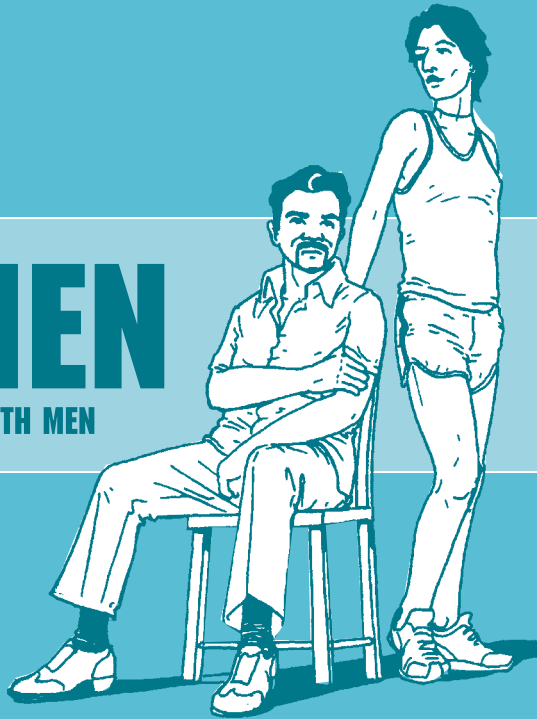


BETWEEN MEN

HIV/STI PREVENTION FOR MEN WHO HAVE SEX WITH MEN



The Key Population Series

Between Men is part of the 'Key Population Series' developed by the International HIV/AIDS Alliance.

The term 'key population' refers to populations who are significant to epidemic dynamics. Depending on the country context and the rate of prevalence, key populations may include men who have sex with men, sex workers, injecting drug users and people living with HIV. The series aims to help non-governmental organisations (NGOs), community-based organisations (CBOs) and others to strengthen HIV and other sexually transmitted infection (STI) prevention work with key populations.

The International HIV/AIDS Alliance

The International HIV/AIDS Alliance (the Alliance) is an international NGO that supports communities in developing countries to make a significant contribution to HIV prevention, AIDS care and to the provision of support to children affected by the epidemic. Since its establishment in 1993, the Alliance has provided financial and technical support to NGOs and CBOs from more than 40 countries.

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INTRODUCTION	3
Sex between men in the context of HIV	3
About this booklet	4
SECTION ONE: Basic Issues	5
Who?	5
A universal phenomenon	6
How many?	7
How old?	7
Why?	7
Social constructs	8
Masculinity and other genders	9
Behaviour and desire, activity and identity	10
Sex, love and emotion	11
How?	11
Foreplay	12
Sex	12
Sexual roles and pleasure	14
Sex work	14
Where?	15
Social and personal issues	18
Legislation	18
Religion	18
Homophobia	19
Women, marriage and family	20
Community and support	20
SECTION TWO: Sex between men and HIV/STI prevention	22
Sexual health and HIV infection	22
Varying risk	22
Viruses and bacteria	23
Drug use	23
Symptoms and treatment	24
Prevention	24
Safer sex	24
Condoms and lubrication	25
Assessing risk and vulnerability	27
Understanding the dynamics of HIV transmission	27
Participatory assessment	28
Interpreting statistics	30
Designing Programmes	31
Goals and strategies	31

More than sex	33
Working with CBOs	33
Working with gatekeepers	34
Working with health care providers	35
Principles that hinder HIV prevention	35
SECTION THREE: HIV/STI prevention strategies for and with men who have sex with men	37
Strategies for individually focused health promotion	37
Open air	38
Under cover	39
Materials	40
Groups	40
Workshops	41
Strategies for scaling up, targeting and improving service and commodity delivery	42
Condoms	42
Lubricants	43
Testing	44
Counselling	44
Ethics and confidentiality	45
To pay or not to pay	46
Other services	46
Strategies for community mobilisation	46
Celebration time	47
A safe house	48
On-line	49
In prison	49
Strategies for advocacy, policy change and community awareness	50
Different environments	50
Visibility and representation	51
Police liaison	52
Social advocacy	53
Political advocacy	54
Faith	54
CONCLUSION	55
RESOURCES	56
Publications	56
Websites	56
Organisations	57
Notes	60

SEX BETWEEN MEN IN THE CONTEXT OF HIV

The global AIDS epidemic is composed of many small, often overlapping epidemics that reflect different patterns of sexual and drug-injecting behaviour. HIV often first spreads rapidly among people who have many sexual partners or who frequently share needles before spreading more slowly from that group to the general population. Where HIV prevalence is low, focusing prevention efforts on people with high risk behaviour not only protects those individuals, but can contain the epidemic at a fraction of the expense that the infection would otherwise cost.

In a few societies sex between men is widely accepted; in some it is tolerated; and in many it is the subject of strong disapproval and legal and social taboos. Official indifference or hostility means that there are few prevention and care programmes for men who have sex with men in developing countries. It also means that little research has been undertaken to discover how many men are at risk and how best to provide them with the information they need to protect themselves and their sexual partners.

Sex between men – in particular, anal intercourse without a condom – is one of the primary ways in which HIV and other sexually transmitted infections are passed on. In every society some men have sex with other men, and some of these men have many sexual partners, including women. This means that anal intercourse without a condom between men also places the men's female partners and their future children at risk of infection.

Although HIV infection rates among men who have sex with men are high in some countries, sex between men may be an unrecognised factor in national and regional epidemics. Prevention activities among this group can therefore make a significant impact on the future shape of the epidemic.

ABOUT THIS BOOKLET

Between Men gives an overview of basic issues for men who have sex with men in the context of HIV and other STIs. The booklet also provides ideas for developing prevention programmes with and for men who have sex with men. It is intended for people or organisations who provide support to NGOs and CBOs starting HIV/STI prevention work with and for men who have sex with men. Although it can be used in many contexts, the booklet aims primarily to support those planning to work in communities in developing countries where few or no organisations work with men who have sex with men.

Between Men is structured into four main sections. The first section is intended to be a basic text about men who have sex with men. It includes why men have sex with men, how men have sex with men, social and personal issues. The second section looks at sexual health, HIV prevention, how to assess vulnerability and risk and what to consider when designing HIV/STI prevention programmes for and with men who have sex with men. Section three outlines strategies and activities to enable men who have sex with men to develop HIV/STI prevention and care programmes most appropriate to their specific needs. The final section lists useful resources for further contacts and information.

This section covers why men have sex with men, how men have sex with men, social and personal issues.

WHO?

Peter, a 17-year-old in a boarding school in South Africa, sometimes crawls late at night into the bed of his 16-year-old friend Daniel. They play with each other. Peter talks about girls and so does Daniel, although the younger boy is more interested in his friend.

Vladimir, a 20-year-old Russian, has been in prison for a year. He had a girlfriend before he was arrested for drug dealing, but he doesn't think he will see her again. Every night he has sex with Boris, a large, violent man in his forties, because Boris protects him from other, more violent men.

Twenty-three-year-old Lal is a rickshaw driver in Dhaka, Bangladesh. Some nights he goes to one of the big parks in the city where he can meet men who are attracted to other men.

Thirty years ago, Julia was born a boy in a small town in Costa Rica, but since the age of 16 she has dressed as a woman and taken hormones to develop her breasts. She makes a little money as an entertainer in bars in San José, the capital, but most nights she stands on a street corner and waits for customers to drive by.

Shen-Wah is an unmarried 33-year-old in Shanghai, China. He has just discovered the city's latest gay bar, where he goes two or three times a week, hoping to meet a man to fall in love with.

Jorge and Hideki are two men in their forties in São Paulo, Brazil. They have lived together for 16 years. Very occasionally they have sex together, but more often each has "adventures" with other men.

Sunil, 35, and his partner Raj, 50, consider themselves lucky to share a large house near the ocean in Mumbai, India. They have just celebrated ten years of living together and being faithful to each other.



René is a 55-year-old businessman in Abidjan, the Ivory Coast. He is married and has three children. At night he sometimes drives down one of the main avenues in the city looking for the young men who wait under the trees for men like René to stop and call them over.

A universal phenomenon

Sex between men is found in every stratum of every society: among the young, middle-aged and old; rich and poor; married and single; educated and illiterate; the ethnic majority and ethnic minorities; criminals and honest men; singers and sportsmen; beggars and businessmen; postmen and politicians.

It is a phenomenon as old as history. In ancient China, it was called the 'Love of the Cut Sleeve', after an emperor who cut off the sleeve of his robe rather than wake his male partner who was sleeping on it. In ancient Greece and medieval Japan, warriors took teenage boys as lovers. In many North American tribes, men who dressed and lived as women spent their lives with other men. Medieval Arab literature contains many examples of men who made love to younger men.

Social attitudes change over time, but men continue to have sex with other men, regardless of whether society approves or disapproves. In Western Europe in the nineteenth century, sex between men was a criminal offence; today it is fairly widely accepted. In many parts of Africa before colonisation, some forms of sex between men were accepted; today some people claim it is "un-African".

Classical Indian sculpture and art shows men embracing, yet Indian law, drafted by the British colonisers, penalises sex between men.



Men who have sex with men are not a discrete group, somehow set apart from the rest of society. Most also have sex with women; many – perhaps the majority – are married. That means any epidemic of HIV/AIDS or another sexually transmitted infection will not be confined to that sector of the population.

How many?

How many men have sex with other men is not known. Research is difficult, particularly in countries where sex between men is taboo. And where research has been undertaken, the methods and results are sometimes uncertain. Respondents may be unwilling to answer the question “have you had sex with a man?” or they may interpret the question differently from the questioner.

Recent statistics from around the world suggest that at least 3 per cent, and perhaps as many as 16 per cent, of men have had some form of sex at least once with another man. That suggests a global figure of anywhere between 45 and 240 million men.

How old?

Some boys are sexually active before they reach sexual maturity – usually defined by the appearance of pubic hair and the ability to ejaculate. This may be with children of their own age, or as the result of abuse by older children or adults. Sexual abuse of children – when adults have sex with children – can cause severe mental and physical trauma and is condemned by every society.

Irrespective of the legal age of consent, many sexually mature boys are sexually active, sometimes with girls or women, sometimes with boys or men and sometimes with both sexes. This may be with both partners’ consent or it may be the result of psychological or physical coercion, either by the boy or by his partner, particularly if the partner is older.

Because there is often no clear legal, social or physical boundary between sexually mature boys and adult men, and because sexual activity can start at an early age, unless otherwise specified, the word “men” in this booklet includes boys who have reached sexual maturity.

WHY?

Men have sex with other men for many different reasons. Most men do so from desire, but others do so for money or some other reward, or because women are not available, or because they are forced to.

In every society a minority of men are sexually attracted to other men. Many have wives or girlfriends and children, but they prefer sex with men. Some are single and only occasionally have sex with women. Some never have sex with women.

Some men have sex with other men for money or gifts. They may prefer men or they may prefer women, but need or want the rewards that other men give them for sex.

Some men have sex with men because no women are available. Teenage boys in boarding school or adult men in single-sex situations, such as prison or the military, may seek other men for sexual release. *“Men need to use their dick to feel like men, and if they don’t have a woman, then they screw a guy”*, explains Enrique, a prisoner in Costa Rica.

Most sexual acts between men are consensual. However, some men are raped or otherwise forced into sex, especially if they are young or weak, by other men, for sexual release, as punishment or to establish power. This is common in prison, but can occur anywhere. Some men use psychological rather than physical coercion to oblige other men to have sex with them.

When two men have sex, they don’t always do so for the same reason. In a commercial exchange, for example, the client probably prefers men, while the man he is paying may prefer women.

We don’t know why most people are sexually attracted to the opposite sex, but some men and women prefer their own sex. Some people suggest that sexual attraction is influenced by a child’s relations with other people, in particular their parents. Others suggest that preferring your own sex is a matter of willpower, and men who have sex with other men do so from a wish to be “perverse”. However, there is little evidence for either of these theories. The most likely explanation is that sexual attraction, whether to one’s own or the opposite sex, is like right – or left-handedness; it is inborn and cannot be explained or predicted.

Social constructs

Although men have sex with other men for different reasons, the words used to describe them usually refer to what they do rather than why they do it. These words reflect social constructs – the way in which societies think about sexual behaviour and social relations.

In western countries, such as North America, much of Europe and Australia, and New Zealand, sexual behaviour is defined according to the sex of one’s partner: to prefer one’s own sex is to be “homosexual”; to prefer the opposite sex is to be “heterosexual”; and to have more or less equal preference is to be “bisexual”. Other words used include “gay”, which means to be homosexual and to demand the same legal and social rights as the rest of society.

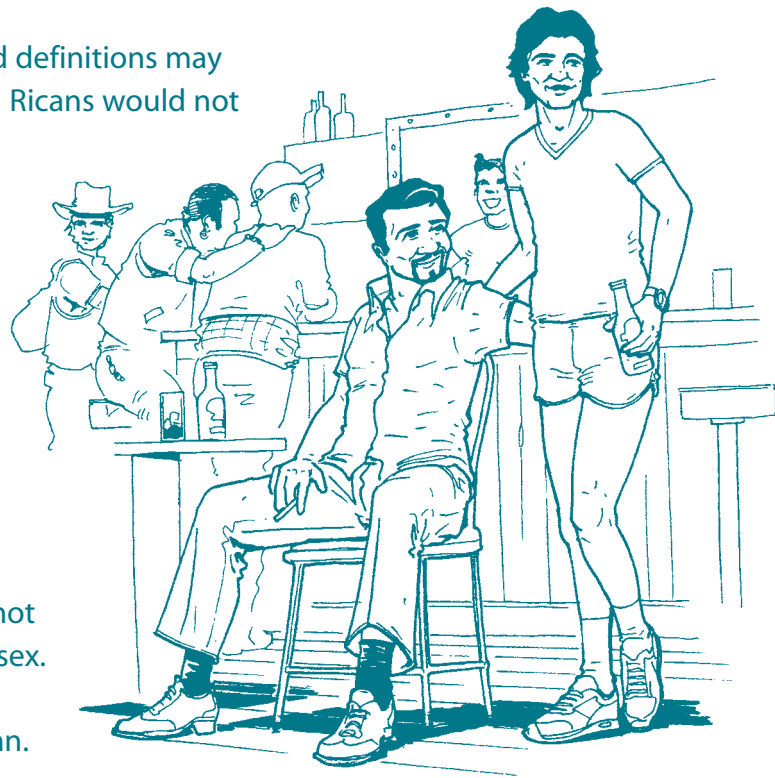
In many other parts of the world, however, sexual identity (who you are) and sexual behaviour (what you do) is often defined according to whether you penetrate or are penetrated. In many parts of Latin America, for example, a man who takes the penetrative (also known as active) role in sex, whether with a woman or another

man, is described as *macho*, while a man who allows himself to be penetrated (takes the passive role) is *maricón* (Spanish-speaking countries) or *bicha* (Brazil). In South Asia and elsewhere, similar distinctions are made: in Hindi and related languages a *kothi* is a man who is penetrated, a *panthi* is a man who penetrates men and *double-deckers* may take either role.

Even within a culture, social constructs and definitions may vary. For example, most middle-class Costa Ricans would not recognise the distinctions drawn in the country's prisons between *cacheros*, who perform active anal sex, *guilas*, young men who are penetrated, *travestis*, who are men dressed as women, and others.

Masculinity and other genders

Definitions of sexual behaviour often reflect definitions of sexual identity or gender – the social roles that men and women are expected to play. These social roles vary from society to society and are not always defined by an individual's physical sex. Not everyone with a penis considers himself – or is considered by others – a man.



Masculinity – the social role associated with boys and men – is a cultural, not physical, phenomenon. Some attributes of masculinity, such as a willingness to take risks, appear to be common all over the world, but others vary. In parts of India, for example, a young man who appears effeminate in western eyes but who has a wife and child, is considered more masculine than a more aggressive older man who is unmarried and childless.

Preference for the passive role in sex is often associated with a measure of femininity, such as dressing as women and using speech and mannerisms associated with women – although it should not be assumed that all effeminate men prefer to be penetrated.

Some men take hormones to develop female breasts, and some also undergo such operations as removal of the testicles and penis, creation of a vagina, removal of their Adam's apple or enlargement of the hips to become women. In English, such people may describe themselves as transvestite (wearing women's clothes) or transsexual (undergoing some or all body changes). Words in other languages include: *yan daudu* in northern Nigeria, *travesti* in South America, *bencong* in

Indonesia, *fa'afafine* in the Pacific Islands and *hijra* (also known as *ali* or *eunuch*) in South Asia. And while many of these terms imply a degree of femininity, some individuals reject labels of both masculinity and femininity, calling themselves “not-men” or a third sex.

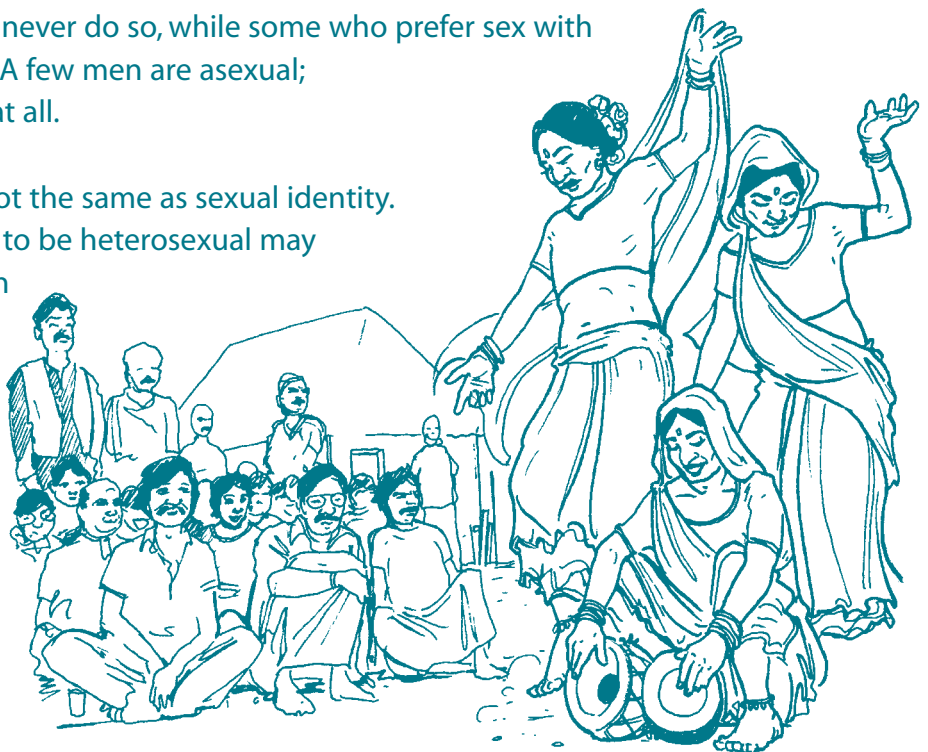
All these categories are fluid and not determined by physical or biological features alone. They are included in the word “transgender”, which covers the many identities and behaviours that cross gender norms.

In other words, many individuals referred to as men in this booklet do not think of themselves as such and are not seen as men by their sexual partners or the society in which they live. Not only is it important to recognise and respect different identities, but those identities must determine the nature of HIV/STI prevention activities.

Behaviour and desire, activity and identity

Sexual behaviour is not the same as sexual desire. Some men who want to have sex with other men never do so, while some who prefer sex with women have sex with men. A few men are asexual; they have no sexual desire at all.

Similarly, sexual activity is not the same as sexual identity. In the West, men who claim to be heterosexual may have sex with men, and men who say they are homosexual sometimes have sex with women. Elsewhere, men who appear highly feminine may take the penetrative role in sex, while men who appear to be the active partner may enjoy being penetrated.



Sometimes society’s taboos are so strong that men will not admit even to themselves where their true preference lies. For example, a young man who sells sex may tell himself he is only doing it for money, when the real reason is that he is attracted to men more than women.

Sexual identity is not fixed but changes over time according to an individual's perception of themselves and changing values in society. As cultures come into contact with each other, words and ideas are exchanged and sometimes used differently. Thus "homosexual" is sometimes used to refer to any man who has sex with another man, irrespective of his sexual preference, while in many parts of the world "gay" has come to mean men who are effeminate or transgendered.

Worldwide, there is a growing tendency to use western definitions of sexual behaviour, particularly among the middle classes. However, millions of men who have sex with men still categorise their sexuality according to the culture in which they live, and those who work with them must conform to their perspectives and needs.

Sex, love and emotion

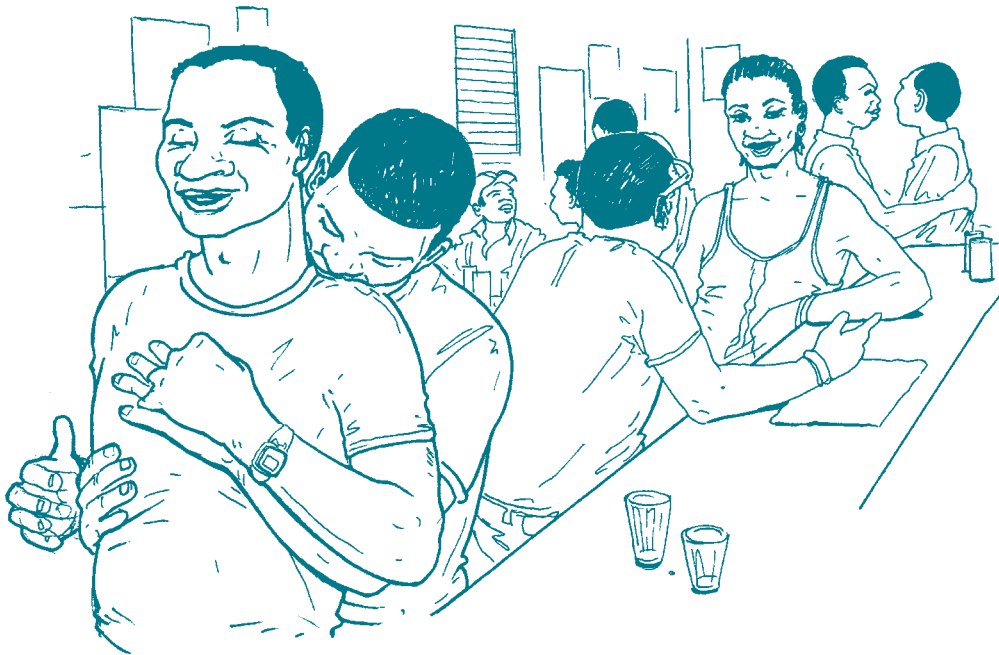
The emotions experienced by two men in a relationship cannot always be easily categorised. The meaning of the word "love" varies not only from culture to culture but from individual to individual. And some men who have sex with other men are afraid to fall in love with them because of the social and psychological problems that it would cause. Others are aware of their strong feelings but are unable to express them.

For many people, sex is an essential part of love, although love may not be essential for sex. Most men who prefer sex with other men often experience a deeper emotional attraction for their partner. Many wish that they could spend their lives with another man rather than with a wife and children. Such relationships are common in the West, but are found everywhere, even in countries where sex between men is highly taboo. All kinds of arrangements can be made, such as meeting regularly in a hotel or hired room, frequent travelling together, or one partner marrying the other's sister.

It is important to recognise the emotional element of sex between men. Not only is it a key aspect of self-respect, but love can significantly affect attitudes towards protecting oneself and one's partner from sexually transmitted infections.

HOW?

The commonest sexual acts between men are anal intercourse, oral intercourse, intercrural intercourse (thigh sex) and mutual masturbation. Many of these acts are also practised by male and female partners, but throughout this booklet it is assumed that both partners are male.



It can be difficult to find the most appropriate words to discuss sex. This chapter uses formal expressions, but gives alternatives commonly used by English speakers in everyday speech. Each language, of course, has its own formal and informal words for sex.

Foreplay

Every part of the body can be sexually stimulating and play a part in sexual activities. In sex between men, attention is usually given to the penis (dick, cock, prick), the anus (ass, asshole), the mouth, the testicles and scrotum (balls) and the nipples (tits).

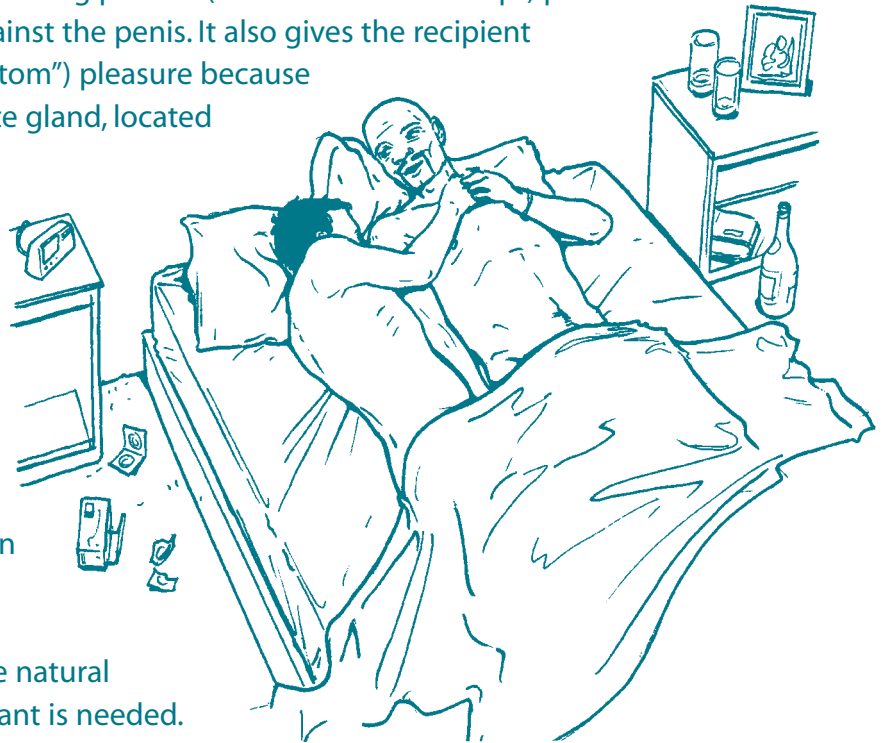
Sexual desire and/or rubbing, or other friction, causes the penis to become erect. Friction against the head of the penis stimulates the prostate gland to ejaculate semen (to come or cum) – an essential part of the male orgasm.

Sexual foreplay can arouse both partners. Examples of foreplay include mouth-to-mouth kissing, caressing or kissing the partner's body, playing with his nipples, scrotum and testicles, and penetrating his anus with a finger. Some men find that prolonged manipulation of their nipples makes them ejaculate.

Sex

The goal of most sexual acts between men is to stimulate the penis until orgasm. In **anal intercourse** (fucking), the erect penis penetrates the anus. Anal intercourse can be performed in many positions, including standing or lying, and with the recipient facing away from his partner or with both partners facing each other.

Anal intercourse gives the penetrating partner (also known as the “top”) pleasure because it produces friction against the penis. It also gives the recipient partner (also known as the “bottom”) pleasure because the penis stimulates the prostate gland, located alongside the rectum (the area inside the anus). It can sometimes be painful for the recipient partner, particularly when the recipient is being penetrated involuntarily, when there is no lubrication and when penetration does not allow time for the muscles in the anus and rectum to relax.



Because the anus does not have natural lubrication, some form of lubricant is needed. This can be spit, which tends to dry quickly, and various oils, which should not be used with condoms because they destroy latex. Water-based lubricants, such as K-Y jelly, are ideal.

In **intercrural intercourse** (thigh sex), one partner places his penis between his partner’s thighs, usually directly under the groin. The recipient partner receives pleasure from pressure against the testicles and along the perineum (the area of skin between the testicles and anus).

Oral intercourse (fellatio, sucking, blowing) is inserting the penis in the partner’s mouth. Some recipient partners find it uncomfortable, but most enjoy it. Mutual fellatio (sixty-nine) – when each man takes the other’s penis in his mouth – is also practised.

Masturbation (wanking) is using the hand to bring oneself or one’s partner to orgasm. Mutual masturbation is when each performs the act for the other.

Some men practise other sexual acts, including sadomasochism (the inflicting of pain on a consenting partner) and insertion into the anus of objects (dildos, “toys”) or the hand (fist-fucking). Such acts are more common in cultures where men have the freedom to explore their sexuality, but can be dangerous when practiced without getting specialised knowledge of safe practices and techniques.

Sexual roles and pleasure

Some men prefer to take only one sexual role, as either the penetrator or the recipient. Others are happy to be versatile, taking either role depending on their mood or the needs of their partner. Like any human activity, sex can and should be creative, and sexual roles can change several times during sex. One partner may fellate (suck) the other, then penetrate him and then be penetrated before either achieve orgasm.

Both anal intercourse and fellatio can be explicitly and implicitly associated with power and domination. Anal rape, in particular, is a means of establishing power over another man. And in many acts of consensual intercourse, one man intentionally dominates his partner, while his partner is willingly submissive. Other men, however, see anal intercourse and fellatio as means of giving and receiving pleasure or as acts of love, where ideas of domination and submission are irrelevant.

Sexual acts which some men find pleasurable are distasteful to others, and men may find some acts pleasurable on one occasion and distasteful on another. Pleasure in sex derives as much from an individual's attitude as from the physical act he performs. Many factors, including his psychological state, whether he has been drinking or taking other drugs, and his emotional and physical attraction to his partner all influence a man's enjoyment of sex.

The limited research that has been carried out in this area shows that men who have strong inhibitions about sex with other men – either because they live in a culture where there is a strong taboo against such sex, or because they have strong religious or other convictions – are less likely to derive great pleasure from it, are less likely to explore their own sexuality and are less likely to consider their partners' sexual needs. They are also less likely to be aware of HIV/STI prevention messages relating to sex between men. On the other hand, men who are truly at ease with their sexual preference are more likely to enjoy sex and to give their partner pleasure – and to be receptive to prevention messages for men who have sex with men.

Sex work

In some societies, sex work provides an opportunity for poor young men, including boys who live on the streets, to make money, irrespective of whether they are primarily attracted to men. Some men find sex work both financially and psychologically rewarding, and find that it enables them to explore their sexuality. Men who are aware of what they are doing, at ease with their sexual preference and accustomed to dealing with clients, are not only more likely to be able to protect themselves and their partners from infection, but can be role models for their

colleagues and clients. Many such men form the backbone of groups working with men who have sex with men across the world.

Sex work also has many disadvantages. It may be practised unwillingly by boys and young men who see no other way of earning an income. Those with very effeminate behaviour or who dress as women often find it difficult to make money in any other way. It can be dangerous, with violence from potential clients, the public and the police, and it may pose a severe health risk.



WHERE?

Men seek and find sex with other men in many different places.

Teenage boys and younger men often find it by chance – two friends talking together and the conversation moves to sex, or sleeping together and finding they are both aroused. Sometimes an older family member or friend makes suggestions that lead to sex; depending on status, power and age difference, this may be welcomed by the younger partner or may constitute abuse.

Men who are aware of their sexual needs often “cruise” – look for other men. This may be anywhere: in the streets, on buses, in shops and restaurants, or places where men spend time together, such as bars and sports and gym associations.

In some countries there are bars, nightclubs and bathhouses that specifically cater to men who are attracted to men. But even where sex between men is taboo, almost every large town has a park or beach or other public place where men meet. And almost everywhere men find other men in public toilets. Bars and nightclubs are more likely to attract wealthier, more educated men; while poorer, less educated men are more likely to cruise public parks and cinemas. There may be little contact between the two groups, except in situations where one is paying the other.

As mentioned earlier, single-sex institutions may also enable sex between men. Sometimes men’s work gives them access to sex; for example, hotel workers may offer or sell sex to hotel customers and masseurs to their clients. This may not always

be consensual; the Blue Diamond Society which works with men who have sex with men in Nepal, for example, reports that feminine men are sometimes forced to have sex with their employers in these situations.



Sex does not always occur where men meet, particularly if it does not offer privacy. It may take place in the home where one partner lives if there is no one there to object. Where most men live with their families, sex is more likely to take place in the park or public toilet where they meet, in a massage parlour, a car, a hotel room or elsewhere. Some men who could take a partner home do not do so because it is too far, because they do not want to take a stranger home or because they are excited by the risk of being seen.

Sometimes sex occurs in full view of others. This may be where sex between men is common, such as in prison, public parks after dark, and nightclubs and bathhouses frequented only by men. Others may join in the sexual activity, sometimes against the wishes of one or both of the original participants.

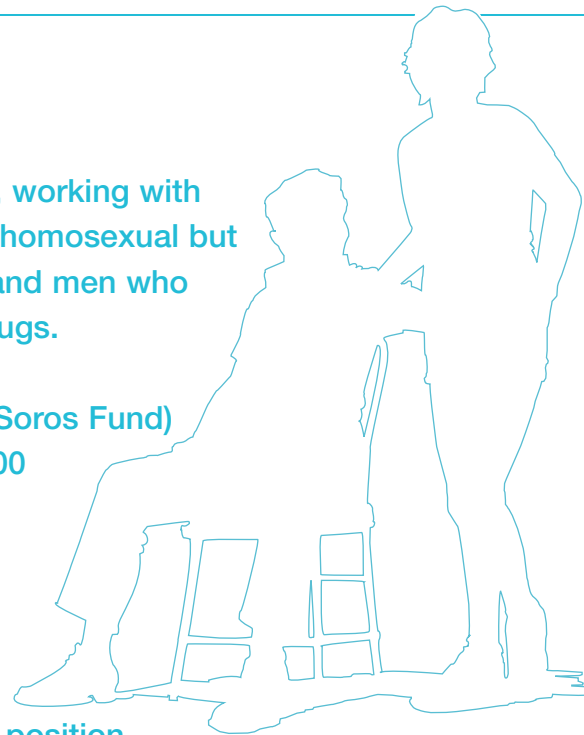
Places that are well-known for cruising can be dangerous if thieves and violent men go there pretending to offer sex but in reality want to steal from or attack their victims. And the police may stage raids, which can lead to blackmail or arrest and trial, or they may attack or even rape the men they find. On the other hand, cruising places can also be havens for men who have no other opportunities to meet others who share their preference. They are social spaces where friendships and love affairs are made and fostered, and communities formed.



MEETING IN BELARUS

Vstrecha (“Meeting”) is an NGO in Minsk, Belarus, working with young gay men, men who do not call themselves homosexual but who have sex with other men, male sex workers and men who both have sex with men and inject recreational drugs.

In 2001, funding from the Open Society Institute (Soros Fund) allowed Vstrecha to undertake research among 300 men who sell sex to other men, identifying their activities, risks and needs. As a result of the research, male sex workers have been offered anonymous testing for HIV, condoms and lubricants, as well as opportunities to build social support with Vstrecha and other men in the same position.



SOCIAL AND PERSONAL ISSUES

As noted above, sexual activity and attitudes towards sex are strongly influenced by the society in which we live. Attitudes are not monolithic, but are composed of several strands that may complement or contradict each other. For example, legislation may penalise sexual activity between men, but public attitudes in large cities, particularly among the educated, younger middle classes, may be relatively tolerant. Or the law may not discriminate against sex between men, but public attitudes are hostile.

Legislation

According to the most comprehensive survey of relevant legislation, undertaken by the International Lesbian and Gay Association,¹ at least 84 countries and territories specifically outlawed sex between men in 1999. These include nine where such acts are theoretically subject to the death penalty, although only three countries are known to have executed men who had sex with other men in the previous ten years.

In most countries where sex between men is legal, it is on the same basis as sex between men and women, but in some the age limit is higher than the age at which men can have sex with a woman.

In some countries there is no specific legislation against sex between men, but other laws, often referring to public morality, may be used to prevent nightclubs or commercial establishments opening, associations forming or the issue being raised in public discussion.

Religion

Religious beliefs are a strong and integral part of many people's identity, including men who have sex with men. Religious attitudes are highly influential in forming social, community and legal attitudes towards all aspects of sexual behaviour.

Religious teachings can be interpreted in many different ways, and those interpretations change over time. Although a large minority of Christians, Jews and Muslims believe that the scriptures of all three religions permit consensual sex between men – and there is evidence that it was much more acceptable to Christians and Muslims several centuries ago – today, most leaders of these three faiths condemn it.

Other religions, such as Buddhism, Hinduism and Shintoism, are less hostile to sex between men, but are still likely to imply that sex between men is less significant or important than sex between men and women.

1. This is an ongoing survey published on the web at: <http://ilga.org/Information/Legal.survey/ilga.world.legal.survey%20introduction.htm>

Homophobia

In most countries there is a strong current of homophobia – disapproval or hatred of sex between men (or between women) – which is expressed in stigma and discrimination and, in extreme forms, violence. Homophobia often has its roots in law, religion and social attitudes.

Social attitudes partly reflect and partly influence legislation and religious attitudes. The origins of homophobia are not always clearly understood and are too complex to discuss here. One theory is that it stems from the insecurity that some men (particularly those who don't have sex with other men) feel in their own sexual identity. Another theory is that power is an essential element of men's control of women's lives, and men who have sex with men or who appear effeminate challenge that power.

In most parts of the world, a combination of legislation and religious and social attitudes threaten men who have sex with men with arrest and imprisonment, dismissal from work and expulsion from the family home, name-calling and public humiliation, blackmail, violence and even death. The Blue Diamond Society reports that blackmail, extortion and the threat of exposure are common experiences for men who have sex with men in Nepal. The Grupo Gay da Bahia in north-east Brazil estimates that over 100 gay men are killed each year as a consequence of homophobia.²

Homophobia forces most men who have sex with men to hide their sexuality from their colleagues, friends and family, and sometimes to deny it to themselves – sometimes known as “internalised homophobia”. Although some men are unaffected, for many others it creates patterns of secrecy, fear and shame, which may lead to depression, abuse of alcohol and violence towards others.

Even those men who do not directly experience violence or discrimination can suffer from homophobia, since they are likely to suppress aspects of their behaviour in order to conform to society's demands. That may include marrying when they would prefer not to, not showing affection in public and having sex in dangerous places rather than in the comfort of their own home.

Homophobia also makes it difficult to provide information on health risks and safer sex behaviour, partly because so many men hide their sexual activity and partly because individuals and organisations involved in HIV prevention may be unwilling to work with them.

2. Grupo Gay da Bahia has an ongoing project monitoring anti-gay violence in Brazil. See: <http://www.ggb.org.br/ftp/artigo1.rtf>

Recognising one's true preferences, meeting others who share those preferences and recognising the harm caused by society's taboos on sex between men is liberating for most men. While it does not resolve all their problems, such as pressure from family to get married, it provides a positive foundation for life, leading to greater enjoyment and greater likelihood of protecting their health.

Women, marriage and family

Many men who have sex with men also have sex with women on a casual basis, in a long-term relationship or in a marriage. In some cultures marriages are arranged by the family, while in others continual questions and pressure from family, neighbours and friends force many men to find a wife. Some enter these relationships willingly and consider women their primary sex partners; some prefer men but marry under compulsion from family and society; while others are unaware of or deny their preference for men. In such circumstances, sex with one's wife is often seen as duty rather than as a source of mutual pleasure.

Some women discover that their partners have sex with men, which can place great strain on the marriage. Some women accept the situation, but both husband and wife, and sometimes the children, can be severely stigmatised if there is divorce or if his sexual behaviour becomes known – although a wife's family may consider divorce a preferable solution. A few women welcome the situation, particularly if they have little interest in sex with men.

Whether or not men tell their woman partners about their sexual activities, they usually face a range of ethical issues around HIV and other STIs. These include concerns about personal responsibility, possible infection of their wife and future children, notifying their partners if they contract an infection, and economic issues brought on by long-term illness and/or death.

Community and support

Despite this often negative picture, social attitudes are changing in many countries as men who have sex with men become more visible. Underlying this visibility is a growing sense of community among men who have sex with men and the dedication of a small number of men willing to challenge society's taboos.



Even in the most hostile societies, many men who have sex with men consider themselves part of a community, which may meet in parks, bars, people's homes or on the internet. Such communities give rise to formal and informal support groups that may offer psychological, physical, economic or legal support.

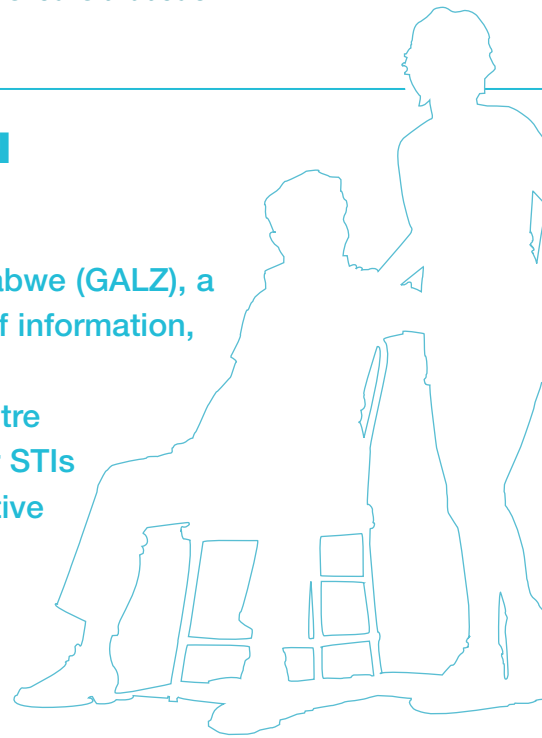
Formally established groups may be involved in a wide range of activities, including campaigning for equal rights, providing legal support for men with problems created by their sexual preference, and offering a safe place for men to discuss the implications of their sexuality. Health promotion, particularly around HIV, is almost always an essential element of their work. Hundreds of such groups exist across the developing world, yet they meet the needs of only a small proportion of the millions of men everywhere who have sex with other men.

Informal groups consist of friends who can provide support during difficult times. They may be able to meet in each others' homes, but more often it will be in public spaces where they can talk but are unlikely to be able to offer each other professional, long-term support for problems that arise from their sexuality. And millions more, particularly the young, the old and those who live in small towns and rural areas, are isolated by their sexuality. Informal groups may provide information about health issues, but without links to wider networks, they cannot always ensure that such information is comprehensive and correct.

GAYS AND LESBIANS ASSOCIATION OF ZIMBABWE

Since 1990, Gays and Lesbians Association of Zimbabwe (GALZ), a membership-based organisation, has been a focus of information, help and advice for lesbians, gay men, bisexual and transgendered people (LGBT). The GALZ drop-in centre provides members with information on HIV and other STIs and pre- and post-test counselling, while GALZ Positive not only helps members living with the HIV virus but has also achieved much by lobbying for the normalisation of homosexuality within the national HIV/AIDS network.

The GALZ Affinity Group Programme encourages LGBT communities across Zimbabwe – and soon to be across Africa – to use HIV/AIDS as a focus for developing an understanding of their sexualities.



This section looks at sexual health, HIV prevention issues for men who have sex with men, how to identify risk and vulnerability and what to consider when designing HIV/STI prevention programmes.

SEXUAL HEALTH AND HIV INFECTION

Across the world, over 40 million people are currently living with HIV. Three million died of AIDS-related illnesses in 2001. Every day one million people contract an STI other than HIV. The extent to which these infections result from sex between men is not known, because in many communities few or no surveys are undertaken and many men are reluctant to admit that they have sex with men.

In addition to HIV, over 20 infections can be transmitted through sexual activity, whether between a man and a woman or between two men. These include gonorrhoea, syphilis, chlamydia, herpes and hepatitis. Some infections are transmitted more easily than others, and the presence of one infection can increase the likelihood of transmission of another; for example, HIV is transmitted more easily when one or both partners has another STI that results in an ulcer or open sore.

Effective HIV/STI prevention depends on individuals understanding their level of risk, being motivated to reduce that risk and living in an environment that allows them to take steps to reduce risk. It also depends on their understanding of sexual matters – how their own body, and their partner's body, functions.

Unfortunately, many people are ignorant about sex, and where sex education does exist, it often ignores sex between men. In order to be effective, HIV and other health programmes for men who have sex with men should include basic information about sex as well as means of preventing transmission of STIs. Furthermore, because many men who have sex with men also have sex with women, women's anatomy and reproductive health should also be covered.

Varying risk

Risk of infection with HIV or STIs depends on physical, epidemiological and socio-economic factors.

The extent of physical risk depends on the sex act practised. Vaginal and anal intercourse without a condom are highly risky, in particular if one partner has another STI which causes sores or lesions. Oral sex carries much less risk, although that risk rises if the recipient partner has mouth ulcers or bleeding gums.

Epidemiological risk depends on the number of partners an individual has unprotected sex with and the overall extent of infection in the community. Different factors make people vulnerable or more likely to behave in ways that put them at risk of infection. Socio-economic vulnerability factors can include a reluctance to discuss sexual behaviour, as well as such issues as poverty, illiteracy and homophobia. For example, poverty reduces access to condoms, illiteracy reduces the options of learning about the risk of infection and homophobia results in limited or non-existent prevention programmes.

Viruses and bacteria

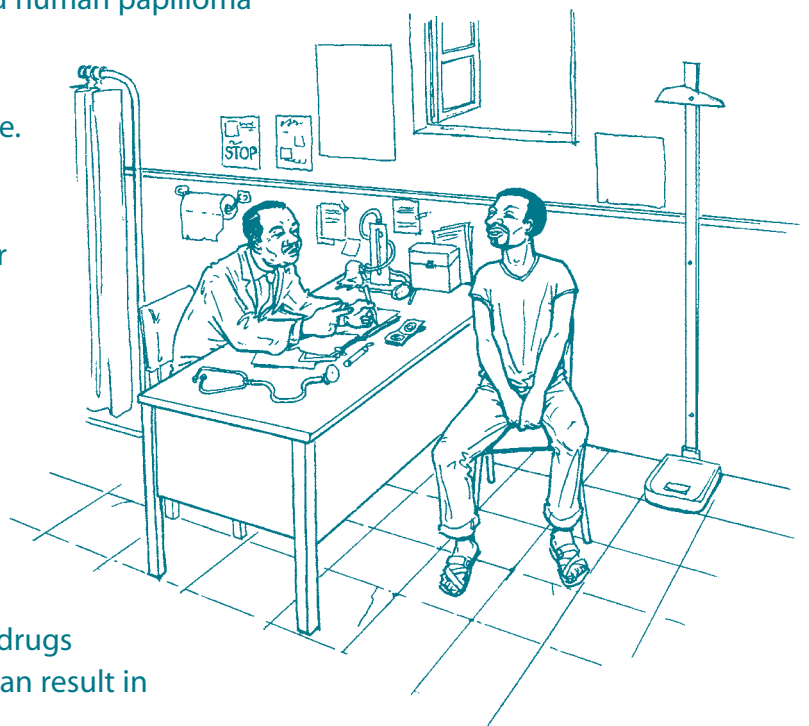
HIV and other infections are transmitted when infected body fluids – usually vaginal fluid, semen and blood – from one person enter another person's body through broken skin or across mucous membrane (the moist tissue that lines some organs and body cavities).

Some STIs, such as HIV and herpes, are caused by viruses. Others, such as chlamydia and gonorrhoea, are caused by bacteria. STIs are present in the bloodstream, semen and/or vaginal fluid. Transmission usually occurs through vaginal and anal intercourse. Tiny blood vessels can rupture unseen on the head of the penis, in the vagina and in the anus, allowing the infection to pass from one person to the other. Because the tissues of the rectum are relatively fragile, HIV is more easily transmitted during unprotected (without a condom) anal intercourse than in unprotected vaginal intercourse.

Some infections, such as herpes and human papilloma virus, which leads to warts and may cause cancer, are relatively easily transmitted through oral intercourse. However, the risks of transmitting other infections, such as HIV, in oral intercourse are considerably smaller than in unprotected vaginal or anal intercourse.

Drug use

Some men who have sex with men also take recreational drugs such as heroin, cocaine, ecstasy, other chemical compounds or alcohol. Injection of recreational drugs using shared injecting equipment can result in



transmission of HIV. Recreational drugs that are smoked, drunk or eaten can lower men's inhibitions and make them less likely to practise safer sex. Some men take drugs because they help them to overcome the social and psychological taboos against having sex with men.

Symptoms and treatment

The symptoms men experience from STIs range from a burning sensation while urinating (gonorrhoea), to a painless sore (syphilis), to symptoms so vague that they are not always noticed. HIV can cause flu-like symptoms in the first 12 weeks after the virus has been contracted, but these symptoms then disappear. Some infections, including HIV, syphilis and hepatitis, are fatal if untreated. Others, such as herpes, may only cause persistent discomfort, although they also have long-term health consequences.

STIs caused by viruses such as herpes and HIV, can be controlled but not cured – scientists have not discovered a way to eradicate viruses from the body. Infections caused by bacteria, such as syphilis and gonorrhoea, can be cured by antibiotics. In both cases, however, the treatment can be lengthy and expensive, and many people who begin treatment do not complete it. As a consequence, many drug-resistant forms of STIs are emerging, making them increasingly difficult to treat.

HIV weakens the body's immune system, making it vulnerable to opportunistic infections such as tuberculosis. HIV may not present serious symptoms for up to ten years after infection, but once symptoms of AIDS appear it is usually fatal within two years. Antiretroviral treatment keeps HIV under control and allows most people living with the virus to lead healthy lives. Antiretroviral treatment must be taken for life and although still too expensive for most people in the developing world, access is increasing, and there is evidence that treatment has a role to play in prevention.

PREVENTION

The best treatment for any STI is prevention – not to become infected in the first place. This subsection looks at the actions that individuals can take to protect themselves and their sexual partners. However, it is also necessary to consider social and psychological issues which may prevent many people from acting in these ways.

Safer sex

Prevention can be accomplished in four ways: abstinence, mutual fidelity, condom use and non-penetrative sex. Penetrative sex without a condom is very risky. Consistent use of a condom and non-penetrative sex are known as safer sex, because they substantially reduce the risk of infection with HIV and other STIs.

Although abstinence guarantees complete protection from STIs, it is a viable option for very few men. Sex fulfils many needs. It is a unique and usually free source of pleasure, which often provides an emotional bond between partners, and for many men it is validation of their identity.

Mutual fidelity – where both partners have been tested for HIV and know they are infection-free and neither has sex outside the relationship – is an option available to very few men who have sex with men. Many do not have regular partners or they live in societies that make it difficult to find and keep a regular partner. Many are married and have sex with their wives out of duty, and with one or more other men for pleasure. Those who are not married but have a regular male partner may not be able to meet that partner as often as they wish, with the result that frustration may lead one or both partners to resort to sex with others.

Non-penetrative sex means stimulating the penis by hand or between the legs, or some other method that does not involve insertion in the mouth, vagina or anus. It affords protection because when infected semen lands on unbroken skin the infection cannot enter the bloodstream. Mutual masturbation and other forms of non-penetrative sex are commonly practised by men who have sex with men, but as occasional alternatives to intercourse rather than replacing it.

Because few people want to or can restrict themselves to abstinence, mutual fidelity and non-penetrative sex, all men who have sex with men should be aware of the need to use **condoms** consistently and efficiently when these other options are unavailable. Where condoms are not used or not available, withdrawing the penis from the anus or the mouth before ejaculation reduces but does not eliminate risk.

Condoms and lubrication

Unless both partners can prove they are HIV-negative, which requires a blood test and no sexual or drug-injecting activity that might lead to infection for three months, condoms should be used in every act of anal and vaginal intercourse. When used properly, male condoms prevent transmission of STIs 99 per cent of the time. Thicker condoms have been recommended for use in anal intercourse, but recent studies suggest that the thickness of the condom makes no difference as long as lubrication is used.

Condom use appears simple, but it requires practice. When not used properly – for example, if air is left in the tip or if the condom is not rolled down the length of the penis – condoms can break or fall off. When with a partner, men are often rushed and do not put the condom on properly. Men should first practise putting on a condom on their own, ejaculating and taking it off; condom use with a partner will then be easier.

Because the anus does not produce lubrication, friction may cause the condom to tear. To overcome this, many men use saliva, but that can dry quickly and is not advised. A water-based lubricant is preferable, but this may be unavailable or too expensive for many men. Oil-based lubricants, such as Vaseline or cooking oil, must not be used as they destroy the latex. A key activity in working with men who have sex with men is ensuring easy access to appropriate lubricant.

Although the risk of transmission of HIV and most other STIs is significantly smaller in oral sex, some authorities recommend that condoms are used. However, many men find the taste and sensation so unpleasant that they prefer not to do so. Studies suggest that ejaculating in the mouth is more likely to cause infection.

Withdrawing from the mouth before ejaculation will reduce the risk.

There are significant variations in penis size. Male condoms are made in different sizes; wearing the wrong size can lead to discomfort or to the condom coming off during sex. Organisations responsible for distributing condoms should make those different sizes available to their clients. It should also be recognised that male condoms cause loss of sensation for some men. This can be remedied by applying saliva to the inside of the condom where it will rub against the head of the penis.

Condoms may be available free, at subsidised prices or commercial prices from many different sources, including health clinics, shops and NGOs. Means of ensuring that men who have sex with men have access to condoms, demonstration of their use and to how to negotiate condom use with partners, are vital areas for programming with MSM.



ASSESSING RISK AND VULNERABILITY

Before HIV/STI programmes can be developed by men who have sex with men, it is important to understand the dynamics of transmission in the location (who, how many, how, where etc.), specific risk behaviours practised and what makes men who have sex with men vulnerable to risk. In addition, existing interventions need to be assessed to see where there are gaps. This subsection gives general information on assessment of this kind, but does not provide a “how to” guide for assessment since this is available elsewhere.

Understanding the dynamics of HIV transmission

Understanding the dynamics of HIV transmission in communities at high risk is the first step to devising appropriate prevention programmes for those who are vulnerable to HIV and STIs. Many different types of assessment methodologies currently exist to do this.³ General objectives of such assessments include analysing the sexual and social networks in which people live, the patterns of behaviour that enable or prevent HIV transmission and the priorities on which prevention programmes should be built.

The following lists the types of issues that are important to consider in order to design prevention programmes for and with men who have sex with men. Work should be carried out predominantly with men who have sex with men in the location, but also with service providers, policymakers, the police etc. This list is not intended to be exhaustive; rather to give an idea of the types of things people look for during participatory assessments:

- Categories and subgroups of men who have sex with men, including transvestites, transgenders
- An estimation of numbers of men who have sex with men
- Patterns of mobility of men who have sex with men (within the location and to other sites)
- Types, location and quality of existing clinical service providers for men who have sex with men (STI diagnosis and treatment that includes anal and oral STIs, voluntary counselling and testing, AIDS care)
- Types, location and quality of other services for men who have sex with men (including informal mutual support and social/cultural groups)
- Access to and quality of commodities such as condoms and lubricant
- Types of risk and also risk reduction behaviour practised
- General and location – specific factors that influence HIV/STI transmission between men (including violence, stigma, the law etc.)

3. For examples of the Alliance’s experience in assessments see the Alliance website: www.aidsalliance.org

- Levels of motivation, knowledge and skills for prevention amongst men who have sex with men, including knowledge of rights
- Categories or types of men who are most at risk of contracting or transmitting HIV
- Priority gaps that exist in services/interventions/self-help and support
- Change that needs to happen to reduce HIV/STI transmission and infection amongst men who have sex with men and their partners
- Suggestions for how change can happen and who should be involved
- Barriers and opportunities which help or hinder change.

Assessment findings can be used as baseline information, a starting point with which to compare how well projects and interventions are doing and to review whether or not they are on track to achieving their goals.

Participatory assessment

While the concept of assessment is widely understood, it is important to stress the importance of participation in assessment. This ensures that assessment is undertaken **by** men who have sex with men and **with** men who have sex with men, and not **for** them. In most situations, the only people who can successfully access a wide representative selection of men who have sex with men will be their peers – other men who have sex with men.

Sometimes men who have sex with men are used as “resource” people and their job is to help find their peers so that “trained” researchers can then carry out the assessment. Experience shows that you do not necessarily need to be a researcher to do a participatory assessment. In some cases it can even be a drawback. What is important is to have a wide range of men who have sex with men from the location who have good knowledge of the location, an ability to listen, good interpersonal skills, who are organised and have everyday analytical skills. So long as some of the team can read and write, this is not important for everyone to be able to do so.

Transparent and fair recruitment processes are important, and full training, fair payment and support should be offered to those recruited to carry out the participatory assessment. Often, a group which carries out participatory assessment becomes well bonded and can go on to be an integral part of prevention and other subsequent programmes for men who have sex with men.

It is important to take steps to make sure that the assessment itself does not increase stigma and discrimination against men who have sex with men. It should be very clear how the information will be used, who will have access to it and how information will be kept secure and confidential. What people can expect as a result of participatory

assessment should also be made very clear. When people are told that programmes and services will result and then nothing happens, it makes them reluctant to participate in anything further.

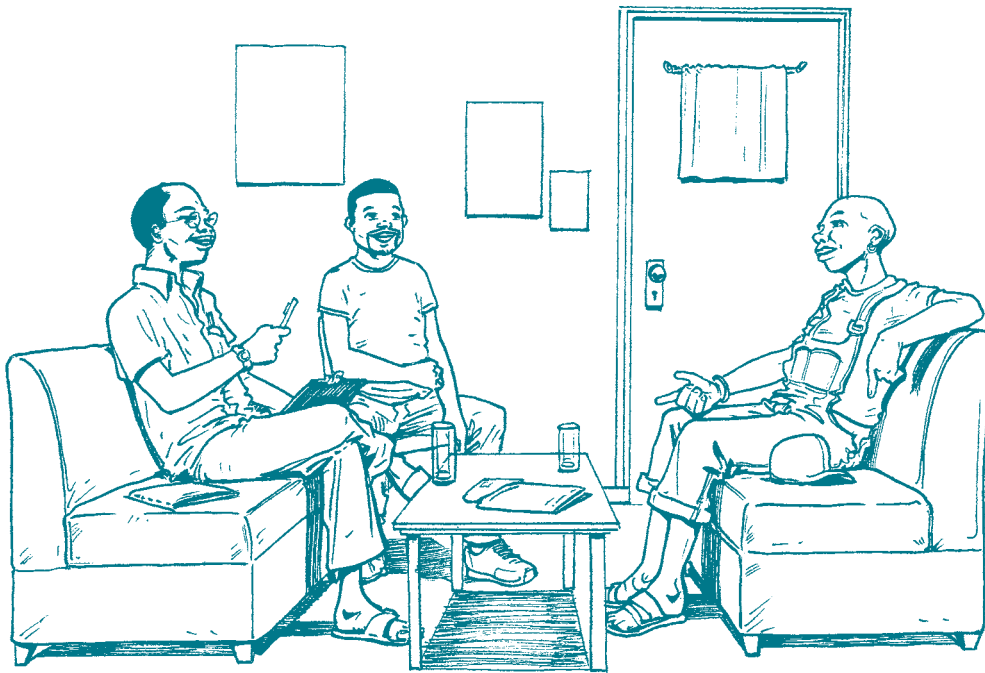
The participatory assessment should use language and vocabulary appropriate to the participants. Academic language, such as “penetrative anal intercourse” should always be avoided. In some communities explicit sexual language such as “fucking (in the ass)” is preferred, while in others locally-accepted euphemisms are better, such as “be the man/woman”.

In order to be very clear about what is happening in the location, participatory assessments often make use of visual tools. Participants are asked to draw maps or diagrams, or make drawings to better communicate the context of their lives. Simple recording tools can be devised to organise information in a logical and helpful way. Verification meetings with a larger group of participants can be held towards the end of the assessment to see if the information accurately reflects the local situation and to highlight any information gaps.

Participatory assessments are not just about “extracting” information for someone else to analyse. Analysis can be done on the spot by individuals and groups. These discussions can result in men making changes to their lives to reduce risk. It can also catalyse positive action by service providers in the area. In this way, participatory assessment can be an intervention in itself. Condoms, lubricant and referral information should be provided to participants in the assessment. Safer and non-penetrative sex techniques can also easily be shared during the assessment.

Participatory assessments must also make a clear distinction between actual risk and men’s perceptions. The many myths about HIV transmission and prevention lead some people to overestimate and others to underestimate the risk they face. In communities where there has been little or no information about the risk of sex between men, individuals may believe that they face no risk at all. Alternatively, some people who are aware that sex between men can lead to HIV transmission may believe that even non-penetrative sex between men is risky.





Interpreting statistics

Participatory assessments also use secondary sources, or other sources of information that do not come directly from men who have sex with men, such as national and local statistics. Often it is not straightforward to interpret these statistics.

The rate at which HIV spreads depends on several interacting factors, including the sexual acts individuals practise, the numbers of partners they have, whether either partner has an STI that assists transmission, and how infective the HIV-positive partner is – for instance, people are often more infectious when they have just contracted the virus.

Not all men who have sex with men are at high risk of infection. Those who only have sex with a regular, long-term partner who is equally monogamous, and those who consistently practise safer sex are at little risk. However, large numbers of men – and their women partners – are at risk from frequent, unprotected anal sex with other men.

Identifying current HIV infection rates among men who have sex with men is an essential but often difficult task. National or local statistics may not include sex between men as a risk category or, where it is recognised as a transmission route, men may be reluctant to admit to doctors or researchers that they have sex with men. The picture may be further obscured by out-of-date statistics, national statistics not distinguishing between infection rates in different parts of the country, and a high percentage of “unknown risk behaviour” responses, which on further research often prove to be mostly men who have sex with men.

While HIV statistics indicate how many people have already contracted the virus, STI rates give some indication of how many are at risk. Where national statistics do not exist, some information may be available from STI clinics. While clinics should never release information on individual patients, they may be able to provide statistics on overall rates of infection in their clients. To gauge the accuracy of such figures, clinic personnel should be asked whether male patients are questioned, even if not directly, about sex with men and whether doctors routinely investigate potential infections in the mouth or anus. Clinics which do not actively consider sex between men are likely to miss some infections and attribute others, wrongly, to sex with women.

Even where information on HIV/STI among men who have sex with men is available, it must be analysed with care. Rates of infection may be exaggerated where only men at high risk are researched, or underestimated when the extent of sex between men is unknown.

DESIGNING PROGRAMMES

Once participatory assessment has identified the men at greatest risk of contracting and transmitting HIV and other STIs, appropriate prevention programmes can be devised. Before looking at different types of interventions (see Section 3), this subsection outlines overall goals and strategies, the principles that should underlie interventions and good practice guidelines.

Goals and strategies

Whether or not an individual adopts safer sex strategies depends as much on his social and psychological circumstances as on his knowledge of HIV transmission and prevention. This means that the goals and strategies of interventions must be equally broad.

Interventions should therefore always aim to achieve the following goals:

- Increased awareness of HIV transmission and prevention
- Increased condom use
- Increased use of water-based lubricants
- Increased use of HIV/STI services
- Increased social capital (the ability to secure benefits through membership in networks and other social structures), solidarity and self-esteem
- Reduced unprotected anal penetrative sex
- Reduced stigma and discrimination (of sex between men and of HIV).

Ideally, other outcomes of interventions will include:

- Increased understanding of male sexual health
- Increased access to primary health care
- Increased use of primary health care services
- Increased capacity to minimise consequences of violence and abuse
- Increased ability to communicate about sex and health issues
- Increased involvement by men who have sex with men in public policy structures and forums
- Reduced violence and abuse
- Reduced risk-taking with female partners
- Reduced shame, fear of exposure and embarrassment.

The priority strategies should be:

- Appropriate STI and HIV services
- Peer outreach and support
- Adequate and sustained supply of appropriate condoms and lubricants
- Skills-building in the use of condoms and lubricants
- Provision of information, in appropriate formats, on HIV and male sexual health
- Social, cultural and community development activities
- Appropriate training of health workers and treatment providers
- Provision of information on recreational drugs, if appropriate.

Other strategies may include:

- Focused anti-discrimination activities
- Leadership training
- Advocacy on issues that affect men who have sex with men
- Programmes for new arrivals in site, people “coming out” or new to sexual activity between men
- Community development and capacity-building for self-help, advocacy, social and cultural activities
- Referrals to primary health care services and to social, legal and economic assistance
- Information and treatment referral on tuberculosis
- Information on HIV/AIDS opportunistic infections and treatment options.

More than sex

People's sexual behaviour and attitudes towards sex are motivated by much more than knowledge. Behaviour change is a complex process motivated by several factors, including awareness of the need for change and of its benefits, practice in new skills such as condom negotiation, and confidence in one's ability to maintain new behaviour in changing circumstances and despite setbacks or failures.

HIV/AIDS prevention must therefore address not only the physical aspects of prevention but the social and psychological contexts in which sex occurs. For men who have sex with men, these contexts may include issues of sexuality, culture, gender, health, social status, religion, politics, law, self-esteem and power. For many men, the most pressing issues are poverty and basic needs such as food and clothing and also the obligation to get married and to care for one's wife and children. Broader social attitudes, such as stigmatisation of sex between men and abuse of men who practise it, are also key issues. Interventions that do not place these concerns at the heart of prevention strategies will not succeed.

Working with CBOs

Prevention strategies are most effective when "owned" by the people they are intended to benefit. As with the assessment process, men who have sex with men must participate in all stages of planning and implementation of interventions. Often this can be through an existing group or CBO run by and for men who have sex with men. The CBO can then take responsibility for certain interventions. Such an organisation may already exist; if not it should be encouraged.

Creating a CBO of men who have sex with men requires time and careful support. Care should be taken to recognise the autonomy of such organisations and the need for them to make their own decisions if they are to be sustainable. Often they start informally, with committed individuals slowly taking on leadership roles.

The concept of leaders is closely allied to that of CBOs. Leaders are those individuals in a community who are recognised as representing the community and/or whose sexual or social practices are admired by the community. Leaders have critical influence: in one study in the United States, risky sexual behaviour among men who have sex with men fell by 30 percent in small towns where the most recognised clients in bars were trained in HIV prevention and encouraged to promote safer sex with their acquaintances. Leadership training is increasingly recognised as a means of maximising leaders' potential to build the solidarity necessary amongst men who have sex with men for a variety of HIV/STI prevention strategies.



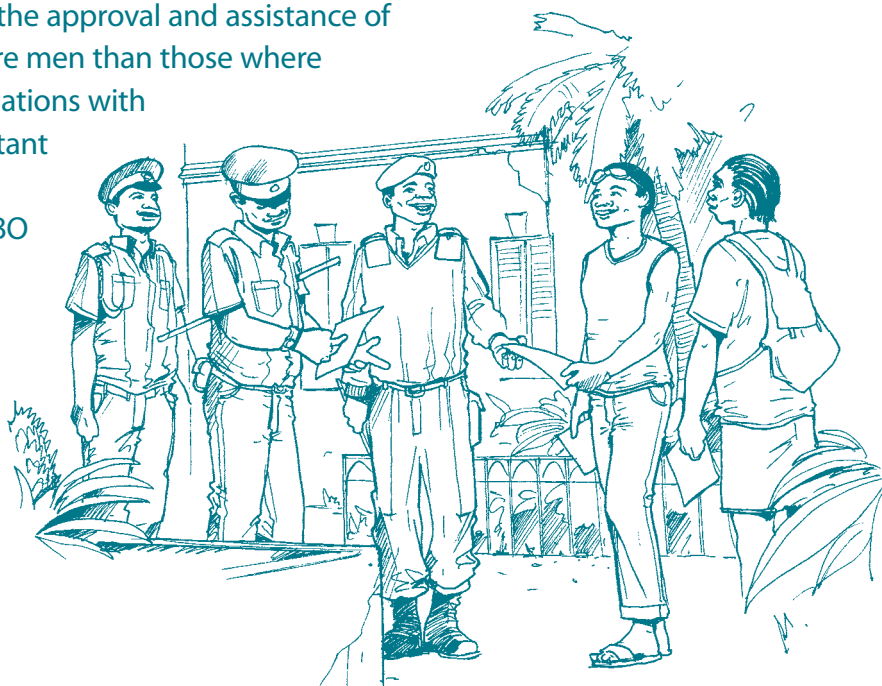
Other types of capacity-building to support emerging CBOs can include administrative and strategic skills; partnership-building and development of referral services; quality assurance, especially for health services; and assistance in developing and implementing advocacy strategies. Equally important are financial systems development; strengthening of governance and accountability systems; development of documentation, monitoring, evaluation and communication functions; and resource mobilisation.

Because CBOs are usually small and have relatively few resources, and because collaboration provides additional strength and resources, mechanisms for networking with NGOs and other CBOs should also be developed.

Working with gatekeepers

Gatekeepers are men or women who indirectly or directly control access to a target audience. They include the owners of commercial venues where men who have sex with men meet, the police, who control access to public spaces where men cruise (seek sexual partners), and prison officers, who permit or prohibit HIV and other interventions in prisons.

Working with gatekeepers is an essential aspect of any prevention strategy. Interventions that have the approval and assistance of gatekeepers will reach many more men than those where gatekeepers are hostile. In negotiations with gatekeepers, however, it is important to ensure that control over the intervention is retained by the CBO and that inappropriate messages that may be suggested by gatekeepers are not accepted.



Working with health care providers

Men who have sex with men have specific health needs that can only be met by medical personnel who are fully aware of and sensitive to the issues involved. This includes an ability to deal with men who have sex with men in a non-judgemental way (using neutral or supportive language and mannerisms) that elicits their sexual history. It also includes a familiarity with and an ability to treat infections in the anus as well as the genital area and mouth.

When working with men who have sex with men, **confidentiality** must be maintained. This applies to behaviour and gender/sexual identity (respecting the individual's right not to divulge their sexual behaviour and identity to others) and to health, in particular whether the individual has contracted HIV or an STI.

Ideally, all health care providers should be aware that some men have sex with other men, but voluntary and confidential counselling and testing for HIV and STIs are seldom targeted at this group. Skilled and sympathetic counsellors and staff should be trained to provide such services. Although many issues surrounding HIV are similar for men who have sex with men to the rest of the population, there are many others, such as safer sex, becoming HIV-positive after rape, partner notification, and care within the family, that require a different approach by both counsellor and client.

Health care providers and others who work specifically with men who have sex with men must recognise that most men who have sex with men also have sex with women. Programmes should ensure that men are also informed of the need to protect their women partners.

Principles that hinder HIV prevention

It is sometimes argued that HIV transmission between men could be stopped if men were prevented from having sex with each other. Instead of providing services such as STI clinics and condoms and lubricants, prevention programmes should focus on reducing the frequency of sex between men. This can be achieved theoretically by:

- Religious prohibitions
- Social stigma
- Legislation outlawing sex between men, with punishments such as imprisonment, fines and, in a few countries, execution
- Police actions closing commercial establishments and preventing sex between men in public spaces
- Reducing the number of locations where men who have sex with men meet
- Discriminating against men who have sex with men or encouraging social, economic or legal sanctions against sex between men

- Reducing the availability of, or demand for, sexual services offered by men
- “Cures” for homosexuality.

These strategies have been widely practised in many societies, both before and after the advent of HIV/AIDS. However, **they have consistently failed to prevent sex between men and consequently they have failed to prevent HIV transmission between men.**

Furthermore, by depriving men of appropriate prevention programmes, in many communities such strategies have actually contributed to the spread of the virus among men and to their women partners. In addition, stigmatising sex between men not only denies many men the ability to lead happy and fulfilling lives, but can cause significant psychological and social problems for the men, their wives and children.

Because this approach to HIV prevention is both counter-productive and a denial of human rights, it is not recommended and not supported by the International HIV/AIDS Alliance. However, the high profile of such strategies in many communities cannot be ignored and it is essential that NGOs and CBOs discuss them in order to respond appropriately to institutions and individuals who propose them. In order to provide an appropriate response, it is often important to work with allies such as human rights organisations, sex worker organisations, politicians and others who understand the need to reject inappropriate strategies.

3 HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

This section outlines strategies for HIV/STI prevention for and with men who have sex with men. The strategies are organised into four categories which are taken from the Alliance Frontiers Prevention Project Framework (International HIV/AIDS Alliance, Oct 2002).⁴

These categories are:

1. Individually focused health promotion
2. Scaling up, targeting and improving service and commodity delivery
3. Community mobilisation
4. Advocacy, policy change and community awareness.

Effective programmes for reducing HIV transmission among men who have sex with men will include strategies from all of these categories, with local conditions and needs determining the relative importance given to each.

Studies confirm that in different communities the strategies outlined in this section have raised awareness of HIV/AIDS and STIs and resulted in some increase in condom use. However, there is regrettably little evidence from the developing world that they have resulted in either a significant reduction in HIV transmission or sustained low rates of HIV among men who have sex with men. That does not mean these strategies do not work, but that little research has been carried out in this area.

One exception is the Naz Foundation in India, whose projects have helped not only to increase good knowledge of HIV and STIs and increase condom use, but which have also seen reduced rates of STI infection. Furthermore, the strategies detailed in this section have been widely used in a number of developed countries, such as Australia, the Netherlands and Norway, where rates of HIV infection among men who have sex with men have remained low for many years. The strategies in this booklet are therefore recommended on the basis that, according to current knowledge, they represent the most likely means of preventing widespread HIV transmission among men who have sex with men and their partners.

STRATEGIES FOR INDIVIDUALLY FOCUSED HEALTH PROMOTION

This subsection examines strategies which aim to influence individual men's attitudes and perceptions towards sexuality and sexual behaviour, with the objective of increasing the frequency with which they practise safer sex and seek counselling and testing.

4. International HIV/AIDS Alliance. Summary Project Description – Frontiers Prevention Project: a global initiative to slow the spread of HIV and build capacity for effective and sustainable community responses. Oct 2002.

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

Individual interventions include outreach (visits to parks, bars and other sites to talk to men on an individual basis), distribution of pamphlets, video shows, counselling, workshops and group discussions, and formal presentations. The content of interventions includes building skills in the use of condoms and lubricants, offering STI diagnosis and treatment facilities and promoting and providing voluntary HIV counselling and testing.

Peer education is critical; wherever possible, individual interventions should be carried out by men who have sex with men, with appropriate training, remuneration and support.

Obstacles to individually focused health promotion can include low awareness of HIV/STIs, reluctance to be identified as a man who has sex with men, negative attitudes towards condoms, and low self-esteem. Hostility from gatekeepers and other HIV/STI service providers can also be a barrier which should be addressed using strategies outlined further on in this section.

Open air

Across the world men cruise in public, most often in parks, streets and beaches with a local reputation for such activity. A high proportion of men who meet in public are poor, with little education or illiterate, socially isolated and/or uncertain of their sexual identity. In some societies men cruise because they cannot meet men anywhere else, but even where alternatives such as bars and saunas exist, open air venues are popular. Sex may take place in those public places, particularly if there are areas that offer a degree of privacy, or it may take place elsewhere. Many sexual encounters are anonymous, with few or no words exchanged.

Interventions in public spaces usually consist of trained workers who regularly visit the location and talk to the men they meet there. They hand out leaflets if appropriate, share safer sex techniques, promote STI diagnosis and treatment and voluntary counselling and testing, and distribute condoms and lubricant. Outreach requires skill in approaching strangers and avoiding assault by others who consider the men targets. The police may also be hostile so security for outreach workers needs to be considered carefully.

Because men who have sex with men are often faced by issues more pressing than HIV, such as hunger, family problems and violence, the information given verbally or in pamphlets often needs to extend beyond HIV/STIs. For example, as described previously, the Blue Diamond Society in Kathmandu, Nepal, fosters solidarity among the men using public parks to protect each other from blackmailers, thieves and the police.

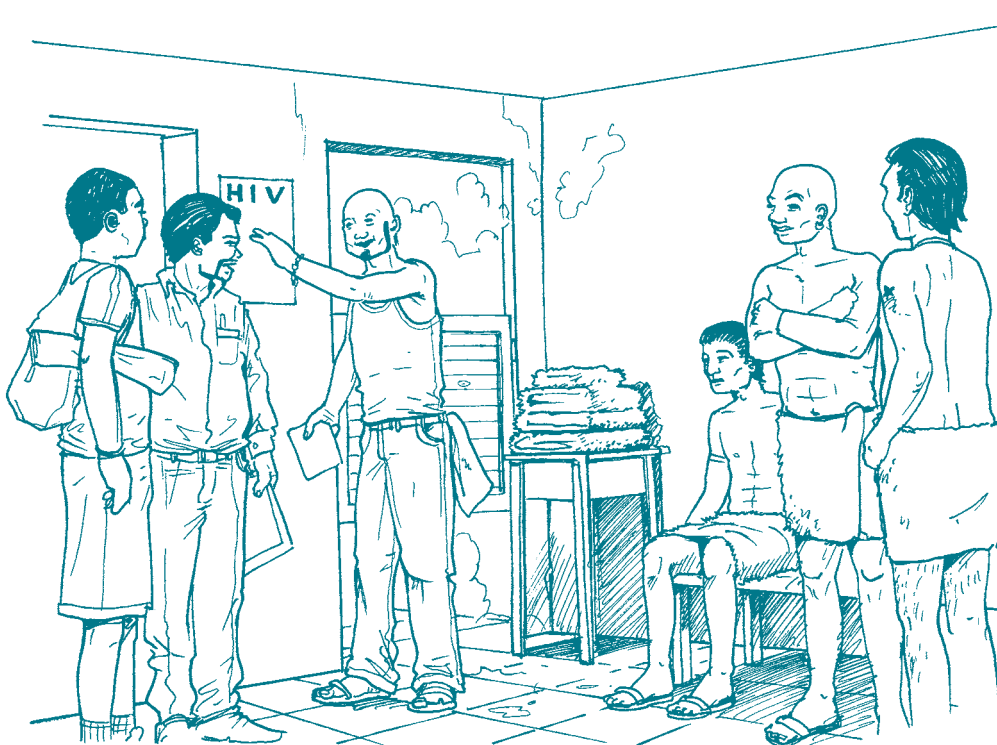
HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

The best outreach workers are usually men who themselves cruise in public spaces and who fully understand the concerns of the men they meet. To avoid confusion between their private lives and their work, ethical standards should be developed as part of their training programme. This may include working in pairs, partly for safety and partly to reduce the likelihood of workers being distracted by offers of sex.

Once their confidence has been gained, men in public spaces generally react favourably to the concern shown for their well-being. Some may express an interest in other activities, such as developing information and communication materials, and a few may offer and be appropriate for training.

Under cover

Outreach work can also be carried out in commercial outlets, such as bars, nightclubs, saunas and cinemas. Possible activities include talking with customers, poster displays, providing leaflets and condoms, and cultural or cabaret acts.



One-to-one conversations on HIV and other issues can be held without the approval of the owner or manager, but activities are generally much more effective with his/her support. Initially this may be difficult to achieve, even when the owner is himself a man who has sex with men. Owners may not wish to acknowledge that men who have sex with men meet on their premises or they may consider publicity on HIV and STIs bad for business.

One argument for persuading owners to change their mind is that HIV itself is bad for business, since it reduces the number of potential clients. And material and presentations that are celebratory and, if appropriate, erotic are likely to attract customers.

Once one owner has agreed to allow outreach on his or her premises, it is usually easier to persuade others to do the same. Their interest may be purely commercial – a regular clientele is good for business – or it may be personal, since they may also be men who have sex with men. Whatever their motivation, as gatekeepers they are critical in helping to establish successful prevention programmes.

Interventions must be sustained to be effective: condoms and leaflets should always be available, cabaret acts can be a monthly feature and World AIDS Day an annual event.

Materials

Men who have sex with men should be involved in the development of posters, leaflets, videos, theatre presentations and all other materials. This includes both the design stage, pre-testing and distribution.

The design stage can be a follow-on from participatory assessment. It confirms who the target group is, the most appropriate means of presenting them with information (written or pictorial etc.) and the most appropriate language and information. Pre-testing means showing the finished material to a representative group of men who were not involved in the development process. Their reaction is critical, and they may identify strengths and weaknesses which were not obvious to the development team. Only when the material has been successfully pre-tested should it be distributed to the target audience.

Groups

One-to-one interventions provide essential information and allow men to focus on questions that particularly concern them; group discussions and workshops encourage broader discussion of issues and help create a sense of solidarity. As more people provide more perspectives, more potential responses can be suggested for problems that affect either the individual or the group. Groups also provide the psychological support that many individuals need to practise safer sex and develop self-esteem.

Meetings should be held in locations where participants feel comfortable but where they are not easily distracted. Where anonymity is important, notices about the meeting should make no reference to sex between men. Different formats can be used, from regular weekly meetings with no obligation to attend, to day- or

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

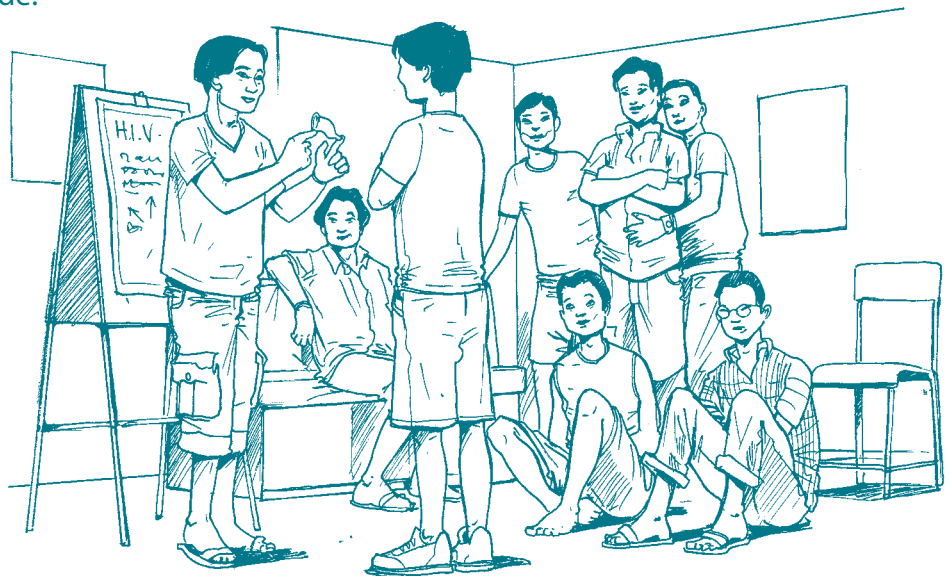
weekend-long workshops where participants commit to attending the whole event. Group discussions are usually no longer than one or two hours. They can be relatively informal and unstructured, although they are more effective with a facilitator who can guide the conversation without forcing it, ensuring that all participants have an opportunity to express their concerns and that they have a sense of ownership of the process and the ideas expressed.

Discussions should not only cover sexual behaviour and safer sex, but other issues that affect men who have sex with men. It is important to allow participants to express negative experiences, including unsafe sex, without disapproval from others; such experiences are common and discussing them forms part of the process of adopting safer sex.

Workshops

Workshops tend to be longer than group discussions, require considerable advance preparation and preferably at least two trained facilitators. Basic issues that can be covered by workshops include:

- HIV/AIDS
- STI diagnosis and treatment, including oral and anal STIs
- Condom and lubricant use and promotion
- Modifying risky behaviours
- Sexual identities and gender
- Socio-cultural/religious issues
- Marriage and families
- Wives and other female sexual partners
- Legal and human rights issues
- Discrimination and stigmatisation
- Sex work
- Community development and mobilising
- Economic issues and poverty.



HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

As the organisation grows and members develop skills, other issues that can be covered include:

- Community needs
- Ownership of health promotion agendas
- Sexual health products and services
- Education and awareness strategies
- Support for people living with HIV/AIDS
- Advocacy.

Workshop techniques include: games, role-playing, case studies, small group work and debates. Lectures are not recommended, except when brief and used as the introduction to a discussion rather than as an end in themselves. Many organisations, such as the Naz Foundation International in South Asia and Oasis in Central America, have developed workshop manuals that can be adapted for use in different communities. Some of these are listed in the Resources Section, pages 56-59.

Group discussions and workshops only reach a small minority of men who have sex with men. Many key groups, such as married men, poor men and men who feel socially isolated, may not be able to attend easily. As the project develops, mechanisms should be developed for reaching such men.

STRATEGIES FOR SCALING UP, TARGETING AND IMPROVING SERVICE AND COMMODITY DELIVERY

Advising men to use a condom is one step towards HIV prevention; making that condom accessible is the second step. Other steps include making STI treatment and HIV voluntary counselling and testing available. In other words, wherever possible, individual interventions must be supported by provision of clinical services and commodities – condoms and lubricants.

Condoms

Consistent and proper use of condoms is the only means of reducing the risk of HIV transmission in anal and vaginal intercourse, but access to condoms is often limited. Many factors prevent men from buying condoms, including cost, the fact they may only be for sale in restricted outlets, and the embarrassment associated with buying them.

A key element in the work of CBOs is therefore making condoms accessible. Male condoms are usually provided by donor organisations at little or no cost.

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

These can be handed out by outreach workers or left in commercial venues for patrons to take – although mechanisms may be needed to be established to prevent individuals taking large quantities to sell to others.

While condoms appear simple, condom use is a skill that can be developed partly through workshops and partly through practice. Furthermore, several factors should be taken into account to make condoms acceptable to men who have sex with men. These include:

Wrapping/motifs: where possible, wrapping should be culturally appropriate and should not imply that condoms can only be used for sex with women.

Instructions for use: printed instructions should be in appropriate, uncomplicated language, combined with culturally appropriate, explicit images for illiterate users.

Size: condom size is an issue for some men; condoms are manufactured in three sizes but usually only one size is made available to CBOs.

Female condom: as an alternative to the male condom, the female condom can be used for anal intercourse; usually the inner ring is removed and the condom placed over the penis before penetration. Advantages include the fact that it is more comfortable for men with large penises and does not require a full erection before it is used; disadvantages include appearance and its high cost.

One-to-one outreach, group discussions and workshops can all help men become more familiar with condoms.

Lubricants

Because the anus does not provide lubrication, alternatives must be found to make intercourse comfortable. Men often use spit, although this is usually insufficient and dries quickly, or seminal fluid (“pre-cum”), which is dangerous since it can carry HIV. Oils for cooking or creams for body care are also used, but they should not be used with condoms because they destroy the latex. Only water-based lubricants should be used with condoms.

Few men have access to water-based lubricants. They are usually only sold in pharmacies and at a price beyond the reach of most who need them. While some CBOs distribute free sachets of lubricant that they receive from donors, most others do not have such a source. Finding a regular supply of free or cheap lubricant is a problem which most CBOs in the developing world have not yet resolved.

Testing

Providing facilities for diagnosis and treatment of STIs and for HIV testing and counselling is an essential element of all HIV prevention. However, even where such facilities are available, many men, whether they have sex with men or women, do not use them. This may be for several reasons, including lack of awareness that they may be infected, inability to pay for consultation or treatment, belief that “real men” do not fall ill and, where relevant, fear of being identified as a man who has sex with men.

Encouraging men to seek treatment for STIs and to test for HIV has an important impact on the epidemic. The desire to take the test reflects a recognition of the risk and, irrespective of the result of the test, men who take it practise safer sex strategies more consistently than men who do not. Such facilities must always be provided on a voluntary basis and at no time should a CBO condone any form of mandatory or obligatory testing and counselling.

Diagnosis and treatment of STIs requires medical staff trained to recognise symptoms and sometimes access to a properly equipped laboratory. Where men who have sex with men are clients, even if they do not identify as such, doctors and other medical staff must be trained to identify and treat infections in the mouth and anus. It also helps if men who have sex with men can learn to recognise and properly describe their symptoms.

HIV testing requires laboratory access and paramedical staff trained to take blood samples. Testing must be preceded and followed by counselling, which also requires trained staff. Self-administered saliva tests for HIV exist, but they are not widely available and not recommended because they make no provision for counselling.

Counselling

Pre- and post-test counselling with a sympathetic counsellor familiar with men who have sex with men not only allows information on HIV/STIs and safer sex to be passed on but also is an opportunity for clients to learn about community-based and other organisations that work with men who have sex with men. Where a client tests positive for HIV, he can also be given details of organisations for people living with the virus. Different models of counselling may be required depending on culture and client need.

Issues that often arise in counselling include internalised homophobia (men may be unwilling to admit that they are attracted to men and therefore unwilling to take protective measures); poverty (including inability to practise safer sex because

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

paying partners refuse to do so); and masculinity (the attitude that “real men don’t get sick” discouraging condom use). Single counselling sessions seldom result in sustained behaviour change, although two sessions each before and after the test have been shown to reduce the rate of new STIs in the United States.

Ongoing counselling is ideal; where this is not possible, clients should be referred to CBOs which offer group discussions and workshops.

Most CBOs do not have the medical facilities to provide STI diagnosis and treatment, although they may have space where HIV counselling can be given and blood samples taken. These organisations often negotiate with other service providers to ensure that appropriate HIV and STI services are made available for men who have sex with men. These include arranging consultations at an accessible time and place, at little or no cost, and usually not publicly identified as being for men who have sex with men or even as STI clinics.



Ethics and confidentiality

Medical staff and counsellors must be trained to deal in a non-judgemental way with men who have sex with men. Ideally, many doctors and counsellors will themselves be men who have sex with men, although the confidentiality of the staff as well as the clients must be respected. Initial training for counsellors, who need have no previous experience, can be short, particularly in communities where work with men who have sex with men is new, but it should be ongoing to ensure that lessons learned from dealing with clients are shared with other counsellors and counselling skills are constantly developed.

Confidentiality should always be maintained by HIV/STI services. This applies both to health, in particular whether the individual has contracted HIV or an STI, and to behaviour and gender/sexual identity – respecting the individual’s right not to divulge their sexual behaviour and identity to others. Confidentiality around HIV should be respected whatever the result, particularly since willingness to disclose a client’s negative status suggests that those whose status are not disclosed are HIV-positive.

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

Everyone diagnosed with HIV faces a range of concerns, which may include ongoing health, whether to inform partners, and HIV/AIDS-related stigma and its consequences, such as loss of employment or home. Men who have sex with men who learn they are HIV-positive often face additional difficulties, including potential disclosure of their sexual activity and in maintaining a relationship. Counselling can help men identify some of these issues, but long-term support is preferable, particularly from groups of men who have sex with men who are also living with HIV.

To pay or not to pay

Services and commodities cost money and the resources of community-based and non-governmental organisations are limited. Most organisations can only provide condoms and lubricants when they are given free by donors. While many donors offer condoms, relatively few offer lubricants, which makes the supply of lubricants uncertain.

Organisations must decide whether to provide such resources free or at a price that its target audience can afford to pay. Such a price is likely to be nominal and is unlikely to recoup more than a small percentage of costs, but it may encourage a sense of value in the product. The Library Foundation in the Philippines encourages participants to buy condoms on a regular basis so that they are assured of availability at all times.

Other services

CBOs can provide many services for men who have sex with men in addition to condoms and HIV/STI services. These include workshops and group discussions, as described above, educational opportunities such as literacy classes and legal advice. These are usually provided in the context of a safe house, as described in the next subsection.

STRATEGIES FOR COMMUNITY MOBILISATION

While some men who have sex with men have strong social networks, many are either physically or socially isolated from their peers. The existence of a CBO, even if it has only a few members, helps to build and mobilise the community as a whole. That community in turn can help to consolidate a sense of identity and solidarity among individual men, underpinning their resolve to practise safer sex.

Communities can only emerge from the needs and desires of the men themselves and cannot be imposed from outside. A single community in a geographical area

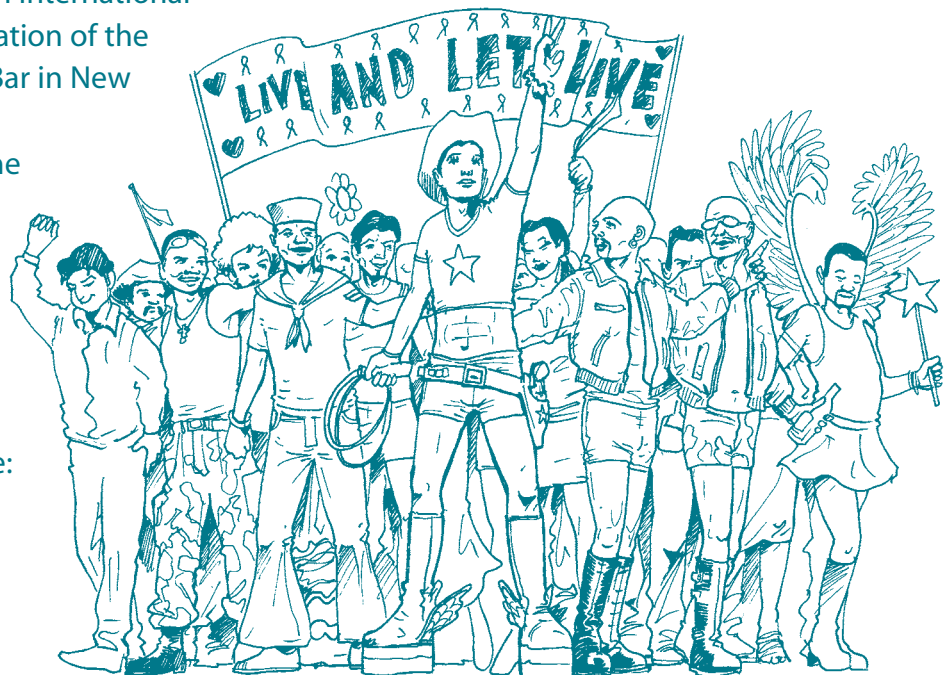
may not be possible: experience from several countries shows that middle-class men are more likely to feel part of a community with a western-style gay identity, while lower income, less-educated men are more likely to promote local identities. Some groups, particularly those that focus on human rights, may include women who have sex with women, while others prefer to work only with men.

As discussed above, a CBO is usually staffed by volunteers and, at least in the initial stages, is likely to require capacity-building support. A well-functioning organisation identifies key issues, such as condom provision, hostile police action or repressive policies, and designs strategies to respond to these challenges. It also develops means of sustaining projects, to reduce the need for external support.

Celebration time

In addition to the essential year-round work of outreach and counselling, the broader community (or communities) of men who have sex with men can be mobilised around specific national or international events or celebrations such as World AIDS Day (1 December) and Gay Pride. These can perform the double function of instilling pride in the community and raising awareness among the general population of the existence and needs of men who have sex with men. Many different events can be held, including public marches and demonstrations, art and photographic exhibitions, cinema, theatre and dance. Some of these, particularly for World AIDS Day, may involve other communities affected by the infection such as sex workers and people with HIV.

While World AIDS Day focuses specifically on HIV, Gay Pride is a more fluid concept. It can be associated with an international event (such as commemoration of the riots at the gay Stonewall Bar in New York in June 1969) or a national celebration. In the Netherlands, for example, the Queen's birthday in late April is also national Gay Pride day. The word "gay" itself may be seen as inappropriate or it may be included in a longer phrase: LGBTQ – lesbian, gay, bisexual, transgender and questioning – is used by some groups.



Higher visibility for both individuals and the community as a whole may have negative consequences, such as increased police repression, violence, and homophobia from political and religious leaders. The overall impact of a public celebration, however, is almost always positive. Men who participate in the planning and implementation gain a strong sense of solidarity and self-esteem, while those who see the events experience a reduced sense of isolation. And society at large begins to reconsider its understanding and opinions of a group that it previously had little knowledge of.

A safe house

In many societies, men who have sex with men, particularly those with little income and who live with their families, have few opportunities to relax and meet their peers in an environment where they do not have to hide their sexuality. Many CBOs therefore see a “safe house” as a priority, particularly where commercial venues do not exist or where many men cannot afford to visit such venues.

A safe house may be anything from a room lent on a weekly basis by an NGO to a building owned by the CBO. The more accessible it is to the community, the greater role it will play in building that community. Depending on size and availability, it can be an office, an informal meeting-place and a place to host a wide range of activities. These activities can range from discussion groups, workshops and planning World AIDS Day events to rehearsal space, literacy classes and film nights. If space permits, a safe house can also host a counselling and testing service and a library.

A safe house requires sustained commitment because it creates considerable work and bureaucracy. Structures must be established that allow volunteers to contribute to the running of the house and to train in computer skills, advocacy and accountancy.

The setting for the safe house should be chosen carefully. Even when anonymous, neighbours are likely to become aware of who visits it. Instead of a residential setting, a safe house may be best situated in a commercial area and near a park or other cruising area.

Safe houses include the Blue Diamond Centre in Kathmandu, which is open seven days a week from 9am to 6pm and offers counselling, clinic services, videos twice a week, training and social and cultural events, and the Library Foundation in the Philippines, which has a community centre which hosts the Foundation’s office, regular one-day workshops, group discussions, meetings and advocacy events.

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

On-line

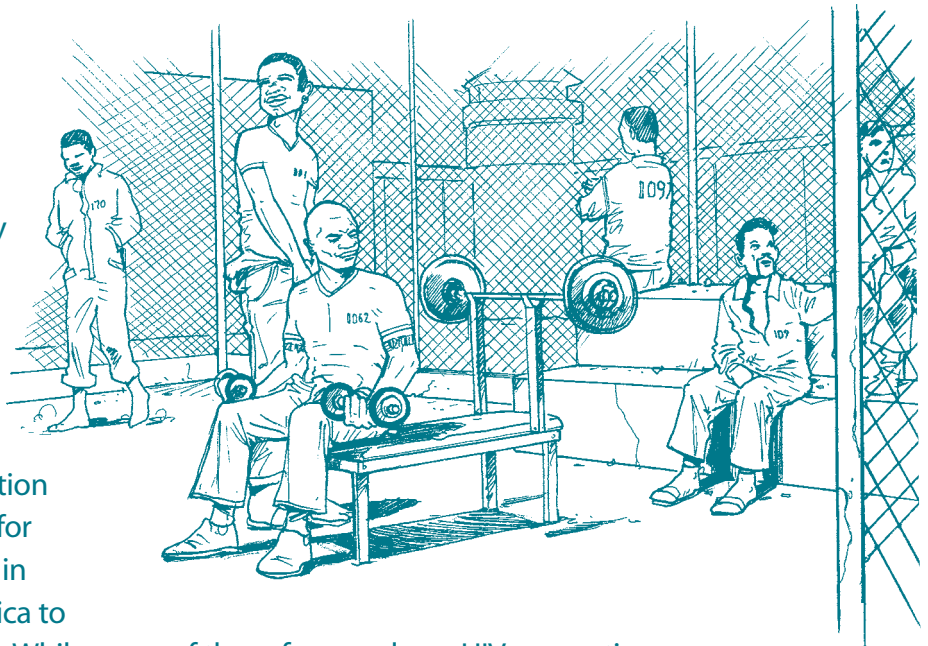
Although still restricted to the middle class in many countries, the internet has become a virtual community for many men who use the web to make social and sexual contacts with other men. This may be on international sites, such as www.gaydar.eu.com and www.gay.com, or sites with a national or smaller focus, such as www.gaybombay.com. Increasing numbers of organisations, such as the Library Foundation (www.tlfmanila.org) also have their own website.

While the internet provides increasing opportunities for men to explore their sexual identities, some activists argue that it allows men to have more sex with other men but without building the sense of community needed to break down homophobia. However, websites and chat rooms provide important opportunities for HIV prevention. In Singapore participants who identify as HIV resource persons frequently respond to private enquiries about safer sex and AIDS.

In prison

Sex between men is a feature of prison life across the world. When it occurs, it may be for sexual release, an expression of affection or an act of violence as one or more men impose their will on another man. Many, if not most, of the men who have sex with men in prison would not do so in other circumstances. Condoms are seldom available, drug injection may be common, and HIV infection rates are frequently higher in prison than in the general population.

HIV intervention projects for prisons, focusing on both sex and injected drugs, are essential but face many obstacles. The authorities may not wish to recognise the extent of the problem, or to let outsiders “interfere” in the running of the prison. The prisoners themselves are often suspicious of education efforts. Nonetheless, projects for prisoners have been initiated in many countries, from Costa Rica to Zambia, often by ex-prisoners. While some of these focus only on HIV prevention, others respond to prisoners’ broader needs, such as literacy classes, self-esteem workshops and drug use.



Given the very different backgrounds and circumstances, the community of prisoners is very different from the communities of men who have sex with men elsewhere. Nonetheless, a sense of community exists and can be built upon.

STRATEGIES FOR ADVOCACY, POLICY CHANGE AND COMMUNITY AWARENESS

The attitudes and activities of men who have sex with men are profoundly affected by the broader communities in which they live. A social environment that stigmatises sex between men frequently leads to poor self-esteem and/or fear of identification, which both inhibit safer sex. Advocacy interventions ensure that organisations of men who have sex with men are seen as part of the solution to the HIV/AIDS epidemic. Men whose social environment supports their right to have sex safely with other men, are more likely to protect themselves and their partners.

Different environments

People live in a series of overlapping social environments, including friends, family, work colleagues, the neighbourhood in which they live and legal, cultural and religious norms. Broader environments such as law and religion influence narrower environments such as the attitudes of family and neighbours. In only a very few countries do most of these environments support the right of men to have sex with men. More often there is conflict between men's desires, activities and the environments in which they live.

While community mobilisation is predominantly directed at men who have sex with men, enabling environment interventions are aimed at the broader community. The immediate goal of such interventions is recognition of the right of men who have sex with men to access appropriate information, skills, services and commodities that will enable them to protect themselves and their partners. A long-term goal may be full legal and social equality.

Advocacy activities depend on the local social and political situation and local needs of men who have sex with men. At a national level activities may be policy research, lobbying and debate leading to legal reform. At a local level enabling environment interventions can include:

- Lobbying for provision of information and services, and against violence against men who have sex with men
- Basic awareness and anti-stigma education in the general population
- Promoting the participation of men who have sex with men in policy-making bodies such as health centre advisory groups and HIV/AIDS committees
- Educational initiatives with the police, religious leaders and others who shape community norms

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

- Provision of information to the general population to enable men and their women partners at risk to seek information and services.

The goal of advocacy depends on local circumstances. Action for AIDS Singapore, for example, directs its advocacy towards HIV rather than sexual orientation because their work with men who have sex with men is only part of their overall activities. Gay/lesbian/bisexual/transgender groups in Singapore work specifically on social and political issues relating to men who have sex with men.

Given the strong stigma often associated with men who have sex with men, advocacy interventions may have considerable obstacles to overcome. Initial goals may therefore be limited, but medium- to long-term goals should be a decrease in stigma and discrimination against men who have sex with men and increased commitment by the broader community to combating the epidemic among such men.⁵

Visibility and representation

The first essential step in advocacy is to raise awareness of the issue. Ideally, this requires one or more men who are willing to identify themselves publicly as having sex with men and able to argue the case for appropriate interventions. Although increasing numbers of men are “coming out” in more and more countries, some societies are still extremely hostile; in these it may be safer and more appropriate to argue on behalf of the community rather than as a member of the community. And wherever possible, men should speak not as individuals, but as representatives of a CBO or NGO.

Representation on institutions that directly or indirectly affect the lives of men who have sex with men is essential. There are many such organisations, from national HIV/AIDS committees to health clinic management boards, from human rights organisations to municipal authorities. Some are composed of elected representatives, others are appointed and some are self-appointed. The CBO should determine which are most influential, and which are most likely to accept a representative of men who have sex with men before planning how to achieve representation as quickly as possible.

When serving as a member of such a body, a representative is more likely to be effective when he takes an active part in the decision-making process that affects others. For example, ensuring that a local clinic not only makes appropriate provision for men who have sex with men but also provides adequate counselling for women rape victims underlines the point that men who have sex with men are

5. Further information on how to develop advocacy strategies is available in the Alliance Advocacy Toolkit *Advocacy in Action: a Toolkit to support NGOs and CBOs responding to HIV/AIDS*. June 2002. www.aidsalliance.org

HIV/STI PREVENTION STRATEGIES FOR AND WITH MEN WHO HAVE SEX WITH MEN

part of a broader community and deserve the same respect that the community offers to others.

In addition, it is important that a representative actually comes from the group he represents or is seen by the group to represent them well. Where education and professional skills are low, a representative of men who have sex with men may need some support and training.

Police liaison

In some communities the police pose the greatest immediate threat to the well-being of men who have sex with men. They monitor places where men meet, sometimes enforcing the law where it prohibits sex between men, blackmailing men by demanding money or sexual services, beating men, jailing them without charge and sometimes standing by while others attack or blackmail them. Outreach can be extremely difficult in such circumstances.

Wherever possible, CBOs should work with the police to create an environment where HIV education can be carried out with minimum risk and maximum impact. This may be difficult to achieve, particularly if requests to meet the police are ignored. Success often depends on the willingness of one or two key police officers to listen to CBO representatives. An alternative approach may be possible through local or national politicians or other CBOs or NGOs which have established good liaison.

The content of discussions and activities depends on the local situation. The emphasis may be on health rather than human rights and may include informal talks, formal membership of a police liaison committee and awareness-raising sessions with police officers or the ranks. Compromise may be essential, since the police generally will be unwilling to be seen to give up their authority or to condone criminal activity.



Social advocacy

As they grow stronger, CBOs usually wish to work, either alone or with others, on national advocacy. This is likely to have two interlinked goals: increased public awareness and acceptance of men who have sex with men (social advocacy), and legislation protecting the rights of men who have sex with men (political advocacy). In some countries these may be long-term goals. Potential partners include CBOs representing men who have sex with men from other parts of the country, human rights groups, health organisations, ethnic minorities, drug users, sex workers and other marginalised groups.

Public opinion is generally influenced through the media, while changes in legislation depend on intensive lobbying of politicians and other policymakers. Changes in religious attitudes may also result from lobbying of religious leaders.

Messages should always be adapted to the receptiveness of the audience. While the reality is that stigmatisation and repression of men who have sex with men places both them and their women partners at risk, local circumstances will dictate whether the best appeal to the public is through health and the importance of protecting those at risk, human rights or a combination of the two. An appeal to the country's history, if there was a period in which sex between men was accepted, can also be used. Ultimately, however, the public must be made aware that repression and stigmatisation of men who have sex with men prevents educational activities and places both men and their women partners at risk.

Approaches to the media can be made in several ways, including press releases, articles submitted for publication, contact with reporters who prepare sympathetic programmes or articles, interviews and appearances on chat shows and phone-ins. Many issues can be the subject of a press release or statement, such as initiatives by the CBO or a reaction to events or statements from others; for example, condemning a statement that stigmatises sex between men or congratulating a policy that promotes HIV information for men at risk. Other approaches to the public can be made through posters, leaflets and books, and participation in public debate; for example, during elections, theatre presentations, etc.

CBOs should be aware that there is often a backlash to increased awareness of sex between men, including hostile coverage in the media and violence against men perceived to have sex with other men, but the long-term rewards are greater than the short-term difficulties.

Political advocacy

Efforts to change public opinion form an important backdrop to political advocacy, which aims to change legislation. The long-term goals of political advocacy are likely to be a review of current laws and drafting of proposed legislation. This may include legalising sex between men on the same basis as between men and women, and anti-discrimination laws. Short-term, more achievable goals may include statements from the health minister, national AIDS committee or leading donor agencies recognising the right of men who have sex with men to appropriate information and services.

Political advocacy in particular requires specific skills, but these can be acquired either through internal training or training by outside organisations.

Faith

Religious leaders are often the strongest critics of sex between men, and the negative attitudes of community and political leaders are often based in religion. A dialogue with religious leaders is therefore essential. Furthermore, some religious leaders have sex with other men, and fear of being identified makes them hostile to any discussion of sex between men. On the other hand, many religious leaders acknowledge that sex between men occurs and that men should be encouraged and enabled to protect themselves and their partners. Such leaders may provide support, although this may be private rather than public.

This booklet has presented the main issues around HIV/STI prevention for NGOs and CBOs, either currently working with men who have sex with men, or who are considering doing so. Men who have sex with men are one of the key populations for effective HIV/STI prevention, particularly in countries with lower HIV prevalence.

To work with this key population successfully requires a context specific appreciation of who men who have sex with men are, the values they hold, and how they behave. This will facilitate an understanding of the specific vulnerabilities and risks they face and form the basis for designing appropriate HIV/STI prevention programmes with them.

A wide range of strategies can be employed for HIV and STI prevention with men who have sex with men. These strategies can be summarised under the following categories:

- Individually focused health promotion
- Scaling up, targeting and improving service and commodity delivery
- Community mobilisation
- Advocacy, policy change and community awareness.

At their heart, all these strategies are based on the principle of working with, rather than for, men who have sex with men.

This section includes useful publications and websites for further information on men who have sex with men and HIV/STI prevention. A list of some of the organisations that work with and for men who have sex with men are included at the end of the section along with their contacts.

PUBLICATIONS

There are many useful publications about men who have sex with men, including:

- Stephen O Murray & Will Roscoe (eds)
Islamic Homosexualities
New York University Press
1997; ISBN 0 8147 7468 7
- Stephen O Murray & Will Roscoe (eds)
Boy-Wives and Female Husbands: Studies of African Homosexualities
St Martin's Press
1998; ISBN 0 312 21216 X
- *AIDS and Men Who Have Sex With Men* (UNAIDS Best Practice Series)
May 2000, includes a bibliography and is available at:
<http://www.unaids.org/publications/documents/specific/men/mentue2000.pdf>
- *An Introduction to Promoting Sexual Health for Men Who Have Sex With Men and Gay Men: A Training Manual* (The NAZ Foundation India Trust 2001)

WEBSITES

Useful websites include:

- www.mask.org.za
- www.utopia-asia.com/aids.htm
- <http://hshlac.sidalac.org.mx>
- www.gaydar.eu.com
- www.gay.com
- www.gaybombay.com.

Please note that many other organisations can be found by entering the words "gay", "organisation" and country name in www.google.com

ORGANISATIONS

A list is included below of some organisations who have significant resources on men who have sex with men and HIV and can identify other organisations working in the field.

- **International Lesbian and Gay Association**

81 Kolenmarkt

B-1000, Brussels

Belgium

Tel and fax: +32 2 5022471

E-mail: ilga@ilga.org

www.ilga.org

Please note that there are regional branches of ILGA

- **UNAIDS**

20 avenue Appia

CH-1211 Geneva 27

Switzerland

Tel: +4122 791 3666

Fax: +4122 791 4187

www.unaids.org

Please note the UNAIDS Best Practice series on men who have sex with men

- **Triangle Project**

101 Millwave House, Waverly Business Park, Dane Street, Mowbray

PO Box 13935, Mowbray, South Africa

Tel: +27 (0)21 448 3812/3

Fax: +27 (0)21 448 4089

Helpline: +27 (0)21 422 2500

E-mail: info@triangle.org.za

www.triangle.org.za

- **Grupo Gay da Bahia**

Rua Frei Vicente, 24 – Pelourinho

Caixa Postal 2552

CEP 40.022-260. Salvador/Bahia/Brazil

Tel: +71 321-1848 / 322-2552 / 322-2176. Fax: +71 322-3782

GGB has an ongoing project monitoring anti-gay violence in Brazil

- **OASIS**

apdo.postal 1289
Ciudad de Guatemala 01001
Guatemala
Tel: +502 253 3453 and 502 220 1332
Fax: + 502 232 1021
E-mail: oasisgua@intelnet.net.gt
www.maxpages.com/oasis

- **Al-Fatiha, UK**

424, 37 Store Street
London WC1
UK
E-mail: alfatiha_London@hotmail.com
www.al-fatiha.net
This is an international organisation for Muslims who are lesbian, gay, bisexual, transgendered or questioning their sexual orientation

- **Naz Foundation International**

Palingswick House
241 King Street
London W6 9LP
UK
Tel: +44 (0) 181 563 0191
Fax: +44 (0) 181 741 9841
www.floatinglotus.com/aidsnaz.html
International HIV/AIDS and sexual health technical support agency working in South Asia

- **The Naz Foundation (India) Trust**

P.O. Box 3910 Andrews Gunj
New Delhi, 110 0-49
India
www.infinityfoundation.com/naz.htm

- **Blue Diamond Society**

GPO Box: 8975, EPC No: 5119
Kathmandu, Nepal
E-mail: cspsb@yahoo.com

- **The Library Foundation**

1074 Estrada Street

Malate, Manila, 1004 Philippines

Tel: +632 400 8375

E-mail: tlf@tlfmanila.org and tlf@edsamail.com.ph

www.geocities.com/tlf_ph/

- **GAYA NUSANTARA**

Jln Mulyosari Timur 46, Surabaya, Ja-Tim 60112,
Indonesia

Tel: + 62-31 593-4924, Fax: + 599-3569

E-mail: gayaweb@yahoo.com

www.welcome.to/gaya

To order copies of Alliance publications, please
e-mail: publications@aid alliance.org or write to:

International HIV/AIDS Alliance
Queensberry House
104-106 Queens Road
Brighton BN1 3XF
United Kingdom

Tel: +44 1273 718900
Fax: +44 1273 718 901

E-mail: mail@aid alliance.org
Websites: www.aid alliance.org
www.aid smap.com

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