HIV when compared to the general population and specifically states that health care services need to be responsive. The NSP defines several population groups as key populations. In this manual we focus on men who have sex with men (MSM), sex workers (SW) and people who use drugs (PWUD). These people are often stigmatised, excluded from society, and some of their behaviours may be illegal. These factors contribute to their vulnerability to HIV.

MSM, sex workers, and PWUD in South Africa experience a disproportionately high burden of HIV but face multiple barriers when accessing health care. The provisional Operational Guidelines for HIV, STI, and TB Programmes for Key Populations in South Africa identifies health care worker sensitisation training as an essential intervention to address these barriers. Health workers sensitised around the issues affecting MSM, SW and PWUD will be empowered to appropriately engage with other key populations. Future training material and tools for other key population groups are planned.

This manual was designed as part of a full sensitisation training programme, but can also be used as a stand-alone resource. The full training programme includes audio visual material, mentoring, and in-person training. In-person trainings should be led by an experienced facilitator and make use of the supplemental Facilitator's Guide (please contact one of the editors for a free electronic copy).

EXCERPT FROM THE NATIONAL STRATEGIC PLAN FOR HIV, STIS, TB 2012–2016

Even though South Africa has a generalised HIV epidemic, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations. For these reasons, despite certain general interventions (e.g. communication), key populations should be targeted for prevention, care, and treatment interventions – and this should be included specifically in provincial strategic implementation plans.

Who is the target audience of this manual?

This manual was designed for health care workers in South Africa. It has been designed specifically for individuals who already have a basic understanding of or experience in health service provision. This is not limited to nurses and medical doctors. Health care workers may also include counsellors, case managers, researchers, and service providers.

What are the specific Aims and Objectives of this manual?

This manual aims to supply health care workers with the necessary information to provide effective care and support within South African health care settings for key populations. This manual will also provide health care workers with an opportunity to understand and address both social and personal stigma toward key populations.

DISCLAIMER

This manual does not aim to promote or advocate any of the behaviours discussed. The objective is to sensitise health workers to the vulnerabilities and health needs of sex workers, MSM and PWUD. We endeavour to take a neutral standpoint and present the issues in a value-free and non-judgemental manner.

How is this manual structured and what information does it include?

This manual includes 10 modules and is divided into the following three sections:

1. 'Key Knowledge'. This section includes the important information relating to key populations, including who they are, explores their common behaviours, and describes the factors and characteristics that define them as key populations. This section also addresses important information regarding stigma, prejudice, discrimination, and human sexuality, which are subjects that will provide an important foundation of knowledge needed for later modules.
2. 'Key Issues'. This section includes modules which review the most critical issues affecting key populations, including the South African law, mental health, and HIV and other health-related concerns.
3. 'Key Services'. This section will highlight the most relevant biomedical, behavioural, and structural tools that can be implemented by health care workers to address lessons learned in the key issues and key knowledge sections. This section also includes additional information as to how best these lessons can be applied to health care settings.

Each module can be reviewed by itself or in sequence and concludes with a consolidated summary or information and important quick-reference facts and recommendations. Activities and exercises in this manual are designed such that they can be completed by an individual using this manual for self-study but can also be used in a small group or full training programme.

A resource list, including organisations currently providing support to key populations has been included at the end of this manual.

What terminology does this manual use?

Throughout this manual, 'key populations' will be used when referring to issues that affect all groups of people at increased risk of HIV infection and transmission. Otherwise, references to individual populations groups (i.e. PWUD, MSM, and sex workers) will be made. The term MSM is used rather than referring to these men based on their sexual orientation, because not every man who has sex with another man identifies himself as being homosexual or gay.

There are many words that can be used to describe someone who engages in the act of selling sex. This manual will refer to this community of individuals as sex workers, rather than prostitute or hooker or other insulting terminology. At the time of publication of this manual, 'sex worker' is the preferred term that sex workers have chosen to describe themselves and also emphasises that sex work is a means of employment.

The term PWUD is preferable to drug addict or drug abuser, which are derogatory terms that are not conducive to fostering the trust and respect required when engaging with people who use drugs. Hence, the term PWUD is preferable because it places the emphasis on people first. Additionally, much of the information presented regarding PWUD can also be applied to people who inject drugs (PWID). The term PWID refers to any person who has injected drugs in the past 12 months. Previously, the term injecting drug user (IDU) was used instead of PWID. Please also note that the term intravenous drug user is incorrect because subcutaneous and intramuscular routes may be involved. To simplify the text, when information refers to PWUD is used it can be assumed to also apply to PWID – unless injecting drug use or PWID is specifically mentioned in the text.

Use of names in case studies

Individual names are used in case studies throughout this manual for illustrative purposes. All names and locations are fictitious and any similarity to real world individuals or settings is purely coincidental.

SECTION 1

KEY KNOWLEDGE

Across South Africa, health care workers have varying levels of experience with MSM, sex workers, and PWUD. Therefore, each of the modules in this section have been designed to provide crucial background information on key populations as well as to introduce important subjects that affect MSM, sex workers, and PWUD in South Africa. These modules will establish standardised knowledge that will be applied throughout the remainder of the modules in this training.

This section includes the following four modules:

Module 1: Introduction to MSM, sex workers, PWUD

Module 2: Stigma, Prejudice, and Discrimination

Module 3: Human Sexuality and Sexual Behaviour

Module 4: Risk Factors and Vulnerabilities among MSM, sex workers, PWUD

Questions that will be addressed in this section include:

- Who are MSM, sex workers, and PWUD and why are they important?
- What is stigma and how is it related to discrimination, prejudice, and MSM, sex workers, and PWUD ?
- Why are MSM, sex workers, and PWUD stigmatised and how does it affect them?
- What is the difference between sex, gender, sexual orientation, and sexual behaviour?
- Who practises anal sex and why is it an important behaviour to understand?
- Why are MSM, sex workers, and PWUD at risk for HIV, STIs, and TB?
- What are the individual, social, and structural factors that affect their health?

MODULE

1

INTRODUCTION TO MEN WHO HAVE SEX WITH MEN, SEX WORKERS, AND PEOPLE WHO USE DRUGS

Learning Outcomes

After completion of this module, you should be able to

- i Explain who a sex worker is and describe the reasons a person may engage in sex work
- ii Describe the reasons why someone may use drugs and define the types of drugs they may use
- iii Define the type of men who are included as part of the term 'MSM' and describe why this term is used
- iv Explain why MSM, sex workers, and PWUD are considered key populations
- v Describe why addressing the health needs of key populations is important

Introduction

Who are key populations in South Africa?

The South African National Strategic Plan on HIV, STIs and TB 2012–2016 (NSP) identifies Key Populations as groups of individuals who are more likely to be exposed to or to transmit HIV and/or TB and whose risk is influenced by prejudice and an inadequate protection of human rights. The NSP identifies the following groups as key populations: people living with HIV; young women between the ages of 15 and 24 years; people living close to national roads and in informal settlements; young people not attending school and girls who drop out of school before matriculating; people from low socio-economic groups; uncircumcised men; persons with disabilities and mental disorders; sex workers and their clients and intimate partners; people who abuse alcohol and illegal substances; men who have sex with men and transgender persons. Each of these groups represent important populations affected by HIV and who are in need of support; however, this training manual will focus specifically on men who have sex with men (MSM), sex workers, and people who use drugs (PWUD).

Why are MSM, sex workers, and PWUD at greater risk for or affected by HIV and STIs?

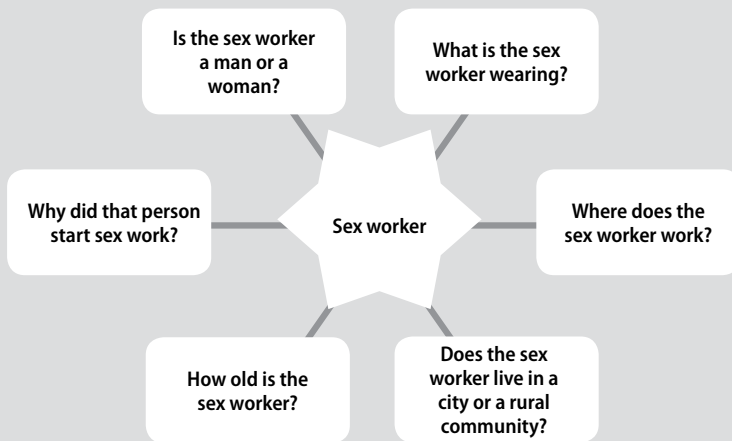
Sex workers, MSM, and PWUD are disproportionately affected by HIV in South Africa. The estimated HIV prevalence among MSM is estimated to be 30%, 60% among sex workers, and 12% among PWUD⁽¹⁾. Like the general population, individuals belonging to key populations engage in behaviours that put them at risk for HIV and other STIs, such as a high number of sexual partners and engaging in unprotected sex. Unlike the general population, however, they also experience added social and structural factors that contribute to their greater risk for HIV/STIs. For example, key populations experience high levels of social stigma which creates barriers to accessing health care services. Additionally, there are fewer health care services that are sensitised to provide care and support for key populations. Module 2 will explore the impact of stigma on the lives of key populations, and risk factors for key populations will be further discussed in Module 5.

Sex workers

EXERCISE 1

Sex Worker Mind Map

When you hear the term sex worker, what is the first thing that comes to your mind? Write down a brief description of what you think of as a typical sex worker and consider the following questions:



Who are sex workers?

A sex worker is any adult who engages in sex work or the act of exchanging money for some type of sexual service with a client. Sex work is a regular income-generating practice for many South Africans and takes place in every village, every town, and in every city across the country. There are many types of sex work, that will be discussed further in Module 4. It is estimated that there are more than 153 000 sex workers in South Africa⁽²⁾.

Sex workers in South Africa are a diverse community. They can be any race, come from any cultural background, can have any sexual orientation, and any gender identity. Most sex workers in South Africa are female, but men also engage in sex work. Transwomen also engage in sex work in South Africa. Transwomen are women who were born male but live their lives as females. More on transgender individuals will be discussed in Module 3.

Many sex workers are migrants from other places within South Africa and from other countries. Both male and female sex workers engage in sex work with male and female clients.

TRANSACTIONAL SEX VS. SEX WORK

Although overlapping, 'sex work' and 'transactional sex' refer to two distinct actions. 'Transactional sex' occurs when some type of sexual services is exchanged for gifts, shelter, drugs, money, or other items. For example, an individual may have sex with their partner because their partner buys them clothes or provides them with spending money. Sex work specifically involves the negotiation and exchange of money for a sexual service. National sex worker movements such as Sisonke encourage sex workers to take on the sex worker identity to further distinguish between those who have transactional sex and those who view sex work as a profession. Sisonke has also established a code of conduct that sex workers prescribe to in order to prepare themselves for when sex work is decriminalised.

Why do people engage in sex work?

Individuals engage in sex work for many different reasons; however, economic need is a major motivation. Many sex workers explain that sex work allows them to provide for themselves and their families. This is the same reality that many South Africans who struggle with unemployment have to face. Some sex workers may choose sex work over other forms of employment because in some cases, it provides better income than other forms of employment, such as domestic work. Additionally, sex work does not require proof of citizenship unlike other jobs; therefore, it may be a feasible means of employment for individuals who do not have citizenship or work visas. In Hillbrow, Johannesburg, for example, there is evidence to suggest that 60% of sex workers may be from other countries or from other cities within South Africa. Without proper documentation, these migrants may have fewer options to find formal work and thus engage in sex work to earn a living⁽²⁾.

Is sex work illegal in South Africa?

Yes, sex work is illegal in South Africa. However, South Africa is currently in a state of law reform, in which many of the apartheid-era laws that make sex work illegal are being reviewed. This review is in line with many international trends to decriminalise or legalise sex work around the world. For example, The World Health Organisation (WHO), United Nations Population Fund (UNFPA), and Joint

United Nations Programme on HIV/AIDS (UNAIDS) all recommend the decriminalisation of sex work⁽³⁾. Despite the illegality of sex work in South Africa: there are no laws that restrict a health care worker's ability to provide medical care to sex workers; there are many laws in South Africa that protect a sex worker's right to receive effective health care; and there are many laws that require health care workers to provide unbiased and fair services to sex workers.

MALE SEX WORKERS

Not all male sex workers identify as gay or bisexual. There are many heterosexual men selling sex to men and women who may have needs specifically relating to their sexuality that must be sensitively addressed. Hence, heterosexual men have the double stigma of being sex workers and having sex with men, just as gay or bisexual men have the double stigma of being sex workers and identifying as gay or bisexual. Heterosexual men may feel uncomfortable going to services designed specifically for gay or bisexual men. They may have female partners, and they may need information on women's sexual health and general wellbeing in order to deal with this aspect of their personal life. Health workers should ensure that they do not exclude heterosexual male sex workers by assuming that men who sell sex to other men are gay.

As many male sex workers are not streetbased, they are often under the radar of the police and other authorities, contributing to a lack of visibility. Also, many male sex workers overlap with the gay commercial scene, making it sometimes difficult to identify who is selling sex, rather than cruising or socialising.

Addressing the specific needs and interests of male sex workers can further reduce the vulnerabilities of the general MSM population. In general, male sex workers tend to be either bisexual men or transgender individuals.

EXERCISE 2

Case Study: Sex Worker

Take a moment and read the following case study about Nazli and consider the questions or comments below:

I was born in a better family and I went to school and I got married to a good husband and had three children. But God separated us with death. I looked for a job, and worked as a receptionist. Economically things started to be bad every day, [and] the money I earned was too small for me to look after my children. So I decided to come to Port Elizabeth for green pastures, so that my kids could enjoy their standard of living. When I got there I looked for a job, but found nothing. So, I had to spend one week sleeping outside, and struggling to find money for food. I met a friend who told me she is working in a hotel, but she didn't specify what kind of job she is doing. We got together because I was in need of a job—so she told me this is the job. I had no choice because I needed shelter, food—that is when I started to be a sex worker. But my kids never died with hunger because I was providing them with food, clothing, and schooling. I can't say this job is bad because you don't need qualifications or experience, you learn it in the field. Being a sex worker doesn't mean you don't do anything—God gave us brain[s] to think, eyes to see, hand to touch, and legs to walk.

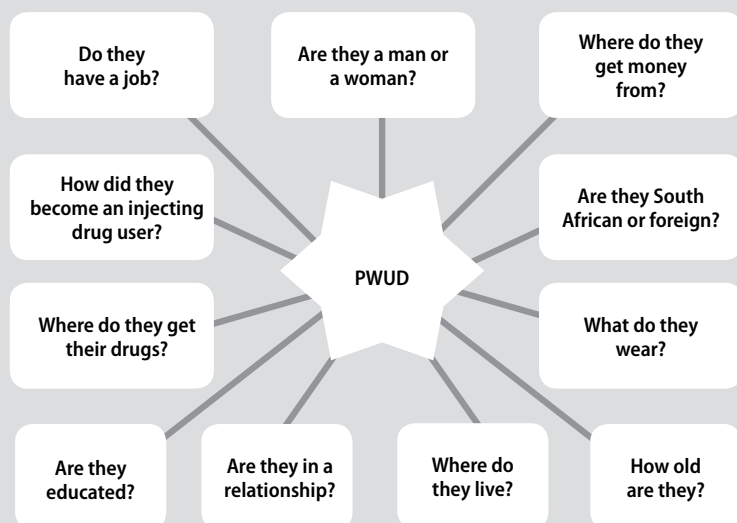
1. How did your description of sex workers from mind map exercise compare to Nazli? Was it similar or different?
2. Do you think other health care workers' descriptions would be similar or different from yours?
3. Consider why Nazli started sex work. Did she have other options? Would you have made the same decision?
4. Briefly describe what you think Nazli's experience is like as a sex worker.
5. What do you think Nazli's experience is like when she seeks health care? How do you think the opinions of health care workers affect her experience?

People who use drugs (PWUD)

EXERCISE 3

PWUD Mind Map

When you hear the words 'drug user' or 'people who inject drugs', what is the first thing that comes to your mind? Using a blank piece of paper write down a brief description of what you think of as a typical drug user and consider the following questions:



Why do people use drugs?

A person may begin to use drugs because of the intense and very appealing feelings they produce. These feelings, such as well-being, elation, happiness, ecstasy, excitement, and joy, can help some individuals within key populations to overcome the negative circumstances they experience regularly. For others, drug taking may form a significant part of their social lives and therefore they feel encouraged to do so by their peers and in order to sustain their social interactions.

Drug use may also not be a choice for some key populations. Partners of drug users, for example, may be pressured into using drugs to sustain their relationship. Similarly, sex workers may be pressured into using drugs by their managers in order to secure their business or by their clients. People

who use drugs may continue to do so because they develop drug dependency and experience both a physical and/or psychological need for the drug. Drug dependency will be further discussed in Module 6.

People who use drugs may also decide to inject drugs because injecting provides the quickest route to the brain which provides the individual with a stronger sensation than through using other methods. PWID may also choose to inject drugs to avoid the physical side effects that result from other methods of drug use such as nausea, damage to the inner lining of the nose, throat, and lungs. Most people who use drugs do not start by injecting them. This behaviour usually happens as a person's dependence on the drug increases.

Over time, the repeated use of a drug will cause its initial effects to decrease. Eventually, they will need to increase the dose to get the same high, which will also increase the amount of money required to purchase the drug. For some users, this may not be possible because of the cost; therefore, they may turn to injecting their drugs instead.

What is injecting drug use?

Injecting drug use involves the direct injection of a drug into the body as opposed to other forms of use, such as inhalation or swallowing. It is most common for drugs to be injected directly into the blood stream but they may also be injected into the muscle (intramuscular injection) or under the skin (subcutaneous injection). Many types of drugs may be injected including heroin, crack cocaine, and meth.

Different ways that drugs are taken:

- Orally / Ingested – This means they are put into the mouth and swallowed, for instance a pill or tablet.
- Smoked – This means the drug is burned and then the smoke that is produced is inhaled in by the user, for instance through a pipe, bong, cigar or cigarette.
- Insufflated – This means the drug is snorted up a person's nose.
- Vaporised – This means a drug is heated up until it turns into a vapour, then the vapour is breathed in.
- Sub-lingually – This means the drug is absorbed through the vein under a person's tongue.
- Bucally – This means the drug is absorbed through a person's cheek.
- Intravenous – Also called IV - this means a drug is injected into a person's veins using a needle.
- Intramuscular – Also called IM - the drug is injected into a person's muscle using a needle.

- Rectally – This means the drug is put into someone’s anus and absorbed there – usually via something called a suppository.
- A few drugs, such as LSD, can be absorbed through a person’s skin.

SUBSTANCES IN SOUTH AFRICA

	Drug/Substance	Type	Street names	Method of use	
ILLEGAL	Cannabis	Downer, Relaxant, Depressant	Marajuana, Dagga, Weed, Zol, Ganja, Spliff	Smoke, eat	
	Heroin	Opiate, Downer, Relaxant, Depressant	Gear, smack, H, horse, brown	Inject, smoke	
	Cannabis / heroin / other substances mixture	Downer, Relaxant	Nyaope, Whoonga	Usually smoked	
	Methaqualone (Mandrax)	Downer, Barbituate	Buttons, white pipe	Smoke, ingest, inject	
	Cocaine / Crack cocaine	Upper / Stimulant / Amphetamine	Coke, Charlie	Snort, inject	
	Ecstasy / MDMA		e, Pills	Tablet (ingest), snort, inject	
	Methamphetamine		Crystal meth, crystal, Tik, ice	Ingest, inject, smoke, snort	
	Methcathinone		Cat, khat	Smoke, ingest, snort	
	LSD	Psychotropic / Hallucinogen	Acid	Ingest	
	Mushrooms		Magic mushrooms, shrooms	Ingest	
	Ketamine		K, special K	Snort, ingest	
	LEGAL	Caffeine	Upper / Stimulant		Coffee, tea, energy drinks
		Nicotene	Relaxant		Cigarettes, nicotine patches/pens
Alcohol		Downer, relaxant	Booze, drink, dop, liqour		

Stimulants / Uppers

Stimulants speed up the central nervous system. People using stimulants may feel happy and excited, and have more energy, concentration or motivation. Stimulants make it difficult to sleep.

Depressants/Downers

Depressants are drugs which slow down the central nervous system. People using depressants may feel happy and content, as well as sleepy and relaxed. Depressants often slow down bodily functions such as breathing and heart rate, and may make it hard to speak (slurred speech) or move properly in large enough doses, in which case they may be harmful.

Hallucinogens

Hallucinogens change the way people see, hear, feel or think. There are three main groups of hallucinogens: psychedelics, dissociatives and deliriants. Each group has different effects. They may cause hallucinations, when a person imagines something that is not really there.

How do PWID inject drugs?

For a drug to be injected, it must first be in liquid form. Many drugs, however, including cocaine and heroin, may come in a crystal, solid or powder form. A PWID will typically dissolve the drug in water in some sort of container. This container, sometimes referred to as a cooker, could be a spoon, the bottom of a soda can or another object. Some drugs may require heat to be dissolved.

Once the drug has been turned into a liquid, it is then collected using a syringe and needle. Typically, a filter from a cigarette will be used to filter the drug as it is collected in the syringe. Once the drug has been collected in the syringe it is ready for injection. The veiny area on the inside of the elbow is a common place for PWID to inject drugs, although many other less noticeable spots may also be used (e.g. the inner thigh or between the toes).

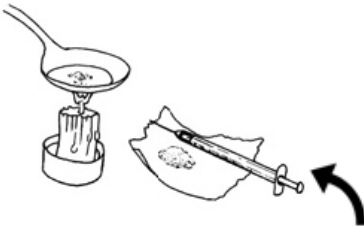
A tourniquet, belt or other strap may be used to restrict blood flow and encourage the blood veins to stick out so they are easier to prick with the needle. As with any regular intravenous injections, after a few uses the same vein grows hard and may collapse, which means that the user is often in search of new veins. For long-term injectors the dependence becomes so intense that they would inject almost anywhere in the body, as long as a hit is assured.

Together, the cooker, needle, syringe, heat source and tourniquet form the gear or paraphernalia that is normally needed to inject drugs (see image 2 on the next page). Someone who frequently injects drugs may have evidence of needle punctures, which may be referred to as track marks. When veins are no longer available for injecting, people may switch to smoking instead.

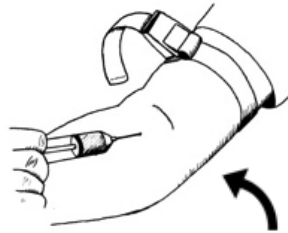
COMMON INJECTION DRUGS⁽⁴⁾

- Heroin
- Heroin in combination with other drugs (i.e. cocaine)
- Amphetamine type stimulants including methamphetamine, liquid ecstasy
- Prescription drugs (including pethidine, Wellconal, steroids)

Typical drug using equipment



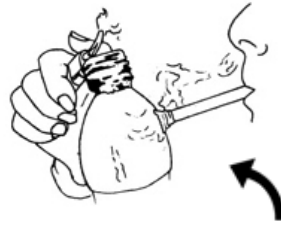
A cooker (spoon held over a flame) is used to melt powder into liquid so it can be injected



Tourniquets are used to make the vein pop out, often a belt is used



Pipes are made using light bulbs or bottles to smoke drugs



What types of people inject drugs?

People who inject drugs exist all over the world, including South Africa. Often, PWID are hidden and do not readily practise their drug-using habits in public but research has shown that PWID exist in all major cities in South Africa. They have been identified in all racial groups and in many age groups, as well as in different social and economic groups. In South Africa, PWID have varying education levels, ranging from no formal education to tertiary level education. Both men and women may be PWID.

While PWID are diverse, South African studies have shown that injecting drug use is highest amongst secondary students, sex workers and prisoners. Overall, it is thought that there are between 10 000 and 50 000 PWID in South

Africa⁽⁵⁾. Although this may seem like a small part of the general population, experience in other African countries has shown that any size population of PWID can grow rapidly. That potential for rapid growth is attributed to the highly addictive nature of injecting drug use.

WOMEN AND INJECTING – RISKS AND VULNERABILITIES

Studies from around the world show that the average HIV prevalence among women who inject is 50% higher than among men who inject. Many women begin injecting drugs in the context of sexual relationships, and they often borrow or share injecting equipment from their male partners. Gender inequality in many developing and transitional countries is also reflected in social patterns that can affect injecting practices. For example, women:

- Are more likely to be injected by their male partners – being injected by another person or being helped to inject is a predictor of HIV infection
- Are more likely to be the last person to use shared injecting equipment
- Who inject drugs are often dependent on their sexual partners to obtain drugs, which compromises their ability to negotiate safer sex or safe injecting practices.
- Who inject drugs have lower access to services than men who inject drugs.

Source: HIV and drug use: Community responses to injecting drug use and HIV – Good Practice Guide. International HIV/AIDS Alliance. 2010

NYAOPE AND WHOONGA

In recent years there has been a lot of media attention on nyaope and whoonga, and various other localised versions. These drugs are said to be a mixture of ARVs or TB medication, combined with rat poison, heroin, cannabis, soap powder and various other chemicals.

EXERCISE 4

Case Study: PWUD

Simphiwe is a 37-year-old man who lives in Kimberley. Simphiwe has a university degree and is a qualified accountant. He has a good job working as an accountant in one of the mines just outside Kimberley. Since Simphiwe started the job at the mine, he has joined his colleagues every Friday night after work to go drinking at one of the local bars. Often after several drinks he has ended up at a nightclub in the centre of town with one of the barmaids, who also worked as an exotic dancer at the club. Simphiwe was first introduced to cocaine at the nightclub. He liked the feeling that cocaine gave him and because it was expensive to buy, taking cocaine gave him prestige amongst the ladies at the club. After taking cocaine regularly for about six months, Simphiwe was offered some heroin. He had heard that heroin was the next step up from cocaine, so he thought he'd try some. Simphiwe really liked the ecstatic feeling that heroin gave him, and he started injecting heroin regularly when he went to the nightclub. He sometimes wakes up after a night out in an apartment he doesn't recognise, not remembering anything from the night before. Simphiwe has managed to limit his heroin use to weekends, and has kept his job at the mine.

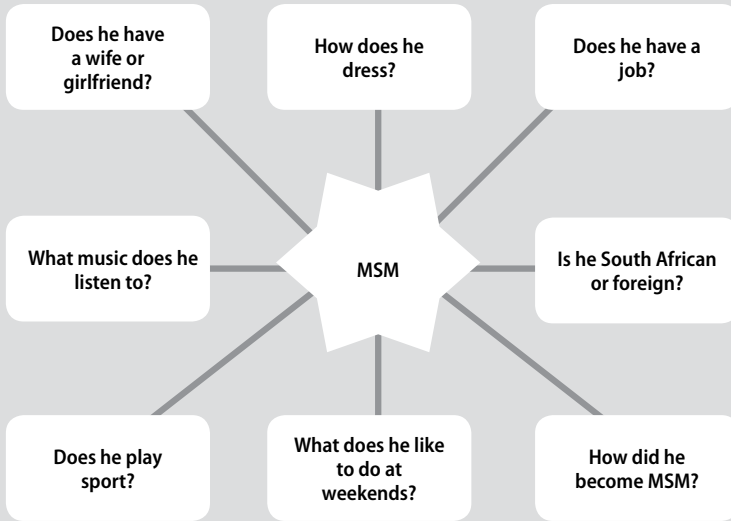
- 1. How did your description from the mind-map exercise compare to Simphiwe? Was it similar or different?**
- 2. Do you think other health care workers' descriptions would be similar or different from yours?**
- 3. Consider the reasons that Simphiwe started to use drugs and specifically why he started injecting. What do you think are the most significant influences on his drug use? How could these influences have been avoided?**
- 4. Can you identify any activities that Simphiwe engages in that could affect his overall health or put him at risk for exposure to HIV? If so, what are they?**
- 5. What do you think Simphiwe's experiences would be like when he seeks health care? How do you think the attitudes of health care workers affect his experience?**

Men who have sex with men (MSM)

EXERCISE 5

MSM Mind Map

When you hear the term 'men who have sex with men', what is the first thing that comes to your mind? Using a blank piece of paper write down a brief description of what you think of as a typical MSM and consider the following questions:



Who are MSM?

Men who have sex with men (MSM) is a term used to describe males who have sex with other males, regardless of whether or not they have sex with women or identify as gay or bisexual. This means that MSM includes men who only have sex with other men as well as includes men who have sex with both men and women. There are men from every race, culture, religion, community, and profession, that can be described as MSM. These men may identify themselves as gay, bisexual, or homosexual, but others may describe themselves as heterosexual, or straight. Sex between men may include any number of sexual activities such as anal sex, oral sex, masturbation or any combination of these practices. The concepts of sexual orientation and behaviour will be discussed in more detail in Module 3.

It is a misconception that all MSM identify as or want to become female. Some people are born male and have sex with other men but identify as female and feel as though they were born into the wrong body type. Instead of being identified as a MSM, these individuals would be considered transgender. Transgender individuals including transmen and transwomen will be further discussed in Module 3.

TRANSGENDER INDIVIDUALS

A transgender person has a gender identity that is different from his or her sex assigned at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). Transgender persons may also prefer not to conform to any gender binary and to instead use gender neutral references⁽¹⁾.

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

Sex between men also occurs in situations where men are unable to have sex with women for periods of time, such as in prisons, mining hostels, in the armed forces or at single-sex boarding schools. Men who have sex with other men due to their circumstances are called situational MSM. Same-sex sexual experimentation before marriage or in adolescence is also common⁽⁶⁾. In some areas, male-to-male sex is a necessary component of certain traditional practices or rituals⁽⁷⁾.

What is 'Coming out'?

Coming out is a term that refers to the process in which an individual becomes increasingly aware of his or her non-heterosexual sexual orientation, and coming out of 'hiding' by disclosing this to others. The process of coming out is different for every individual; some are comfortable with their experiences, while others experience a crisis period. The process can commence at any age, but most often happens during adolescence, which is already a challenging period of physical, emotional and social change. The coming-out process typically involves a period of confusion and ends in the

formation of a sexual identity that the individual feels comfortable with, and finally with the disclosure of the sexual orientation to others⁽⁸⁾.

Why is coming out important for health care workers to take into consideration?

Not all MSM choose to come out publicly, in fact, many remain 'in the closet', or choose to publicly hide their same-sex sexuality or behaviour. All MSM have the right to choose how, when, and if they publicly acknowledge their sexuality and/or behaviour. When an individual's status as an MSM is disclosed without their permission, this is referred to as being 'outed'.

Outing a client, whether intentional or accidental, should be avoided. Should a client choose to disclose their status as an MSM with a health care worker does not mean that they have 'come out' to everyone in their lives or in the health care facility. Therefore, a health care worker should keep any MSM-behaviour discussed with the client in the strictest of confidence (unless necessary for the provision of services). Coming out, or the lack thereof, can make identifying MSM clients challenging. Managing and working with key populations clients will be further discussed in Module 10.

Why is it important to consider the needs of MSM, sex workers, and PWUD?

MSM, sex workers, and PWUD are not segregated from the rest of their communities. They are active members of society and regularly interact with the general population. For example, an MSM may also have female sexual partners, a sex worker regularly interacts with male and female clients from the general population, and PWUD may also have sexual or romantic partners who do not belong to key populations. If the needs of key populations are not addressed in the response to HIV then it will continue to thrive in this community and therefore also continue to affect the broader population. Therefore, it is impossible to fully address HIV in any community without also taking into consideration the needs of key populations. Most importantly however, key populations, regardless of their behaviour or legal standing, are entitled to health care rights as granted to all people, by the South African Constitution.

EXERCISE 6

Case Study: MSM Stereotype

Marlon works as a football coach at a sports club in Ficksburg. Marlon always wanted to be a professional football player but injured his leg in a car accident when he was 16. Football is his life and passion, so he was lucky to get a job coaching a local team, even though the pay is poor. He volunteers at weekends to coach a men's team at the local football club. When Marlon is not coaching football he likes to relax with his friends and cousins, drinking beer, braaing meat and listening to music. Despite his injury, Marlon keeps himself fit by going to gym, he is well-built and is very proud of his six-pack. Women find Marlon very attractive and many of the girls who hang around the sports club flirt with him. Marlon is very friendly towards them, however he is not interested in them sexually as he prefers men. Marlon doesn't really identify with the gay-scene, but when his team travel to play a tournament in Bloemfontein he decides to go to a gay-club to see if he can meet some likeminded people. The bouncer at the club though won't let Marlon in, telling him that this is a gay club and straight guys aren't allowed to come in. Marlon tries to argue with the bouncer, saying 'how do you know I'm not gay?', but the bouncer won't budge and says Marlon doesn't look gay, he just wants to go into the club to cause trouble. Marlon gives up and goes back to the hotel.

- 1. How did your description in the mind-map exercise compare to Marlon?**
- 2. Do you think other health care workers' descriptions would be similar or different from yours?**
- 3. What do you think Marlon's experience is like when he seeks health care? Do you think health care workers have the same reaction to Marlon as the bounce in this case study?**
- 4. How do you think health care workers' perception of Marlon's sexuality affects the type of health care he receives?**

EXERCISE 7

Case Study: Male Sex Worker

Sizwe is a 19-year-old man who moved to Cape Town from his family home in the Eastern Cape two years ago. He dropped out of school because his family were struggling to pay the fees, so he came to the city to find work. Sizwe spent three months sleeping on the streets when he arrived, as he didn't know anyone in the city. One night when he was standing at the traffic lights, begging passing motorists for money to buy food, a fancy car stopped and the driver called him over. The man in the car was well-dressed and looked like a businessman. He asked Sizwe if he would be interested in doing some work for the man, to which Sizwe excitedly said he would. Sizwe got into the man's car and was taken to an apartment nearby. The man explained to Sizwe that he had some wealthy male and female clients who were interested in meeting attractive local young men, and Sizwe would be paid well to spend the evening with one of these clients. The man told Sizwe that the client would probably want to have sex with Sizwe. At first Sizwe was shocked and was about to walk out, but then when he heard how much he would be paid, he decided to stay and try it out. That night Sizwe had his first client. Having never had anal sex before, he found the anal sex very painful at first, but the man was gentle with him, and at the end of the night Sizwe had more money than he had ever earned in a whole month. After a while Sizwe began to enjoy his work, and enjoyed the lifestyle that he could now afford.

- 1. Do male sex workers face different health risks from female sex workers?**
- 2. What social challenges do you think male sex workers face that are different to female sex workers?**
- 3. What factors do you think led Sizwe into sex work?**
- 4. How does Sizwe compare to your descriptions in the mind map exercise for an MSM and SW?**

EXERCISE 8

Case Study: Cross Cutting

Tambo is a 37 year old man from Polokwane. Tambo came from a loving and supporting family, and was well educated, passing his matric with good marks. After school Tambo went to work for his uncle's transport business. Tambo had a few girlfriends when he was at school, but by the age of 19 realized that he was more interested in men than in women. He thought his family would disapprove though so he kept his sexuality hidden from them. When Tambo was 22 both his parents were killed in a car accident. Tambo was fortunate to be taken in by his uncle and aunt. Tambo enjoyed working for his uncle, and business was doing well. Tambo started travelling to Maputo to meet with his uncle's clients in the shipping trade. When in Maputo he started going out to listen to live music in some of the bars. He met a cute musician one night, a guy called Mario, and the two of them hooked up one night. Every time Tambo came to Maputo he would stay with Mario and accompany him to all the gigs he played. Usually after the shows, all the musicians would get together to smoke dagga and drink brandy. One night Mario took Tambo aside and offered him some heroin. Tambo was a bit nervous, but Mario assured him it would be fine and he would look after him. Mario helped Tambo to inject the heroin between his toes, saying it was better there as no one would see the needle marks. Tambo really enjoyed the heroin and that night they had the best sex they'd ever had. Tambo started doing heroin regularly, and used to buy some in Maputo to take back to Polokwane with him. He would get very nervous at the border but was always lucky. When Tambo ran out, he would get very grumpy, and his uncle and aunt started to get worried about him as he wasn't his usual happy self. When they approached him about it he became very defensive. Tambo's work performance started suffering and after three months his uncle said that he'd have to sort himself out or he would be forced to fire him. Tambo became very angry, and ended up punching his uncle before storming out and jumping in his car to drive to Maputo. In Maputo he moved in with Mario, and for two months they lived off Tambo's savings and started taking heroin daily. When Tambo's money ran out things started to get difficult. The two of them would fight when they were getting withdrawal symptoms. Mario suggested Tambo start selling sex to support them, as he was so good looking. Tambo was reluctant at first but realised that he had no other way of supporting his heroin habit. Their drug dealer said he would act as Tambo's pimp, and find the clients for him, and in return he would supply the heroin.

1. What factors lead Tambo to start injecting drugs? (individual and environmental)
2. What factors lead Tambo to start selling sex? (individual and environmental)
3. How does Tambo compare to your descriptions from the mind map exercises?

SUMMARY AND KEY FACTS

- Key populations are defined as groups of individuals who are more likely to be exposed to or to transmit HIV and/or TB and whose risk is influenced by prejudice and an inadequate protection of Human rights. They also experience added social and structural factors that contribute to their greater risk for HIV/STIs.
- Estimated HIV prevalence amongst key populations:
 - MSM: 30%
 - Sex Workers: 60%
 - PWUD: 12%
- Sex work is a regular income-generating practice for many South Africans and takes place in every village, every town, and in every city across the country. Individuals engage in sex work for many different reasons; however, economic need is a major motivation. Sex work is illegal in South Africa. However, South Africa is currently in a state of law reform, in which many of the apartheid-era laws that make sex work illegal are being reviewed.
- Drug use may also not be a choice for some key populations. Partners of drug users, for example, may be pressured into using drugs to sustain their relationship. Similarly, sex workers may be pressured into using drugs by their managers in order to secure their business or by their clients. People who use drugs may continue to do so because they develop drug dependency and experience both physical and/or psychological need for the drug.
- Injecting drug use involves the direct injection of a drug into the body as opposed to other forms of use, such as inhalation or swallowing. While PWID are diverse, South African studies have shown that injecting drug use is highest amongst secondary students, sex workers

and prisoners. Overall, it is thought that there are between 10 000 and 67 000 PWID in South Africa⁽⁵⁾.

- Men who have sex with men (MSM) is a term used to describe males who have sex with other males, regardless of whether or not they have sex with women or identify as gay or bisexual. These men may identify themselves as gay, bisexual, or homosexual, but others may describe themselves as heterosexual, or straight.
 - 'Coming out' is a term that refers to the process in which an individual becomes increasingly aware of his or her non-heterosexual sexual orientation, and coming out of 'hiding' by disclosing this to others. Not all MSM choose to come out publicly, in fact, many remain 'in the closet', or choose to publicly hide their same-sex sexuality or behaviour.
 - If the needs of key populations are not addressed in the national response to HIV then it will continue to thrive in these communities and will therefore also continue to affect the broader population. Most importantly however, key populations, regardless of their behaviour or legal standing, are entitled to health care rights as granted to all people, by the South African Constitution.
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MODULE

2

STIGMA, PREJUDICE, AND DISCRIMINATION

Learning Outcomes:

After completion of this module, you should be able to:

- i Define stigma, discrimination, prejudice, and stereotypes
- ii Describe the ways in which stigma develops as well as the define the common signs of stigma
- iii Explain the reasons why MSM, sex workers, and PWUD are stigmatised
- iv Define double stigma and describe how this applies to key populations
- v Describe how stigma affects MSM, sex workers, and PWUDs' access to health care services

Introduction

What is STIGMA?

Stigma refers to the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait. For example, in the past stigma has developed towards individuals with mental illness or diseases such as HIV. Stigma can be experienced both internally and externally. External stigma is experienced when it results from the actions of others. Internal stigma is experienced inwardly by an individual who is being stigmatised. It can result in low self-esteem, shame, and low moral worth when the person begins to believe and relate to the the stigma they are experiencing⁽¹⁾.

What is DISCRIMINATION?

Stigmas often lead to discrimination, which occurs when a person or group of individuals are treated unjustly or unfairly because of a specific trait they possess. For example, Siphon and Lindiwe are both eligible for the same promotion but their boss is aware that Lindiwe is thinking of getting pregnant, so he gives the promotion to Siphon instead. In this circumstance, Lindiwe is being discriminated against because she is a woman and capable of getting pregnant.

What is PREJUDICE?

A prejudice is a preconceived idea or opinion towards a person or group because of a personal trait or characteristic. Prejudices are usually negative and generally connected to significant characteristics, such a sex, age, ethnicity, or religious background.

What are STEREOTYPES?

Stereotypes are fixed ideas or thoughts about a type of person or thing. Stereotypes are usually negative, not necessarily accurate, and generally create an oversimplified view of a diverse person or thing. For example, most people are aware of the stereotype that exists of individuals with blonde hair not being as intelligent as individuals with brunette hair. It is common knowledge that hair colour has not impact on an individual's intelligence level and yet it still persists.

How does stigma develop?

Stigma develops because of many factors, but is often influenced by the values and beliefs of an individual or group. A person can become stigmatised

when they are considered to be different from other people and when that difference is considered to be negative or undesirable. Often, a person's or community's values and beliefs determine what they believe to be negative or undesirable. Religion and culture can also affect the values and beliefs of communities and individuals. Therefore, stigma can be developed from values and beliefs, as well as from religious and cultural practices.

DEFINING VALUES, ATTITUDES, AND BELIEFS

Values – an individual's, a family's, or a society's principles or standards of behaviour.

Attitudes – the way of thinking or feeling about someone or something typically reflected in a person's behaviour.

Beliefs – the trust, faith, or confidence a person places in someone or something.

EXERCISE 1

Identifying values, attitudes, and beliefs

Learning to address both personal stigma and the stigma that may occur in your health facility is a process that begins with identifying what may cause stigma to develop. For many people, strongly held values and beliefs may lead to the development of stigma. Therefore, the first step to understanding and identifying stigma is to better identify your own values and beliefs. Take a moment to reflect on the following questions:

1. How would you describe your most important values?
2. What are the five most important beliefs that you have? List them below.
3. Can you identify for each of these values and beliefs, when you developed them, and why?

What are the signs of stigma?

External stigma

In certain situations, stigma may be very clear, but in other circumstances it may be more difficult to identify. In some cases, individuals may even be unaware that they are stigmatising someone or that they are being stigmatised by others. Therefore, it is important to understand the signs of both external and internal stigma so that proper actions can be taken to address it. Most of the signs of external stigma are centred around the way people interact with one another. These may include the following:

- **Avoidance.** Avoidance occurs when individuals spend less time with or do not want to be around stigmatised people. This might include a person who begins to avoid a close friend because he or she is stigmatised.
- **Rejection.** Rejection occurs when individuals are no longer willing to associate or welcome stigmatised people in their lives. This might include a family member rejecting a stigmatised relative and no longer allowing that person to live with them.
- **Moral judgement.** Moral judgement happens when individuals begin to see a stigmatised person as immoral or when they use their values to justify stigmatising someone. This might occur when an individual becomes stigmatised because he or she does something that conflicts with the religious beliefs of others.
- **Stigma by association.** Stigma by association occurs when those who associate with a stigmatised person are also stigmatised themselves. This may occur to someone who remains a close friend with a stigmatised person.
- **Gossip.** Gossip happens with individuals begin to speak negatively about other people who are stigmatised. Gossip could occur within a social circle when one of the members becomes stigmatised.
- **Unwillingness to employ.** Someone may be exhibiting external stigma when he or she is unwilling to hire an individual who would otherwise be qualified for the job, only because of certain characteristics that may be stigmatised.
- **Abuse.** When a person physical, emotionally or verbally abuses someone, they may be doing so because of stigma they may have toward that person.
- **Victimisation.** Victimisation occurs when someone is blamed for problems that are unrelated to them and singled out for cruel or unjust treatment. People who are stigmatised may often be victimised.

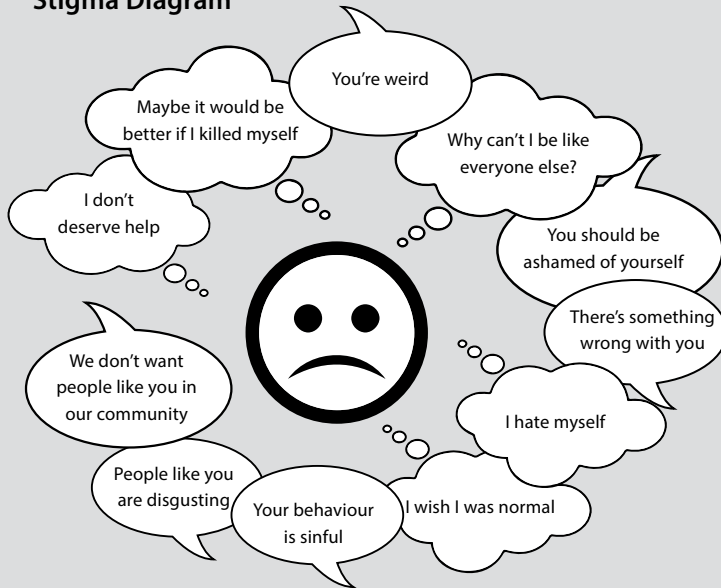
Internal stigma

Unlike external stigma, the signs of internal stigma may be much harder to identify because many of them occur within the individual and are focused on the way they feel about themselves. Some signs of internal stigma include the following:

- **Self-exclusion from services** (including health services) or opportunities. Self-exclusion may occur when a stigmatised individual avoids opportunities due to fear of being further stigmatised, or the individual feels unworthy of those opportunities.
- **Perceptions of self.** A person who is experiencing internal stigma may have low self-esteem, sense of self-worth or other self-confidence issues, including low self-efficacy or a low perception of their ability to conduct a specific task, like accessing health care.
- **Social withdrawal.** Often a person who is experiencing internal stigma may disengage from their social networks.
- **Overcompensation.** Overcompensation may occur when a person who is feeling internal stigma feels the need to overly contribute to a situation to make up for their perceived stigmatisation. This could happen when a stigmatised individual is overly grateful when someone is kind to them.
- **Mental health issues.** Internal stigma may cause a person to become depressed or develop mental health issues. For example, a stigmatised person may develop generalised anxiety disorder because of continual stress and anxiety from his or her perceived stigma.
- **Substance abuse.** Substance abuse may be the result of internal stigma because a stigmatised person may turn to drugs or alcohol in order to cope with his or her stigma.
- **Suicide, or attempted suicide.** Sadly, some individuals may not be able to cope with their internal stigma and may turn to suicide in order to escape the pain of their stigma. In some circumstances, sex workers may resort to trying to kill themselves to escape the pain of stigma.

EXERCISE 2

Stigma Diagram



1. Identify which bubbles represent Internal Stigma
2. Identify which bubbles represent External Stigma
3. Discuss how Internal Stigma and External Stigma are inter-related
4. Think how this relates specifically to:
 - MSM
 - Sex workers
 - People who use drugs

EXERCISE 3

Stigma Self-Reflection

Think back to a time in the past when you were in any way treated differently by other people. For example, it may have been a time when you moved into a new area and attended a new school, and the learners there teased you for being new to the area. It could have been when you were taken care of by a distant family relative who was not your mother or father, and the relative treated you with less love and affection than his or her own children.

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

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

Why are MSM, sex workers, and PWUD stigmatised?

MSM, sex workers, and PWUD experience stigma because of a number of characteristics, rather than any one particular attribute. These layers of stigma create an additive burden on their lives and well-being. This burden is often greater than any of the individual stigmas alone. Addressing these multiple layers of stigma can be challenging, given their interconnectedness. This is often referred to as double or over-lapping stigma when an individual or group experiences stigma because of multiple characteristics. Below are some of the reasons that key populations may be stigmatised:

Deviancy and legal status

The first reason that MSM, sex workers, and PWUD are stigmatised is because they engage in behaviours that may be considered deviant or illegal in South Africa; specifically, using drugs, selling sex, or having sex with other men. Actions, behaviours or characteristics tend to be more heavily stigmatised when they are perceived to be immoral or heavily connected to strongly held values⁽²⁾.

In addition, because drug use and sex work is illegal in South Africa, PWUD and sex workers may immediately be perceived as wrongdoers, criminals and deviants. It may be extremely difficult to move away from this perception if it is the first impression individuals make when engaging with a PWUD and sex workers. Perceiving key populations to be deviant and criminal further distances people from the harsh realities that many key populations experience. Module 4 will discuss the legal context in South Africa in more detail.

EXERCISE 4

Exploring Norms

Make a list of all the substances that you know are used in your community. Rank the substances in order of which ones are most socially acceptable (with the most acceptable at the top and the least acceptable at the bottom). Considering this list, why do you think some substances are more acceptable or less acceptable than others? How is injecting drug use viewed in your community?

Stigma towards homosexuality and transgender individuals

Many communities discriminate against same-sex sexual behaviour, and many individuals may have a very strong aversion to homosexuals; this is known as homophobia. MSM, including male sex workers who engage in sex with male clients, may therefore experience homophobia and stigma because of their sexual behaviour. For more information on sexuality, please refer to Module 3.

TRANSPHOBIA

Transphobia is fear, rejection, or aversion, often in the form of stigmatising attitudes or discriminatory behaviour, towards transgender people.

HIV-POSITIVE SEX WORKERS

Disclosure of HIV status is becoming contentious as case law emerges and guidelines are developed. Health care workers are not sexual or moral police. Health workers should be familiar with case law and recommendations in their area, and should inform HIV-positive sex workers of this, providing correct and accurate information to help them make informed choices. Neither the sex worker nor the public health service can take away the reality of risk that clients take when buying sex.

(Source: UK Network of Sex Work Projects)

TRANSGENDER SEX WORKERS

Experiences of marginalisation can mean that transgender sex workers are reluctant to engage with health services. Health workers need to be aware of appropriate gender pronouns to use for transgender clients. Referring to a transwoman as 'he', for example, could be very hurtful to the individual as well as affecting her confidence in the service. It should be made clear to service users that they are accepted as whatever gender they present as.

(Source: UK Network of Sex Work Projects)

Associations with other stigmatised characteristics and stereotypes

Another way in which MSM, sex workers, and PWUD become stigmatised is by their association to other stigmatising characteristics. For example, sex has become linked with HIV since it is the most common way that the virus is spread. Since sex workers engage in frequent sex, they are then seen as carriers and spreaders of HIV. This is similar for MSM with high numbers of sexual partners. PWUD may be associated with homelessness, mental or physical illness, or being criminalised⁽³⁾. PWUD may have poor hygiene because they may not have access to facilities such as bathrooms, showers or running water, which may make individuals less likely to engage with PWUD and judge them for being unclean. Also, PWUD may be associated with people who commit crimes such as robbery or assault, which further adds to an image of violence and danger. All are these examples are of characteristics that tend to be stigmatised by society. MSM, sex workers, and PWUD may experience stigma because they are often connected to many of these stereotypes.

Independent choice of actions

Lastly, characteristics that are seen by others as negative tend to receive higher levels of stigma if they are the result of a personal choice than if they

are the result of circumstance. Thus, MSM, sex workers, and PWUD may be stigmatised because they are perceived by others as having made a poor personal decision to become drug users, sex workers, or MSM.

Take for example, Bongo and Hector, they are both HIV-positive young men from Port Elizabeth who regularly attend their local clinic to collect their antiretroviral drugs (ARVs). During a consultation with his nurse, Bongo explained that he acquired HIV through a blood transfusion when he was younger. The nurse responded by sympathising and apologising for his misfortune. When Hector explained to his nurse that he acquired HIV because he had unprotected sex with a girl he met one evening, she told him that people like him are to be blamed for HIV and that he should be ashamed of himself.

In the above scenario, Hector is experiencing greater stigma than Bongo even though they have the same diagnosis. This is explained because Hector's HIV status was perceived by the nurse to have resulted from his poor personal choice, whereas Bongo was unable to influence the situation that led him to be HIV-positive. Many key populations experience the same reaction that Hector received; they are stigmatised and seen as deserving of any consequences because it was their personal choice that led them to use drugs, or engage in sex work, or have sex with other men.

Sexual frequency or sexual taboo

Sex workers and some MSM may experience stigma or be discriminated against because they engage in frequent sexual activity. Many societies have conservative views or taboos about sexual behaviour. This means that they have very restrictive beliefs about how sex should and should not occur. Therefore, sex workers and some MSM may be considered immoral because they engage in sex outside of marriage or because they are promoting behaviours that a community considers taboo.

Stigma as women and migrants

Most sex workers are women, and women often experience unique stigma and discrimination in many places around the world. In certain cultures, both within and outside South Africa, women are not seen as being equal to men and are expected to willingly consent to the directions of a man. Additionally, many societal norms do not recognise women as sexual beings. Therefore, sex workers may experience being stigmatised for outwardly promoting their sexuality. Furthermore, some cultures perceive sex workers to be 'cheap' women that do not deserve dignity or who have given their right to dignity away when they became sex workers. When this stigma is applied to sex workers, it can often mean that they are exposed to physical violence or rape.

Migration and xenophobia

Some MSM, sex workers, and PWUD are migrants from other communities in South Africa or immigrants from other countries. In these situations, they may experience stigma because they are seen as foreigners who do not belong in the community. They may be excluded because of their foreign status and may be unable to find other forms of employment.

People living with HIV

A great deal of stigma exists towards people who live with HIV. In addition to the reasons above, those MSM, sex workers, or PWUD living with HIV are also affected by this particular stigma.

What effect do stigma and discrimination have on key populations?

Often, MSM, sex workers, and PWUD are perceived to be bad or immoral people. This stigma can often lead to a person being excluded from society, feeling devalued and shamed. It can result in extraordinary mental distress that can erode self-esteem and ultimately affect psychological and, potentially, physical health⁽⁴⁾. Stigma, prejudice, and discrimination specifically affect the ability of MSM, sex workers, and PWUD, to access health care and also reduce the impact of targeted HIV prevention programming. Understanding this negative impact is an important component to providing health-related services to key populations.

Access to care

Health care workers are meant to provide support, care and treatment to all people who are in need. However, discrimination against PWUD is widespread and it often leads to some health care workers refusing to provide proper medical care or access to social services. Relationships with health care workers are often negatively affected if they suspect or know that a client or patient is an injecting drug user⁽⁵⁾. It is this poor relationship with health care workers that may drive away many PWUD who are in need of health care support. Some health care workers may perceive this as a rare interaction with few ramifications; however, without adequate testing and treatment for HIV and other STIs, PWUD may have an impact on broader community health.

When sex workers do seek health care, external stigma can often make their experiences less than ideal. For example, nurses within community clinics who stigmatise sex workers may use insulting language toward them or blame them for whatever current medical condition they may have. Many reports have also indicated that many health care providers break the confidentiality of sex workers by exposing them as sex workers or even disclosing their HIV status to others within the clinic. Take for example the following testimonial from Lulu, a sex worker in Cape Town⁽⁶⁾:

I stopped going to the clinic. They [the nurses] looked down on me for what I do. The last time, the sister started shouting at me in front of others. She said: 'Why do you open your legs for so many? Because you are a prostitute? This is your fault, this is why you are sick now.'

Many sex workers may also not feel comfortable disclosing to health care workers that they engage in sex work because they are afraid of the negative stigma they may experience. In these cases, the health care workers are not provided full details of the patient's risk or behaviour, and are therefore unable to provide effective health care or treatment. Similarly reports from MSM have indicated prejudicial behaviour and stigma from health care workers:

Some of them don't treat us with respect. Sometimes, if you were having sex without a condom and maybe you get an STD, then you go to the clinic, the nurse will ask questions like: 'What was in here?' – she means in the anus. And that makes us afraid of going to the clinic to get treatment on time and that's why many gay men get sick⁽⁷⁾.

I once went to the clinic and there were two gay men at the clinic, apparently one of them had an STD, then a nurse said to them she expected that, she wasn't expecting them to have flu but an STD, because they sleep around and God is punishing them⁽⁷⁾.

Access to justice

Also, PWUD are likely to be discriminated against by the police, not just because of the illegality of injecting drug use but also because of they are seen as undeserving of the rights granted to all citizens. They may experience violence and sexual assault, as well as infringements on their right to justice. In a similar context to the health care setting, negative attitudes from police make addressing these violations nearly impossible, thereby leaving PWUD vulnerable to experiencing them again. Health care workers may be unable to address police stigma, but understanding the effects and influences it has on PWUD can assist in treating clients who use or inject drugs⁽⁷⁾.

Sex workers also experience stigma and discrimination when they attempt to report abuse or crime committed against them to police. For example, if a sex worker is raped by a client or otherwise physically assaulted, he or she may have difficulty in reporting this to the police. In many reports from South Africa, sex workers have detailed the lack of support they receive from police, often stating that upon reporting a rape, they are simply laughed at and told that 'that was what you were looking for'.

EXERCISE 5

Stigma Cause and Effect

Fold a blank piece of paper into three parts. Label one part 'Examples', another part 'Effects', and the last part 'Causes'. Think of every time you have witnessed or heard about a client from a key population being stigmatised in your health care environment and write this under 'Examples'. For each of these examples, think of the potential effect it had on the client and write this under 'Effect'. Conclude by identifying the potential cause or reasons for each of these examples of stigma and write this under 'Causes'. Once you have finished, compare your list to the table below.

Examples	Causes	Effects
Name calling	Lack of knowledge or understanding	Withdrawal
Labelling		Depression
Gossiping	Lack of information	Loneliness
Making assumptions about someone	Ignorance	Isolation
Judging and criticising	Religious beliefs	Sadness
Rejecting	Cultural beliefs	Anger
Excluding	Society's norms and expectations	Feelings of hopelessness
Denying services to an individual	Perceived difference	Low self-worth
Discriminating against someone	Fear	Substance abuse
Prejudice	Competition over resources (e.g. health care or jobs)	Self-destructive behaviour (e.g. not looking after health)
Physically attacking the individual		Lack of access to services such as health care
Chasing someone away		
Killing someone		

EXERCISE 6

Case Study: MSM and Stigma

Read the case study below and answer the questions that follow:

Senzo is a 27 year old man from Kokstad. After searching for a job for a year he finally got work on a building site. Senzo identifies himself as being gay, he is tall and slim and is quite effeminate. He found the manual labour on the building site very challenging but really tried his best to work hard as he wanted to keep the job. After having a few beers with his co-workers on the building site one Friday evening, one of the other construction workers James suggested that he and Senzo go back to his place for another drink. The two of them got quite drunk and started telling each other all about themselves. Senzo felt very comfortable and decided to tell James that he was gay. James reacted badly and started to get aggressive with Senzo, calling him a sissy boy and forced Senzo to perform oral sex on him. After James fell asleep Senzo sneaked out of the house. On Monday when Senzo arrived at the site for the afternoon shift, his co-workers were treating him differently, and he heard a few of them muttering 'stabane' under their breath as he passed. In the tea break one of his co-workers cornered Senzo in the toilets and forced Senzo to touch his penis, saying 'I heard you're a moffie whore, come on give me some'. The next few days things got worse and worse for Senzo at the site, he was constantly harassed and called names. On Friday after work Senzo decided to skip the usual after-work beer and go straight home. However, as he was leaving, four of his co-workers dragged him to the back of the site and after beating him up badly, they ran off laughing.

- 1. Identify each of the signs of stigma in Senzo's story using the list that you made in Exercise 4 on page 35.**
- 2. How do you think Senzo felt in this situation?**
- 3. How could Senzo respond to this situation? What options are available to him?**

EXERCISE 7

Case Study: Sex Work and Stigma

Read the case study below and answer the questions that follow:

Gloria is a 32-year-old sex worker from Bloemfontein. She lives with her boyfriend in a flat on the outskirts of the city. Gloria has not told her boyfriend that she sells sex, but told him instead that she has a job working in a factory doing night shifts the other side of town. One night Gloria gets beaten up quite badly by one of her clients who was drunk, and was demanding to have sex without a condom. The client ends up raping Gloria, without using a condom. Gloria is in pain and bleeding but she is too scared to go home and tell her boyfriend what happened, as she is scared he will throw her out of the house if he discovers she is a sex worker. Gloria tries to get a room in a nearby hotel, but the doorman of the hotel refuses to let her enter, telling her that they don't allow 'filthy whores' in the hotel. Gloria instead finds a place to sleep behind some empty crates and waits for the clinic to open. In the morning Gloria goes into the clinic to see a nurse. There is a long queue at the clinic and many people waiting to see the nurse. After waiting for a long time, Gloria is called in to see Sister Penny. Sister Penny arrived at work today to find that two of her co-worker nurses had called in sick, so Sister Penny has to see all the patients at the clinic on her own this morning. As a result, she is feeling stressed and tired by the time Gloria comes to see her, and is hungry as she hasn't had time for her tea break. Gloria begins to tell Sister Penny what happened to her, and Sister Penny starts shouting at her, telling her that she is just a 'dirty whore' and she deserves what she gets. Gloria runs out of the clinic crying, feeling lost and hopeless.

1. What types and forms of stigma are present in this case?
2. Can you identify the ways in which Gloria is affected by stigma?
3. How would you provide appropriate support for this client?

EXERCISE 8

Case Study: PWUD and Stigma

Read the case study below and answer the questions that follow:

Sarah works as a nurse at the government clinic in Mbekweni. One afternoon a new client came to see Sarah, complaining about bad stomach pains. The new client was a young woman in her early 20s. Her clothes were old and torn and she smelled unwashed. When the young woman sat down in Sarah's consulting room, Sarah moved her chair away from her and held her nose to avoid the smell. When the client rolled up the sleeve of her jersey so Sarah could take her blood pressure, Sarah noticed some marks on the inside of her arm that looked like needle wounds. When the young woman slowly started explaining her symptoms, Sarah became impatient and shouted at the young woman, telling her it was her own fault she was sick if she was doing these bad things like taking drugs. Sarah told the young woman there was nothing she could do to help her if she continued taking drugs as she was just killing herself. The young woman started crying and left the clinic without receiving any medication for her stomach problems.

- 1. What types and forms of stigma were being experienced by Sarah's client?**
- 2. What are the effects that stigma and discrimination had on Sarah's client?**
- 3. Do you think Sarah's actions were intentional? Why or why not?**
- 4. What do you think influenced Sarah's thoughts and actions towards her client?**
- 5. Brainstorm one to three ways you think that this situation could have been prevented.**

SUMMARY AND KEY FACTS

- Stigma refers to the strong negative feelings or significant disapproval that is linked to a specific person, group, or trait. Stigma develops because of many factors, but is often influenced by the values and beliefs of an individual or group.
- Stigmas often lead to discrimination, which occurs when a person or group of individuals are treated unjustly or unfairly because of a specific trait they possess. A prejudice is a preconceived idea or opinion towards a person or group because of a personal trait or characteristic.
- Stereotypes are fixed ideas or thoughts about a type of person or thing. Stereotypes are usually negative, not necessarily accurate, and generally create an oversimplified view of a diverse person or thing.
- MSM, sex workers, and PWUD experience stigma because of a number of characteristics, rather than any one particular attribute. For key populations, these layers of stigma create an additive burden on their lives and well-being.
- MSM, sex workers, PWUD may experience stigma or discrimination because:
 - they may engage in behaviours that may be considered deviant or illegal in South Africa; specifically, using drugs, selling sex, or having sex with other men.
 - many communities discriminate against same-sex sexual behaviour because of religious, social, and cultural beliefs.
 - they may engage in frequent sexual activity.
 - they may be women, and women often experience unique stigma and discrimination in many places around the world.
 - they may be foreigners in communities who think that they do not belong there.
- Often, MSM, sex workers, and PWUD are perceived to be bad or immoral people. This stigma can often lead to a person being excluded from society, feeling devalued and shamed. It can result in extraordinary mental distress that can erode self-esteem and ultimately affect psychological and, potentially, physical health⁽¹⁾.
- Stigma and discrimination can prevent many MSM, sex workers, and PWUD from accessing appropriate health care. Discrimination against PWUD often leads to some health care workers refusing to provide proper medical care or access to social services. Reports have also

MODULE

3

HUMAN SEXUALITY AND SEXUAL BEHAVIOUR

Learning Outcomes:

After completion of this module, you should be able to:

- i Describe the difference between sex, gender, sexual orientation, and sexual behaviour
- ii Describe the difference between transgender and intersex
- iii Define anal sex, describe who has anal sex, and explain why people engage in anal sex
- iv Explain why understanding human sexuality and sexual behaviour is important when working with key populations
- v List other common sexual practices that key populations engage in

Introduction

Why is it important to understand human sexuality and sexual behaviour?

Many of the main individual risk factors of MSM, sex workers, and PWUD are associated with sexual behaviour. Human behaviour, particularly sexual behaviour, is complex. Therefore, an introductory understanding of human sexuality will provide the necessary background required to further understand key populations and allow for improved service delivery. Additionally, exploring human sexuality often exposes individuals to the vast spectrum of human behaviour that naturally exists amongst our societies and, in so doing, offers a new lens through which to consider key populations and their place that society.

What is human sexuality?

According to the World Health Organisation (WHO) the working definition of sexuality is stated as: 'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.'

Human sexuality can be broadly broken down into five concepts: biological sex, gender identity, sexual orientaton, sexual identity, and sexual behaviour.

Sexuality

What is biological sex?

In this context, biological sex refers to the scientific concept that categorises individuals based on certain characteristics like their chromosomes, internal and external genitalia, and their hormonal profile. A person's sex is usually categorised as either 'male' or female'.

EXERCISE 1

Defining Male and Female

How would you define someone biologically as a male? On a piece of paper, make a list of the physical characteristics that a human being would need to have in order to be considered biologically male.

How would you define someone biologically as female? List the physical characteristics that a human being would need to have in order to be considered biologically female.

How do your characteristics compare with the following lists:

Biologically Male: has a penis, testicles, XY chromosomes, produces testosterone

Biologically Female: has a vagina, ovaries, XX chromosomes, produces estrogen

Can you think of any situations where an individual does not fit into either of these categories?

What is intersex?

Intersex people are born with chromosomes, external genitalia, and/or internal reproductive organs that do not fit clearly into either sex category of male or female. For example, instead of an XX or XY set of chromosomes, a person may be born with an XXY set. Or instead of a penis or vagina, a person may be born with ambiguous genitalia. Intersex is not uncommon in South Africa.

Historically, intersex individuals are surgically altered soon after birth to cosmetically appear more definitely male or female. These surgeries are often riddled with complications that can affect individuals for the remainder of their lives. Specifically, these 'corrective' surgeries remove any choice intersex individuals have in deciding their biological gender which can leave many mentally and emotionally traumatised.

Intersexuality challenges the notion that human sex is binary, either male or female. Intersexuality shows that biological human sex is actually a spectrum with male on end, a variety of intersexualities in the middle, and female on the other end.

What is gender?

A person's gender refers to attitudes, feelings, and behaviours that society associates with the biological sexes. A person's gender identity refers to how that individual feels about themselves as a man or a woman. It is common to confuse 'sex' and 'gender' but they do not refer to the same thing. Sex is a biological concept while gender is a social construct. A construct is an idea, philosophy, or belief that is developed by society in a specific context. In other words, it is an idea that is built or 'constructed' by society rather than nature.

Gender, therefore, describes a common set of traits and social expectations attached to a person's biological sex. People are born with their biological sex but they are taught their gender through their society and culture.

EXERCISE 2

What Makes a Man a Man, and a Woman a Woman?

1. How would you define someone socially as a man or masculine?
On a piece of paper, make a list of the characteristics that a person must have in order to be considered a man.
2. How would you define someone socially as a woman or feminine?
List the characteristics that a person must have in order to be considered a woman.
3. How do your characteristics compare with the following lists:
Masculine/Man: strong, muscular, aggressive, a leader, powerful, loud voice, bold, brave, hairy, potent, manly, honorable, courageous.
Feminine/Female: nurturing, caring, submissive, sexy, emotional, quiet, slim, soft-spoken.
4. Can you think of any situations where any men and women do not fit these characteristics?

Gender is not fixed and can change because society and culture are forever changing and redefining what it means to be masculine and feminine.

What is transgender?

Transgender is a broad term that refers to individuals whose gender, their self-identification as a man or woman, does not match their biological sex. Consider the example of a baby who is born with a vagina and is assumed to be a girl. Growing up, the person is raised to follow the gender roles associated with women, but feels uncomfortable with themselves as a woman and instead feels more comfortable as a man. He feels trapped in the wrong body. The human rights of transgender people and their right to freedom from discrimination, right to dignity and access to health care are enshrined in multiple local and international charters and these should be ensured.

What is transitioning?

Transitioning broadly refers to the act of changing genders to more clearly fit a person's gender identity. For example, the baby girl described above would mostly likely 'transition' to living life as a man. Transitioning can take many forms, for some transgender individuals it may include hormone treatments, surgery, or simply adjusting their clothing and role within their community. Transwoman is used to refer to an individual who was born male but is transitioning to female. Transman is used to refer to an individual who was born female but is transitioning to male. In South Africa, transgender individuals are legally able to adjust their identity documents to reflect their gender. The need for gender-congruent identification is necessary to empower people to realise their human and health rights, and few individuals attempting to ensure documentation accurately reflects their gender identity are able to do so.

What is sexual orientation?

Sexual orientation is part of identity and refers to the way in which a person feels attraction to other people of a specific sex or gender. Sexual orientation includes sexual attraction but also includes emotional, romantic, and intellectual attraction as well. Essentially, sexual orientation encompasses all of a person's intimate psychological and physical feelings towards others. There are three different sexual orientations, heterosexuality, homosexuality, and bisexuality.

Heterosexual – refers to an individual who has romantic, sexual, intellectual, and intimate feelings to others of the opposite sex.

Homosexual – refers to an individual who has romantic, sexual, intellectual, and intimate feelings towards others of the same sex.

Bisexual – refers to an individual who has romantic, sexual, intellectual, and intimate feelings towards others of the same sex or the opposite sex.

GAY AND LESBIAN

A gay man is someone who has romantic, sexual, intellectual and intimate feelings for or a love relationship with another man (or men) and identifies as gay.

A lesbian woman is a woman who has romantic, sexual, intellectual and intimate feelings for or a love relationship with another woman (or women) and identifies as lesbian.

For many years society thought that homosexuality should be fixed or cured because it was seen as an illness but this is no longer the case. In 1973, in the Diagnostic and Statistical Manual of Mental Disorders, homosexuality was taken out as a mental illness. It is still unclear what determines a person's sexual orientation but it is not a choice. The same factors that determine whether or not a person becomes heterosexual are also the factors that determine if a person will become homosexual or bisexual.

Gay men, lesbians, and bisexuals still experience stigma and prejudice, known as homophobia or homonegativity because their sexual orientation is homosexual.

What is sexual identity?

Sexual identity refers to the way in which an individual identifies themselves sexually. This may be linked to their sexual orientation, but also refers to the lifestyle and labels they associate themselves with. Examples of sexual identities are gay, lesbian, straight, bisexual and queer.

What is sexual behaviour?

Sexual behaviour is the way in which individuals experience their sexuality. All people, no matter their sexual orientation, use various body parts to experience sexual pleasure, on their own or with others. Sexual behaviour and roles are independent from but may be influenced by an individual's biological sex, sexual orientation, sexual identity, or gender. For example, a MSM who is married to a woman can have sex with another man but not identify as being a gay man. A straight man may enjoy being penetrated anally by a woman with a sex toy but this does not make him gay. A female sex worker may have sex with a female client, but not identify as lesbian.

EXERCISE 3

Describing Gays and Lesbians

What are the common stereotypes of a gay man?

What are the common stereotypes of a lesbian woman?

There are many stereotypes that assume if a man is gay he must be 'feminine' and engage in activities commonly associated with women. Likewise, there are many stereotypes of lesbian women that assume they are 'masculine' and engage in activities typically associated with men. In reality it is possible for a male who is very masculine to be homosexual and likewise it is possible for a female who is very feminine to be homosexual. Behaviour (masculine or feminine) does not determine a person's sexual orientation. There are males with feminine traits who are heterosexual identified, just as there are females who have masculine traits who are heterosexual identified. You will usually only know a person's sexual orientation if they disclose it to you.

EXERCISE 3

Binaries and Boxes

Below is a chart representing sex, gender, sexual orientation, and sexual behaviour - the main components to human sexuality.

1. Sex Male Female Intersex	2. Gender Masculine Feminine Transgender • Transsexual • Transvestite
3. Sexual Orientation Heterosexual Homosexual • Gay • Lesbian Bisexual	4. Sexual play Vagina Mouth Penis Hands Anus

Draw a line connecting the main characteristics associated with sexuality in our society across each of the boxes, for example:

<p>1. Sex</p> <p>Male Masculine</p> <p>Female ——— Feminine</p> <p>Intersex</p>	<p>2. Gender</p> <p>Masculine</p> <p>Feminine</p> <p>Transgender</p> <ul style="list-style-type: none"> • Transsexual • Transvestite
<p>3. Sexual Orientation</p> <p>Heterosexual Vagina</p> <p>Homosexual</p> <ul style="list-style-type: none"> • Gay • Lesbian <p>Bisexual</p>	<p>4. Sexual play</p> <p>Vagina</p> <p>Mouth</p> <p>Penis</p> <p>Hands</p> <p>Anus</p>

Now, using the chart below, draw similar lines for the following examples:

1. Biological male – married (to a woman) with children, with masculine gender presentation – identifies as heterosexual – is a practising MSM (has anal sex, giving or receiving, by visiting men only sex clubs, once a month)
2. Biological male – married (to a woman), with a bit of a feminine gender presentation – identifies as bisexual – has mostly vaginal sex, never had sex with a man (and choose not to) but has sexual fantasies with same sex, currently NOT a practising MSM
3. Biological male – divorced, masculine gender presentation – identifies as heterosexual – has anal sex with and receives oral sex from a man (he is in prison for the next 10 years)
4. Biological female – married (to a man) with a masculine gender presentation – identifies as heterosexual – and has vaginal sex
5. Biological female – with feminine gender presentation – identifies as a lesbian – has sexual fantasies with the opposite sex
6. Biological female – with a masculine gender presentation – prefer to be a FTM – identifies as bisexual – receives anal sex
7. Biological female – married (to a man) with feminine gender presentation – identifies as heterosexual – practises WSW (through threesomes with her husband present)

EXERCISE 3

Continued

1. SEX Male Female Intersex	2. GENDER Masculine Feminine Transgender • Transsexual • Transvestite
3. Sexual Orientation Heterosexual Homosexual • Gay • Lesbian Bisexual	4. Sexual play Vagina Mouth Penis Hands Anus

What does this chart demonstrate about human sexuality and behaviour?

Anal sex and other common sexual practices

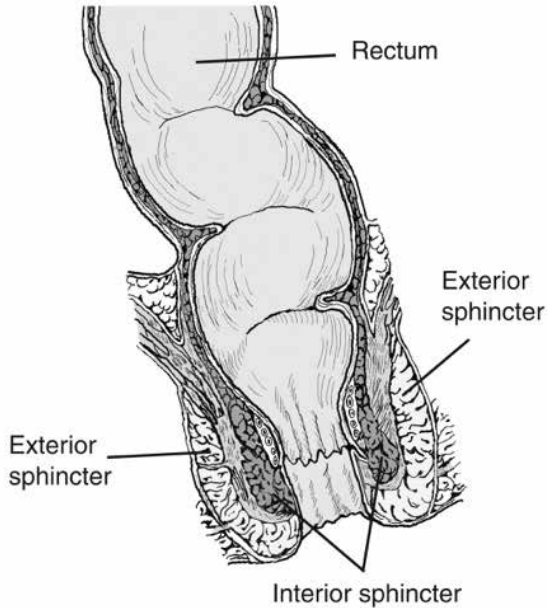
What is anal sex?

Anal sex is a sexual act that involves the penetration of the anus. When being penetrated, the internal and external sphincter muscles around the anus are stretched. To accommodate penetration, the rectum, about 20 cm long, is able to expand a great deal as well.

Who has anal sex?

Anal sex can be practised by any individual regardless of their sex or sexual orientation. Even though anal sex is typically associated with gay men, it is in fact also practised among heterosexual men and women and among lesbian women.

Anatomy of Rectum



HETEROSEXUAL ANAL SEX?

A study of almost 2 600 men and over 1 800 women sampled from townships in South Africa found that 360 (14%) men and 172 (10%) women reported practising anal sex in the three months before the study⁽¹⁾. A study in South Africa in 2003 of almost 12 000 men and women aged 15–24 years found that anal sex was practised by 4% of heterosexual men and women⁽²⁾.

ANAL SEX POSITIONING

When a person engages in anal sex they can engage in:

1. Insertive anal sex – when they penetrate their partner's anus. This is also called topping, being the active role, etc.
2. Receptive anal sex – when they are penetrated by their partner. This is also called bottoming, being the passive partner.
3. Versatile anal sex – when they change position positioning between insertive and receptive with their partner.

Why is it important to understand anal sex?

The inside of the anus and rectum is a very sensitive place, like the inside of the mouth. Because it can be easily hurt and damaged, it is highly susceptible to STIs and carries a high risk of HIV transmission.

Unfortunately, anal sex remains highly stigmatised, particularly as a heterosexual behaviour⁽³⁾. This leads to guilt and shame and results in a lack of knowledge among sexually active individuals about anal sex, its risks, and its benefits. For example, many individuals are unaware that there is a significant risk of HIV transmission when engaging in unprotected anal sex. Therefore, it is important to understand anal sex in order to more effectively work with clients engaging in anal sex.

Why do people have anal sex?

Men and women engage in anal sex for a variety of reasons. Below are just a few:

Pleasure

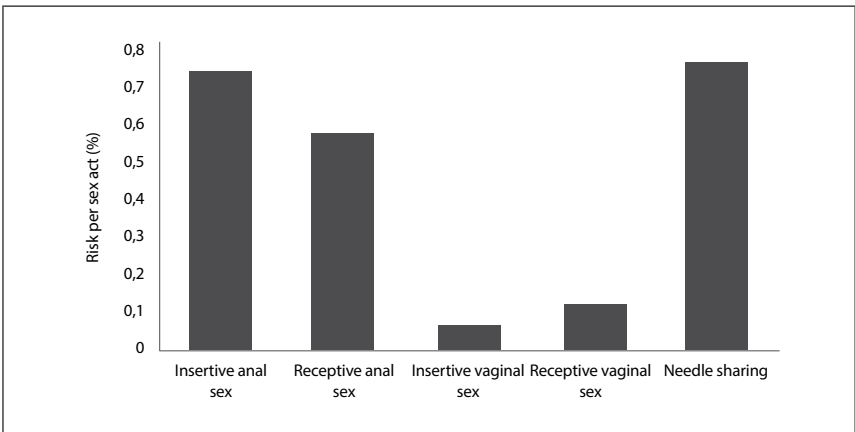
Anal sex can be pleasurable to both men and women because the ano-rectal region is highly sensitive. Some women also experience pleasure during anal sex because the legs of the clitoris extend into the musculature of the anal and perianal region and are stimulated during anal sex⁽⁷⁾. Men can receive pleasure during receptive anal sex through stimulation of the prostate gland. When pressure is applied to prostate it can produce orgasm or heighten orgasm and ejaculation⁽⁷⁾. Men engaging in insertive anal sex receive pleasure from the tight friction created by their partner's sphincter muscles when penetrating their anus. With that said, every individual is unique and some may find anal sex unpleasant, uncomfortable, or painful. Where 'dry sex', or sex with little or no vaginal or water-based lubricant, is practised, anal sex may be preferred because the anus is tighter and drier⁽³⁾.

- Much of ano-genital physiology is the same between male and female bodies. People with 'female' anatomy can experience pleasure during anal penetration, even though the source of their pleasure may be different than in someone with 'male' anatomy.
- Really, 'anyone with a bum' may experience anal pleasure, whether they identify as male, female, intersex, straight, gay, bi, or anything else.
- This expression, 'anyone with a bum,' does not suggest that everyone would enjoy anal stimulation. There is great range to human sexual response, and what some people find stimulating, others might find irritating or uncomfortable. To this point, some MSM / SW / PWUD may not enjoy anal sex themselves or some SW might have to offer it to their clients, and not enjoy it themselves.

COMPARING THE VAGINA TO THE ANUS

Anus	Vagina
<ul style="list-style-type: none"> • No natural lubrication in anus • Colon and rectum only a single layer of epithelial cells (one cell thick) • Tears easily with no lubrication • Anus has limited elasticity • Vagina has elasticity and stretches • Presence of faecal matter possible (containing bacteria) • Many inflammatory cells (CD4 receptors) under surface in rectum 	<ul style="list-style-type: none"> • Vagina produces natural lubrication when sexually aroused • Vagina has much thicker epithelial layer (approximately 40 cells thick) • Vagina does not tear as easily, and is more robust • No faecal matter present • Fewer CD4 receptor cells in vagina than rectum

Relative risk for transmission from a person living with HIV (Centers for Disease Control and Prevention, United States)



Virginity

Some women engage in anal sex with their male partners in order to preserve their virginity⁽³⁾. Some cultures practice traditional coming-of-age ritual of some 'virginity testing' is practised; young girls are examined before marriage to ensure that their hymen is intact. Discovery of a ruptured hymen brings shame to a girl and her family, and can jeopardise her eligibility for marriage. As a result of the high value placed on virginity and hymen maintenance (a falsity as the hymen can be ruptured in non-sexual activity such as tampon use or physical exercise) young people choose to have anal sex instead.

Avoiding pregnancy or during menstruation

There is no risk of pregnancy when anal sex is practised exclusively. Therefore some heterosexuals may engage in anal sex as an alternative to vaginal sex if they are concerned about pregnancy. Additionally, in some cultures menstrual blood is seen as a polluting substance, so anal sex is practised when a woman is menstruating so that her male partner does not come into contact with her menstrual blood⁽³⁾.

Requested by clients or partners

People may be forced or pressured into having anal sex by their sexual partner. For sex workers, their clients regularly request anal sex and they may often earn more money from a client if they provide anal sex.

What other sexual behaviours are common among key populations?

Typically, key populations engage in the same type of sexual activity as the general population. Some of these activities include:

Kissing. This is the act of using one's lips to touch another person or object. Kissing is used to express emotions like love and affection. While kissing traditionally occurs between two people's lips, a person can use their lips to kiss anywhere on someone else's body.

Dry sex, dry humping, rubbing, frottage. All these describe a sexual activity in which two people rub their bodies (or body parts) together using similar movements as penetrative sex but without penetration.

Mutual masturbation. This is a sexual act in which two or more people stimulate themselves sexually using their hands.

Oral-penile sex ('blow job', 'sucking off', 'giving head'). This is the sexual act that involves stimulating the penis using the mouth and tongue.

Oral-vaginal sex ('going-down', 'muff-diving', 'eating pussy'). This is the sexual act that involves stimulating the vagina using the mouth and tongue.

Using sex toys. A sex toy is any object that can be used to sexually arouse or stimulate a person. There are countless varieties of sex toys but the most familiar, like the dildo for example, are shaped to resemble the penis.

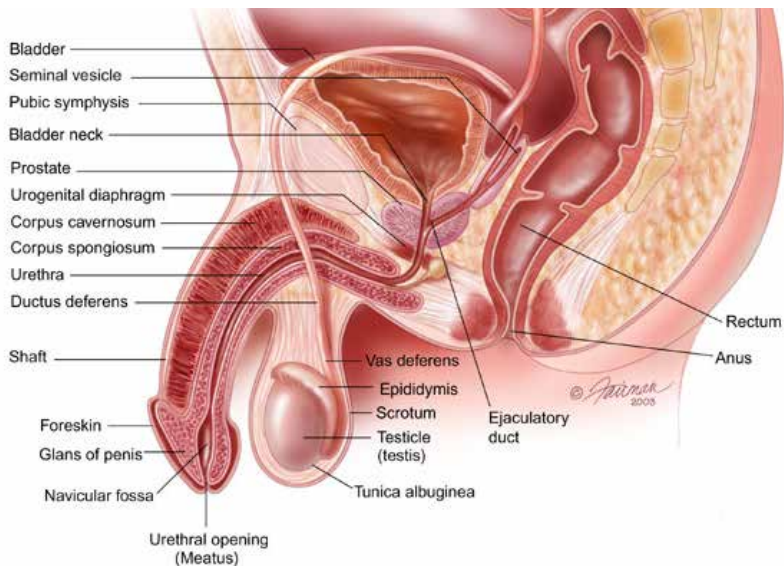
Fingering. This is a sexual act in which a finger or fingers are used to penetrate and stimulate a partner's genitalia.

Oro-anal (rimming, anilingus, 'ass licking'). A sexual activity that involves the mouth and tongue to sexually stimulate another person's anus.

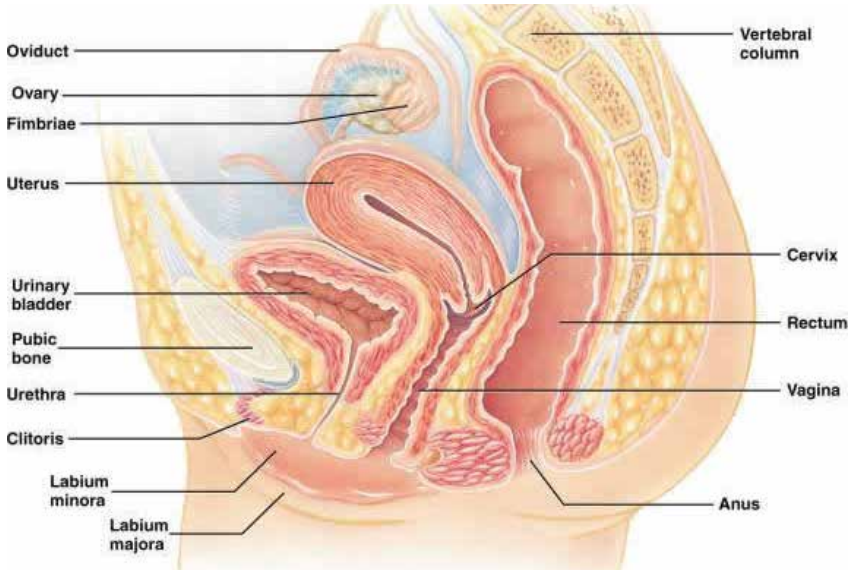
THE P-SPOT

- You can feel it about 4cm inside the rectum, pressing toward the belly button.
- Urethra passes through it.
- Muscle contraction around the prostate produces the sensation of an orgasm, even without ejaculation.
- For males, muscular contractions around the prostate are responsible for the experience of orgasm, so gentle pressure on this organ can radiate similar pleasure. Some men experience this 'Prostate-spot' or 'P-spot' similarly to the 'Graffenberg-spot' or 'G-spot' in women, which is the region 4cm inside the vagina which when rubbed ventrally initially causes a sensation of needing to urinate and then later sensations of pleasure.
- During anal penetration, the prostate is responsible for this 'P-spot' of pleasure in men; in women, the legs of the clitoris extend into the musculature of the anal and perianal region and allow some women to experience pleasure during anal sex.

Prostate: The P-Spot

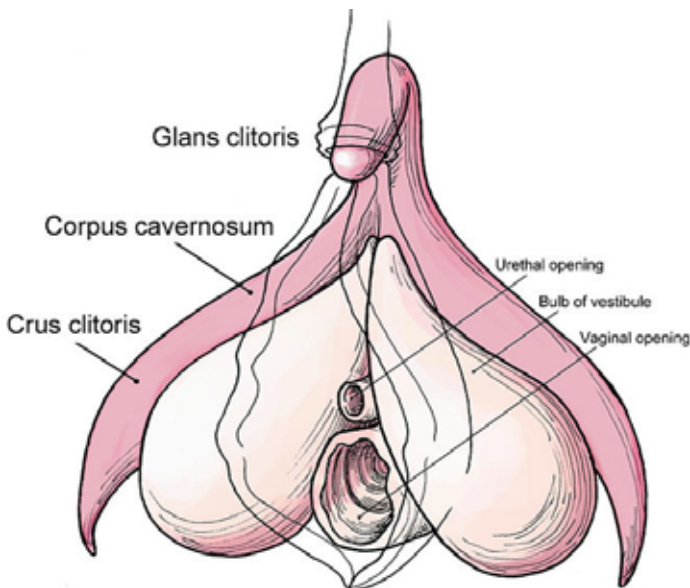


Female anatomy



People with female anatomy do not have a prostate, but the legs of the clitoris extend into the pelvic muscles that contract and produce orgasm.

The legs of the clitoris allow the experience of pleasure and possibly orgasm during anal sex.



WHAT HAPPENS DOWN THERE?

- When gas or faeces leave the sigmoid colon and fill the rectum, this triggers the 'rectal reflex,' the urge to release gas or faeces.
- If someone eats adequate fibre, the rectum is generally free of visible fecal matter.
- Fibre makes stool properly soft and full, so that faeces leave the sigmoid colon and enter the rectum, triggering the rectal reflex. We then release faeces. Little to no faeces is left in the rectum.
- Most diets lack adequate fibre, which means stool may not be properly soft and full. In this case, the rectal reflex may still be triggered, but faeces may not exit in whole pieces, leaving behind smaller pieces of fecal matter in the rectum. The easiest solution is to eat more fibre (from natural sources or from supplements like flax seed or bran) and drink enough water – though this may be limited in resource-constrained settings.
- Patients might be concerned about encountering faecal matter during anal penetration, and therefore use enemas or douches to clean the rectum before anal play. These are not recommended, since they can irritate the lining of the rectum and make disease transmission easier. If patients insist on using enemas, only warm water should be used, introduced via a lubricated smooth-tipped device that will not puncture the rectal lining.

HUMAN SEXUALITY – SIMPLE DEFINITIONS

SEXUAL IDENTITY: How you define yourself sexually, what term and lifestyle you identify with. Examples: Gay, Lesbian, Straight, Bisexual, Queer.

SEXUAL ORIENTATION: Who you are sexually attracted to, who turns you on (this is not something you choose). Examples: Heterosexual, Homosexual, Bisexual.

BIOLOGICAL SEX: Your biological sex at birth is determined by the genitalia you have and your physiology. Examples: Male, Female, Intersex.

GENDER IDENTITY: How you identify your own gender, and what gender norms and social roles you identify with. Examples: Masculine, Feminine, Man, Woman, Transgender (Transman, Transwoman).

SEXUAL BEHAVIOUR: What you do sexually. Your sexual behaviour is not necessarily determined by your sexual identity or sexual orientation. Examples: Oral-penile sex, Oral-vaginal sex, Oral-anal sex, Penile-anal sex, Penile-vaginal sex, MSM, WSW, MSW, WSM.

EXERCISE 4

Sexual Acts

Column A:	Column B:
lips/mouth	lips/mouth
breast/chest	breast/chest
hands	hands
vagina	vagina
penis	penis
anus	anus
feet	feet

For each body part of Person A, draw a line to the body parts for Person B that could be used during a sex activity. For example, a line could be drawn from 'lips' under person A to 'lips' under person B because those two body parts would be used during kissing.

1. How many different combinations were you able to identify?
2. What conclusions can you draw regarding the number of potential sexual acts that two people can engage in?

SUMMARY AND KEY FACTS

- Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. Human sexuality can be broadly broken down into four distinct concepts: sex, gender, sexual orientation, and sexual behaviour.
- Sex refers to the biological concept that categorises individuals based on certain characteristics like their chromosomes, internal and external genitalia, and their hormonal profile. A person's sex is usually categorised as either 'male' or 'female'.
- Intersex people are born with chromosomes, external genitalia, and/or internal reproductive organs that do not fit clearly into either sex category of male or female. Intersexuality shows that biological human

sex is actually a spectrum with male on end, a variety of intersexualities in the middle, and female on the other end.

- A person's gender identity refers to how that individual feels about themselves as a man or a woman. Gender, therefore, describes a common set of traits and social expectations attached to a person's biological sex. People are born with their biological sex but they are taught their gender through their society and culture.
 - Transgender is a broad term that refers to individuals whose gender, their self-identification as a man or woman, does not match their biological sex. Transitioning broadly refers to the act of changing genders to more clearly fit a person's gender identity.
 - Sexual orientation is part of identity and refers to the way in which a person feels attraction to other people of a specific sex or gender. Essentially, sexual orientation encompasses all of a person's intimate psychological and physical feelings towards others. There are three different sexual orientations, heterosexuality, homosexuality, and bisexuality.
 - For many years society thought that homosexuality should be fixed or cured because it was seen as an illness but this is no longer the case. In 1973, in the Diagnostic and Statistical Manual of Mental Disorders, homosexuality was taken out as a mental illness.
 - Sexual behaviour is the way in which individuals experience their sexuality. All people, no matter their sexual orientation, use various body parts to experience sexual pleasure, on their own or with others. Sexual behaviour and roles are independent from but may be influenced by an individual's biological sex, sexual orientation, or gender.
 - Anal sex is a sexual act that involves the penetration of the anus. Anal sex can be practised by any individual regardless of their sex or sexual orientation, including among heterosexual men and women. Anal sex carries a high risk of HIV transmission because the anus can be easily hurt and damaged making it highly susceptible to STIs.
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MODULE

4

RISK FACTORS AND VULNERABILITIES AMONG MSM, SEX WORKERS, AND PWUD

Learning Outcomes

After completion of this module, you should be able to:

- i Describe the sexual and drug-taking risks experienced by key populations
- ii Understand why individuals among key populations may engage in risky behaviour
- iii Discuss the side effects of drug use, including relapse, overdose, and drug dependence
- iv Describe the social and structural factors that affect the risk of key populations
- v Explain how environmental risks for MSM, sex workers, and PWUD affect their overall health and well-being

Risk factors among MSM, sex workers, and PWUD

What are the types of risks factors experienced by MSM, sex workers, and PWUD?

Key populations experience both individual and societal risk factors. Individual risk factors include behaviours such as sexual and drug-taking risks. Societal risk factors more broadly include those factors experienced by key populations within their environment or community such as stigma and violence.

Do all key populations have the same risk for HIV and STIs?

Individuals do not experience a specific level of risks because they belong to a key population. Their risk for HIV infection is dependent on their individual risk behaviour and their level of exposure to societal risk factors. Take for example two sex workers, Dora and Chantal. As sex workers, both Dora and Chantal are defined as belonging to a key population that is considered at high risk for HIV. Chantal always uses condoms, never experiences violence from her clients, and is able to access health care regularly, while Dora never uses condoms, is sexually assaulted by her clients, and is unable to receive regular health care. Even though both Chantal and Dora belong to the same high-risk key population, their levels of risk are completely distinct from one another because of the individual and societal factors they both experience.

Sexual risks

Multiple and concurrent sexual partners

Multiple and concurrent sexual partners are common among key populations and create opportunities for the sexual transmission of HIV and other infections within these populations. Many MSM in South Africa have reported large numbers of sexual partners, PWUD may also have increased sexual partners depending on the drug they use, and sex workers by nature of their job, have a high frequency of sexual partners.

Unprotected vaginal and/or anal sex

This risk factor includes having penetrative sex without the use of a condom or other protective barrier. Unprotected sex can occur because of substance use, which can decrease social and sexual inhibitions, known as disinhibition and reduce decision-making skills. Sex workers may use drugs to facilitate their work and MSM may use drugs to enhance their sexual activity. Gender inequality promotes the submission of sex workers to client pressure to engage in unsafe sex for more money, which makes safer sex difficult to negotiate⁽¹⁾.

EXERCISE 1

Why Engage in Risky Behaviour?

We all make hundreds of decisions on a daily basis. At some point, everyone makes a decision that results in engaging in a dangerous or harmful behaviour. Likewise, sex workers also have to make daily decisions about the types of activities in which they engage.

Like the rest of us, there are always psychological, economical and social reasons for making decisions that could lead to risky actions. To better understand why key populations may be encouraged to engage in risky behaviour, think of a time that you engaged in a behaviour that may have been harmful to you. Use the list below for ideas, or think of your own and think about why you took a chance.

- Smoking cigarettes
- Unprotected sex
- Driving while drunk
- Driving over the speed limit
- Using drugs
- Crossing the road when the light is red for pedestrians
- Placing a baby or child in the front seat of the car
- Eating a lot of fried food
- Walking alone at night in the street
- Not brushing one's teeth
- Exercising less than three times per week
- Being very drunk

1. What were some of the reasons you engaged in a risky behaviour?
2. Did it have to do with pressure from another person?
3. Was it because you felt like there were no other options?
4. What factors played a role?
5. What are some of the reasons you think sex workers engage in risky behaviour?
6. How do they relate to your own reasons?

Sex workers may also be exposed to unprotected sex through rape from their clients and have also reported instances where police officers have confiscated their condoms. MSM also reported a high frequency of unprotected anal sex as well. The hidden nature of sex work makes the adoption of safer sex practices more difficult, and low self-esteem due to the negative values imposed by society on MSM, increases the likelihood of risky sexual behaviours⁽¹⁾.

EXERCISE 2

Case Study: Ntombi, from Durban

Ntombi is a 26-year-old woman who lives in Berea in Durban with her boyfriend Thabo and their 3-year-old son, Lindo. Thabo has a job as a fuel attendant at a nearby fuel station, and Ntombi is studying at college. On weekends Ntombi works in a brothel called Happy Endings. The madam at Happy Endings has an agreement with a few of the local hotels. When a businessman from the hotel requests a sex worker, the madam sends one of her girls. The madam agrees on a price with the client beforehand, when the client specifies what kind of girl he wants, and what kind of sex he wants. The madam then informs Ntombi of what the client wants, and it is Ntombi's work to provide this to the client's satisfaction. Sometimes the client demands things that he has not paid for or agreed to with the madam. For example, the client may ask Ntombi not to use a condom, offering to tip her generously. Ntombi knows that she only gets paid a portion of what the client pays the madam, and the cut that goes to the hotel, so it is very tempting to take the tip and not use a condom. Ntombi is on the contraceptive pill, so she doesn't worry about getting pregnant.

1. How does Ntombi practise sex work? Is it different than what you expected?
2. Why do you think Ntombi became a sex worker?
3. What alternatives would Ntombi have if she was not a sex worker?
4. What risks do you think Ntombi faces in her work?
5. What factors do you think facilitate Ntombi's risk behaviour?
6. What strategies would you provide Ntombi to support reducing her risk?

Incorrect lubrication during sex

Without proper lubrication during penetrative sex, the lining of the anus or vagina can tear or become irritated, which facilitates the transmission of HIV and other infections. For vaginal sex, this can occur if there is no vaginal lubrication present during penetration. For anal sex, this may occur because water-based lubrication is not accessible for free in many locations and may be too expensive for some people to purchase. The lack of available water-based lubrication often results in the use of other substances, which if oil-based, can cause condoms to break. More information on lubricant will be provided in Module 9.

WHAT IS LUBRICANT?

- Lubricant is a specialised jelly-like substance that helps reduce the friction between body parts during sexual activities.
- Lubricant can be applied to the penis, hand, inside a vagina, or inside a rectum before engaging in a sexual act in order to facilitate movement.
- Lubricant is especially necessary for anal sex, since the rectum does not produce a natural lubricant similar to the vagina.

Vaginal and anal hygiene practices

Vaginal and anal hygiene practices are not often discussed, even between patients and health care professionals. However, these practices are fairly common. Some practices used for the purposes of vaginal or anal hygiene are not beneficial. They may indeed increase the risk of rashes and ulcers in the vagina and/or anus, and consequently increase the risk of HIV.

1. Frequent washing. Some men and women, especially those who engage in sex work, wash their vaginas and/or anuses too often and may use harsh chemicals. Repeatedly washing the genitals, but also the skin and hands, can cause damage to the natural protective properties of the skin and mucous membranes, and may lead to conditions such as dermatitis, which can increase the risk of infection. Frequent showers (e.g. in between customers) can cause skin to dry. Health workers should advise clients to replace highly perfumed products such as soaps and shower gels with pH-balanced products, which help maintain the natural flora of the skin.

2. Vaginal drying. In addition, some women use products to dry out or tighten their vaginas, and these may also increase their risk. One reason for

this is that, in sub-Saharan Africa, 'dry sex' is popular, as a dry vagina during intercourse seems to be equated with being young and innocent, whereas a lubricated vagina is associated with being promiscuous. Women report using various 'home remedies' including herbs, lemon juice, a cloth, cold water or antiseptics (such as Dettol) to dry the vagina. However, vaginal dryness places the woman at greater risk for HIV infection, as there is a greater risk of trauma to the vaginal tissue. The increased friction also increases the risk of the condom breaking.

At least Dettol makes me dry always. I just pour it in my bath water and I believe it works because my clients always ask me if I am new in the field⁽²⁾.

3. Anal and vaginal douching are widely practised to cleanse the genital areas, however they carry the risk of damaging the vagina and rectum. Health workers should know about these practices including use of suppositories and enemas, and offer practical advice to clients to prevent risk of infection and/or vaginal/rectal trauma. This includes advising clients that the anal and rectal lining is a highly absorbent mucous membrane, and substances placed inside the anal passage during sex play (such as alcohol or cocaine) are quickly absorbed into the blood stream in a concentrated form.

Concurrent STI infection

Because key populations may not have access to adequate health care services they may be unable to have STIs effectively treated. STIs increase the risk of HIV transmission during sex.

Drug-taking risks

What is drug dependence?

Not everyone who uses a drug will develop drug dependence, which occurs when a person physically and/or mentally requires the drug to function normally. Drug dependence is a chronic relapsing mental illness, not simply a behaviour that can be changed through counselling alone. When an individual is dependent on a drug and the drug is stopped abruptly they may experience withdrawal symptoms (e.g. vomiting, diarrhoea, sweating) which indicate that physical dependence has developed. Drug dependence can also be identified when an individual experiences disturbances in their psychological functioning, such as difficulty in concentrating, anxiety, depression, irritability, insomnia, headaches and muscle cramps. Drug

dependence will be further discussed in Module 6: Mental Health Amongst PWUD. Also, Appendix 2 provides more details on dependence.

What are the health issues or risks associated with injecting drug use?

HIV, hepatitis C, and other infections

People who inject drugs are especially vulnerable to blood-borne and bacterial infections because they may use unsterilised injection equipment or share needles when they inject drugs. In these situations, PWID may become infected if they use a needle, syringe or other equipment that is contaminated with bacteria, viruses and/or other foreign material.

These infections can lead to a variety of illnesses and can cause death of drug users, their sex partners, and their children through mother-to-child transmission. Drug use can increase sexual risk among key populations because it can lead to an impaired sense of judgment and decision making as well as lower inhibitions during sexual activity. For example, cocaine use can sustain an enhanced period of sexual activity but also it dries out the mucous membranes and the long duration of sex might cause small bleedings.

Tuberculosis (TB)

Injecting drug use is associated with increased rates of TB infection. Increased TB disease rates among drug users are likely due to other risk factors for TB disease, such as incarceration, homelessness and poverty. Tuberculosis is a leading cause of death among PWID living with HIV. Both all-cause and TB-associated death rates are several times higher among drug users living with HIV than among other people living with HIV⁽³⁾.

What is the use of non-sterile injecting equipment?

Non-sterile injecting equipment refers to the re-use of previously used injecting equipment to inject a drug. The association between using non-sterile injecting equipment or sharing needles and HIV infection will be further discussed in Module 5.

There are a few methods for sharing injection drugs and equipment. Frontloading refers to a method of drug sharing where drug from one syringe is injected into the front end of another syringe. This allows for an equal division of the drug between two or more users. Backloading refers to injecting drug from one needle into the back, open end of another syringe. This may be more difficult because it requires that the plunger be reinserted carefully without wasting any drug. Both methods can easily lead to contamination of the injection equipment by HIV and other infections.

WHAT ARE COMMON SIGNS AND SYMPTOMS OF DRUG USE?

Drug use can result in common signs and physical, behavioural and psychological symptoms. A few of these are listed below; however, be aware that that these symptoms could also be associated with a variety of other conditions and are contingent on the types of drugs someone may be using.

Physical symptoms and signs	Behavioural symptoms and signs	Psychological symptoms and signs
<ul style="list-style-type: none"> • Red eyes or dilated or pinpoint pupils • Changes in appetite • Changes in sleep patterns • Sudden weight loss or gain • Deterioration of physical appearance • Skin manifestations such as abscesses or ulcers • Needle marks or puncture wounds on skin from injecting 	<ul style="list-style-type: none"> • Drop in attendance and lack of interest in work or school • Unexplained need for money that leads to borrowing and stealing • Engaging in secretive or suspicious behaviour • Sudden changes in friends, favorite hang outs, and hobbies • Frequently getting into trouble (fights, accidents, illegal activities) • Possession of drug gear or paraphernalia 	<ul style="list-style-type: none"> • Unexplained change in personality, attitude, and behaviour • Mood swings, irritability, angry outbursts, or unexplained excitement • Periods of unusual hyperactivity, agitation, or giddiness • Lack of motivation and ambition • Appears lethargic or spaced out • Appears fearful, anxious or paranoid with no reason

Another practice for sharing drugs is referred to as 'Flush blood' or 'Flashblood'. This practice is common among heroin users who may be unable to afford to buy the drug, and instead, inject the blood of someone who has just used the drug. Furthermore, a person may use an empty needle or other equipment, such as a spoon that had previously been used. Without properly cleaning this equipment, it also creates risk of transmitting HIV and other infections.

Why do some PWID share needles?

According to recent South African research, injecting alone or in pairs is more common than group injecting. For those PWID who do share needles and syringes or use non-sterile equipment, their reasons for sharing vary. In

other contexts, poverty is cited by PWID as a key reason for sharing needles and syringes: having expended great energy and time procuring the necessary money to purchase drugs, they feel that the cost of a new needle and syringe is too expensive.

The most-cited reasons for sharing needles and syringes are the fear of purchasing and carrying needles and syringes, as well as the inability of PWID to purchase sterile injecting equipment from pharmacies that stigmatise PWID. While injectable drugs may be hidden in many places on the body, needles and syringes are easily found during police searches.

What are the side effects of injecting drug use?

Because the drugs are not metabolised when injected, the effects are more intense and addictive – and so are the risks for overdosing. There are also many social, physical and mental consequences of using injection drugs. For example, injecting drug use is much more addictive than other forms of drug use, creating physical dependence and often leading to more severe withdraw symptoms than when non-injection users stop taking the drug.

In addition to the high risk for overdosing, injecting drug use can also result in damage to the arteries and scarring of the peripheral veins. Bacterial infections can also occur at injection sites. A common effect is skin irritation or itching that is relieved by scratching. Some injectable drugs such as heroin also activate the part of the brain that governs vomiting and users often throw up right after injecting. They sometimes use the force of their nausea to judge the strength of the dose.

What is an overdose?

People who use drugs are also vulnerable to overdose, which occurs when they take too much drug in a single episode of injecting or using. This can happen if a PWUD increases the actual quantity of drug they are using but also if they use the same quantity of a higher quality drug. Using bad quality or impure drugs does not increase risk for an overdose but may increase risks for infections or other side effects. Another risk of overdosing is in the combined use of substances. For example, the use of multiple downers together (i.e. alcohol, GHB, heroin) generates a '1+1=3' effect and the combining of downers and uppers (alcohol and cocaine) makes the user unaware of how intoxicated they really are, which leads to the risk of using more substances.

Overdosing can have significant consequences, including death. For PWUD, accessing care to manage an overdose can be challenging because of fear of being arrested or otherwise becoming involved in the criminal justice system after disclosing their drug use to a health care worker. There is also very little

information available for PWUD on what to do if an overdose occurs, and often the health care system is not capacitated to manage such a situation.

TYPES OF OVERDOSES⁽⁴⁾

DEPRESSANT DRUGS like opiates (e.g., heroin) and sedatives (e.g. Valium and alcohol) slow down the body's functions. A person who overdoses on a depressant will experience breathing that can become life-threateningly slow or stop altogether, leading to heart failure.

STIMULANT DRUGS, such as cocaine and speed, can cause a person who has overdosed to have a heart attack or experience cardiac arrest, collapse from exhaustion, have a seizure, or become so disoriented that they accidentally hurt themselves.

What are the signs of an overdose?

One of the clearest signs that someone is overdosing is that their face or lips will turn blue. They may also look very pale; be very limp; be able to breathe and look at you, but not be able to talk; be breathing, but very slowly and shallowly; stop breathing altogether; have a slow pulse (heartbeat) or no pulse at all; foam at the mouth; vomit; be shaking or have a seizure; complain of chest pain, pressure, tightness, or shortness of breath; or suddenly collapse and become unconscious. You have about four minutes from the time your lips turn blue to coma. A person who is overdosing isn't usually aware of what is happening because of the effects of the drug they're on. They are helpless and need someone to act quickly. If a person stops breathing, it can take only a few minutes for them to die. Just waiting for them to 'get over it' is the worst thing you can do if someone is overdosing. Immediate action must be taken to help them survive⁽⁴⁾.

MANAGING AN OVERDOSE

If an overdose occurs outside of a medical setting, phone emergency responders immediately. Follow standard emergency medical response protocols, such as CPR if indicated, until the individual is in a health facility. If the overdose was the result of an opioid, such as heroin, the use of an opioid antagonist (i.e. Naloxone) can be given. Naloxone requires regular monitoring and multiple doses.

EXERCISE 3

Exercise: Understanding an Overdose

On a piece of paper, make a list of the symptoms of an overdose. Secondly, list the reasons why someone might have an overdose (causes). Compare your list to the following:

- Bad quality drug (impure)
- Using drug after a long break (i.e. spending time in prison)
- Having a relapse (using drug again) after a period of detox
- Taking drug in a hurry or incorrectly
- Injecting drug instead of usually smoking it

Now, list the ways in which overdose might be prevented. Compare your list to the following:

- Only using the drug in a controlled setting (quiet safe space or 'consumption room')
- Never using the drug alone (always having someone to assist if something goes wrong)
- If injecting drugs, smoking a little bit of the drug first to calm down and test the quality of the drug before injecting

What is withdrawal?

Withdrawal occurs when a PWUD suddenly stops using the drug on which he or she has become dependent. This usually results in a number of physical and mental withdrawal symptoms, including abdominal cramps, muscle spasms, vomiting, chills, high fever, restlessness, irritability or depression⁽⁵⁾. PWUD commonly call withdrawal 'getting sick'. The symptoms of withdrawal are very intense, leading many PWUD to do what ever is needed to remove these symptoms – for those injecting – this might mean finding a needle that they do not know who used it previously, or sharing with people they do not know, in serious times. Shaking and tremor is common during severe withdrawal, and may prevent PWID from being able to inject a drug into a vein, so they may inject intramuscularly to alleviate the symptoms before injecting into a vein.

What is a relapse?

A relapse occurs when a PWUD begins using drugs again after having successfully stopped using drugs for a certain period of time. Relapse is

common for PWUD and is a normal part of recovery. Drug use, particularly injecting drug use, is highly addictive and it can often take a number of attempts before a PWUD can stop using drugs.

Societal and structural risks

Lack of accessible public health services to address the needs of MSM, sex workers, and PWUD

Although coverage is expanding for MSM services, access outside of major metropolitan areas is still limited thereby restricting the the ability of MSM to access sensitised services such as HIV testing or STI screening.

EXERCISE 4

Exercise: When Did You Last Relapse?

Working with a PWUD who has, or frequently does, relapse can be challenging. It is normal to feel frustrated and discouraged that your support is seemingly not working. It is also normal to feel confused as to why your client is unable to abstain from drug use. In these situations, keeping a focused perspective on your client's circumstances is critical.

You can achieve this partially by asking yourself, 'When was the last time I relapsed?' Even though you may not be a PWUD, you most likely have tried to adapt a health activity or habit at some point in your life and may not have been successful. Therefore, in this situation, you relapsed back into your previous habits.

- 1. Take a moment and write down a few examples of healthy behaviours you have attempted to include in your lifestyle. Some examples may exercising three times a week, not eating sugary foods, or not allowing yourself to work over the weekend.**
- 2. What encouraged you to take up these habits or new behaviours?**
- 3. Were you successful in forming these habits? If not, what were the factors that caused you to 'relapse' back into your older, less healthy habits?**
- 4. How is this situation different from a PWUD who is in recovery? How is it different?**
- 5. What lesson could you pull from your experience that might help you provide support to a PWUD who is relapsing?**

Discrimination and stigma surrounding drug use have been reported as barriers to accessing HIV testing services and other medical services in South Africa, which adds to the overall vulnerability of the PWUD⁽⁶⁻⁹⁾. Fear often prevents PWUD from seeking help, not only because of the punitive legal aspects, but also because of a lack of easy access to evidence-based treatment interventions and medication.

Sex workers experience a very similar situation in health care facilities where they are commonly refused services and where their confidentiality is broken, thereby exposing their HIV status and/or their status as a sex worker.

MSM, sex workers, and PWUD face additional structural risks because relevant HIV prevention commodities, including condoms and lubricant are not provided or readily available within the public health system.

Social stigma and violence

MSM, sex workers, and PWUD may be fearful to disclose their risk behaviours to members of their family or to health care staff because of social stigma or discrimination. This often prevents them from accessing the knowledge, skills and services that would help meet their HIV prevention and treatment needs. Additionally, this can lead to isolation which increases key populations risk for mental illnesses.

For example, an MSM may be less likely to address a possible anal STI with a health care worker for fear of having to disclose his sexual practices; a sex worker may not report a sexual assault to the police for fear of being arrested for practising sex work; and a PWUD may be less likely to seek health care for fear of being reported to the police as a drug user.

Social stigma and discrimination often lead to violence towards MSM, sex workers and PWUD. Violence, particularly sexual assault and increases risk for HIV and other infections but also puts key populations at risk for mental illnesses such as trauma, depression, and anxiety. Mental health will be discussed further in Module 6.

Homophobic violence towards MSM can lead to physical injury as well as sexual assault and rape. Similarly, social marginalisation associated with the life style of sex workers maximises their exposure to violence, increased risk of sexual assault, rape, and physical violence from their clients⁽¹⁾. Sex workers can also experience high levels of violence and abuse from police if they refuse to cooperate with them⁽²⁾. Various studies have reported the reluctance of sex workers to report rape and abuse to authorities due to fear and unsympathetic treatment by the police⁽¹⁰⁾. PWUD may be forced to inject or use drugs in unsafe venues where they are at risk for physical violence. Many

individuals within key populations may be migrants from other parts of South Africa or from other countries and experience xenophobic violence.

Environment

Some sex workers practise street-based sex work. This means that they wait or walk along certain streets or highways in their communities and engage with clients from the street. Street-based sex workers are particularly vulnerable to crime and violence, as well as police harassment⁽¹¹⁾. Other sex workers practise sex work in brothels. Conditions of brothels as well as the treatment received by a manager can vary greatly across South Africa. Some brothels may have strict hygiene standards and provide regular doctor visits and condoms to all of their sex workers, while others may have extremely unhygienic conditions, lack basic HIV prevention tools, and restrict sex workers' movements in and out of the brothel⁽¹²⁾.

Because of social stigma and discrimination, MSM may be forced to remain hidden and therefore may seek casual sex in isolated and dangerous places. This leaves these MSM vulnerable to police violence, theft, and even murder. Due to the legal framework adopted in South Africa which criminalises drug use PWUD are forced into hiding, isolation, and moving underground, which as with MSM leaves PWUD vulnerable to violence and assault⁽¹⁾.

RISK FACTORS FOR MSM / SW / PWUD

Individual risks	Societal risks	Environmental risks	Structural risks
<ul style="list-style-type: none"> • Unprotected sex • Substance use • Substance use while having sex • Sharing injecting needles • Multiple partners • Low self esteem • Disinhibition • Depression • Internal stigma • Lack of information 	<ul style="list-style-type: none"> • Stigma • Discrimination • Prejudice • Social norms • Family expectations • Homophobia • Heteronormativity • Penile-vaginal normativity • Cultural / religious beliefs 	<ul style="list-style-type: none"> • Dangerous places • Invisibility • Badly lit • High levels of crime • Having to hide • Having to buy drugs from dangerous place/person • Having to sell sex in dangerous place • High levels of violence • Unhygienic conditions 	<ul style="list-style-type: none"> • Lack of access to justice / police support • Lack of access to health care • Difficult to get employment • Illegality of behaviours • Punitive legislation • Lack of access to commodities: lubricant, clean injecting equipment

EXERCISE 4

Case Study: Sex Work and Human Rights

Consider the following case study and answer the questions below.

Faith is a 42-year-old lady from Mozambique who came to South Africa a year ago to work as a fruit picker on a farm in rural Limpopo. She paid someone in Mozambique to organise a job for her, and left her children in her home town with her mother so she could come to South Africa to work. Faith has no papers, because she crossed the border illegally with a group of other immigrants who had also paid the people smugglers. Faith was dropped off at the farm where a job had been arranged for her. She shares a room with seven other female migrant workers who have come to pick fruit on the farm. Faith gets paid R100 a week for picking fruit, and she sends the money back to her mother in Mozambique to pay her children's school fees. Faith tried to find work on another farm that pays the workers more, but because she has no papers, the manager would not hire her. Another worker on the farm suggested that she try to sell sex to the male farm workers, who were also migrants living far from their wives. Faith started selling sex to the men on the farm, and sending back the money to Mozambique. One night Faith was beaten up badly and raped by one of her clients, who was very drunk and refused to pay her. She decided to report the case to the police in the nearest town, and ask the police to help her get to a clinic. When she got to the police station, she had trouble reporting the case, as her English is very poor. The duty officer laughed at her, calling her a mkwerekwere, and making jokes. The officer asked her for her papers, and when Faith failed to produce a valid permit, the officer said that if she had sex with him, then he would let her go without arresting her.

1. Were any of the sex worker's rights violated? If so, which ones?
2. If you found yourself in this situation, how would you respond?
3. What options can you think of for this sex worker to report this misconduct?

DEFINITIONS

What is a brothel? A brothel is an establishment or building where multiple sex workers live and can host clients. In some cities, brothels may also be referred to as hotels. Often brothels are overseen by a manager who also coordinates the clients for the sex worker.

Who is a manager? A manager is someone who 'owns', 'protects', and/or 'manages' one or multiple sex workers. The term manager should be used instead of **pimp**; pimps are commonly associated with violence and drug use. Managers are responsible for attracting clients and negotiating with them for the sex workers' services. Sex workers, in turn, are forced to pay a portion of the money they earn from the client. Often, managers will organise clients for the sex worker and negotiate rates and actions without the sex worker's consent. Sex workers across South Africa can have varied relationships with managers. Although many managers can be abusive and controlling, it is important to note that not all managers or pimps are bad. They can also play a positive role, assisting sex workers to get medical care, supporting the sex workers in getting clients, as well as providing security and protection from violence. More often, however, these managers can be a significant barrier for sex workers in protecting themselves from HIV and other STIs. This happens because often the manager will determine with whom and when the sex worker has unprotected sex. Additionally, they may restrict a sex worker from visiting a clinic to receive tests or treatment for HIV or other STIs.

Criminalising laws and legislation

Some key populations engage in behaviours that are criminalised by South African law. These laws are a source of social stigma and discrimination and can diminish the ability of key populations to access health care services. This legal context is discussed in greater detail in Module 5.

EXERCISE 5

Case Study: PWID: Stigma and Lack of Access to Health Care

Consider the following case study and answer the questions below.

Sammy is a 31-year-old man who works part-time as a long-distance truck driver for a fruit company. Sammy has been injecting heroin for three years, after one of his co-drivers introduced him to the drug as a way to escape the boredom and loneliness of living on the road. Sammy developed an abscess on the inside of his arm where he had been injecting for some time. He found it difficult to go to a clinic as he was always driving during clinic hours. As a result, the wound was left untreated for a few weeks and started to get infected. Eventually, Sammy found time to go to a clinic when his truck had mechanical problems in Springbok in the Northern Cape. When Sammy rolled up the sleeve of his jacket to show the nurse his wound, she asked him how he got this wound and why he left it untreated for so long. Sammy felt scared to tell the nurse how he got the wound, and she kept asking him. He finally blurted out that he got the wound from injecting needles. The nurse dropped his arm in disgust and chased Sammy out of her consulting room, shouting: 'Get out of my clinic you dirty drug addict, we don't need dangerous sinners like you here, corrupting our young people and stealing from us, get out!'

1. Were any of Sammy's rights violated? If so, which ones?
2. If you found yourself in this situation, how would you respond?
3. What options can you think of for Sammy to report this misconduct?

SEX WORKERS WHO USE DRUGS

Sex workers who use drugs face different risks and vulnerabilities than sex workers who don't use drugs, as well as PWUD who don't sell sex. The environment of sex work also differs between those who inject drugs and those who do not. There is higher prevalence of injecting drug use and higher levels of problematic drug use among street based sex workers over brothel based sex workers with many street sex workers forced out of indoor markets due to their drug use.

Because PWUD sex workers are more likely than non drug-using sex workers to work on the street, they face an increased likelihood that they will have PWUD clients and experience violence from their clients. Street-based sex workers are also more likely to work nights and longer hours than their non drug using counterparts and are at higher risk for adverse contact with law enforcement officers, and more likely to be subjected to physical assault and rape. It is important to remember that many PWUD may transition in and out of sex work, that sex work may be hidden or covert, and that individuals who engage in both drug use (particularly injecting drug use) and sex work may experience significantly greater marginalisation than both non-drug using sex workers and non-sex worker PWUD.

Reference: National Drug and Alcohol Research Centre (Australia), 2010

SUMMARY AND KEY FACTS

- Individuals do not experience a specific level of risks because they are a MSM, sex worker, or PWUD. Their risk for HIV infection is dependent on their individual risk behaviour and their level of exposure to societal risk factors.
- MSM, sex workers, and PWUD experience individual factors that increase their risk of being infected by HIV including sexual risks such as multiple and concurrent sexual partners and unprotected vaginal/anal sex. Like the rest of us, there are always psychological, economical and social reasons for making decisions that could lead to risky actions.
- The hidden nature of many MSM, sex workers, and PWUD makes the adoption of safer sex practices more difficult and lowers self-esteem. Due to the negative values imposed by society on key populations, the likelihood of risky sexual behaviours increases.

- STIs increase the risk of HIV transmission during sex. Because MSM, sex workers, and PWUD may not have access to adequate health care services they may be unable to have STIs effectively treated.
- Lubricant is a specialised jelly-like substance that helps reduce the friction between body parts during sexual activities. Without proper lubrication during penetrative sex, the lining of the anus or vagina can tear or become irritated; which facilitates the transmission of HIV and other infections.
- Some practices used for the purposes of vaginal or anal hygiene by MSM, sex workers, and PWUD increase their risk of rashes and ulcers in the vagina and/or anus, and consequently increase the risk of HIV. They include frequent washing, vaginal drying, and anal or vaginal douching.
- MSM, sex workers, and PWUD may also experience drug-taking risks and drug dependence. Drug dependence is a chronic relapsing mental illness, not simply a behaviour that can be changed through counselling alone.
- PWUD are also vulnerable to overdose, which occurs when they take too much drug in a single episode. Overdosing can have significant consequences, including death. For PWUD, accessing care to manage an overdose can be challenging because of fear of being arrested or otherwise becoming involved in the criminal justice system after disclosing their drug use to a health care worker.
- People who inject drugs are especially vulnerable to blood-borne and bacterial infections such as HIV and Hepatitis C because they may use unsterilised injection equipment or share needles when they inject drugs.
- Increased TB disease rates among drug users are likely due to other risk factors for TB disease, such as incarceration, homelessness and poverty.
- Societal risk factors more broadly include those factors experienced by key populations within their environment or community such as stigma and violence. MSM, sex workers, and PWUD may be fearful to disclose their risk behaviours to members of their family or to health care staff because of social stigma or discrimination. This often prevents them from accessing the knowledge, skills and services that would help meet their HIV prevention and treatment needs.
- Because of social stigma and discrimination, key populations may be forced to remain hidden and therefore may access isolated and dangerous places. This leaves them vulnerable to police violence, theft, and even murder.

SECTION 2

KEY ISSUES

Section 2 continues to build on the core information in Section 1 by discussing the contextual factors, or 'key issues' that influence the health and well-being of MSM, sex workers, and PWUD. These factors, including the law, mental and physical illnesses, and substance use, affect the lives of MSM, sex workers, and PWUD in a complex way. Understanding this interaction will provide useful perspective and tools for health care workers when engaging with MSM, sex workers, and PWUD.

This section includes the following three modules:

Module 5: Contextualising the law and the human rights of MSM, sex workers, and PWUD

Module 6: Mental health and substance use

Module 7: HIV and other infections

Questions that will be addressed in this section include:

- How do laws and legal policy impact MSM, sex workers, and PWUD?
- What are the legal implications for HCW working with MSM, sex workers, and PWUD?
- How can health care workers address the effects of this legal context?
- Are key populations MSM, sex workers, and PWUD?
- Is drug dependence a mental illness?
- What affect does mental illness have on MSM, sex workers, and PWUD?
- How are MSM, sex workers, and PWUD affected by HIV, TB, and STIs?

MODULE

5

CONTEXTUALISING THE LAW AND THE HUMAN RIGHTS OF MSM, SEX WORKERS, AND PWUD

Learning Outcomes

After completion of this module, you should be able to:

- i Describe the ways in which South African law affects MSM, sex workers, and PWUD's access to care, behaviour, and rights
- ii Explain the legal obligation and ethical obligation of health care workers to provide care and support to MSM, sex workers, and PWUD
- iii Describe the laws that support MSM, sex workers, and PWUD
- iv Explain the ways in which health care workers can support MSM, sex workers, and PWUD within the current legal context
- v Define the difference between decriminalisation and legalisation

South Africa's legal context

In many ways, South Africa is considered to have one of the most progressive constitutions in the world. For example, South Africa, unlike many African countries, guarantees equality and non-discrimination on the basis of sexual orientation. Therefore, MSM receive full constitutional protection in South Africa. There are however, a number of South African laws and policies that harm sex workers and PWUD and increase their overall vulnerability and risks. For example, sex work in South Africa is criminalised under the sexual offences act of 1957, both selling and buying of sex and auxiliary activities like brothel keeping and pimping are illegal. Also the possession, use, selling, and involvement in activities supporting drugs is illegal in South Africa⁽¹⁾.

How do laws and legal policy impact key populations?

As discussed in Module 4, laws that criminalise sex work and drug use have also been associated with violence, harassment, disempowerment, and lack of legal recourse to address injustices among sex workers and PWUD⁽¹⁾.

Current laws that criminalise sex work infringe on multiple constitutional rights given to sex workers. For example, the right to choose one's profession, the right to dignity, to freedom from violence, and to bodily integrity. These laws create challenging barriers for sex workers when engaging with health care workers and police. Sex workers have reported situations where health care workers refuse treatment, In some cases, critical prevention and treatment tools are withheld, including PEP, emergency contraception, STI treatment, drug treatment, and condoms and lubricants, and make very abusive remarks when discovering or even suspecting the person is a sex worker⁽¹⁾.

Some sex workers may be identified by the police and regularly interact with them. Since sex work is illegal in South Africa, sex workers are forced to adhere to the directions of the police, even when the police officers themselves are acting against the law or are corrupt⁽²⁾. Some sex workers may pay police officers to let them continue working; this can take the form of a fine, when in reality the money that is paid to the police is simply pocketed⁽³⁾. Some sex workers will give their services away by having sex with the police officers in order to avoid getting arrested. In several cases, police have used condoms as 'evidence' that a woman is committing the crime of prostitution. This creates fear and anxiety among sex workers who may limit their use of condoms because they fear police harassment. In some cases, police have destroyed or confiscated condoms, increasing sex workers vulnerability.

THE AFFECT OF CRIMINALISATION ON SEX WORKERS⁽⁴⁾

Human rights argument	Public health argument
Criminalisation of sex work violates the human rights of sex workers	Criminalisation of sex work fuels the AIDS epidemic
<p>The Constitution gives:</p> <ul style="list-style-type: none"> • Sex workers the same rights as everyone else • Everyone the right to choose who you have sex with • The right to choose when you have sex • The right to choose where you have sex • The right to choose if you want to have sex at all • The right to dignity • The right to non-discrimination • Access to health care services • The rights to bodily and psychological integrity • Freedom of thought, belief and opinion • The right to choose their trade, occupation or profession freely. 	<p>Criminalisation affects people's health:</p> <ul style="list-style-type: none"> • Sex workers are at risk of being infected with HIV. In some areas many sex workers are infected with HIV • Sex workers are affected by violence, from their clients and from the police. Their work can be dangerous • Sex workers are stigmatised • Sex workers sometimes find it difficult to earn money • Sex workers find it hard to access health, social, police, legal and financial services and security

The criminalisation of drug use forces PWUD 'under-ground' where they may be exposed to violence, assault, and fail to seek health care due to fear of arrest or discrimination⁽¹⁾. The fact that drug use is illegal in South Africa significantly affects PWUD and their ability to access health care. Many PWUD may not disclose to a health care worker that they use drugs because they may be afraid that they will be arrested. If a client does not disclose to a health care worker that they inject drugs, the health care workers will be unable to provide the full scope of services they may need. In addition, Health care workers would not be able to take this behaviour into consideration when prescribing medications that could potentially interact with the drugs the client is already using.

EXERCISE 1

Case Study: PWID and Needle Access

Consider the following case study and answer the questions below.

Rita and Jamil have been in a relationship for six months now. They started using heroin together a few weeks ago, when the dealer they usually buy mandrax from suggested that they should try it. Rita was scared at first, because she doesn't like injections, but Jamil convinced her that it would be ok and that he would look after her. Rita had seen a programme on television about drugs which said that you shouldn't share needles with anyone, so she said to Jamil that she would only try heroin if they could each use a new needle. The two of them decide to go to the pharmacy to buy some needles, but when the pharmacist starts questioning them on what they need the needles for Rita gets nervous and runs out; Jamil follows her and so they don't manage to buy any needles. They tell their problem to the dealer and he says that he can only give them one free needle with the heroin, because they are difficult to get. That evening they are at home and have taken some mandrax, when Jamil suggests that they try the heroin. Rita has smoked quite a bit of mandrax already and feels very relaxed, so she doesn't feel so worried about the needles. Jamil decides to inject himself first to see if he can do it properly. After he has successfully injected himself he re-loads the needle and injects it into Rita's arm.

- 1. Why do you think Rita and Jamil shared a needle?**
- 2. What would have made it easier for Rita and Jamil to use clean needles?**
- 3. What risks do Rita and Jamil expose themselves to in this case study?**

DECRIMINALISATION VS. LEGALISATION⁽⁴⁾

The **decriminalisation** of sex work would get rid of all laws that criminalise sex work. This means that sex work would be recognised as work and enjoy the protection of labour laws and occupational health laws. Decriminalisation of sex work in South Africa is considered to be the safest option for sex workers. This is because the sex work industry would be regulated like any other industry.

Legalisation would mean that sex workers would have to work under very specific conditions. Local municipalities and Parliament would create these conditions. For example: Creating specific 'Red Light Districts' where sex workers could work; Sex workers might have to register with authorities and carry cards identifying them as sex workers; or forcing sex workers to go for regular health checks. An issue with legalisation is that the prescribed conditions can be used to abuse sex workers. For example: if a municipality puts the Red Light District in a horrible place, the sex workers will work outside this area to get clients. Working outside the area would be illegal and they may face personal danger without any protection from the law.

1. What are the laws in South Africa relating to sex work?
2. What are the laws in South Africa relating to drug use, and injecting drug use in particular?
3. How do these laws impact vulnerability and HIV risk?
4. What human rights are violated by these laws?
5. How are these laws in conflict with the Constitution of South Africa?

What are the legal implications for HCW working with MSM, sex workers, and PWUD?

Are health care workers required to provide medical care to MSM, PWUD or sex workers?

All South Africans are equal before the law and the South African Constitution binds all branches of government, including public health care settings, to 'respect, protect, promote, and fulfil' the obligations set out in the Bill of Rights. This means it is every health care worker's duty to provide MSM, sex workers, and PWUD the same care and treatment that are provided to other clients. Health care workers may have personal beliefs that make providing care to MSM, sex workers, and PWUD challenging but these beliefs should not take precedence over their duty to provide care and support to any individual in need. In order to fulfil this duty, all health care workers must recognise that MSM, sex workers, and PWUD are human beings who deserve fair treatment and who are not powerless victims or irresponsible criminals.

Are health care workers required to provide medical care to MSM, sex workers, or PWUD without South African identification?

There is no requirement for identity documentation to be produced in order for people to access health care services. Many MSM, sex workers, and PWUD do not have identity documentation due to their marginalised status, even if they are South Africans. No person may be denied health care services because they do not have documentation⁽¹⁻³⁾.

The South African Department of Health have directed that refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic health care and ARVs in the public sector.

Are health care workers required to report to the police if a client discloses that they are a sex worker or that they use drugs?

Health care workers should not fear arrest when providing services to PWUD or sex work clients. In fact, health care workers are not required to report to the police if a client discloses that they use drugs or engage in sex work. Specifically, Section 54 of the Sexual Offences Act only requires reporting of sexual offenses involving minors and people with disabilities. South African law does require an individual to report if they come in contact with heroin, which is an illegal substance. In a health care setting, this would only apply if a client brought heroin with them into the clinic which is highly unlikely and therefore has little impact on a health care workers' ability to provide services to PWUD.

BATHO PELE PRINCIPLES⁽⁵⁾

The eight principles of Batho Pele:

CONSULTATION

Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.

SERVICE STANDARDS

Citizens would know the level and quality of public service they are to receive and know what to expect.

ACCESS

All citizens have equal access to the services to which they are entitled.

COURTESY

Citizens should be treated with courtesy and consideration.

INFORMATION

Citizens should be given full accurate information about the public service they are entitled to receive.

OPENNESS and TRANSPARENCY

Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.

REDRESS

If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.

VALUE FOR MONEY

Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.

Is it legal to provide Opioid Substitution Therapy and Needle Syringe Exchange Programmes to PWID?

Opioid Substitution Therapy (OST) and Needle Syringe Exchange Programmes (NSPs) are internationally recognised strategies that prevent the spread of HIV among people who use drugs and will be discussed further in Module 8. In South Africa, these programmes are not illegal to implement, but they are uncommon. However, the South African National Department of Health's Mini Drug Master Plan (2011/12-2013/14) does acknowledge the short, medium, and long term activities that will be required to support PWUD and the

National Strategic Plan on HIV, STIs and TB 2012–2016 highlights ‘the need to consider scaling up substance abuse reduction programmes and needle exchange programmes’ (DOH). In South Africa, PWID are at a significant disadvantage without these recognised forms of care and treatment. The South African government supports the harm-reduction approach, which is currently being used by the Department of Social Development in developing a new strategy to address drug use in South Africa.

How can health care workers address the effects of this legal context?

Provide unbiased care in support to all MSM, sex worker, and PWUD clients. It is not uncommon for health care workers to perceive assault or injury, as inevitable consequences of engaging in sex work or doing drugs. Further still, some health care workers may let this bias affect the level of service that is provided to a sex worker. It is the responsibility of every health care provider to give unbiased support to each of their clients. Module 2 on Stigma and Module 10 on creating an enabling environment offer a variety of strategies that can be used to provide unbiased care.

HEALTH WORKER RIGHTS

Rights of health care personnel (from South African National Health Bill):

1. Health care personnel may not be unfairly discriminated against on account of their health status.
2. Despite subsection (1) but subject to any applicable law, the head of the health establishment concerned may in accordance with any guidelines determined by the Minister impose conditions on the service that may be rendered by a health care provider or health worker on the basis of his or her health status.
3. Subject to any applicable law, every health establishment must implement measures to minimise:
 - a) injury or damage to the person and property of health care personnel working at that establishment; and
 - b) disease transmission.
4. A health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her.

Where possible, health care workers should engage with MSM, sex workers, and PWUD individually in order to address any fear they may have in accessing health care. Remind MSM, sex worker, and PWUD clients that their support will be confidentiality and reassure them that they are entitled and have the right to nonjudgmental care and services. During this engagement, health care workers should encourage MSM, sex workers, and PWUD clients to share their experiences and explain their circumstances. This would give the provider an opportunity to assess the possible services that the client may need, including the prescription of PEP, ARVs, counselling services, or wound care.

LAWS THAT PROTECT THE RIGHTS OF MSM, SEX WORKERS, AND PWUD

Several South African laws are in direct contradiction to the rights provided by the South African Constitution, specifically those allowing access to justice and health services. The constitutional pillars of dignity, freedom and equality are undermined by punitive laws relating to sex work and drug use. So too are the constitutional rights of sex workers and drug users to access food, water, social security, education, health care and freedom from discrimination.

MSM: Laws and policies exist in South Africa to protect MSM from discrimination. The Constitution of the Republic of South Africa (1996), specifically prohibits unfair discrimination on the grounds of sexual orientation under Section 9⁽⁶⁾. Litigation brought to the Constitutional Court challenging discriminatory laws and policies on the basis of equality resulted in the supportive legislation which exists today.

PWUD: The Prevention of and Treatment for Substance Abuse Act (70/2008) outlines the state's responsibility to use harm reduction to combat substance abuse. It describes harm reduction as including 'holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse.' There is no explicit mention of the need for inclusion of NSE programmes and OST.

SW: In contexts where sex work is illegal, SWs' human and constitutional rights are often violated – in particular their rights to freedom, access to health care and non-discrimination.

SUMMARY AND KEY FACTS

- A number of South African laws and policies that harm MSM, sex workers, and PWUD and increase their overall vulnerability and risks. Laws that criminalise sex work and drug use have also been associated with violence, harassment, disempowerment, and lack of legal recourse to address injustices among Sex Workers and PWUD⁽¹⁾
 - Current laws that criminalise sex work infringe on multiple constitutional rights given to sex workers. These laws create challenging barriers for sex workers when engaging with health care workers and police.
 - The criminalisation of drug use forces PWUD ‘under-ground’ where they may be exposed to violence, assault, and fail to seek health care due to fear of arrest or discrimination.
 - The fact that drug use is illegal in South Africa significantly affects PWUD and their ability to access health care. Many PWUD may not disclose to a health care worker that they inject drugs because they may be afraid that they will be arrested.
 - All South Africans are equal before the law. This means it is every health care worker’s duty to provide MSM, sex workers, and PWUD the same care and treatment that are provided to other clients.
 - Health care workers may have personal beliefs that make providing care to MSM, sex workers, and PWUD challenging but these beliefs should not take precedence over their duty to provide care and support to any individual in need.
 - There is no requirement for identity documentation to be produced in order for people to access health care services.
 - Health care workers should not fear arrest when providing services to PWUD or sex work clients. In fact, health care workers are not required to report to the police if a client discloses that the use of drugs or engaging in sex work.
 - Where possible, health care workers should engage with MSM, sex worker, or PWUD clients individually In order to address any fear they may have in accessing health care.
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MODULE

6

MENTAL HEALTH AND SUBSTANCE USE

Learning Outcomes

After completion of this module, you should be able to:

- i Explain why mental illness is prevalent among MSM, sex workers, and PWUD
- ii Describe the common mental illnesses among MSM, sex workers, and PWUD
- iii Understand why some individuals may use drugs
- iv Describe how substance use can effect MSM, sex workers, and PWUD

Mental illness among MSM, sex workers, and PWUD

Are MSM, sex workers, and PWUD mentally ill?

It is a misconception that MSM, sex workers, and PWUD are mentally ill or that individuals become part of these groups because they have a mental illness. For example, individuals engage in sex work not because they are mentally ill but because sex work provides an income and financial support. For some time, homosexuality was considered a mental illness but by 1973, in recognising that it was a normal part of human sexuality, it was removed from the Diagnostic and Statistical Manual of Mental Disorders as a mental illness. MSM engage in sex with other men for many reasons. For some it is a natural part of their sexual orientation or behaviour and for others it is situationally determined, such as in prisons.

Not all PWUD are mentally ill although mental illness does, however, have a complex interaction with drug use. In some cases, mental illness may already be present before an individual becomes a drug user. In this situation, mental illness may be one of the factors that lead individuals to drug use as a method of coping. In other cases, mental illness may occur as a direct result of drug use. This may be due to a variety of reasons. For some, drug use creates situational and social stressors, such as homelessness or unemployment, which can lead to mental illness. For others, mental illness may be a physiological result of drug use, since some drugs manipulate neurotransmitters in the brain.

Why are mental health illnesses prevalent among MSM, sex workers, and PWUD?

Mental health issues are common among MSM, sex workers, and PWUD because they are regularly exposed to many factors that can result in the development of a mental health illness⁽¹⁾. Mental illnesses develop for many reasons, but in some circumstances they can be related to events that a person continually experiences in his or her life. Often, events that lead to mental health illness are those that result in continued stress, violence, instability and/or trauma.

For many MSM, sex workers, and PWUD, these factors are experienced regularly. For example, the issue of mental health is relevant to sex workers because sex work can often occur under poor working conditions and unsafe working environments. These conditions are unable to be regulated because sex work is illegal in South Africa. Therefore, sex workers are continually and regularly exposed to unsafe and dangerous environments and may be regularly exposed to traumatic events. Similarly for PWUD, they may

experience traumatic events or be exposed regularly to unsafe conditions. For MSM, even though their rights are protected under the Constitution, many still experience, violence, and other threats to their health. These continued threats put many MSM at risk for mental illness as well.

Stigma and discrimination are also factors that make key populations vulnerable to mental illness. As discussed in Module 2, key populations are readily stigmatised, which can lead to discrimination, social isolation, and even prevent key populations from accessing care.

Trauma

A traumatic event is any experience that is significantly emotionally disturbing or distressful. Traumatic events may provoke extreme emotions, thoughts, and behaviours. A traumatic event differs from a common negative experience in that it generally leaves a lasting mental and emotional impact. Unlike the general population, traumatic experiences can be very common for MSM, sex workers, and PWUD.

Consider Siphos experience in Port Elizabeth: Siphos is a sex worker who regularly spends his evening with other friends in a common part of town known to be good for picking up clients. One evening Siphos witnesses his friend get into a fight with a client who refuses to pay him. The client violently attacks his friend and eventually stabs him to death. Siphos has trouble going back to that spot and as a result is not finding as many clients. Weeks later, Siphos is struggling to leave his home because of feelings of overwhelming fear.

Siphos experienced a traumatic event when he witnessed his friends death, and is likely suffering from depression because of it. Witnessing death is one of many examples of traumatic episodes that key populations may experience regularly. Experiencing trauma, can result in post traumatic stress disorder (PTSD), which is discussed further below.

Other examples of traumatic events include police harassment, rape, torture, trafficking, physical or sexual assault, corrective rape (the rape of a gay or lesbian or transgender person by someone who believes they can 'correct' the victims sexuality), or child abuse. Additionally, unlike other populations, key populations may then be challenged with finding effective care and counselling to deal with the trauma.

Most significantly, traumatic events, especially when experienced over a period of time, are one of the causes of depression, anxiety, and substance abuse among MSM, sex workers, and PWUD.

WHAT ARE THE COMMON EFFECTS OF TRAUMA?

The effects of trauma can result in various symptoms ranging from physical to emotional. Some effects that may be evident follow:

- Difficulty in sleeping or nightmares
- Irritability
- Actively avoiding any reminders of the event
- Developing various phobias or fears that were not present beforehand
- Withdrawing socially from others
- Using alcohol and drugs to numb feelings

What are the common mental illnesses among MSM, sex workers, and PWUD?

Anxiety

Anxiety is a normal emotion in everyday life and is closely related to fear. Anxiety can become a mental illness when it is prolonged or never-ending or when the anxiety becomes out of control and affects an individual's daily functioning. Signs and symptoms of anxiety may include excessive worry, fear, feelings of uneasiness, tightness in the chest, difficulty breathing, heart palpitations, dizziness, light headedness, nausea, diarrhoea and excessive sweating.

Anxiety can also be caused by drug use, particularly the use of stimulants such as cocaine. At the extreme, anxiety can often lead to panic (or a panic attack) whereby a person experiences intense apprehension and a sense of not being in control, and where feelings of unreality in relation to themselves or the world may occur.

A special type of anxiety disorder that may affect MSM, sex workers, and PWUD is social anxiety disorder. When someone suffers from social anxiety, they experience intense fear, panic or stress while engaging in everyday social situations. It can create feelings of humiliation, embarrassment and judgement. Social anxiety may include symptoms such as sweating, blushing, trembling, nausea and stammering. It may even lead to panic attacks. Social anxiety is particularly acute among key populations as they may experience high levels of social discrimination and stigma. An individual who is experiencing social anxiety may be less likely to seek health care services because of fear of being judged or scrutinised by health care staff.

Another severe anxiety disorder that may affect MSM, sex workers, and PWUD is post-traumatic stress disorder (PTSD), which occurs after an individual has been exposed to a severely traumatic event. After the event, an individual who suffers from PTSD may experience panic attacks and extreme fear or they may re-envision the event continually. The disorder can have a significant impact on normal everyday functioning, and MSM, sex workers, and PWUD may experience traumatic events regularly.

EXERCISE 1

Case Study: Nozipho

Nozipho is 29-year-old-woman from Fort William. She was very bright at school, and always received the highest marks in the class. She left school with an excellent matric and planned to get a scholarship to continue with her education. Nozipho's dream was to be an actress, and she watched soapies daily, one day imagining she would be on the TV. After Nozipho had been out of school for six months and had still not managed to find work, her mother suggested she go to stay with her aunt in Johannesburg, where she was sure to find a job. The next month Nozipho left her home town and travelled to Johannesburg by bus, she was full of excitement about her future and her new life in the big city.

After a month of walking around the city, handing her CV in at hundreds of companies, and still not managing to find any work, Nozipho was beginning to get depressed. Her aunt complained that she was not contributing and that if she didn't get a job in a week then she would be out on her own. Nozipho became desperate, she lost her appetite and couldn't sleep at night as she lay awake worrying about what she would do. The next day Nozipho was again trudging around the streets searching for work. She saw a bar that was open, and although usually she would never step foot inside a bar, she thought she should see if they had any work. Because it was still in the afternoon, the bar was quiet – Nozipho walked up to a man who was sitting at table doing paperwork.

He turned out to be the manager, and so she asked him if he had any work. He looked her up and down and she said 'ok, I'll give you a chance, come back tomorrow night at 6pm and we can find some work for you'. It turned out that the manager wanted Nozipho to work as a topless waitress in the bar. Nozipho was horrified to hear this, but as she was desperate she accepted, thinking to herself it would only be until she found something better. Nozipho hated the work and soon lost all hope

of her dreams of becoming an actress. When she would get home at night, her aunt would yell at her for not bringing home enough tips and force her to clean the house. Nozipho soon struggled to get out of bed each morning and felt hopelessly sad. She started stealing alcohol from the bar as she found that was the only way to numb her feelings and get through each night. After a few weeks she started thinking that the only way to escape her situation would be to end her life. One night, Nozipho's manager suggested that if she wanted to make some extra tips she should offer to provide the clients with oral sex in a back room behind the bar. At first, Nozipho was opposed to the idea but after she saw a few of the other waitresses doing it, she gave it a try. She didn't enjoy doing it but soon realised that she could make enough cash in tips to move out of her aunt's house. The idea of a new beginning motivated Nozipho to start thinking about her future once again.

- 1. Can you identify Nozipho's mental illness? How is her mental health affecting her life?**
- 2. What factors contributed to Nozipho's mental illness?**
- 3. If Nozipho arrived at your health facility, what course of action would you take?**
- 4. What role is substance use playing in Nozipho's life? Is it contributing to her mental illness?**
- 5. What role is sex work playing in Nozipho's life? What alternatives would Nozipho have if she wasn't engaging in sex work?**

Depression

Depression is a psychological disorder that involves decreased mood, low self-esteem and a loss of interest in things that were previously stimulating to the individual for an extended period of time. Signs and symptoms can include the following:

- Depressed mood most of the day and nearly every day
- Loss of interest or pleasure in all or almost all activities most of the day
- Feelings of worthlessness and hopelessness
- Inability to think or concentrate
- Recurrent thoughts of death or suicide

Many factors may cause someone to become depressed, such as genetics or stressful life events. For key populations, depression can greatly impact their health, particularly if they are unable to find a means of treatment. Individuals may actively seek out drug use as a means of coping with their depression or, alternatively, depression can be a result from recurring drug use.

If depression is severe and left untreated it could also lead to increased suicidal behaviour. Depression may also lead key populations to be less diligent in reducing their risk behaviour and protecting their overall well-being.

EXERCISE 2

Case Study: Luke

Read through the case study and answer the following questions.

Luke is a 35-year-old man who was recently divorced. His ex-wife won custody of their two children and refused to allow him visitation rights. Three months ago he was retrenched from his job and is currently unemployed. A few months ago his mother was diagnosed with cancer and told that she does not have long to live. Luke and his mother have a very good relationship and she is his support structure. Luke's father is an alcoholic and was never present in his life. Ever since the divorce Luke has not had a good night's sleep. He wakes up in the early hours of the morning and cannot go back to sleep. He stays indoors increasingly and does not want to visit family or friends. He used to love playing soccer but now refuses his friends' invitations to play a game. He also said that he sees no reason to continue living and was wondering that maybe it would be better if he ended his life. On weekends Luke smokes dagga and drinks heavily. About a year ago a friend introduced him to heroin. Luke found the feeling extremely euphoric and it made him forget all his problems. He now injects heroin more frequently, almost daily. He and his friends share needles because the pharmacy down the road refuses to sell them needles. The pharmacist thinks that by selling them needles he will be encouraging their drug-taking behaviour. His friend has also introduced him to many women, and often Luke wakes up next to a woman that he does not know. Luke's mother tried to talk to him about his deteriorating behaviour and suggested that he seek help. Luke got angry with her, told her that there is nothing wrong with his life, and it's only a phase that he is going through.

- 1. Can you identify the mental illness/illnesses that Luke is suffering from?**
- 2. Can you list the signs and symptoms of his mental illness/ illnesses?**
- 3. What are the contributory factors or causes of Luke's condition?**
- 4. What is a possible treatment plan for Luke's condition?**

Substance use and drug dependence

Is drug dependence a mental illness?

Drug dependence is a complex and often chronic brain disease; it is classified as a relapsing mental illness. It occurs when the use of a drug dominates a person's life and becomes a compulsive behaviour that is hard to control. When a person who uses drugs is experiencing drug dependence, he or she has extreme difficulty in resisting the urge to use drugs despite the negative consequences and harmful effects. Drug dependence is considered a mental illness because it changes the chemistry of the brain, which leads to changes in an individual's behaviour. When drug dependence occurs, a person who uses drugs becomes dominated by a strong and powerful motivation to use. The drug-seeking, compulsive behaviour weakens the individual's ability to control impulses. This is due to changes in the brain structure and function, which then leads to taking the drug despite the negative consequences. These changes occur in some of the same brain areas that are affected by other mental disorders, such as depression, anxiety or schizophrenia.

Cravings

Cravings are strong memories that are linked to the effect of drugs on the brain and can cause strong physiological effects.

SIGNS OF DRUG DEPENDENCY

- Drug-seeking behaviours (obtaining the drug from multiple doctors, illegally obtaining the drug)
- Cravings for the drug
- Preoccupation with obtaining the drug
- Misusing the drug for intoxication or pleasure
- Dependence and withdrawal upon stopping the drug
- Interference with normal life functions (decreased work productivity; decreased motivation; social, family, and relationship problems)
- Continued use despite negative consequences

Why do some key populations use substances?

Not all MSM, sex workers, and PWUD engage in substance use. Some do turn to substances like alcohol, dagga (cannabis), tik, cocaine or heroin, in order to cope with feelings of anxiety or depression that may experience. Individuals from key populations may use substances to cope with a traumatic experience or to escape the stress they experience as a result of discrimination by society. Some MSM, sex workers, and PWUD use substances to enhance sexual activity, and for sex workers, to make it easier to do their job.

EXERCISE 3

Case Study: Bongsi from Limpopo

Read through the case study and answer the following questions.

Bongsi is a 23-year-old gay man from Limpopo who works for a small LGBT NGO. Bongsi was waiting for a taxi late one Saturday evening after a night out when he noticed three men getting out of a car which had been driving behind the taxi. One of the men shouted abuse at him as the men ran up to him and threw him to the ground. One person held him down while the other two people punched him in the face and kicked him in his stomach, shouting 'Stabane!' The three men ran off and Bongsi was left bleeding by the side of the road. It is several months after the accident, and Bongsi constantly feels nervous and that his heart is racing all the time. He sweats excessively, especially when he is in a taxi, and has difficulty talking about what happened or going anywhere near where the attack took place. He sleeps poorly and his nights are often disturbed by bad dreams. Bongsi started drinking heavily, helping him cope with the nightmares and chronic feelings of anxiety. He feels hopeless most of the time, and find it difficult to see a positive future for himself.

1. Why do you think Bongsi was attacked?
2. What condition do you think Bongsi is suffering from?
3. What do you think the implications on his long-term health and life will be?
4. What support would you provide Bongsi with if he was your client?

What effect does mental illness have on MSM, sex workers, and PWUD?

Health-seeking behaviours and treatment

Depression can prevent MSM, sex workers, and PWUD from adhering to medical treatments or even inhibit them from seeking initial health care. Anxiety can limit an individual's willingness to engage with others, which may include health care service providers. Individuals who are experiencing a mental illness may be more difficult to treat for HIV and other issues. For example, a sex worker who is experiencing depression or anxiety may be less likely to come to a clinic to receive ARVs or other medication and adhere to the regimens. Or a PWUD who exhibits signs of a behavioural disorder may act out in a clinic setting and become challenging to treat.

Behavioural risks

Drug dependency can particularly affect MSM, sex workers, and PWUD. A MSM, sex worker, or PWUD who is experiencing depression or bipolar disorder may be less likely to protect his or her health and may choose to engage in riskier behaviours. Others may also engage in riskier behaviour in order to sustain their drug addiction. Abuse of drugs and alcohol can make MSM, sex workers, and PWUD more vulnerable to HIV and STIs because it may cause them to engage in riskier sexual behaviour, such as not using condoms, not worrying about consequences or outcomes of their actions, or by feeling an inflated sense of courage and fearlessness.

Drug-taking risks

Some people who experience high levels of anxiety or depression may further be encouraged to turn to alcohol and other substances to cope with or numb their intense feelings so that they can return to work even in face of the anxiety and depression. Mental illness may also be a significant barrier to overcoming drug use and, in some cases, may encourage key populations to continue using drugs. Mental illness such as depression, anxiety or personality disorders may affect the effectiveness of substance abuse and other health care treatments.

EXERCISE 4

Case Study: Janice, from Port Elizabeth

Janice is a 31-year-old woman who lives in Port Elizabeth. She works part-time as a barmaid in a popular nightclub in the centre of town. Three months ago, Janice was dumped by her long-term boyfriend, who left Janice for her best friend, Ayanda. Since the breakup Janice has felt really low. She often cries, and she finds it difficult to get out of bed in the mornings as she has nothing to look forward to. Janice has felt really lonely since she lost her boyfriend and her best friend. She has started hanging around with some of her co-workers from the club, John and Thulani. Her new friends suggested that Janice try taking heroin to forget about her broken heart. Janice was willing to try anything to escape her misery, so one evening Janice went back to Thulani's flat after work. Thulani prepared the heroin, shot himself up, and then injected Janice with the same needle. Janice really liked how the heroin made her feel. The pain of her loneliness and heartache went away while she was high, and she felt so good. Janice started going back to Thulani's place regularly, sometimes with John too. The three of them would shoot up together, using the same needle, as Thulani said it was difficult to get needles so they must not waste them. One night, neither Thulani nor John came to work, and Janice was worried because she really needed a hit. She found she could not concentrate and was getting very anxious and upset. Before her shift ended, Janice walked out of the club as she was desperate to find some heroin. Janice walked to the house where she knew Thulani bought his drugs. The man there said he would give Janice a hit if she has sex with him. Janice did not hesitate and ended up having unprotected sex with the man, who shot her up afterwards. The next morning Janice remembered what happened and went to the clinic to get the emergency contraceptive pill.

- 1. What are some of the psychological, health and social issues that Janice faced because of her drug-taking behaviour?**
- 2. As a health care provider, how would you suggest providing support to Janice?**
- 3. What effect do you think depression had on Janice's drug-taking behaviour?**

SUMMARY AND KEY FACTS

- MSM, sex workers, and PWUD are not mentally ill; however, mental health issues are common among them because they are regularly exposed to many factors that can result in the development of a mental health illness such as continued stress, violence, instability and/or trauma.
- Stigma and discrimination are also factors that make MSM, sex workers, and PWUD vulnerable to mental health illness, because they lead to social isolation and prevent MSM, sex workers, and PWUD from accessing care.
- Unlike the general population, traumatic experiences can be very common for MSM, sex workers, and PWUD. A traumatic event is any experience that is significantly emotionally disturbing or distressful. Traumatic events, especially when experienced over a period of time, are one of the causes of depression, anxiety, and substance abuse among MSM, sex workers, and PWUD. Unlike other populations, MSM, sex workers, and PWUD may then be challenged with finding effective care and counselling to deal with the trauma.
- Depression is a psychological disorder that involves decreased mood, low self-esteem and a loss of interest in things that were previously stimulating to the individual for an extended period of time. For MSM, sex workers, and PWUD, depression can greatly impact their health. Individuals may actively seek out drug use as a means of coping with their depression or, alternatively, depression can be a result from recurring drug use.
- Depression can prevent MSM, sex workers, and PWUD from adhering to medical treatments or even inhibit them from seeking initial health care. Drug dependency can particularly affect MSM, sex workers, and PWUD. A MSM, sex workers, or PWUD who is experiencing depression or bipolar disorder may be less likely to protect his or her health and may choose to engage in riskier behaviours. Others may also engage in riskier behaviour in order to sustain their drug addiction.
- Not all MSM, sex workers, and PWUD in substance use. Some do turn to substances in order to cope with feelings of anxiety or depression, a traumatic experience, or to escape the stress they experience as a result of discrimination by society. Some MSM, sex workers, and PWUD also use substances to enhance sexual activity, and for sex workers, to make it easier to do their job.

MODULE

7

HIV AND OTHER INFECTIONS

Learning Outcomes

After completion of this module, you should be able to:

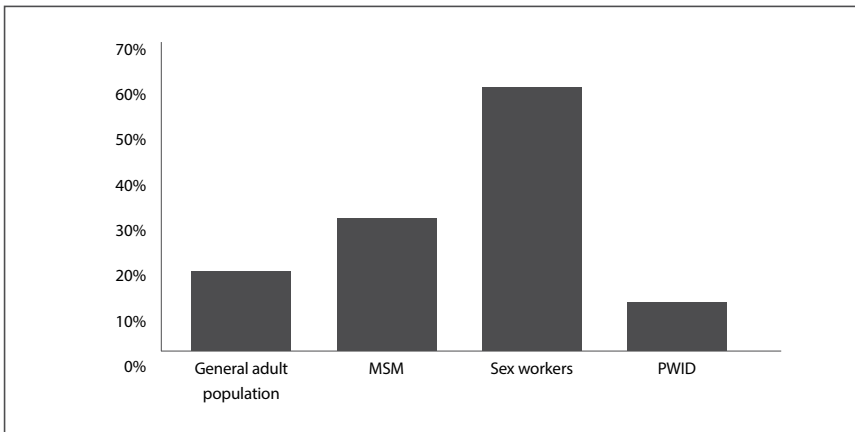
- i Describe the HIV epidemic among MSM, sex workers, and PWUD
- ii Explain why key populations are at risk for TB
- iii List STIs and other infections that are common among MSM, sex workers, and PWUD

Human Immunodeficiency Virus (HIV)

Sex workers, MSM, and PWUD, like everyone else, are exposed to HIV and other STIs through the exchange of bodily fluids, which includes blood, vaginal fluid and semen. This exposure is most likely to occur from direct contact during penile-vaginal, penile-anal, oral-penile or oral-anal sex, or from sharing drug injecting equipment.

South African HIV prevalence (2008–2012 estimates)⁽¹⁾

Overview of HIV prevalence among the general population and selected Key Populations based on estimates from national surveys and smaller research studies^(2–5)



HIV TRANSMISSION DURING INJECTING DRUG USE⁽⁶⁾

- Used needles returning to a common spoon can transmit HIV (even if the same person has kept his or her own needle and syringe).
- HIV can be transmitted via sharing either the needle or the syringe.
- Sharing a filter or spoon can transmit HIV.
- Injecting in a public place where a lot of injecting occurs, even with all the right equipment, tends to be done hastily, which increases the likelihood of mistakes and HIV transmission.
- PWUD often need to negotiate the difficulty of sharing various materials. This often has to be done quickly, enhancing the chance of health risks such as HIV transmission.

Tuberculosis (TB)

South Africa has the third highest burden of TB in the world⁽⁷⁾. The NSP identifies drug use, alcohol abuse, and living or working in poorly ventilated and overcrowded environments as some of the factors used to determine populations who are at risk for TB infection. Sex workers and PWUD specifically experience these factors and are therefore at risk for TB infection. For key populations like sex workers and PWUD, simply engaging in sex work or using drugs does not place them at risk for TB; however, these actions can expose them to other factors that do increase their risk. For example, while drug use itself is not a risk factor for getting TB, the living conditions of some PWUD may place them at risk, particularly individuals with weak immune responses who live in overcrowded spaces with other PWUD where there is frequent coughing. Similarly, sex workers may work in brothels that are often poorly ventilated and overcrowded. They may also have little ability to come and go freely, thereby increasing their risk. Furthermore, both sex workers and PWUD experience incarceration, since many of their actions are illegal in SA, where prison conditions also expose them to TB.

SEX WORK, DRUG USE, AND TB

Sex workers and PWUD may be at risk for TB because:

1. They may live in poorly ventilated and/or overcrowded environments that increase their risk of exposure to mycobacterium TB.
2. They may engage in drug use or alcohol abuse which may lower their immune system thereby increasing the likelihood of developing TB if exposed to mycobacterium.

Sexually transmitted infections (STIs)

STIs are common among key populations; specifically herpes simplex virus type 2 (HSV), human papillomavirus (HPV), gonorrhoea, chlamydia, and syphilis. Large numbers of sexual partners and frequent unprotected sex is commonly reported among MSM, sex workers, and PWUD and increases their risk for STI infection. Untreated STIs also increase the HIV risk among these groups and contribute to their transmission within communities. Rectal infection or the presence of STIs around the anus may be experienced by key populations who engage in anal sex.

Genital ulcers

Genital ulcers, or sores, may be either painful or painless. The former are most commonly caused by the herpes virus and the latter most often by syphilis. Other causes of genital sores include lymphogranuloma venereum, chancroid, primary HIV infection, granuloma inguinale, trauma, cancer, drugs, Behcet's disease and Reiter's syndrome⁽⁸⁾.

Genital herpes

Genital herpes consistently accounts for roughly 20% of new HIV infections at all stages of the epidemic, making it the most significant STI driving the transmission of HIV⁽⁹⁾. Infection is for life and no cure exists. Most commonly, a few painful sores are found on or near the penis and anus, surrounded by a red area. This virus can also cause sores on the mouth (cold sores), which usually heal by themselves. These cold sores on the mouth are not necessarily caused by sexual contact. The virus is spread through direct contact. By touching open sores with a body part (hand to vagina, hand to penis, penis to anus, mouth to penis, mouth to vagina, etc.) the virus can be passed to other people. The virus may also be spread from person to person even if there are no open sores and the skin is intact⁽¹⁰⁾. Treatment (an antiretroviral such as acyclovir) is expensive and not freely available, and works to control the sores if it is started early. Treatment is needed for severe sores or for those which do not heal.

Hepatitis A, B, and C

Viral hepatitis may be caused by one of a group of viruses which directly affect the liver, most of which can be spread in the same way as other STIs. Sex workers, MSM, and PWUD may be exposed to the Hepatitis B or Hepatitis C viruses through the infected bodily fluids of sexual partners, which include blood, vaginal fluid, pre-seminal fluid, and semen. Additionally, PWUD and other drug users may be exposed through the use of non-sterilized (injecting) equipment. Hepatitis B and C viruses both lead to the inflammation of the liver and can lead to liver cancer.

In Africa, many people become infected with Hepatitis A during childhood. Lifelong protection can be obtained from natural infection or through immunisation. It may be spread through oral-anal sex. In adults, the disease is usually short lived, causing nausea, vomiting, yellowing of the skin (jaundice), abdominal pain, swollen glands, and joint pain. For those not previously infected, there is an effective immunisation available for Hepatitis A⁽¹¹⁾.

Hepatitis B is spread through bodily fluids, similarly to HIV; but unlike HIV, Hepatitis B can be prevented by vaccination. Hepatitis B infection is common in Africa. Most individuals are able to recover fully from hepatitis infection; however, between about 1 in 4 and 1 in 20 have long-term infection, depending on whether it started in childhood or adulthood. Some of these people develop scarring of the liver (cirrhosis), which may cause the development of liver cancer⁽⁸⁾.

Individuals who are infected with HIV and Hepatitis B need special attention due to the medications used to treat the infections and the possibilities of liver problems. Treatment for Hepatitis B is very expensive, not very effective, and only available in areas with extensive resources. Hepatitis B vaccination is recommended for all people who practise riskier sex, such as sex workers and MSM⁽¹²⁾.

Hepatitis C is primarily spread through blood-to-blood contact and is therefore very relevant to PWID who may use non-sterilised needles during injection. Hepatitis C transmission is also increasingly linked to the anal penetrative sex among MSM. Hepatitis C affects the liver and while up to 80% of those infected can be cured, it can also result in liver cancer and failure.

COMMON VIRAL INFECTIONS

- Human immunodeficiency virus (causes AIDS)
- Herpes simplex virus type 2 (causes genital herpes)
- Human papillomavirus (causes genital warts and certain subtypes lead to cervical cancer in women)
- Hepatitis B virus (causes hepatitis and chronic cases may lead to cancer of the liver)
- Cytomegalovirus (causes inflammation in a number of organs including the brain, the eye, and the bowel)

Human Papilloma Virus: Genital warts and cervical cancer

Another virus, HPV (the human papilloma virus) is the precursor to cervical cancer and causes warts in the genital area. Cervical cancer is a very slow-growing cancer, and PAP smears are provided to screen for these. The genital warts appear as growths around the genitals and/or anus of both men and women. Sometimes they are itchy, and they may bleed if scratched. Warts often heal without treatment. Large warts need treatment with medication or may need to be surgically removed. Warts may be numerous, and become

very large in HIV-positive individuals. The presence of warts around the genitals or anus is a sign of unprotected sex⁽¹¹⁾. Occasionally infection with HPV may lead to anal cancer, which is 17 times more likely to occur in MSM than in non-MSM⁽¹⁴⁾. A vaccine (Gardasil®) is now available for the prevention of HPV infection. Owing to the cost of this vaccine, access is currently limited but is available in the private sector.

Syphilis

Syphilis is caused by bacteria and can first appear as a painless sore (ulcer) on the labia or vulva, penis, anus, or surrounding area. This sore heals, and individuals may then develop a rash, swollen glands, and muscle and joint pains. These symptoms then disappear and the person may be symptom-free for many years. The bacteria continue to live in the body and may spread to cause disease in the testicles, heart, and brain. Often, syphilis is only diagnosed in a blood test. Penicillin, given as three injections over three weeks, is effective for treating most cases of syphilis^(15, 8).

Gonorrhoea

Some men with gonorrhoea may have no symptoms at all. However, some men have signs or symptoms that appear 1 to 14 days after infection. Symptoms and signs include a burning sensation when urinating, or a white, yellow, or green discharge from the penis. Sometimes men with gonorrhoea get painful or swollen testicles.

In women, the symptoms of gonorrhoea are often mild, but most women who are infected have no symptoms. Even when a woman has symptoms, they can be so nonspecific as to be mistaken for a bladder or vaginal infection. The initial symptoms and signs in women include a painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods. Women with gonorrhoea are at risk of developing serious complications from the infection, regardless of the presence or severity of symptoms.

Symptoms of rectal infection in both men and women may include discharge, anal itching, soreness, bleeding, or painful bowel movements. Rectal infection also may cause no symptoms. Infections in the throat may cause a sore throat, but usually causes no symptoms.

Many of the bacteria mentioned above may cause infection in other parts of the body. *Neisseria gonorrhoea* and *chlamydia* may also infect the anus and mouth. Infection in the anus may cause painful bowel movements and painful receptive anal sex, and there may be a white or bloody discharge from the anus. Diagnosis may be made by direct observation using a

proctoscope—an instrument inserted into the anus that allows a health care professional a better view of the lining of the anus. Laboratory tests on a sample from the anus can also be used to make the diagnosis. Treatment is by means of antibiotics to cover the most likely bacteria⁽¹³⁾.

Chlamydia

Chlamydia is known as a 'silent' disease because the majority of infected people have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure.

In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. If the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilised eggs from the ovaries to the uterus), some women still have no signs or symptoms; others have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods. Chlamydial infection of the cervix can spread to the rectum.

Men with signs or symptoms might have a discharge from their penis or a burning sensation when urinating. Men might also have burning and itching around the opening of the penis. Pain and swelling in the testicles are uncommon.

Men or women who have receptive anal intercourse may acquire chlamydial infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men who have oral sex with an infected partner.

Lymphogranuloma venereum (LGV) is another infection caused by a type of chlamydia bacteria. It may cause a sore in the genital area and swelling of the glands in the groin, and result in abscesses. Antibiotics are needed to treat this infection⁽¹⁶⁾.

Other common infections

PWID may also experience the following common infections:

Abscesses and ulcers – People who inject drugs may be affected by abscesses or ulcers around the areas of their bodies where they inject, usually the arms or legs. Abscesses are pus-filled cavities that are created as a reaction to a bacterial infection or foreign element. Abscesses may be difficult to heal and can have a foul odour. Ulcers are generally not deep and can heal with good wound care and antibiotics.

Septicaemia – Septicaemia is a potentially fatal blood infection resulting from bacteria that has been injected via the tools or paraphernalia of PWID. Symptoms of septicaemia include high fever, shivers, headache and possibly convulsions.

Endocarditis – Endocarditis is an inflammation of the heart due to infection from foreign matter that PWID may introduce into their blood through injection. Endocarditis symptoms include irregular heartbeats and chest pain.

Cellulitis – Cellulitis is a common bacterial skin infection that can affect PWID. Cellulitis presents as a localised inflammation of the skin.

Phlebitis – Phlebitis results in the development of track marks along the veins where a PWID has injected. Track marks are actually damaged or infected veins that can lead to the formation of blood clots.

GONORRHOEA AND CHLAMYDIA IN RESOURCE-LIMITED SETTINGS

Neisseria gonorrhoea and *Chlamydia trachomatis* are the bacteria or germs which commonly cause most infections in the urethra (the pipe joining the bladder to the outside). The tests used to identify the exact germ causing the infection are expensive and not normally needed. These tests are commonly done on urine or from a sample of the fluid on the inner lining of the penis. Infection with both germs at the same time is common, and the WHO recommends treatment of both germs with a combination of antibiotics in resource-limited settings. One can be reinfected and need to be retreated whenever symptoms are present⁽¹⁶⁾.

COMMON BACTERIAL INFECTIONS

- *Neisseria gonorrhoea* (causes gonorrhoea or gonococcal infection)
- *Chlamydia trachomatis* (causes chlamydial infections)
- *Treponema pallidum* (causes syphilis)
- *Haemophilus ducreyi* (causes chancroid)
- *Klebsiella granulomatis* (previously known as *Calymmatobacterium granulomatis*, causes granuloma inguinale or donovanosis)

SUMMARY AND KEY FACTS

- Sex workers, MSM, and PWUD, like everyone else, are exposed to HIV and other STIs through the exchange of bodily fluids, which includes blood, vaginal fluid and semen. This exposure is most likely to occur from direct contact during penile-vaginal, penile-anal, oral-penile or oral-anal sex, or from sharing drug injecting equipment.
 - Many key populations are linked to factors that place them at high risk for TB infection and progression to disease. Drug use itself is not a risk factor for getting TB but more so the living conditions and lifestyle of the person using drugs, which are often overcrowded, frequent coughing, and bad immune resistance due to lack of healthy food. And due to drug use it might be that you don't recognise the first symptoms of TB.
 - STIs are common among key populations; specifically herpes simplex virus type 2 (HSV), human papillomavirus (HPV), gonorrhoea, chlamydia, and syphilis. Genital herpes consistently accounts for roughly 20% of new HIV infections at all stages of the epidemic, making it the most significant STI driving the transmission of HIV. Symptoms of rectal infection of gonorrhoea in both men and women may include discharge, anal itching, soreness, bleeding, or painful bowel movements. Rectal infection also may cause no symptoms. Infections in the throat may cause a sore throat, but usually causes no symptoms.
 - Untreated STIs also increase the HIV risk among key populations and contributes to their transmission within communities. Rectal infection or the presence of STIs around the anus may be experienced by key populations who engage in anal sex.
 - Sex workers, MSM, and PWID may be exposed to the Hepatitis B or Hepatitis C viruses through the infected bodily fluids of sexual partners, which include blood, vaginal fluid, pre-seminal fluid, and semen. Additionally, PWID and other drug users may be exposed through the use of non-sterilized (injecting) equipment. Hepatitis B vaccination is recommended for all people who practise riskier sex, such as sex workers and MSM.
 - PWID may also experience the following common infections: Abscesses and ulcers, septicaemia, endocarditis, cellulitis, phlebitis.
-

SECTION 3

KEY SERVICES

The final section of this manual will address providing key services and interventions to MSM, sex workers, and PWUD. Information in these sections is based on the final draft of the Department of Health Operational Guidelines for HIV, STIs, and TB Programmes for Key Populations in South Africa (November 2012) (Operational Guidelines).

This section includes the following three modules:

- Module 8: Providing health services for MSM, sex workers, and PWUD
- Module 9: Biomedical interventions for MSM, sex workers, and PWUD
- Module 10: Behavioural and psycho-social interventions for MSM, sex workers, and PWUD

Questions that will be addressed in this section include:

- How do HIV, TB, and STIs affect MSM, sex workers, and PWUD?
- What biomedical interventions are available for use with MSM, sex workers, and PWUD in South Africa?
- What is harm reduction and how can it be applied to reducing the risk of PWUD?
- What behavioural strategies are available for use with MSM, sex workers, and PWUD in South Africa?
- What are the best strategies for managing mental illness and substance use among MSM, sex workers, and PWUD?
- How can health care workers contribute to the development of enabling environment within their health care facility?

MODULE

8

PROVIDING HEALTH SERVICES FOR MSM, SEX WORKERS, AND PWUD

Learning Outcomes

After completion of this module, you should be able to:

- i Describe methods for identifying clients who are MSM, sex workers, or PWUD
- ii Describe the principles of sensitive service provision for MSM, sex workers, or PWUD
- iii Describe the ways in which individual health care workers can improve service delivery to MSM, sex workers, or PWUD
- iv Understand how to address stigma within the health care setting

How can a client be identified as belonging to a key population?

Identifying whether or not a client is a MSM, sex worker, and/or PWUD is a necessary first step that a health care worker must take before they are able to provide effective health care services. If health care workers do not identify clients as belonging to one of these groups then they may be unable to provide the necessary services that these patients require.

MSM, sex workers, and PWUD are groups that include countless highly diverse people. There are no set characteristics that can identify a client as a key population on appearance alone. The best way to identify clients that are part of these groups is by confidentially and non-judgementally documenting their behaviours. This documentation should occur as a standard process for every client if possible.

What questions help identify high risk practices of clients?

When assessing any client, they should be asked about the following questions in order to identify high risk practices:

1. **If they have ever exchanged money for sex.** This includes having ever sold sex and/or having ever bought sex.
2. **If they engage in anal sex.** For both men and women, it is important to ask if they have engaged in penetrative and/or insertive anal sex.
3. **If they use drugs and how they are used.** For all clients, it is important to understand the types of drugs that are being used but also the method (i.e. injecting) that is being implemented.
4. **Determine the sex of their sexual partner.** Understanding the types of sexual partners that a client engages with will help to determine the level of sexual risk they may be exposed to.

It is challenging to provide appropriate health care services without assessing clients for these characteristics. Consider the case of George below.

EXERCISE 1

Case Study: George

George is a young gay man from Bloemfontein who is attending university in Cape Town. George has always been very active in sport and especially loves rugby. Recently, after a match he met a player from the opposing team and they have since been dating. Before their relationship gets serious, George decided to go to the clinic and get screened for HIV and STIs. The nurse was very friendly and was asking him lots of questions about rugby while she was running his tests. After conducting a visual exam of his genitals for STI symptoms, and rapid test for HIV and syphilis, the nurse gave George some free condoms and a clean bill of health. George knew there was something bothering him in his anus but he was too embarrassed to bring it up, especially because his nurse kept asking him about his girlfriend. He left feeling disappointed.

Akona is the nurse who helped George with his STI screening. She asked George her clinic's standard questions regarding his behaviour while she was conducting the HIV test. She remembers being confused because George said that he hadn't slept with any women in the last three months but on arrival he mentioned needing to test because he had been sexual active recently and had just started dating someone. Akona suspected George might be referring to sleeping with men but she had never met a masculine rugby player like George who was gay. Akona had received training and knew she should ask about male partners and inspect George's anus for STIs as well but the last time she attempted to do that with a male client he got incredibly angry with her and stormed out of the clinic. Akona was nervous that George would react the same way, so she decided to rather leave it.

- 1. Why do you think George was embarrassed to address his health concern with Akona? Is there something Akona could have done different to make George comfortable? What could George have done differently?**
- 2. What services did Akona provide to George? Can you think of other services George should have received? In addition to condoms, what other tool should George have been provided with?**

3. Why do you think Akona was hesitant to ask George if he was gay? Have you ever dealt with a client who responded like Akona's?
4. Akona had to use the standardised questions from her clinic, what types of questions are you required to ask clients? What other questions could you add that would assist in addressing key populations?
5. What condition do you think George had in his anus? In what way could his future health be affected because this was left untreated? Is George at increased risk for HIV now?
6. If George was your client, how would you have asked him about his male sexual partners?



George's story above illustrates that while asking these questions may feel uncomfortable for some health care workers at first, they are critically important to addressing the health needs for clients. George left his clinic with his HPV untreated and now may experience increased risk of HIV transmission during anal sex because of it.

How should these questions be asked to clients?

Just like in Akona's situation above, not all clients will respond positively to being asked about selling sex, engaging in anal sex, or using drugs and other clients may not respond honestly because they are embarrassed or concerned that they will get in trouble. The following strategies can be used when working with clients:

1. In order to facilitate a trusting environment, it is important to **emphasise to all patients that the questions are confidential**, and reassure them that they will not be criticised or judged for their responses. Another strategy is to remind clients that you will not report illegal behaviour such as selling sex or using drugs to the police.
2. Patients should be informed that, by **being honest** with the health care worker, they will be able to **receive the most effective and appropriate support and services**.
3. **Do not ask clients about their sexual orientation, rather focus on sexual behaviour**. For example, some men may not identify as gay but still have

sex with other men. When asked if they are gay by a health care worker, they will respond negatively.

4. Before asking any questions to clients, explain that you ask **the same standardised questions regardless of the client**. This way clients may feel less like the questions are 'targeted' at them and may respond less defensively.
5. **Set a relaxed tone**. Clients can feel the non-verbal body language and tone of a health care worker. A client may not respond positively if the health worker appears nervous or hesitant when asking clients these questions.
6. **Remain professional**. When asking clients sensitive questions health care workers should not laugh, make jokes about the questions, or be otherwise dismissive.

MALE SEX WORKERS

Health workers should ensure that they do not exclude heterosexual male sex workers by assuming that men who sell sex to other men are gay. There are many heterosexual men selling sex to men and women who may have needs specifically relating to their sexuality that must be sensitively addressed. They may have female partners, and they may need information on women's sexual health and general wellbeing in order to deal with this aspect of their personal life. Heterosexual men may feel uncomfortable going to services designed specifically for gay or bisexual men.

Do MSM, sex workers and PWUD require special services?

It is a misconception that MSM, sex workers, and PWUD require services that can not be offered within standard clinics and that providing such services will increase the workload of health care workers and facilities. In fact, every key population can benefit from the standard health care services offered in clinics across the country. These services, such as HIV testing, counselling, STI treatment and ART already exist and providing them to key populations should not create any new burden on facilities. With that said, service provision should be sensitive to the needs of MSM, sex workers and PWUD. Also, there are additional services as discussed in Module 9 and 10 that can benefit key populations greatly.

What are MSM, sex worker, and PWUD sensitive health services?

Health care services are considered sensitive to the needs of MSM, sex workers, and PWUD when they are relevant and acceptable.

1. **Relevant services.** Services should take into consideration the needs of these groups. For example, rectal exams, and lubrication should be made available, in addition to HIV testing. A further discussion of these services can be found in Modules 9 and 10.
2. **Acceptable services.** Services should not be judgemental or stigmatising towards MSM, sex workers, and PWUD.

What role can health care workers play in the provision of sensitive services?

Health care workers are a critical part of service delivery to all key populations. The values and beliefs of health care workers can either encourage key populations to uptake the health service, or can drive them away. Even though they are just one part of a much larger system, a health care worker does have the potential to considerably influence the services key populations may receive. Below are some strategies that health care workers, as individuals, can use in any health care setting to improve services for specifically for MSM, sex workers, and PWUD:

- ✓ **Be informed about MSM, sex workers, and PWUD** – Understanding the common sexual practices and behaviours of key populations will allow health care workers to interact more genuinely and build a stronger client-provider relationship. It is also important to not to make false assumptions about individuals risks or behaviours⁽¹⁾. Health care workers may have a personal curiosity about key population behaviour. While it is acceptable to ask questions regarding a client's behaviour, it is inappropriate to do so out of curiosity. All questions should be directly related to health care service provision.
- ✓ **Establish a welcoming environment** – Health care workers can significantly influence the health care environment within which they work. They can address personal and group stigma and they can welcome all clients for care. Creating this welcoming environment is a critical first step in providing services to MSM, sex workers, and PWUD. The patient's first impressions of the facility are crucial as they can influence the whole interaction. Thus health care workers should ensure that all staff who interact with patients, including clerks, cleaners and security guards are able to set a tone which is friendly and welcoming.

- ✓ **Establish a trusting and supportive relationship** – MSM, sex worker, and PWUD clients may be hesitant to disclose their behaviour to health care providers. Therefore, establishing a trusting relationship is necessary in order to engage clients about their risk behaviour and health needs.
- ✓ **Do not include judgemental or personal values in service provision** – It is not the job of health care workers to judge their patients, because this will not provide a patient with any helpful service. For example, if a man is in a relationship with a woman but having sex with other women ‘on the side’, a health care worker should not encourage him to stop having sex with others because he is cheating on his girlfriend. Instead, the health care worker could encourage the man to decrease his risk of HIV infection by always using condoms with his sexual partners, creating open communication with his girlfriend, and undergoing regular HIV testing.
- ✓ **Protect confidentiality** – Health care workers should ensure that client’s rights to privacy and their right to anonymity are protected at all times.
- ✓ **Engage with MSM, sex workers, and PWUD who visit health care centres and those in the community** – There is no better way to improve health care services for MSM, sex workers, and PWUD than by engaging them and getting direct feedback regarding the health care services. Including these groups into peer educator teams is an effective means of engaging this community, and provides a channel through which feedback can be derived. Additionally, promoting the inclusion of MSM, sex workers, and PWUD on any committee which liaises with the community is useful mechanism to ensure that the needs and opinions of key populations are included.
- ✓ **Providing services and acting as a referral pathway into care** – Health care workers may be an individual’s first access point into the health care system. Therefore, they can perform a very crucial role of assessing their needs as well as providing him or her with the basic health services that are required. Not all health care workers will be equipped to manage the specific needs of all key populations; therefore, having a keen understanding of the possible referral pathways is necessary.

WHAT CAN I DO AS A HEALTH WORKER?

- Start talking openly and honestly with colleagues and clients about key populations
- Be specific and clear in the language you use, especially about sex and drugs
- Try to be more accepting and less judgemental
- Integrate SW/PWUD/MSM into existing services
- Make information relating to SW/PWUD/MSM available in our facilities
- Network with other organisations already working with SW/PWUD/MSM to get advice
- Use appropriate language
- Educate, train and sensitise all clinic staff (including cleaners etc.) – regularly
- Market services as SW/PWUD/MSM friendly
- Raise awareness of anal STIs
- Create a safe and supportive environment
- Advocate for availability to condom-compatible lubricants
- Be open to learning from key populations. Patients are the experts in their own lives.

How can stigma and discrimination be addressed in health care facilities

Stigma and discrimination can prevent MSM, sex workers, and PWUD from receiving quality health care and may also result in further discrimination. In order for conditions to improve, stigma and discrimination must be addressed in health care facilities.

There are many ways to address personal stigma and discrimination as well as within the health care environment and in the broader community.

PERSONAL



Get to know MSM, sex workers, and PWUD who frequent your clinic to break down stereotypes. Stigma can often grow from misconceptions and stereotypes. Health care workers can work to break down personal stigma by making an effort to learn more about PWUD/SW/MSM who are visiting their health care facility. This will also create new opportunities for learning and can challenge biases and misconceptions. It can provide health care workers with the background information and perspective needed to look beyond their stereotypes and see a client who is in need.

EXERCISE 2

Assessing Stigma and Discrimination in Your Work Place

Stigma and discrimination can sometimes be difficult to identify. Consider the following questions about stigma and discrimination in your work place:

1. Have you ever witnessed discrimination towards a client belonging to a key population within your own health care facility? Do you think that stigma exists in your facility?
2. What positions of staff do you believe engage in discriminatory or stigmatising behaviour in your health care facility? What do you believe motivates them?
3. What impact do you think this behaviour had on the person being discriminated against?
4. What other factors do you think influence discrimination and stigma in your facility?

- ✓ **Treat key populations just like any other client.** Sometimes health care workers may be unaware that they are stigmatising a client. To address this situation, health care workers should constantly ask themselves if their responses or level of service delivery for a PWUD/SW/MSM would be similar for an average client. This provides an opportunity for health care workers to evaluate their work and establish a better level of awareness for their own actions and internal biases.

INSTITUTIONAL

- ✓ **Remind other staff members to treat key populations with respect.** If other colleagues are discriminating or stigmatising MSM, sex workers, or PWUD within a health care facility, it can be useful to remind them that more than likely, they entered into the health care profession to support and help people. PWUD/SW/MSM are in great need of support and help and should be addressed, interacted with, and supported, just as any other client in the health care facility. Health care providers should treat all clients in the same way. If this is not the case, it should be brought to their attention and they should be reminded that all clients deserve respect.

I know it's easy to just see the 'drug user' when you look at him, and think that he doesn't deserve help. I know he made that choice [to use drugs] the first time, but I've seen what this stuff [tik] does to people. It takes away their choice, it takes away their life. That man, standing there, he deserves help, in fact he needs it, because he doesn't have a choice. – Service provider

- ✓ **Discourage the use of language that is stigmatising towards MSM, sex workers, and PWUD.** It is not uncommon for individuals to disregard PWUD/SW/MSM by referring to them as druggies/junkies, hookers, moffies etc. It is important to create a welcoming environment in a health care facility that is safe for all those who are seeking care. Specifically, by using stigmatising language, health care workers are showing disrespect for and dehumanising the client.
- ✓ **Create case studies to share with staff.** Often, health care clinics or centres will schedule regular meetings with the entire staff. These meetings can be an opportunity to share with other health care workers a case study of a PWUD/SW/MSM client. This will create an opportunity to have an open dialogue and discuss stigma and PWUD/SW/MSMs' right to health care.
- ✓ **Display welcoming material for MSM, sex workers, and PWUD** Among the many HIV educational posters, clinic staff can also place affirmative posters for PWUD/SW/MSM. They should include messages that show that the clinic space is welcoming to all people and that confidentiality is assured with any health service.
- ✓ **Establish a formal stigma advisory board.** Some clinics have successfully established small working groups within the clinic to develop a stigma policy and guidelines for the entire staff. These are used to set behavioural standards and can help keep to staff accountable for their actions towards PWUD/SW/MSM.

COMMUNITY

- ✓ **Train peer outreach teams and include MSM, sex workers, and PWUD.** If health care facilities provide any type of peer outreach or education, then efforts should be made to connect with PWUD/SW/MSM in the community to facilitate their engagement with health services. An effective means of doing this would be to include recovered drug users within the peer educator team. Having a peer who can interact and engage with PWUD/SW/MSM will facilitate learning, trust, and potential uptake of health services by the PWUD/SW/MSM community.

EXERCISE 3

Addressing Stigma at Your Work Place

Using the situations you developed in the exercise above, brainstorm strategies you could implement in order to address stigma and discrimination in your work place. Take into consideration the reasons this stigma or discrimination is taking place.

1. Are personal values and beliefs playing a role in these situations?
2. How can your solutions address these values?
3. Would you be able to realistically implement these solutions in your workplace? If not, what barriers would you anticipate experiencing?
4. How could you overcome the barriers?

What types of services should be implemented for MSM, sex workers, and PWUD?

The types of services and interventions discussed in the remainder of this manual were established by the Department of Health's Operational Guidelines for HIV, STIs, and TB Programmes for Key Populations in South Africa (Operational Guidelines).

The Operational Guidelines were drafted in 2012–2013 after a series of consultations with health planners; managers and health care workers; representatives of civil society; government; core groups; donors and other stakeholders. Once finalised, they will assist health planners to develop and implement programmes that will lead to an achievement of the targets set for Key Populations in the NSP. The guidelines were founded on international best practice and current scientific evidence.

The guidelines implement a combination approach for HIV/STI/TB prevention among key populations based on an established World Health Organisation (WHO) Framework. The combination approach takes into consideration the many interacting factors that lead to increased risk and vulnerability among key populations by using a mix of biomedical, behavioural, and structural interventions.

COMBINATION APPROACH

A combination approach to HIV/STI/TB prevention is client-focused. It looks at the client holistically, including the physical, environmental, psychosocial and economic factors that make them vulnerable to HIV. With this in mind, the client is seen as someone who needs a combination of interventions to give them the best health outcomes possible.⁽¹⁾

Recommended priority interventions and services

The following services are considered standard services for clients from key populations:

Biomedical interventions (Module 9):

1. HIV counselling and Testing
2. STI screening and treatment
3. TB screening and Treatment
4. HIV Care and Treatment
5. Condoms and Condom-Compatible Lubricant
6. Sexual and Reproductive Health Services
7. Post Exposure Prophylaxis
8. Medical Male Circumcision

Behavioural interventions (Module 10):

1. Peer education and outreach
2. Sexual health screening, risk reduction counseling
3. Referral for drug and alcohol abuse
4. Promotion of utilization of HIV, STI, and TB screening and treatment

Additional optimal interventions:

The following additional services should be provided where possible in order to create an optimal package of care for key populations:

1. Provision of pre-exposure prophylaxis (PrEP)
2. Biomedical interventions for PWID including needle syringe exchange programmes, drug dependency treatment and drug overdose prevention and treatment.
3. Hepatitis B screening and vaccination
4. HPV Screening and vaccination
5. Periodic presumptive treatment for STIs among sex workers

COMPREHENSIVE PACKAGE OF INTERVENTIONS FOR PWID

1. Needle and Syringe Programmes (NSPs)
2. Opioid Substitution Therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy (ART)
5. Prevention and treatment of STIs
6. Condom programmes for PWID and their sexual partners
7. Targeted information, education, and communication
8. Vaccination, diagnosis, and treatment of viral hepatitis
9. Prevention, diagnosis, and treatment of TB.

KEY POPULATION OPERATIONAL GUIDELINES – PRINCIPLES UNDERLYING SERVICE DELIVERY FOR ALL (Final draft guidelines, Nov 2012)

- Ensure interventions do no harm
- Drawing on the human rights approach of the South African Constitution, respect the human rights of the all people and accord them basic dignity (e.g. services are voluntary)
- Respect the views, knowledge and life experiences of the individual
- Recognise that people most affected by HIV/STI/TB are part of the solution ('nothing for us without us'), as they are usually highly motivated to improve their health and well-being
- Build capacity and leadership among community members in order to facilitate participation and community ownership
- Include clients/partners/controllers/gatekeepers in the planning, design and implementation of interventions
- Recognise the diversity of settings where different groups of society come together and adapt interventions accordingly
- Ensure sensitivity toward social, cultural, psychological, physical, gender and sexual orientation of clients
- Service providers should be available and competent to provide all elements of the basic package of services and make references as appropriate

SUMMARY AND KEY FACTS

- Health care settings should be equipped to provide acceptable, non-stigmatising, and accessible services that are relevant to MSM, sex worker, and PWUD clients.
- Barriers to seeking services for MSM, sex workers, and PWUD have included inconvenient hours and locations, unwelcoming or judgmental attitudes on the part of staff and other clients, and the cost of services.
- A health care facility becomes an enabling environment for MSM, sex workers, and PWUD when it empowers and supports those clients to fully engage with its services.
- Identifying whether or not a client is a MSM, sex workers, and PWUD is a necessary first step to provide appropriate health care services. MSM, sex workers, and PWUD are a highly diverse community. The best way to identify these clients is by confidentially and non-judgementally documenting their behaviours.
- An individual health care worker can improve service delivery to MSM, sex workers, and PWUD by:
 - Establish a welcoming environment in their health care setting by engaging with MSM, sex workers, and PWUD who visit health care centres and those in the surrounding community
 - Be educated about MSM, sex workers, and PWUD and do not make assumptions about their behaviour
 - Establishing a trusting and supportive relationship and respect the confidentiality of these clients
 - Provide client-centred advice and recommendations that do not include judgemental or personal values
 - Use appropriate language and ask for clarification
 - Provide appropriate services and act as a referral pathway into care
- Stigma can prevent MSM, sex workers, and PWUD from receiving quality health care and may also result in further discrimination.
- Stigma and discrimination can be addressing on the individual, institutional, and community level by:
 - Breaking down stereotypes by getting to know MSM, sex workers, and PWUD who frequent your health care setting

MODULE

9

BIOMEDICAL INTERVENTIONS FOR MSM, SEX WORKERS, AND PWUD

Learning Outcomes

After completion of this module, you should be able to:

- i Explain the combination approach for HIV/STI/TB prevention for MSM, sex workers, and PWUD
- ii Describe the biomedical HIV prevention interventions currently available for MSM, sex workers, and PWUD
- iii Understand the HIV prevention and treatment strategies for MSM, sex workers, and PWUD
- iv Understand the sexual and reproductive health strategies for MSM, sex workers, and PWUD

Biomedical interventions

The biomedical intervention components of the Operational Guidelines include diagnostic, treatment, and surgical interventions to protect key populations from becoming infected with HIV or transmitting HIV. They include: HIV counselling and testing (HCT), condoms and condom-compatible lubrication, STI screening and treatment, TB screening and treatment, HIV care and treatment (including ART), sexual and reproductive health services, post-exposure prophylaxis, medical male circumcision, needle syringe exchange programmes, drug dependency treatment, and drug overdose prevention and treatment. These biomedical interventions are designed to work in combination with the behavioural and psychosocial interventions discussed in Module 9.

HIV, STIs, and TB interventions

HIV counselling and testing

All health care workers should provide non-judgemental and sensitive testing for HIV. Many MSM, sex workers, and PWUD may have experienced poor service or have been discriminated against when trying to access testing services in the past. Providing these services offers key populations an opportunity to know their HIV status, potentially start ART if needed, and receive vaccinations or treatment for certain STIs if required.

Testing should be provided in a confidential space without other staff members present in case sensitive questions are asked about their behaviour or identity.

WHAT IF CLIENT IS UNDER THE INFLUENCE OF ALCOHOL OR DRUGS?

First, ensure your own safety. If the client is functional considering continuing with your work if possible. It may not be feasible to wait for the client to become sober and the effects of withdrawal may further complicate the interaction.

HIV care and treatment (including ART)

Beginning ARVs is not only important for the health of all key populations, but also because of the added benefit of significantly lowering the risk of passing the virus on others. Since MSM, sex workers, and PWUD regularly

interact with broader populations (i.e. sex workers with clients) initiating and sustaining ART can add a protective benefit to larger communities in addition to the individual.

Many MSM, sex workers, and PWUD are mobile and may be challenging to retain over long periods of time. This may result in missed appointments and losing contact with a client for long periods. Health care workers should anticipate this difficulty by obtaining multiple types of contact details so they can efficiently follow up with clients. It is also advisable to distribute long-term supplies of ARVs to ensure that a client's supplies is uninterrupted should they move from their clinic's community. Key population clients should also be made aware of referral options or clinics within various communities, so that they may easily link into new health care facilities.

When giving adherence counselling, health care providers should make sure that clients have emotional and practical support in his or her life and is able to fit the ART regimen into a daily routine. Education is critical so that all clients understand that non-adherence (to ART, antibiotics, and so forth) leads to resistance and treatment failure, and recognise that all doses must be taken. Especially for clients who use drugs, it is useful to provide an overview of the side effects of ARVs and antibiotics and their interactions with drugs they may be taking.

ANTICIPATE RETENTION CHALLENGES

Retaining key populations in health care may be a challenge given that some clients may not be able to access services during regular hours. Additionally, key populations who use substances may have poor follow-up because of their drug use. It is important for health care workers to not get frustrated if clients do not return to the clinic regularly. Instead of scolding a client when he or she misses a monthly HIV test, a health care worker should rather work with them to identify barriers to attending monthly tests when he or she first arrives.

Screening and treatment of STIs and other infections

MSM, sex workers, and PWUD are highly susceptible to STIs and other infections such as hepatitis. Anal STIs are often overlooked and should be assessed as well, particularly for MSM and sex workers. Where available, the HPV vaccine should be distributed to female sex workers in order to lower the risk of cervical cancer.

Some clinics require that clients bring their sexual partners into the clinic when they are receiving treatment for STIs. This often puts key populations into compromising positions. For example, a sex worker would be unable to bring in their clients (sexual partners), as would MSM who are not out of the closet, without disclosing their identity as a sex worker or MSM.

STI screenings should include oral, vagina, penile, and anal exams and HIV-positive sex workers should be syndromically screened at least quarterly and provided treatment⁽¹⁾. MSM should be screened for chronic Hepatitis B infection.

HEPATITIS A AND B VACCINATIONS

Hepatitis A vaccination is recommended for MSM and PWID

Hepatitis B vaccination is recommended for heterosexual sex workers, MSM, and PWID.

Vaccine schedules:

- Hepatitis A vaccine: 2 doses separated by a minimum of 6 months
- Hepatitis B vaccine: 3 doses (timing depends on vaccine used)
- Combination Hepatitis A and B: 3 doses (timing depends on vaccine used)

TB screening and treatment

Key populations are at risk for TB infection, particularly those who are HIV positive and/or using drugs. Key populations, both negative and positive should be screened for the symptoms of TB. Early detection of TB infection will improve the health outcomes of the individual and decrease the chance of spreading TB.

KEY POPULATION GUIDELINES - COMPONENTS OF STI SCREENING AND TREATMENT

1. Obtain a sexual history from the client
2. Provision of correct STI information including male and female STI symptoms
3. Conduct sexual history and behavioural risk assessment
4. Screening of anal, oral, and genital STI syndromically and/or through laboratory testing
5. Provision of free/affordable STI treatment in line with national guidelines
6. Provision of provider-initiated HIV testing and counseling and referral to appropriate services based on HIV rapid test results.
7. Ensure the 4 Cs: Compliance (adherence) to prescribed therapy; Condoms – promotion, demonstration, and distribution of male and female condoms and lubricants; Counselling – risk reduction counselling and skills building; and Contact tracing – partner STI tracing when feasible for sex partners
8. Quarterly syndromic management of anal, oral, and genital STIs
9. Assess the needs of clients and refer to additional components of HIV/STI package
10. Ensure accurate record keeping of STI screening and treatment activities

Condoms and condom-compatible lubricant

Health care workers play an important role in delivery, promotion, and education around the consistent and correct use of condoms and lubricant. When used correctly, condoms are an effective tool in preventing HIV and STI infection among key populations.

When used correctly and for all sex acts, condoms are 80–95% effective at preventing HIV and STIs. These estimates are based on research among heterosexual couples engaging in regular sexual intercourse using condoms consistently⁽²⁻⁴⁾. Often, however, individuals do not use condoms correctly or consistently⁽⁵⁾, resulting in potential exposure to HIV/STIs.

What types of condoms are available?

There are two main types of condoms – male condoms and female condoms. Male condoms are usually made out of latex (rubber). Female condoms are

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

Currently, the female condom is approved for vaginal use only – that is why it is called the female condom. However, female condoms can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection⁽⁶⁾.

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

What are lubricants?

Lubricants (or ‘lubes’) are substances that reduce friction between the penis, vagina, or anus during sex. Lubrication helps prevent condom breakage, and decreases the risk of slippage during anal sex⁽⁷⁾. Lubrication is very important during anal sex in order to prevent anal/rectal trauma.

SIMILARITIES AND DIFFERENCES BETWEEN MALE AND FEMALE CONDOMS

Insertive condom	Receptive condom
Also referred to as a male condom	Also referred to as a female condom
Worn over the penis of the insertive partner	Inserted into the receptive partner. Can be inserted into the vagina or the anus, when engaging in anal sex ⁽⁶⁾ before penetration
Made of latex	Made from polyurethane (plastic)
Can be used with water-based or silicone lubricants only	Can be used with any lubricant
Can break if used incorrectly	Do not break easily
Must be put on/taken off the erect penis immediately before/after penetration	Can be inserted before penetration and left in for longer
Some men find it too tight/restrictive	Not tight on penis
Does not conduct heat	Conducts heat, warms up to body temperature

What types of lubricant should be used?

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

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

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

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

Why should lubricant be used during sex?

The use of lubrication during sexual activity can prevent pain, bodily harm, and condom breakage by preventing the friction that occurs between moving the body parts. This frictions can specifically cause cause pain, tearing, and bruising, to the vagina, anus, and penis which can lead to bleeding which exposes the underlying cells to HIV and other STIs. Men and women who have receptive anal sex should always use a sufficient amount of lubricant. This can help can help reduce little wounds or fissures of the anal sphincter, as these do not heal easily, create discomfort, and increase risk of infection. When touching the anal area with fingers, good hand hygiene is important (wash with soap) to avoid transmitting intestinal infections.

How should clients be educated about condoms and condom-compatible lubricant?

Consistent condom use is a challenge for many key populations and condom-compatible lubricant may not be available or used regularly. Health care workers play a key role in educating clients about their use. The following information should be provided to clients:

1. Health care workers should explain to their clients the **types of condoms** that are available for both anal and vaginal sex as detailed in the table below.
2. The **proper use of condoms** should be explained to all clients and any myths should be dispelled. For example, some may believe that the use of two condoms simultaneously will provide increased protection when in fact, the use of two condoms increases the chances of the condom breaking. For additionally information on condom use, please see Appendix 2.

USING THE FEMALE CONDOM

Challenges of using the female condom include difficulty inserting and keeping it in place, irritation, unpleasant texture, and noise of the condom^(6, 8). Advantages of female condoms are that they allow for more sensation by the insertive partner their material and texture means that the receiving partner cannot feel the condom. Female condoms are a more satisfactory option for men who do not enjoy using male condoms.

3. Additionally, health care workers should ensure that clients are provided with the correct information regarding condom-compatible lubrication:

WATER- VS. OIL-BASED LUBRICATION

Water-based - uses water as its liquid base, can be used with insertive and receptive condoms.

Oil-based - uses oil as its liquid base. Hand lotions, petroleum jelly, and cooking oil are common oil-based lubricants but should never be used with latex condoms due to breakage.

How can health care workers support the use of condoms and condom compatible lubricant?

Although it should be advocate for, health care workers should take into consideration that 100% condom use may not be possible for many individuals in key populations. Health care workers should remain sensitive to these circumstances and support clients in identifying ways to increase condom uptake and use. For example, a sex worker may have their supply of condoms confiscated from the police or may be required to not use condoms by a client in order to earn more money. Furthermore condoms should be provided to

clients in sufficient quantities to cover all sexual acts. Only providing a small amount of condoms to a highly sexually active client is not helpful.

Clients may refer to the use of other products for lubrication include saliva and food-based alternatives such as yogurt or egg whites. There is no data as to their effectiveness to prevention HIV or other STIs and there is some concern of illness related with the use food-based lubes. Health care workers should discuss proven alternatives with clients.⁽⁹⁾

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

GIVING ADVICE ON LUBRICANT USE TO CLIENTS

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

Other interventions

Post exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) refers to the use of ART to prevent HIV seroconversion in an HIV negative individual who has recently been exposed to HIV. For MSM, sex workers, and PWUD who may have been exposed to HIV through unprotected sex, sexual assault, condom breakage, or through the

sharing of needles, PEP can be an effective means of preventing HIV infection. The regimen must be strictly adhered to and should be distributed according to the NDOH guidelines. Completion of the 28-day course is necessary for maximum efficacy of PEP, therefore it is important for health care workers prescribing PEP to counsel their clients on the importance of drug adherence. As explained in the text box below, PEP should not be limited only to situations involving sexual assault but should also include instances of high-risk exposure from consensual sex, especially for MSM, sex workers, and PWUD clients.

PEP AFTER SEXUAL EXPOSURE: SA CLINICIAN'S SOCIETY GUIDELINES

'Post sexual exposure prophylaxis is indicated for those who present within 72 hours of unprotected risky sexual activity, including but not limited to insertive intercourse, and including but not limited to rape survivors. As a public health intervention equal access to treatment of persons who might otherwise not have been considered to have been raped, but who have definitely sustained a high-risk exposure, is essential to equality of therapy and minimisation of HIV transmission.'⁽¹⁰⁾

HPV VACCINE

In addition to the testing and treatment of STIs, all sex workers should be encouraged to vaccinate against HPV, the human papilloma virus. If not already infected, this vaccine can help protect female sex workers from strains of HPV that can lead to life-threatening cervical cancer. Further information regarding HPV can be found later in this Module.

Medical male circumcision

Medical male circumcision has been proven to increase protection against HIV for men during penile-vaginal sex. For MSM who engage in penetrative anal sex, the benefits of male circumcision are less clear. Recent studies suggest that circumcised MSM may experience increased protection against HIV but only if they are primarily the insertive partner; however, overall male circumcision as an HIV prevention strategy for MSM requires further

investigation. Therefore, medical male circumcision should be made available to men who are sex workers, or PWUD if they are primarily engaging in insertive vaginal sex. Education should be provided to MSM, that the effectiveness of circumcision has not been proven among MSM and therefore, should not be relied upon as providing any protective effect for this population.

Pre-exposure prophylaxis

Pre-exposure prophylaxis (PrEP) involves the administration of ARVs to HIV negative individuals as a method of preventing HIV infection. When used consistently, PrEP has been shown to be partially effective in preventing HIV among MSM, heterosexual men and women, and PWID. Guidelines for the use of pre-exposure prophylaxis (PrEP) for HIV prevention among high-risk men who have sex with men have been developed by the South African Clinician's Society.

VAGINAL AND RECTAL MICROBICIDES

Microbicides are gels or creams that are designed to be inserted into the rectum or vagina before sexual intercourse. In 2009, a clinical trial showed that vaginal microbicides added an additional 39% protection from HIV⁽¹¹⁾. Unfortunately, a publicly-available microbicide is not on the market, but could be a potential HIV prevention in the future. Likewise, rectal microbicides are still being researched to determine their ability to prevent HIV in men and women. Both of these tools could someday be potential tools that SW/PWUD/MSM could use to protect themselves from HIV.

Sexual and reproductive health services for key populations

Family planning services

Female sex workers are also exposed to the risk of unwanted pregnancy. Health care workers should discuss contraceptive needs with female sex workers with particular emphasis on dual protection and emergency contraception⁽¹²⁾. Information should be made available on termination of pregnancy where appropriate.

Cervical and anal cancer screening

Yearly routine cervical cancer screenings are recommended for all female sex workers, since they are at greater risk for acquiring HPV and having it progress

to cervical cancer⁽¹²⁾. Similarly, anal sex could result in exposure to HPV and progress to anal cancer. Therefore, anal cancer screenings are recommended for all MSM, sex workers, and PWUD who engage in receptive anal sex.

Biomedical interventions for PWID and other people who use drugs

What types of care and treatment options are available for PWUD?

International and South African Guidelines support the use of policies, programmes and approaches that work to reduce the health, social, and economic risks associated with the use of drugs. This is also known as harm reduction⁽¹³⁾. Harm-reduction strategies support PWUD in finding ways to engage in their behaviour more safely. The following interventions are internationally recognised by the United Nations Office on Drugs and Crime (UNODC) as comprehensive interventions for PWUD and are proven in their ability to prevent HIV with PWUD⁽¹³⁾.

Needle and syringe exchange programmes

Needle and syringe exchange programmes are services that provide clean equipment to PWID and/or assist them in properly discarding their used equipment. The programmes also create opportunities for outreach workers, health care workers or peer educators to meet with PWID and provide them with information on rehabilitation services, broader health care and other treatment options. The NSEs can take many forms, depending on the context within which they are implemented. Some NSE programmes may take place in formal health care settings, such as a pharmacy, or they can be community-based, taking place in a mobile unit⁽¹⁴⁾.

NSEs supports the prevention of HIV and the overall health of PWID by:

- Raising awareness and knowledge of the risk of contracting infectious diseases through injecting drug use;
- Providing information and advice on the steps to inject safely;
- Providing sterile injecting equipment, if possible;
- Providing pragmatic information on how to disinfect needles, syringes, and other equipment;
- Providing safe disposal for non-sterile injecting equipment; and
- Providing pragmatic steps on how to dispose of non-sterile equipment⁽¹⁵⁾.

Opioid Substitution therapy

Opioid substitution therapy (OST) provides medication, specifically methadone or buprenorphine, to users who are dependent on opiates. These

medications counteract the physiological effects of withdrawal and can be used in combination with outpatient support services to facilitate rehabilitation for PWUD. The therapy was developed to be a long-term maintenance programme for PWUD. By holding back the effects of drug withdrawal, OST provides PWUD with the option of slowly reversing their dependence.

Overdose prevention and treatment

Where available, health care workers should provide medication to PWUD that can be used to counteract the effects of an overdose. This can include the provision of naloxone, a short-acting opioid antagonist, which overturns the immediate effects of heroin and prevents overdose among injection drug users⁽¹⁴⁾.

What services are available for PWUD in South Africa?

Rehabilitation and aftercare programmes do exist for PWUD in South Africa, but their coverage is not widespread and their availability is minimal. Many barriers also exist for PWUD who do choose to seek this treatment. These barriers can include the cost of treatment, legislation preventing access to treatment, restrictive inclusion criteria at rehabilitation centres, limited governmental support of effective treatment options, lack of confidentiality within treatment centres, and stigma and discrimination aimed at people who use drugs⁽¹⁶⁻¹⁹⁾. NSE is not available in South Africa except for one small pilot programme for PWUD who are MSM in Cape Town. While some OST does exist in South Africa, its availability is limited.

SUMMARY AND KEY FACTS

1. When providing care to MSM, sex workers, and PWUD, all health care workers should:
 - **Provide non-judgemental and sensitive testing for HIV.** Testing should be provided in a confidential space without other staff members present in case sensitive questions are asked about their behaviour or identity. This offers key populations an opportunity to know their HIV status, potentially start ART if needed, and receive vaccinations or treatment for certain STIs if required.
 - **Screen for STIs.** MSM, sex workers, and PWUD are highly susceptible to STIs and other infections such as hepatitis. Anal STIs are often overlooked and should be assessed as well, particularly for MSM and sex workers. STI screenings should include oral, vagina, penile, and

anal exams and HIV-positive sex workers should be syndromically screened at least quarterly and provided treatment. MSM should be screened for chronic hepatitis B infection.

- **Provide hepatitis and HPV vaccinations.** Hepatitis A vaccination is recommended for MSM and PWID. Hepatitis B vaccination is recommended for heterosexual sex workers, MSM, and PWID. Where available, the HPV vaccine should be distributed to female sex workers in order to lower the risk of cervical cancer.
- **Screen for TB.** Key Populations are at risk for TB infection, particularly those who are HIV positive and/or using drugs. Key populations, both negative and positive should be screened for the symptoms of TB.
- **Provide condom and lubricant education and counselling.** Health care workers should explain to their clients the types of condoms that are available for both anal and vaginal sex. When used correctly, condoms are an effective tool in preventing HIV and STI infection among key populations. Additionally, health care workers should ensure that clients are provided with the correct information regarding condom-compatible lubrication. Health care workers should remain sensitive to the fact that some individuals experience circumstances where they are unable to use condoms. They support clients in identifying personalised ways to increase condom uptake and use.
- **Provide PEP for high-risk sexual exposures.** For MSM, sex workers, and PWUD who may have been exposed to HIV through unprotected sex, sexual assault, condom breakage, or through the sharing of needles, PEP can be an effective means of preventing HIV infection. PEP should not be limited only to situations involving sexual assault but should also include instances of high-risk exposure from consensual sex.
- **Initiate ART where indicated.** Since MSM, sex workers, and PWUD regularly interact with broader populations initiating and sustaining ART can add a protective benefit to larger communities in addition to the individual. It is also advisable to distribute long-term supplies of ARVs to ensure that a client's supplies is uninterrupted should they move from their clinic's community.
- **Provide medical male circumcision** should be made available to men who are part of key populations, particularly if they are engaging in insertive vaginal sex. Education should be provided to men, however, that its effectiveness has not been proven among MSM and therefore, should not be relied upon as providing any protective effect for this population.

- **Discuss contraception and family planning needs.** Health care workers should discuss contraceptive needs with female sex workers with particular emphasis on dual protection and emergency contraception⁽¹⁾. Information should be made available on termination of pregnancy where appropriate.
 - **Screen for cervical and anal cancer.** Yearly routine cervical cancer screenings are recommended for all female sex workers, since they are at greater risk for acquiring HPV and having it progress to cervical cancer⁽¹⁾. Similarly, for any anal cancer screenings are recommended for all i MSM, sex workers, and PWUD who engage in receptive anal sex. This could result in exposure to HPV and progress to anal cancer.
2. The following are some of the interventions recommended by the World Health Organisation, United Nations Office on Drugs and Crime and UNAids, as part of their comprehensive package of HIV intervention services for PWID, and are proven in their ability to prevent HIV with PWID.
 - **Needle and syringe exchange (NSE) programmes.** Needle and syringe exchange programmes are services that provide clean equipment to PWID and/or assist them in properly discarding their used equipment.
 - **Opioid substitution therapy (OST).** Opioid substitution therapy provides medication, specifically methadone or buprenorphine, to users who are dependent on opiates.
 - **Overdose prevention:** Where available, health care workers should provide medication to PWID that can be used to counteract the effects of an overdose. This can include the provision of naloxone, an opioid antagonist.
 3. Rehabilitation and aftercare programmes do exist for PWUD in South Africa, but their coverage is not widespread and their availability is minimal. Many barriers also exist for PWUD who do choose to seek this treatment. NSE is not available in South Africa except for a small number of NGO pilot programmes. While some OST does exist in South Africa, its availability is limited.
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MODULE

10

BEHAVIOURAL AND PSYCHO-SOCIAL INTERVENTIONS FOR MSM, SEX WORKERS, AND PWUD

Learning Outcomes

After completion of this module, you should be able to:

- i Describe the behavioural and psycho-social interventions available for MSM, sex workers, and PWUD
- ii Understand risk reduction counselling among MSM, sex workers, and PWUD
- iii Describe how to best to provide mental health treatment or referrals for MSM, sex workers, and PWUD

Overview of behavioural and psycho-social interventions

The Operational Guidelines' behavioural intervention component include peer education and outreach, sexual health screening, risk reduction counselling and skills building, Promotion of health care seeking behaviours such as the utilisation of HIV, STI, and TB screening and treatment, adherence counselling and retention in care. Additionally, other support components include the screening and treatment for drug and alcohol abuse. These behavioural and psychosocial interventions are designed to work in combination with the biomedical interventions discussed in Module 9.

Promoting HIV, STI, TB screening and treatment

Each engagement with MSM, sex workers, and PWUD in a health care setting offers an opportunity to provide educate and increase their awareness of HIV risks and the prevention tools available to them. Health care workers should take this opportunity to provide facts and support to key populations.

Furthermore, health care workers should educate key populations by dispelling common misconceptions or myths associated with HIV. For example, it is a common misconception that HIV-positive individuals do not face any risk if they are re-exposed to HIV after they have become infected. This is known as HIV reinfection and, unfortunately, it can significantly reduce future treatment options as well as increase a client's viral load. Many HIV-positive individuals are at significant risk for HIV reinfection because they may be unaware of the consequences associated with continually exposing themselves to HIV.

Health care providers should also actively work to educate MSM, sex workers, and PWUD against the dangers of infecting other people in their community. If an individual is HIV-positive, he or she risks infecting his or her sexual partners and anyone with whom they may be sharing injection equipment.

Health care workers should take into consideration the impact that mental illness or substance use may have on any other treatment they are providing to MSM, sex workers, and PWUD. For example, sex workers with mental illness may be neglectful in taking long-term medication or may find it difficult to return to a clinic for follow-up visits. These factors should be considered when developing a care and retention plan for a sex worker patient. Health care workers should carefully educate clients about medication dosing and assist them in the development of adherence plans that take into consideration their unique circumstances.

Sexual risk reduction counselling and harm reduction

WHAT IS HARM REDUCTION?

The goal of harm reduction is to help reduce the risk that PWUD may face when using drugs, not necessarily to promote abstinence from drug using. Even though PWUD may continue to use drugs after engaging in harm reduction interventions, it will be safer for them to do so and they will face less risk of becoming infected with or transmitting HIV.

In fact, harm reduction interventions can be some of the most effective methods for reducing the spread of HIV among people who inject drugs. This is important to consider, since people who inject drugs also interact and engage with individuals who do not inject or use drugs. Health care workers who implement harm reduction interventions are therefore not only supporting people who inject drugs in improving their health but also providing services that can support their broader community as well.

Harm reduction interventions can also support the development of trusting relationships between PWUD and health care workers, since these interventions are non-stigmatising. These relationships can be useful for health care workers to foster, since PWUD will be more likely to return for follow-up care and serves and more likely to update referral services from health care workers they trust. Harm reduction can be used to address various types of risk, not just those related to HIV.

Some health care workers may feel uncomfortable with aspects of harm reduction interventions. For example, some may interpret a needle and syringe exchange programme as actively promoting drug use, since these programmes provide the equipment needed for PWUD to use drugs. This may be challenging for some health workers who feel that they should be actively encouraging PWUD to discontinue drug use completely. It is important to understand that health care workers who implement harm reduction interventions do not promote drug use.

In fact, a core approach for harm reduction is to take a neutral stance on drug use. This means that the health care workers does not promote or condemn the use of drugs. In this way, health care workers are able to actively address the health risks that PWUD face, particularly HIV acquisition, and support PWUD in receiving care without stigmatising or isolating them.

Please see Appendix 1 for further harm reduction strategies that can be shared with clients.

WHAT IS RISK-REDUCTION COUNSELLING?

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

The main objective of risk-reduction counselling is for patients to set realistic goals for behaviour change that could reduce their chances of contracting or transmitting HIV. As a prevention tool, risk-reduction counselling is the most effective when it is patient-centred, meaning that the counselling sessions focuses on the specific risks, needs and thoughts of the individual patient. Risk-reduction counselling can easily be conducted during an HIV test or during a medical consultation, and can be adapted to any client.

How is risk reduction counselling applied to MSM, sex workers, and PWUD?

Risk-reduction counselling should be conducted with MSM, sex workers, and PWUD just like any other patient, as long as it takes into account their specific needs, background and challenges. Therefore, each risk-reduction counselling session will be unique and require different strategies and approaches. While there is no standardised risk-reduction model specifically for MSM, sex workers, and PWUD, there are a number of factors that can influence a risk-reduction session.

Confidential

The first and most important influencing factor is confidentiality. Fundamental to providing ethical care for any client is to keep strict confidentiality at all times. This is true for MSM, sex workers, and PWUD in particular, because they may or may not be open to the general public about their inclusion in a key population. Should their behaviours or identity be made public, they could face significant stigma and discrimination. Guaranteeing confidentiality with key population clients may also encourage them to be more direct and open regarding their sexual practices and behaviours. This will provide a significantly more effective platform from which to conduct a risk reduction session.

Non-judgemental

Another significant factor that can influence a risk-reduction session with a key population client is the personal beliefs of the health care provider conducting the session. Health care workers' personal bias and stigma can negatively impact the level of service that they can give. It is therefore

essential to conduct a risk-reduction counselling session with an open mind and to direct the session toward the risks identified by the patient.

Client-centred

Many health care workers may assume that MSM, sex workers, and PWUD should be counselled to abstain from the activity that is causing them the greatest risk for HIV infection. For example, some health care workers may believe that sex workers should be counseled to discontinue sex work, MSM should be counseled to stop having sex with other men, and PWUD should be encouraged to discontinue drug use.

However, this is highly ineffective and extremely discouraged. Sex workers rely on the income from sex work for survival and are unlikely to discontinue sex work easily. Similarly for MSM, having sex with other men forms a significant part of their sexuality and would not be a behaviour they could change easily, if at all. Drug use also creates dependency for PWUD which serves as a major barrier to discontinuing that behaviour quickly. A more

EXERCISE 1

Changing Behaviour

Changing a bad habit or behaviour can be challenging. This is because there are often social, mental, or emotional factors that support these behaviours. Can you think of behaviour that you have tried to change in yourself, for example:

Smoking cigarettes; biting your finger nails; having unprotected sex; driving while drunk; driving over the speed limit; eating a lot of fried food; walking alone at night in the street; not brushing your teeth; exercising less than three times per week; being very drunk.

- 1. Were you successful in changing your behaviour the first time you tried? Why or why not?**
- 2. What factors influenced that behaviour that made it easier or more difficult to change? Did it have to do with pressure from another person? Was it because you enjoyed it or felt like a better person when you did it?**
- 3. What are some of the reasons you think it may be challenging for PWUD to stop using drugs? How do they relate to your own reasons?**

effective method of supporting key populations is to provide counselling in order to assist them in reducing their risk behaviours.

Conducted in an enabling environment

Health care workers need to create a caring and welcoming environment where clients feel comfortable to discuss their risk behaviour and sexual practices. This can be achieved by emphasising to the patient that participation is voluntary. Additionally, using caring and non-confrontational language is helpful. For example, instead of referring to a client's boyfriend/girlfriend or husband/wife, rather use a general term such as 'partner'. Many patients may not disclose their risk behaviour due to fear of embarrassment. In these cases, helping to normalise their behaviour can assist in helping the patient to discuss further.

Use appropriate language

As long as the health care worker is comfortable, using the same language that clients use to describe their behaviour can create a stronger sense of understanding and connectedness. For example, sex workers may make the distinction between sexual partners and clients with whom they have sex. Accurately conveying this distinction when discussing behaviours with a sex worker will show that the health care worker can understand and relate to them, thereby increasing the likelihood of the sex worker returning. Use language that is open and honest about sex, does not judge any sexual behaviours and does not refer to some acts as acceptable and some as not acceptable.

Do not make assumptions about behaviour

Not all key populations are the same and, as mentioned throughout this manual, there is a wide variety of behaviours and actions among key populations. Health care workers should not make automatic assumptions about clients. Instead, clients should be treated as individuals and have their risk assessed one-on-one. Asking questions about sex work, anal sex, and drug-taking behaviour should be integrated into routine risk assessments so that all clients are screened for these behaviours.

Ask for clarification

Health workers should ask for clarification from their clients if there is a term/wording or behaviour that they are discussing that is unfamiliar. Some health care workers may feel the need to be perceived as 'knowing everything', but it is better to seek clarification and be better equipped to support your client.

CASE STUDY

SW and Risk Reduction

Consider the following case study about a sex worker from Cape Town and answer the following questions.

Monica has been doing sex work for 14 years, and while she has occasionally had unprotected sex with clients, she understands the necessity of using condoms, and normally does so. Last month, the police and the neighbourhood security committee implemented a campaign to clear the area of sex workers where Monica works. So Monica instead went to a hotel in the next precinct, which is a sex worker hotspot. She was soon offered a room by a bouncer in the hotel, on condition that she provide him with sexual services. Monica used a condom but, after intercourse, Monica noticed that the condom had broken.

By Monday morning, Monica noticed that her vagina was itchy. She visited a mobile clinic run by an NGO, but did not tell the nurse that the condom had broken; she only mentioned her symptoms. She was not sure how the nursing sister would respond to her story of the condom breaking, and worried that she might interrogate her or discover that she was a sex worker. Monica was also worried that nursing sister would reprimand her for being irresponsible.

Two weeks later, Monica was feeling nauseated and weak, and she had missed her period. She feared she was pregnant, and decided to go for a pregnancy test. Monica goes to a local sex worker advocacy group, where they refer her to a friendly clinic. They did a pregnancy test, which was positive, and booked Monica for a termination of pregnancy at her request. They also tested her for HIV and STIs, for which she tested negative. However, Monica knows that she is in the window period for HIV infection, and she is worried.

- 1. Using the information provided in Module 4, what do you think are Monica's risk behaviours? Can you identify other facilitators that increase her risk?**
- 2. What strategies would you suggest to Monica in order to reduce her risk?**
- 3. Can you identify any barriers or challenges that Monica may face in trying to access health care?**
- 4. Use the above scenario to role play a risk reduction counselling session if you have a partner available. Switch roles after completing the first session. Consider which methods you found the most effective and useful when counselling Monica.**

Following is an outline for one particular method of risk-reduction counselling.

Step 1: Assess the behaviours of clients

In order to assist clients in developing risk-reduction goals, it is first important to gain a better understanding of their sexual practices, including both safe and risky behaviours. Particular focus can be placed on behaviour from the previous three months, as this may impact their need for further HIV testing. This basic assessment can be achieved by asking them key questions regarding the number and type of sexual partners they have, the types of sexual acts in which they have engaged, and their use of alcohol or other substances.

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

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

Step 3: Discuss the 'cost and benefits' of this behaviour

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

Step 4: Set goals

Once clients have a deeper understanding of why they engage in the risk behaviour and motivators that influence them, they should create a personalised goal to change this behaviour in some way to become safer. This goal should be specific, achievable, realistic, and measurable. Goals that

are less detailed can be difficult to achieve or follow through with. Most importantly, a behaviour-change goal should be realistic for clients and based on their specific circumstances. Setting a behaviour-change goal that is impossible for them to achieve right away may lead them to become demotivated or disappointed in themselves. For example, it may be unrealistic for a client who very regularly has a large number of sexual partners to set a behaviour-change goal of becoming monogamous. Instead, a smaller but achievable goal might be for such clients to always use or increase their use of condoms with all of their sexual partners, which may also be something that they can sustain over time.

Step 5: Discuss barriers

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

Step 6: Reinforcement

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

Step 7: Create a plan for action

Health worker and client establish a plan for action, which they agree on. This plan for action should have a timeframe.

EXERCISE 2

Identifying Risky Behaviour

Read the following list and identify why the specific behaviour is risky for a PWID. Afterward, rank the behaviours in order from most risky to least risky.

1. *Sharing injection equipment with a stranger*
2. *Cleaning his or her personal equipment before using it again*
3. *Never sharing injection equipment*
4. *Cleaning equipment after someone else has used it*
5. *Using new equipment for every injection*

WORLD HEALTH ORGANISATION RISK HIERARCHY FOR INJECTING DRUG USE

The following levels of risk can be a useful tool when supporting PWID in reducing their risk:

1. You will not get infections from sharing needles if you stop or never start injecting drugs.
2. If you cannot stop using drugs, use them in any way except injecting. If you do not inject drugs, you cannot catch infections through needle sharing.
3. If you cannot stop injecting drugs, do not share needles, cookers, spoons or filters with other drug users, or use new injecting equipment every time. If you use new injection equipment every time you cannot catch viral infections such as HIV through needle sharing.
4. If you need to re-use any equipment, use your own injecting equipment every time. If you re-use your own injection equipment every time you cannot catch viral infections such as HIV unless someone else has used your equipment without your knowledge.
5. If you need to re-use any equipment and you believe you need to use someone else's equipment, then clean needles by an approved method. There is some risk for HIV transmission after needle cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

TIPS FOR RISK REDUCTION COUNSELLING⁽¹⁾

- ✓ Do what is possible first: Emphasis on short-term pragmatic goals (for example, preventing HIV transmission in a specific circumstance) over long-term idealistic goals (for example, overall reduction in harm/risk from drug use).
- ✓ Small changes are easier than big changes: Establishment of a scale of means to achieving specific goals: for example, a hierarchy of risks
- ✓ Say the same thing many times in many ways: Use of multiple strategies to achieve goals.
- ✓ Give clients the tools they need; Provision of the means to accomplish risk reduction, for example condoms and sterile needles and syringes.

EXERCISE 3

Risk Behaviours

Identify which of these behaviours are relevant to MSM, to sex workers or to PWUD:

- Anal sex without a condom (bare-backing)
- Having sex during menstruation
- Anal sex without lubricant
- Sharing injecting equipment
- Using oil-based lube with a latex condom
- Having sex while on drugs
- Re-using injecting needles
- Group sex
- Trading sex for drugs
- Prolonged sex (marathon sex)
- Using vaginal/anal cleansing or tightening products
- Having unprotected sex with partner of unknown HIV status
- Buying drugs from unknown dealer

Treating mental illness and substance use

Providing support

Mental health is a critical factor in the successful HIV/STI/TB treatment of key populations. It can influence other tools that are being implemented and

inhibit other treatments or therapies that may be provided. Health care workers may have varying levels of capacity to manage mental illness. Comprehensive mental health support may be beyond the scope of many general health facilities, but there is still a lot of support that can be given by health care workers. Health care workers should:

- Provide key populations with a welcoming environment in which they feel comfortable to disclose information to a health care worker.
- Encourage clients to engage honestly. Health care workers will then have the opportunity to gather more information regarding their circumstances and be better equipped to refer the patients for more significant care.
- Health care workers should be familiar with referral pathways that are available in their community. They will then have the capacity to connect key populations with mental illness to effective mental health services.
- Health workers should be educated on the presence and impact of mental illness in the lives and health of key populations.
- Health care workers who have an opportunity or the resources to deal first hand with mental illnesses should conduct a non-judgemental and thorough psychological assessment on all clients in order to establish a feasible treatment plan. Key population clients should be continually monitored throughout their treatment in order for them to cope with the effects of their mental illness.
- Attempts should be made to link clients with supportive psychotherapy or other related services that may be available.

Referrals for care

Health care workers may have limited time or resources to fully provide the range of services needed by key populations; particularly those suffering from mental illnesses or drug dependency. Their needs may still be met through referrals to care by other organisations. Support for mental health issues is a strong example of services that may require referral to more extensive care.

Wound care and managing comorbidity for PWUD

A possible risk associated with injection use is infection that can lead to conditions such as ulcers and abscesses. With this in mind, health care workers should conduct a visual inspection of clients who use or inject drugs to assess the presence of such infections. If infections are found, these clients should be provided immediate wound care as per standard protocol. Wound care could include the cleaning and bandaging the wound and possibly distributing antibiotics. Health care workers should also educate clients about these infections, as well as how they can continue to clean and care for the wound outside the health care facility.

Addressing comorbidity is an important component to effectively treating and providing services for PWUD. Comorbidity may pose a challenge for health care workers by making it difficult to establish a treatment plan for their client. For example, if a client is depressed and addicted to opiates, should he or she be treated first for the depression or the drug use? Which caused the other to occur, and how do they interact?

Create a treatment plan: When working with PWUD, it is critical to gain a comprehensive perspective of their treatment needs. It will be important to understand their various health issues and create a long-term plan to address each of them. Certain conditions will need to be addressed immediately, while others may need to be addressed or revisited in the future.

Always address the drug-taking behaviour: Regardless of the co-occurring disorders, drug-taking behaviour will always continue to complicate treatment and should be addressed as soon in the treatment plan as possible. Take, for example, a client who comes to the facility with extensive ulcers on his or her arm, a side effect of injecting drug use. The ulcers are an immediate health concern, but the drug use is the underlying cause. If the ulcers are treated

CASE STUDY

Difficult Clients: SW

Consider the following case study about a sex worker from Cape Town and answer the following questions.

Sister Betty is sitting in her consultation room when a young woman enters. The young woman, who is wearing a very short skirt and low-cut top, sits herself down and, speaking very quickly and loudly, demands that Sister Betty give her the emergency contraceptive pill. Sister Betty tells the woman to calm down, and says that first she must ask her a few routine questions and fill out some paperwork. The young woman starts shouting at Sister Betty, saying that she has come here to ask for help and now she is being treated badly by the staff. Sister Betty tells the young woman that she is not treating her any differently and wants to help her, but that she has to ask her a few questions before she can give her the emergency contraceptive. The young woman gets out of her seat shouting that just because she is a sex worker, it doesn't mean she should be treated like dirt. Before Sister Betty can say anything the young woman storms out of the room, slamming the door behind her.

1. Why do you think the young woman acted in the way that she did?
2. What would you have done in this situation?

without addressing the drug use, they will simply reoccur and require treatment again. Therefore, in addition to taking care of immediate health needs, health care workers should also begin addressing the drug-taking behaviour.

Address care in short-term and long-term goals: When working with PWUD, it is helpful to establish a long-term health care goal that takes into consideration each of their specific ailments over time. That goal should be broken up into more manageable time frames and objectives, for instance, dealing with drug-taking behaviour while simultaneously addressing immediate health needs, and then slowly building layers of treatment to address other issues such as depression or mental health.

CASE STUDY

Difficult Clients: PWID

Consider the following case study about a sex worker from Cape Town and answer the following questions.

Mavuso is a regular heroin user who has been injecting for the past four years. He believes that he has his heroin use under control because he doesn't take heroin every day and manages to keep his job as an electrician. One morning when he is getting ready to go to work, he has a very painful sensation when he tries to urinate, and some pain in his abdomen. He tries to forget about it but all day at work he suffers from the same burning sensation whenever he tries to urinate. Mavuso decides he should go to the clinic on his way home from work. He describes his symptoms to the nurse, and she asks him a few questions about his health. She asks him to roll up the sleeve of his jersey so that she can take his blood pressure. Mavuso does not want her to see the track marks (injecting punctures) on his arm so tells her that he doesn't have a problem with his blood pressure, he just needs treatment for his urinary infection. The nurse explains that she just needs to carry out some routine procedures before she can provide him with any medication, and so she needs to take his blood pressure. Mavuso starts shouting at the nurse, he grabs her arm and starts calling her names. This frightens the nurse and so she tells Mavuso to get out of her room. Mavuso gets up and walks out of the clinic, shouting swear words at the nurse as he leaves.

- 1. Why do you think Mavuso wanted to hide his track marks from the nurse?**
- 2. Why do you think Mavuso reacted the way he did?**
- 3. How would you have reacted in this situation?**

SUMMARY AND KEY FACTS

When promoting HIV, STI, and TB screening and testing, health care workers should:

- Take every opportunity to provide facts and support to MSM, sex workers, PWUD in order to increase their awareness of HIV risks and the prevention tools available to them.
- Dispel common misconceptions or myths associated with HIV.
- Educate MSM, sex workers, PWUD regarding spreading HIV within their community.
- Take into consideration the impact that mental illness or substance use may have on any other treatment that is being provided.

Sexual risk reduction counselling and harm reduction

- Risk-reduction counselling is a behavioural intervention that attempts to decrease an individual's chances for acquiring HIV or other STIs.
- The main objective of risk-reduction counselling is for patients to set realistic goals for behaviour change that could reduce their chances of contracting or transmitting HIV.
- Risk reduction counselling should be Confidential, Non-Judgemental, Individualised, and Conducted in an enabling environment.
- The goal of harm reduction is to help reduce the risk that PWUD may face when using drugs, not necessarily to promote abstinence from drug using.
- Harm reduction interventions can be some of the most effective methods for reducing the spread of HIV among people who inject drugs.
- Health care workers who implement harm reduction interventions do not promote drug use. In fact, a core approach for harm reduction is to take a neutral stance on drug use.

Mental illnesses and substance use

- Mental health is a critical factor in the successful HIV/STI/TB treatment of MSM, sex workers, PWUD.
- Mental health illnesses can influence other treatments or therapies that may be provided.

When treating mental illness and substance use:

- Provide MSM, sex workers, PWUD with a welcoming environment in which they feel comfortable.
- Encourage clients to engage honestly.
- Be familiar with referral pathways that are available in their community.
- Be educated on the presence and impact of mental illness.
- Conduct a non-judgemental and thorough psychological assessment on all clients in order to establish a feasible treatment plan, if resources and skill to do so are available.
- Link clients with supportive psychotherapy or other related services that may be available.

Wound care and managing comorbidity for PWUD

- Conduct a visual inspection of clients who use or inject drugs to assess the presence of such infections. If infections are found, these clients should be provided immediate wound care as per standard protocol.
 - Wound care could include the cleaning and bandaging the wound and possibly distributing antibiotics.
 - Educate clients about these infections, as well as how they can continue to clean and care for the wound outside the health care facility.
 - Addressing comorbidity is an important component to effectively treating and providing services for PWUD.
 - Create a treatment plan.
 - Always address the drug-taking behaviour.
 - Address care in short-term and long-term goals.
-

HARM REDUCTION STRATEGIES FOR INJECTION DRUG USE (FROM UNODC)

1. Needle/syringe exchange programmes: preventing the sharing of injecting equipment and strategies for the safe disposal of non-sterile injecting paraphernalia (such as needle exchange programmes) through the following:
 - Raising awareness and knowledge of the risk of contracting infectious diseases through injecting drug use
 - Providing information and advice on the steps to inject safely
 - Providing sterile injecting equipment, if possible
 - Providing pragmatic information on how to disinfect needles, syringes, and other equipment
 - Providing safe disposal for non-sterile injecting equipment
 - Providing pragmatic steps on how to dispose of non-sterile equipment
2. Emphasising non-injection routes of administration over injection routes. Reduce initiation of drug injection among people who do not use this route of administration and to reduce drug injection by promoting other routes of administration among IDUs.
3. Voluntary HIV counselling and testing. Early detection of HIV infection is critical. Barriers such as lack of HIV testing availability and the questionable accuracy of HIV tests, together with people's fears of discrimination, fears about getting a positive result from the test, and fears of social stigma need to be overcome to better implement HIV testing as a prevention programme. Voluntary testing should, ideally, be accompanied by HIV counselling. This includes a risk evaluation and information on prevention of HIV transmission. Pre-test counselling should focus on assessment and getting the necessary information from the client on his/her medical history, drug use, knowledge of HIV and AIDS, sexual behaviour (number of partners, condom use, etc.), exposure to high-risk situations, and other information. Information about the test should also be provided at this moment. Post-test counselling depends on the test results. If negative, the client should receive information that the results might not be reliable and that a new test should be conducted in 3–6 months. Counselling after a positive test requires more details and sensitive treatment. In addition to this, anti-retroviral treatment for HIV-infected drug users should be made available and accessible.

4. Overdose prevention. Naloxone, a short-acting opioid antagonist, overturns the immediate effects of heroin and prevents overdose among injection drug users. Other drugs, such as methadone, which have similar properties to heroin and morphine, help to reduce overdose, risk of HIV and hepatitis infection, and criminal acts and other high-risk behaviours (the latter two because methadone is delivered legally). Other overdose management strategies include peer-to-peer education in first aid and resuscitation (CPR); establishing collaborations among peers, and encouraging peers to seek help and call an ambulance when an overdose is suspected.

5. Prevention and services for the management of sexually transmitted infections. It is critical to provide information to drug users about the risk of HIV transmission and the main strategies to reduce such transmission. Strategies may include using condoms, reducing the number of sexual partners or being faithful to one partner, treating sexually transmitted diseases, abstinence, etc. Strategies for men and women may vary depending on socio-political and cultural factors (e.g., many women do not have a choice regarding their own sexuality). Working with those involved in sex work is particularly important. Also educating mothers on the risks of transmission of HIV to their babies (e.g., infant feeding) should be included when working with women and parents in general.

CONCLUSION

Establishing a plan for change

Taking an active role in supporting change in your health care facility can be challenging, but it is a necessary step to providing more effective care for MSM, sex workers, and PWUD. This section will assist you in the development of an individualised action plan that you can implement within your health care facility to provide better care for PWUD.

EXERCISE 1

Identifying Areas for Change

MSM, sex workers, and PWUD experience many barriers and challenges when accessing health care services. These can range from stigma and discrimination to breeches in confidentiality. (Think back to the barriers you came up with in Exercise 3, Module 7).

Using these examples, list the challenges that you believe most affect key populations at your clinic, specifically. If you are not able to identify barriers (perhaps you do not know of any who attend your clinic), then select barriers that make it difficult for other types of clients.

Once you have completed your list, if you are with a partner, divide the barriers into two groups. First, please list those barriers or challenges that are linked to individual health care workers (either you or colleagues).

Next, list those that are associated with facility-level difficulties (operational time, service limitations etc.). For this exercise, select one of the challenges or barriers (from Exercise 1) that you would like to support changing at your health care facility.

Before you develop specific actions to achieve your goal, it will be helpful to first understand the main causes behind the barriers you would like to change. Identifying the underlying cause of a barrier will better support you in determining a course of action to take to correct it.

For example, suppose that key population clients did not attend your clinic and this was the problem you were attempting to change. This problem could have many different causes. Are key populations not coming because they do not know about the services you offer at the clinic, or because they have come before but had poor experiences? Each of these causes led to the same problem (key populations not attending your clinic) but they would require drastically different courses of action to change.

Setting a goal for change

Now that you have identified a barrier or challenge and its causes, begin to consider how you would like to see it change. In other words, set a goal that you would like to achieve by changing this barrier or challenge. Make sure to use the SMART Criteria when setting your goal.

S.M.A.R.T GOALS

- **Specific:** Your goal should be clear and direct. For example: Over the next four months, I would like to conduct two training in my clinic to address stigma among the staff.
- **Measurable:** You should be able to effectively monitor your progress towards your goal. It should not be ambiguous.
- **Achievable:** You should be able to actually reach your goal within a set amount of time.
- **Realistic:** Your goal should be feasible and not impossible to reach.
- **Timely:** Your goal should include a specific timeframe within which it could feasibly be achieved

EXERCISE 2 (TABLE)

Challenge	Cause(s)	Type of Cause		Goals
		Individual	Facility	
Example: PWID do not come to this clinic	Staff stigmatise PWID	X		Hold sensitisation training with staff

EXAMPLES OF S.M.A.R.T GOALS

The following goals illustrate the components of the SMART criteria:

Goal: *I will reduce stigma in my workplace.*

This goal is not specific because it does not indicate how stigma will be reduced. The goal is also not measurable; that is, how will stigma be monitored? The goal does not indicate a set amount of time, so it is not attainable. The goal may or may not be realistic, depending on the health care worker's position and organisation of their clinic. It is difficult to determine whether this goal is timely because the actions associated with it are not specified, measurable or attainable..

Goal: *I will attempt to reduce stigmatising behaviour in my workplace over the next 2 months conducting a 2-hour training with the 10 counsellors in my clinic to better sensitise them to the experiences at our clinic of sex workers.*

This goal is specific because it states how the goal will be achieved and with whom. The goal is measurable because it indicates not only the number of people to be trained but also the length of the training. This goal is attainable because the time frame, amount of work and individuals involved are clearly stated and it could easily be implemented. It is very realistic to conduct one training session for 10 individuals, and it is realistic to assume that education will assist in lowering stigma among health care workers. This goal is timely because it provides a sufficient amount of time needed to carry out the activities that have been declared.

Establishing a next step

Change can sometimes be difficult, and achieving big goals can understandably feel overwhelming. The most effective way to make progress towards a large goal is to break that goal down into smaller action steps. Each action step should be easily achievable and move you one step closer to achieving your overall goal. If a person succeeds with enough of their action steps, they eventually make progress towards achieving their overall goal.

Take, for example, someone who is trying to lose a lot of weight. What steps are needed to achieve this? Perhaps their first step could be to join a gym or learn more about good nutrition habits. Whatever the next step may be, it is easier to focus on and achieve it than their major goal of weight loss.

EXERCISE 3

Identifying SMART Goals

For each of the following goals, determine which of the SMART criteria are met and which ones are not. Rewrite each goal to better fit the SMART criteria.

1. I will make all of my colleagues work better with key populations.
2. I will address stigma and discrimination against key populations in my workplace.
3. I will set up a discrimination committee in my clinic that consists of nurses, doctors and counselling within two months of my training.
4. I will ask each of my clients who are part of key populations in the next three months about their experiences in my clinic and how they think I can improve them.
5. I will get 100 new MSM, sex workers, or PWUD to attend my clinic by next month.

Take into consideration your goal. What is the very first step you can take when you return to your health care facility?

Achieving your goal

Use the following questions to assist you in developing a specific plan to address your goal for change.

1. How long will you need to achieve your goal? Consider if this is a goal that you can work on daily, or if you will need a certain amount of time before it can be implemented. Will you need to repeat an action regularly to achieve this goal or will you be able to achieve it once off?
2. What resources will you need? Will achieving this goal require other people, or are you able to achieve it by yourself? Will this goal require additional funding or other tools that your facility would need to contribute? Will you or your colleagues need to contribute additional time during work hours to achieve this goal?
3. Who will need to be involved to make this goal a success? Will this be a goal that you can implement by yourself or will you need to involve other staff? If other staff are involved, from what level will they be employed?

4. How will you determine whether or not you have reached your goal? Will your goal be achieved at one final point, or can it be achieved in smaller increments and timeframes?
5. What challenges do you see that may be a barrier toward achieving your goal? A barrier could develop during the planning or implementing of your action plan. Are there facility or individual barriers that could prevent you from reaching your goal?
6. What do you need to make your goal a success? What are the most important parts of your goal and action plan? How can you guarantee that those parts are available to you for your plan?

HEALTH CARE PROVISION

POST-COURSE EVALUATION AND QUESTIONNAIRE

Thank you for completing this manual on health care provision for men who have sex with men, sex workers, and people who use drugs. Please take a moment to complete the post-course evaluation. This can be used to compare your change in knowledge since the beginning of the course.

SW/PWUD/MSM POST-TRAINING EVALUATION

SECTION A: Training details

A1	Training Date:	_____ (Day) / _____ (Month) / (Year)
A2	Training Venue:	
A3	City/District:	
A4	Province:	

SECTION B: Trainee details

B1	Gender:	
B2	Age:	
B3	Job title:	
B4	Employer:	

SECTION D: Knowledge assessment

	Question	Answers: tick all that apply	
D1	SW, PWUD and MSM are at higher risk for HIV and STIs than the general community because:	a. They may have unprotected sex	<input type="checkbox"/>
		b. They may share contaminated needles to inject drugs	<input type="checkbox"/>
		c. They are more likely to be exposed to violence or sexual assault	<input type="checkbox"/>
		d. They often do not get effective health care because of stigma or discrimination	<input type="checkbox"/>
		e. They often do not have the correct information about their own level of risk	<input type="checkbox"/>
D2	Sex workers are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They are dirty or smell bad	<input type="checkbox"/>
		c. They engage in an illegal activity	<input type="checkbox"/>
		d. They are dishonest and untrustworthy	<input type="checkbox"/>
		e. They never adhere to treatment	<input type="checkbox"/>
		f. They are rude	<input type="checkbox"/>
		g. They are responsible for spreading HIV	<input type="checkbox"/>

D3	People who use drugs are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They are dirty or smell bad	<input type="checkbox"/>
		c. They engage in an illegal activity	<input type="checkbox"/>
		d. They are dishonest and untrustworthy	<input type="checkbox"/>
		e. They never adhere to treatment	<input type="checkbox"/>
		f. They are thieves	<input type="checkbox"/>
D4	Men who have sex with men are stigmatised because:	a. They engage in immoral behaviour	<input type="checkbox"/>
		b. They engage in unnatural behaviour	<input type="checkbox"/>
		c. They are mentally ill	<input type="checkbox"/>
		d. Homosexuality is a sickness	<input type="checkbox"/>
		e. They are rude	<input type="checkbox"/>
		f. They engage in disgusting behaviour	<input type="checkbox"/>
D5	Stigma towards SW, PWUD and MSM can be reduced in a health care setting by:	a. Ensuring that inappropriate language and behaviour are not tolerated in health facilities	<input type="checkbox"/>
		b. Encouraging the police to visit the clinic regularly	<input type="checkbox"/>
		c. Having separate queues for SW, PWUD and MSM away from the other clients	<input type="checkbox"/>
		d. Refusing to provide SW, PWUD and MSM the same services as other clients	<input type="checkbox"/>
D6	Sex workers, PWUD and MSM find it hard to access health services because:	a. They often face unfair treatment and discrimination from health care staff	<input type="checkbox"/>
		b. Many don't have money for transport	<input type="checkbox"/>
		c. They worry about the lack of confidentiality	<input type="checkbox"/>
		d. They cannot disclose their behaviour to health workers for fear of judgement	<input type="checkbox"/>
		e. They worry that they will be refused services	<input type="checkbox"/>
		f. They don't believe they deserve treatment	<input type="checkbox"/>
		g. They worry that they will be abused by clinic staff	<input type="checkbox"/>

D7	Risk-reduction counselling is a behavioural technique meant to reduce HIV risk by:	a. Telling the client that they are engaging in dangerous and immoral behaviour and that they should stop these behaviours immediately	<input type="checkbox"/>
		b. Discussing ways they could reduce their risk and practise safer behaviour	<input type="checkbox"/>
		c. Telling the client that you will not provide them with health care until they stop their risky behaviour	<input type="checkbox"/>
D8	Which of the following factors affects the mental health of SW, PWUD and MSM?	a. High levels of stigma and discrimination	<input type="checkbox"/>
		b. They spend time in dangerous places and environments	<input type="checkbox"/>
		c. They are vulnerable to high levels of physical and emotional abuse	<input type="checkbox"/>
		d. They face rejection from family and friends	<input type="checkbox"/>
		e. They worry that they will be caught or discovered doing something that is not generally accepted in their community or family	<input type="checkbox"/>
		f. They face police harassment	<input type="checkbox"/>
		g. The behaviour they engage in is judged to be immoral	<input type="checkbox"/>
		h. They engage in risky behaviours	<input type="checkbox"/>
D9	To provide better services for SW, PWUD and MSM, health care services should:	a. Provide risk-reduction counselling	<input type="checkbox"/>
		b. Provide information and advice on anal sex	<input type="checkbox"/>
		c. Provide information and advice on how to inject drugs safely	<input type="checkbox"/>
		d. Provide moral and religious guidance	<input type="checkbox"/>
		e. Provide clean needles for injecting drug users	<input type="checkbox"/>
		f. Include input from Sex workers, PWUD and MSM in the design of relevant services	<input type="checkbox"/>
		g. Provide a range of combined HIV prevention and safer sex strategies for clients to use e.g., condom negotiation skills)	<input type="checkbox"/>

SECTION E:

	Question	Response guide 1. Strongly disagree 2. Disagree 3. Don't know 4. Agree 5. Strongly agree
E1	Sex workers, PWUD and MSM do not visit my clinic.	
E2	Selling sex is immoral	
E3	Using an illegal drug is immoral	
E4	Having sex with someone of the same sex is immoral	
E5	Sex workers deserve to get HIV because of the behaviour that they engage in.	
E6	People who use drugs deserve to get HIV because of the behaviour that they engage in.	
E7	Men who have sex with men deserve to get HIV because of the behaviour that they engage in.	
E8	If a sex worker came to my clinic, I would provide him/her services just like anyone else.	
E9	If a person who uses drugs came to my clinic, I would provide him/her services just like anyone else.	
E10	If a man who has sex with other men came to my clinic, I would provide him with services just like anyone else.	
E11	If a sex worker wanted treatment for an STI, I would not provide it because he or she will just get infected again.	
E12	I feel comfortable providing health care services to sex workers	
E13	I feel comfortable providing health care services to people who use drugs.	
E14	I feel comfortable providing health care services to men who have sex with men.	

E15	Sex workers, PWUD and MSM should be offered services tailored to their needs because they are more vulnerable than other people and may need specific treatment.	
E16	This kind of sensitisation training is helpful in addressing stigmatising attitudes amongst health care workers.	

SECTION F: Knowledge assessment

	Question	Answers: tick all that apply	
F1	After this training, I feel more comfortable providing services to	a. Sex workers	<input type="checkbox"/>
		b. People who use drugs	<input type="checkbox"/>
		c. Men who have sex with men	<input type="checkbox"/>
		d. I do not feel more comfortable providing services to any of the above	<input type="checkbox"/>
F2	Sex workers are stigmatised because:	a. Sex workers	<input type="checkbox"/>
		b. People who use drugs	<input type="checkbox"/>
		c. Men who have sex with men	<input type="checkbox"/>
		d. I do not feel more knowledgeable about providing services to any of the above	<input type="checkbox"/>
F3	After this training, I feel more skilled in providing services to	a. Sex workers	<input type="checkbox"/>
		b. People who use drugs	<input type="checkbox"/>
		c. Men who have sex with men	<input type="checkbox"/>
		d. I do not feel more skilled in about providing services to any of the above	<input type="checkbox"/>

SECTION G:

	Question	Response guide 1. Strongly disagree 2. Disagree 3. Don't know 4. Agree 5. Strongly agree
G1	This kind of sensitisation training is helpful in addressing stigmatising attitudes amongst health care workers.	
G2	It is important to have SW/PWUD/MSM friendly and affirmative services at my facility.	
G3	There is a need for SW/PWUD/MSM friendly and affirmative services in my community.	
G4	I will now be able to address discrimination against SW/PWUD/MSM at my facility	

APPENDICES

APPENDIX I

STRATEGIES FOR SAFE INJECTING DRUG USE

The options below provided harm reduction strategies when injecting drugs; however, the use of new and unused materials for injecting is always the safest method.

The '2 by 2 by 2' method

Injectors should be advised that all syringes that they think may be re-used should be cleaned immediately after first use. They should then be cleaned again before second use. The best method for cleaning is to use the '2 by 2 by 2 method':

- Draw COLD water (sterile or cool boiled water is best) into the syringe and then flush it out down the sink or into a different cup. Do this twice.
- Then slowly draw bleach into the syringe and shake it for as long as possible: 3-5 minutes is ideal, 30 seconds is the minimum. Flush it out down the sink or into a different cup. Do this twice.
- Then draw COLD water into the syringe (as in step 1) and then flush it out down the sink or into a different cup. Do this twice as well.

Responding to co-occurring conditions in PWUD

- As part of a comprehensive program for HIV among PWUDs, it is necessary to address other common health conditions, including tuberculosis, hepatitis C, sexually transmitted infections and mental health problems, to reduce the broader harms experienced by PWUDs, and to augment efforts to prevent and treat HIV.
- Active injecting drug use should not be a criterion for delaying or denying treatment of HIV or other comorbid conditions. Conversely, the presence of these conditions should not be criteria for delaying or denying treatment for drug use or efforts to reduce drug related harm.
- PWUDs should be provided with appropriate treatment for co-occurring conditions in order to improve treatment adherence and outcome.
- It is imperative that services or facilities that are most likely to have contact with PWUDs, such as harm reduction services, drug treatment providers and criminal justice settings, have the capacity to manage a broad range of conditions, or be integrated with services that do.
- Various strategies may be utilised to better integrate services, including: co-locating services; cooperation between multidisciplinary services to provide co-management of PWUD patients; and efficient and supported referral pathways between services. The most appropriate strategy for a particular setting will depend upon how health systems and other relevant sectors are structured, and how capacity is distributed. To ensure universal access to comprehensive treatment for the range of serious health conditions PWUDs may face, it is important for collaborative planning and service delivery.

Responding to mental health problems among PWUDs

- Appropriate screening, assessment, and services providing mental health should be provided as key components of care for PWUDs.
- Comorbid mental health problems and drug dependence should never be a reason to delay or deny treatment for either condition, or for any other.
- The capacity of both mainstream and specialist services to provide mental health services for PWUDs should be assessed, and where lacking, efforts to increase capacity should be undertaken.

Source: Consensus Statement of the Reference Group to the United Nations on HIC and Injecting Drug Use 2010 – UNAIDS, UNODC, WHO

HARM REDUCTION TIPS TO PROVIDE TO A PERSON INJECTING DRUGS

You can protect yourself from infection by always using your own: new, sterile needles and syringes; mixing water, cups or pots; spoons or cookers (used to heat powdered drug and mix it with water); filters; swabs/alcohol wipes; tourniquet; and never sharing, lending or borrowing them.

Sharing isn't just using a syringe that someone else has used. It is also using the following that someone else has used, or passing them on to someone else: a filter; mixing water; water cup/container; or spoon. And, where possible use each needle and syringe once only, prepare injections with clean hands on a clean surface and clean the injecting site, and wash your hands before and after each injection.

Additionally, you should swab more than one spot injecting site so you have a cleaned place available if the first attempt doesn't work. You should also swab just once to prevent from spreading any dirt to other sites.

Harm reduction for PWID trouble-shooting solutions Training guide for HIV prevention outreach to drug users, Medical Research Council, South Africa

1. No clean needle and syringes are available.

- Boil needle and syringe for 15-20 minutes.
- Clean with bleach (2 by 2 by 2).
- Clean with water ten times immediately after and before use.
- Use the drugs by smoking.
- Snort the drugs.

2. No bleach is available.

- Boil needle and syringe for 15-20 minutes.
- Clean with water ten times immediately after and before use.
- Use the drugs by smoking.
- Snort the drugs.

3. No fresh tap water is available.

- Use mineral water.
- Boil water for 15-20 minutes.

4. You have an abscess.

- Make a compress of wet bandages.
- See a doctor as soon as possible.

5. The needle clogs when pulling up a shot of heroin.

- Stop injecting, put the liquid back in the spoon, remove the clot, add some cold water, put on a new needle or use a new needle and syringe.
- To unblock the needle, warm the needle with a lighter to expand it.
- Pull up some fresh, cold water and shake the syringe.

6. The needle has a barb (burr).

- Sharpen it on a glass or matchbox and clean it with a (lighter) flame.

7. No fresh cotton wool or other filter is available.

- Use the filter of an unsmoked cigarette.
- Use whatever is available, such as an alcohol swab, the lining of a clean coat, etc.
- Use no filter. Carefully tip the spoon and keep the residue at the other end from where you draw up.

8. No spoon is available.

- Use the bottom of a can, cleaning it by heating with a cigarette lighter.

9. You have difficult veins: hard, rolling and lying deep.

- Learn to smoke or consume the drugs some other way.
- Ask someone else to help you inject.

10. You hit an artery.

- Immediately pull the needle out and apply pressure for five to ten minutes.
- Raise the limb.
- If bleeding does not stop, seek urgent medical treatment.

11. No alcohol swab is available.

- Clean the injection spot with water and soap.
- Clean it with water only.

Good injecting technique

This is the optimum method of injecting. When injecting drug users inject, they are often unable to take all of these steps due to lack of equipment or time, or lack of knowledge:

1. Prepare for the injection by obtaining new injecting equipment. Needle and syringe, alcohol swab, filter, spoon, tourniquet and any other equipment should be owned by the drug user and should not be shared with anyone else.
2. Clean hands.
3. Use a filter (for example, cotton wool).
4. Swab injecting site.
5. Rotate injection sites to avoid vein damage. This allows damage to heal, there is less bruising and bruised sites can lead to infection. It reduces scarring, which thickens the vein wall and makes future injection more difficult and more damaging.
6. Avoid damaged, especially infected, sites.
7. Jack back: push the plunger partly down, pull it back, letting blood, enter the syringe, push all the way down to inject into the vein. This is important because it can signal if you have injected into an artery instead of a vein.
 - Arterial blood is bright and frothy, compared to venous blood, which is dark.
 - Arterial blood is under high pressure, and difficult to inject into.
 - Arteries are deep.
8. If you suspect an artery has been hit, immediately pull the needle out; apply pressure for five to ten minutes, raise the limb; if bleeding does not stop, seek urgent medical treatment.
9. Inject slowly:
 - There will be less risk of fatality/overdose.
 - There will be less wear and tear on the vein.
 - It will decrease the effect of contaminants.
 - It will help to ensure that the drug is going into the vein.
10. Always inject in the direction of the blood flow, towards the heart.
11. Apply pressure after injecting for at least one to two minutes.
12. Do not use an alcohol swab when applying pressure since this may interfere with clotting.

APPENDIX II

CONDOM INFORMATION

Instructions for correct male condom use

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

13. Make a knot in the condom and dispose of it appropriately out of the reach of children.
14. Use a new condom for each new act of intercourse.

Instructions for correct female condom use

Method 1: Use by receptive partner

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

Method 2: Use by insertive partner

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

APPENDIX III

SOUTH AFRICAN NURSING COUNCIL – CHARTER OF NURSING PRACTICE, 2004

Excerpt from the Charter of Nursing Practice

The Constitution of the Republic of South Africa lays the foundation for ensuring that all people are treated equally and that each person is afforded basic rights. Nurses must at all times protect and maintain the rights of people they provide care to.

These rights are contained in the Bill of Rights in the Constitution of the Republic of South Africa and must be adhered to all times... Do not discriminate on the grounds of race, colour, creed, gender, religion, culture, politics, social status, personal attributes or the nature of the health problem... Nurses must not permit considerations of religion, nationality, race or social standing to influence the quality of the care they render.

Nurses' Pledge of Service

- I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.
- I will maintain, by all the means in my power, the honour and noble tradition of my profession.
- The total health of my patients will be my first consideration.
- I will hold in confidence all personal matters coming to my knowledge.
- I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient.
- I will maintain the utmost respect for human life.
- I make these promises solemnly, freely and upon my honour.

APPENDIX IV

MANAGING CHALLENGING SITUATIONS

Some clients may be reluctant to come to acknowledge their risk behaviour (i.e. drug taking, sex work, unprotected anal sex) out of fear of being arrested or experiencing discrimination. To protect themselves, they may apply defence mechanisms to justify their behaviour. Aggression may be used as a defence mechanism and may be directed towards themselves or others. These situations may be challenging but like other clients, health care workers should aim to establish clear communication and trust with these clients to facilitate support and treatment.

Communication and trust may be difficult due to previously poor experience they may have had with health care providers. Some of the behaviours that may be exhibited include: aggression, threats of physical violence, impulsiveness, verbal abuse, sexually inappropriate gestures, suggestions, actions, lack of responsiveness to treatment or slow change, inability to appreciate concern for them, inability to take responsibility for their own behaviours/actions.

General ways of dealing with these challenging situations

Setting boundaries and limits. It is important to have a clear sense of your personal limits, of where you end and other people begin. Only give extra time, after hours contact numbers etc. when it is necessary, not because of wanting to be liked, or difficulty setting limits, or fear of the client's aggression, etc.

Set limits early. This will reduce misunderstanding in terms of boundaries, limits, and inappropriate behaviours and make it easier to contain difficult behaviours.

Do not break service policies and procedures to calm a client. While this may seem easier in the short term, it can be damaging and counterproductive in the long run. Instead, explain the policy to the client, and stand firm on the rules.

Do not personalise the client's behaviour. Most of the time another person's difficult behaviour is not about you. When someone else is being difficult, it is always a reflection of his or her innermost state. Even if you provoke or upset someone, it is not what you have done, but rather what you bring up in him or her.

Be consistent across situations, workers and clients. Use the same strategies, guidelines, boundaries and limits, etc. across the different situations in which you encounter the client. Discuss difficult clients with your colleagues, so that you can all be considered in your approach.

Certain limits should automatically be put in place for more difficult clients. For example, these clients should not be seen in isolated settings or during 'off hours'. Help should be readily available in case a client becomes aggressive or threatening.

Managing defensive or aggressive behaviour

- ✓ **Use active listening.** Mirror back what is being said and ask for confirmation and clarification: 'What I am hearing you say is that...Is that right? Is there more?' This simple technique performs the valuable functions of gathering correct information, and of allowing the client to feel heard.
- ✓ **Identify the key problem, misunderstanding or failure that may have put the relationship with this client on the wrong track.** Determine if there is anything that you can do to alleviate the problem. If there is, do it.
- ✓ **Do not take personal offence.** If the client is critical of you or the service you work for, do not take it personally. Offer the client the opportunity to talk to someone in a supervisory position.
- ✓ **Allow the client to speak.** If the client is upset, but not verbally or physically aggressive, allow him or her to speak, to ventilate their anger. He or she will release their frustrations and often feel better.
- ✓ **Do not debate.** If the client is complaining of bad service or of rules or procedures, etc. do not engage in a debate even if you know the client's

perspective is incorrect. Be careful not to get defensive, as this can inhibit your ability to hear what is really happening, and will only upset the client more. Discuss the raised issue with the client at another time, when the client is calm, and can hear what you have to say.

- ✓ **Do not accept verbal abuse or aggressive behaviour/threats.** If someone is using overly offensive language, is engaging in threatening behaviours, or is out of control emotionally or is attacking you personally, you do not have to accept this behaviour. You can ask the client to leave the service, you can leave the area, call your supervisor to assist, call other colleagues to assist, or call the police. There will be times when the best strategy is to simply walk away.
- ✓ **Learn to pause to regain balance.** It is OK to say something like 'I need to think this through'. And this may be the best way to regain your composure when things get derailed.
- ✓ **Build islands of understanding.** When mutual confusion occurs, frequently summarizing the facts that you and the client both agree on and understand can be helpful.
- ✓ **Apologise if needed.** The key word here is empathy. If you discover that somehow you have offended the client, or inadvertently given incorrect information etc. it is appropriate to apologise to get past a mistake and on to a solution. Most clients will accept an apology, it diffuses anger and frustration, and it shows that you are listening and care about the client.

General principles of 'on the spot' management of:

An aggressive client

- The safety of the patient / client, the nurse, other staff, other patients and potential intended victims is of most importance while interviewing an aggressive client.
- The doors of the interview room should not be lockable from inside or capable of being blocked from inside.
- While working with impulsively aggressive or violent clients in any setting one must take care to reduce accessibility to clients of movable objects as well as jewellery and other attire that might add to the risk of injury during an assault, including neckties, necklaces, earrings, spectacles, lamps and pens.
- Adequate in service training and the availability of appropriate supervision are critical safeguards in the management of potentially dangerous clients.

- The nurse may choose to present a few key observations in a calm and firm but respectful manner, putting space between self and client; avoiding physical or verbal threats, false promises and build rapport with client.
- Allow the client to use any language they want because scolding them may only make things worse. Don't allow the client their delusions. Orient them to reality, even if it is harsh. Don't get angry, defensive or challenge a patient's opinions.

The following might escalate the situation and potentially spawn a physical confrontation and need to be avoided:

- Do not touch the client or attempt to restrain them by hand. This may cause a physical confrontation.
- Do not try to interrupt a tirade with the truth. It will only make them feel as if you aren't listening and may make them angrier.

A client who is traumatised

- A nurse interviewing a traumatised client, should be active, vigilant, and directive in managing the degree of emotional stimulation.
- Be mindful that every individual experience and responds to trauma differently.
- Provide a safe space for the interview.
- To regulate the intensity of the trauma, first increase the intensity and anchor the trauma:
 - Ask affect questions
 - Ask for specific details of trauma, step-by-step
 - Ask for sensory (visual, kinesthetic, auditory, olfactory) memories of the event
 - Ask about their fears
 - Ask what happened to their body
- Then decrease the intensity and anchor in the present:
 - Ask content questions not related to trauma
 - Use calming voice tone
 - Stop client from talking and anchor in the present
 - Repeat and rephrase what the client has just said
 - Get client to describe the current setting
 - Use relaxation and breathing techniques in the session
 - Ask the client about activities before and after present session or other events not related to the trauma

A client requesting an abortion

- Any women in South Africa (irrespective of age) can get a legal abortion for an unwanted pregnancy according to the Choice of Termination of Pregnancy Act No. 92 of 1996.
- Pre- and post-TOP (Termination of Pregnancy) counselling that is not prescriptive should be provided.
- Parental or partner's consent is not required.
- Women should be advised to go for safe, legal abortions rather than 'backstreet' abortions that are likely to endanger their health and their lives.
- To get a free abortion, the request for a TOP must be made at a primary healthcare clinic, where the pregnancy will be confirmed, counselling provided, an appointment made, and a referral letter be given to a facility where the procedure can be performed.
- As a health worker you might not be willing to be involved in the TOP service, but you are obligated by law to inform the client of her rights and must refer the client to a health worker or facility where she can get the service.
- The service can also be accessed via a General Practitioner (GP) but a consultation fee will be required. Marie Stopes Clinics and private hospitals also provide the service for a fee.
- Any girl or women can ask for a TOP in the first three months (12 weeks) of pregnancy. It is important to act quickly if an unwanted pregnancy is suspected.
- If the client is three to five months (13–20 weeks) pregnant, a different set of rules apply for TOP. The doctor, in this case, will carry out the TOP only if:
 - There is a risk to the physical or mental health of the woman or foetus.
 - Having the baby will cause major social or economic problems for the mother.
 - The woman is pregnant from rape or incest.

APPENDIX V

ORGANISATIONS THAT SUPPORT MSM / SW / PWUD IN SOUTH AFRICA

Abuse Helpline

T: 0800 24 64 32

Addiction Action Campaign

98 3rd Avenue, Fontainebleau, Gauteng

Tel +27 (0) 79-066-3382

Email : info @ aac.org.za

Alcoholics Anonymous

National 24-hour helpline: 0861 HELP AA (435-722)

Cape Town Drug Counselling Centre

Website: www.drugcentre.org.za

Email: ctdcc@iafrica.com

Observatory Office - 021 447 8026

Address: 1 Roman Road, Observatory

Mitchell's Plain Office - 021 391 0216

Address: Unit 12 Woolworths Arcade 2 Symphony Walk, Town Centre, Mitchell's Plain

Cross Over Project (COP)

5 Inez Street, Sunnyside, Pretoria

Shelter: Plot 202 Tambotie Street, Grootvlei

Mobile: 072 674 3245

E-mail: crossoverproject2@gmail.com

Services provided to sex workers: counselling, shelter for abused, raped, abducted, child trafficking, training of sex workers, referral for treatment, support groups/income generation projects

De Novo Treatment Centre

Old Paarl Road, Kraaifontein, Western Cape

T: 021 988 1138

Desmond Tutu HIV Foundation Men's Division, Cape Town

www.desmondtutuhivcentre.org.za

Durban Lesbian and Gay Community and Health Centre

Lesbian, Gay, Bisexual and Transgender focused services

Website: www.gaycentre.org.za

Email: info@gaycentre.org.za

Contact: 031 301 2145

Address: 320 West St, Durban

East London High Transmission Area Project

T: 043 742 2651

Eastern Cape

Gender Dynamix

Saartjie Baartman Centre, Klipfontein Road, Athlone, Cape Town

Tel: +27 21 6335287

Website: www.genderdynamix.org.za

Health4Men ANOVA HEALTH INSTITUTE

www.anovahealth.co.za

Website: www.health4men.co.za

Email: yeoville@anovahealth.co.za

Contact number: 072 654 0816

Address: Corner of Kenmere and Hopkins

Health4Men Treatment sites:

CAPE TOWN: Ivan Toms Center for Men's Health, Woodstock

Tel. +27 (0)21 447 2844

SOWETO: Simon Nkoli Centre for Men's Health, Soweto

Tel. +27 (0)11 989 9756/9865

ICAP:

Tel: +27 (0)12 360 0640/1

Website: www.columbia-icap.org

Address: Rigel Park, Block A, Unit 202AS, 446 Rigel Avenue, Erasmusrand, Pretoria, 0181

LEGBO Northern Cape

Phone: 073 626 3346

Kimsec Building, 33 Community Road, Florianville, Kimberley

Website: www.legbo.org

Lethabong Legal Centre

T: 012 270 1343

Beaufort West

Lifeline

National Counselling Line: 0861 322 322

National AIDS Helpline: 0800 012 322

Life Line Durban

Website: lifelinedurban.org.za

Crisis Line: 031 312 2323

Office Line: 031 303 1344

Address: 38 Adrain Road Stamford Hill Durban 4001

Limpopo LGBTI Proudly Out

Polokwane

Phone: 0817919248

Mosaic

T: 021 761 7585

Narcotics Anonymous

National 24-hour helpline: 083 900 69 62

OUT Well-being, Tshwane, Gauteng

Lesbian, Gay, Bisexual and Transgender focused services

Tel. 012-430-3272

Helpline. 0860 OUT OUT (0860 688 688)

Website: www.out.org.za

POWA (People Opposing Woman Abuse)

T: 011 642 43 45/6

PSH (Partners in Sexual Health)

T: 023 414 4169

Eastern Cape

Rape Crisis

T: 021 447 9762 (24-hour line)

SANCA Lowveld

8 Hope Street, Nelspruit, Mpumalanga

TEL :013-752-4376 / 013-755-2710

EMAIL : info@sancalowveld.co.za

SANCA Western Cape

18 Karoo Street, Bellville, Western Cape

Tel: (021) 945 4080/1

Email: sanca@sancawc.co.za

Sediba Hope Medical Centre/ PEN

Website: www.pen.org.za

Email: info@pen.org.za

Contact number: 012 323 6688

Address: Corner Vermeulen and Bosman Streets, Pretoria

Sex Workers Education and Advocacy Task Force (SWEAT)

Sex worker focused services

Website: www.sweat.org.za

Email: helpline@sweat.org.za

Contact: SWEAT/Sisonke National Toll-free Helpline: 0800 60 60 60

PLEASE CALL ME: 071 357 7632

Trafficking Helpline

T: 0800 555 999

Triangle Project, Cape Town

Email: info@triangle.org.za

Tel. +27 21-4483812

www.triangle.org.za

Tshwaranang (Legal Support)

T: 011 403 4267

TVEP (Thohoyandou Victim Empowerment Programme), Limpopo

T: 015 963 1222

TB/HIV Care Association

Website: www.tbhivcare.org

Email: info@tbhivcare.org

Contact number: 021 425 0050

uSizo Lwanamuhla (USL)

Phone: 073 232 0402

23 Webb Street, Yeoville, Johannesburg

Western Cape Treatment

Old Faure Road, Eerste Rivier, Western Cape

T: 021 843 3200

Wits Reproductive Health Institute: Esselen Street Clinic, Johannesburg

T: 011 725 671

HIV counselling and testing, TB screening and treatment, psychosocial support groups, mobile clinic outreach services, ARV initiation

Woman's Legal Centre

T: 021 424 5660

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Module 10

1. Medical Research Council. Training Guide for HIV Prevention Outreach to Drug Users – Field Worker Training.

This manual was developed in order to support the sensitisation of health care workers who are providing services to men who have sex with men (MSM), sex workers (SW) and people who use drugs (PWUD). These are some of the populations defined as key populations in the National Strategic Plan on HIV, STIs and TB 2012-2016. Key populations are those individuals who are at greater risk for being infected by or transmitting HIV.

Key Populations in South Africa experience a disproportionately high burden of HIV but face multiple barriers when accessing health care. The Operational Guidelines for HIV, STI, and TB Programmes for Key Populations in South Africa identifies health care worker sensitisation training as an essential intervention to address these barriers.

This manual aims to supply the necessary information to provide effective care and support within South African health care settings for MSM, SW and PWUD. This manual will also provide health care workers with an opportunity to understand and address both social and personal stigma towards these populations.

This manual is comprised of the following sections and modules:

Section 1: Key Knowledge

- 1: Introduction to Key Populations
- 2: Stigma, prejudice, and discrimination
- 3: Human Sexuality and Sexual Behaviour
- 4: Risk Factors and Vulnerabilities among Key Populations

Section 2: Key Issues

- 5: Contextualizing Key Populations, the Law, and Human Rights
- 6: Mental Health and Substance use
- 7: HIV and Other Common Issues

Section 3: Key Services

- 8: Providing Health Services for Key Populations
- 9: Biomedical interventions for Key Populations
- 10: Behavioural & Psycho-Social Interventions for key populations

Additional contents include:

- Pre and Post Course Assessments
- Resources and Referral Information
- Glossary

