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Training toolkit

MODULE 1
CORE KNOWLEDGE

همزة وصل

TRAINING MANUAL FOR MSM PEER EDUCATORS

Acknowledgements

This orientation manual has been developed jointly by the Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for the Middle East and North Africa (UNAIDS RST MENA), the International HIV/AIDS Alliance (the Alliance) and its partners in the region: ATL (Association Tunisienne de lutte contre les MST/SIDA), APCS (Association de Protection Contre le Sida), SIDC (Soins Infirmiers et Développement Communautaire), Helem, OPV (Oui Pour la Vie), AMSED (Association Marocaine de Solidarité et de Développement), OPALS-Fes (Organisation Panafricaine de Lutte Contre le Sida, section de Fes) and ASCS (Association Sud Contre le Sida). Together with the NGO MSM Project Orientation Manual and two other modules for training MSM peer educators, it constitutes a training toolkit on MSM programming for the Middle East and North Africa (MENA) region available in English and Arabic.

The training manual for MSM Peer Educators was written by Nadia Badran, in collaboration with John Howson. Staff from the Alliance, UNAIDS RST MENA and USAID Middle East Bureau and the Office of HIV/AIDS provided feedback and inputs during the writing process and completed the toolkit.

The Alliance worked within the framework of the *Responding to Key Populations in the Middle East and North Africa programme* (MENA programme), which is a regional programme targeting MSM and people living with HIV funded by the United States Agency for International Development (USAID) and implemented through the Leadership, Management & Governance (LMG) Project in partnership with civil society organisations in Algeria, Lebanon, Morocco and Tunisia.

We sincerely thank the associations that organised and facilitated local workshops in April 2014 to review the toolkit: APCS in Algeria, AMSED in Morocco, ATL in Tunisia and SIDC in Lebanon. We are also grateful to the stakeholders who participated in these local workshops and provided valuable comments and input: ASCS, Association de Lutte contre le SIDA (ALCS) and OPALS-Fes in Morocco, Helem, Oui Pour la Vie, Lemsic and Lebmash in Lebanon, Arken and Damj in Tunisia, and Green Tea and AIDES-Algérie in Algeria.

Last but not least, we would like to thank Arab Foundation for Freedoms and Equality (AFE) and M-Coalition for their comments during the review process.

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Registered charity number 1038860

First published in 2016

www.aidsalliance.org

All the quotes in this manual have been collected from MSM living in different countries of the region. We believe they are representative of the regional context and reality, hence have chosen mostly to omit the specific countries where they were collected.

The MENA programme's partner associations

- APCS (Association de Protection Contre le Sida) in Algeria
- SIDC (Soins Infirmiers et Développement Communautaire), OPV (Oui Pour la Vie) and Helem in Lebanon
- AMSED (Association Marocaine de Solidarité et de Développement), ASCS (Association Sud Contre le Sida) and OPALS-Fes (Organisation Panafricaine de Lutte Contre le Sida, section de Fes) in Morocco
- ATL (Association Tunisienne de lutte contre les MST/SIDA) in Tunisia

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Abbreviations and acronyms

ART	Antiretroviral therapy
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MENA	Middle East and North Africa
MSM	Men who have sex with men
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization

Presentation of the training manual

Objectives

The training presented in this manual has been developed to help operationalise the UNAIDS MENA regional publication *HIV and outreach programs with men who have sex with men (MSM) in the Middle East and North Africa (MENA): from a process of raising awareness to a process of commitment*.

It provides technical information and practical tools for peer educators to use as part of MSM outreach programmes in the Middle East and North Africa. These programmes aim to reduce the spread of HIV and other sexually transmitted infections (STIs) among MSM within a framework and context where their privacy, confidentiality and rights are respected.

Target group of this training manual

- Trainers from existing peer educator programmes
- Future/potential trainers who will work in outreach programmes with MSM

Contents

Practical instructions

This section includes:

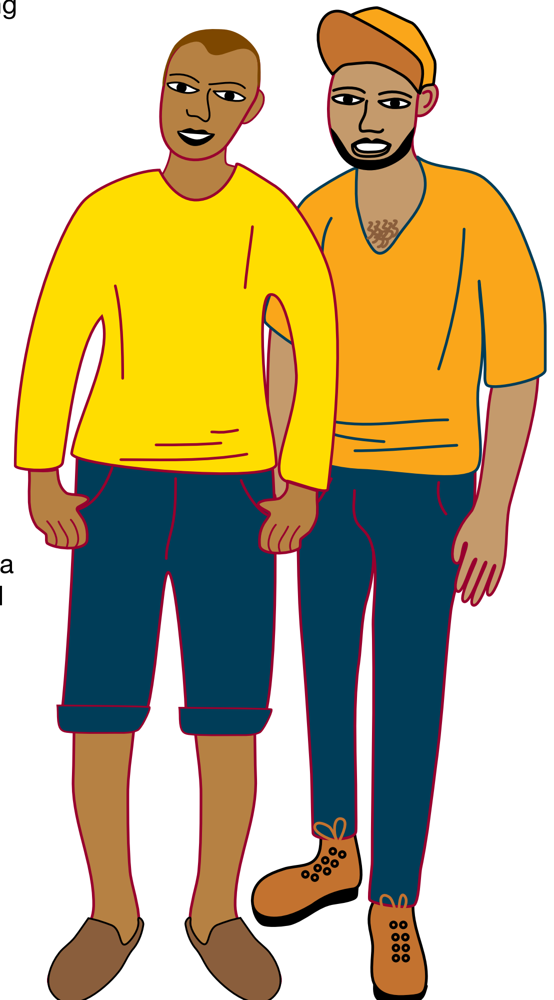
- how to run peer education training sensitively using effective training approaches and tools
- the principles of adult learning
- the different personalities the trainer may encounter, with tips on how to manage them
- how to prepare for sessions and evaluate them.

The training package

This section includes:

- three modules that help to build peer educators' capacity to implement MSM outreach
- Module 1 covers core knowledge, Module 2 covers skills development and Module 3 covers implementation and evaluation
- the modules include practical sessions and exercises with annexes of supporting material.

The three modules of this training manual have been conceived using a 'building blocks' approach, as such the order of the sessions is logical and it is recommended that the order is followed. Some sessions are sequenced and you need to complete one in order to understand the next. However, the suggested order is not rigid and skilled facilitators should naturally adjust the training according to their own experience and the baseline knowledge and skills of participants. It is however, important to keep in mind that certain sections are critical to implementing an effective, evidenced-based outreach programme.



ILLUSTRATIVE TRAINING OUTLINE		
MODULE	DURATION	OBJECTIVES
Module 1: Core knowledge	**22 hours 35 minutes**	Analyse: ■ what is needed in the design of an effective MSM intervention programme ■ the personal characteristics of MSM within their social, health, cultural, religious and legal context ■ the specific needs of MSM, and the root causes and impact of stigma and discrimination ■ the specific technical knowledge needed to be able to conduct effective outreach to raise awareness in the street about the risks of drug use, HIV and other STIs
Module 2: Skills development	**28 hours 35 minutes**	Practise skills necessary to implement outreach-based educational activities aimed at promoting behaviour change among MSM to reduce risk of HIV and other STIs
Module 3: Implementation and evaluation	**31 hours**	Analyse the components needed to design effective outreach programmes, including approaches to advocacy Design the programme and discuss the referral systems associated with it: ■ explore the importance of monitoring and evaluation (M&E) systems; recognise the importance of the follow-up system of the outreach programme ■ learn about measuring indicators and report writing

Methodology

This training toolkit was developed by:

- conducting a detailed review of the toolkit *HIV and outreach programs with MSM in MENA: from a process of raising awareness to a process of commitment*
- reviewing relevant training materials, references and tools related to MSM outreach programmes in the region (*see* the NGO MSM project orientation manual, Annex 2)
- learning from case studies, success stories, documents about programme learning, testimonials, and the practical experience of other programmes working with MSM in the region
- ensuring that scientific and theoretical content is correct
- developing a preliminary draft to help agree training components, plus provide a guide and easy-to-apply exercise for facilitators.

Initial drafts were reviewed during workshops in Lebanon, Tunisia, Algeria and Morocco with peer educators, field supervisors, and programme managers and experts in MSM outreach programmes and HIV prevention.

Success stories were gathered from participants to reflect regional expertise.

Practical instructions

Principles of adult learning[1]

When training adults, it is important to understand the factors that contribute to them learning in the most effective way. When children learn in schools, the situation is often one in which a teacher has the knowledge and imparts that learning to the child. Although the best teachers will help children to reflect and analyse what they are being taught, for much of the time at school children have to absorb and learn predesigned curricula, often linked to examinations.

This approach does not work well with adults. Adults bring into any training their own knowledge and experience. Adult learning tends to be focused on problem solving and collaboration. There is also an expectation of equality between the teacher or facilitator and the learner.

Research over the years has identified a number of principles that support adult learning.[2] They include:

- Adults are internally motivated and self-directed
- Adults bring life experiences and knowledge to learning experiences
- Adults are goal oriented
- Adults are relevancy oriented
- Adults are practical
- Adult learners like to be respected

In 1984, Malcolm Knowles, one of the leading researchers on adult learning, suggested that there are four principles that should be applied to adult learning. These principles are particularly relevant to the peer education learning environment and should be applied when preparing the training sessions:

1. Adults need to be involved in the planning and evaluation of their training.
2. Experience (including mistakes) provides a good basis for the learning activities.
3. Adults are most interested in learning subjects that have immediate relevance to and impact on their job or personal life.
4. Adult learning is generally problem centred rather than content oriented.

How to use the training manual

First read the NGO MSM project orientation manual and then Modules 1, 2 and 3 of this manual.

- Think about what you will need to create a successful training programme – knowledge, skills and logistical arrangements.
- Identify what you want to achieve, and select the training sessions and practical exercises from the toolkit that are relevant to your audience and needs.
- Prepare to deliver the theoretical content by ensuring that you fully understand the content. At the end of each training session there are handouts of the theoretical content to help participants to remember what they have learnt. These can be downloaded to your laptop and printed as handouts.
- Prepare the evaluation forms.

1. *Principles of Adult Learning*. Available at: www.visionrealization.com/Resources/Organizational/Adult_Learning_Theory.pdf

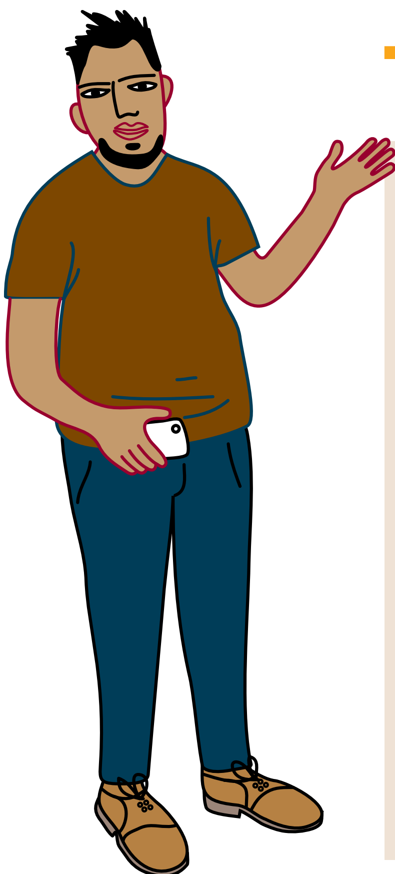
2. *OTPEC-Q: The Clinical Educator's Resource Kit* [online]. Available at: www.qotfc.edu.au/resource/?page=65375

- The references at the end of the orientation manual are a good way to gain more in-depth knowledge of the subject.
- Real-life stories, experiences, testimonials and lessons learnt will make the training more personal to participants.
- Asking experienced MSM peer educators to assist during the sessions can add real value and richness to the training.
- Complete the manual evaluation form.

Creating an active learning environment

A: Establishing a productive training environment

- Choose a venue that is big enough to carry out the exercises; that is quiet, with good lighting and ventilation, and with tables and chairs arranged so everyone can see one another. Provide lunch and coffee breaks.
- Promote an atmosphere of mutual respect. Encourage experience-sharing. Allow adequate time for questions and the sharing of lessons learnt, and apply the principles of adult learning.
- Before the start of every training session, set out rules regarding mutual respect, management of discussions and timekeeping.
- Promote participation by creating committees, for example, for documenting and presenting the learning from each day at the opening of training on the following day.
- Encourage creativity in how the learning is presented.
- Use entertainment to maintain enthusiasm and energy throughout the training (humorous exercises, riddles and games).
- Build self-confidence by using exercises such as *Ahlan wa Sahlan* or *Mouhakat* at the beginning of each day.



Ahlan wa Sahlan is a warm-up exercise for participants to help to assess their mood and enthusiasm for the training day ahead.

Muhakat (Simulation) is an exercise that can be used in the mornings for about 15 to 20 minutes and encourages participants to get to know each other on a deeper and more meaningful level. This exercise gradually builds their confidence and their self-esteem, and allows them to discover their likes and dislikes, their values and what aggravates them. The facilitator can adapt this exercise to the topic of the day.

Examples of *Ahlan wa Sahlan* and *Muhakat* exercises to start the day

Ask participants to:

- express their feelings at the start of the day through a simple expression or word
- nominate one participant to demonstrate a gesture or body stance that will mimic or express what they perceive to be the feelings of another participant just by looking at them. Ask the group to guess what feeling they are trying to express, and ask the person they are imitating if they got it right
- talk about their state of mind using the vocabulary of a “weather man” presenting the weather forecast on TV – a happy mood will be presented as a shining day while a sadder mood will be a day with clouds and rain.

B: Building relationships through ice-breakers at the beginning of the workshop

These exercises give each participant a chance to talk about themselves and their tendencies, likes and dislikes, and experiences. Participants should be encouraged to express themselves freely.

Examples

Throw a ball, and whoever catches it has to introduce themselves and then pass the ball on until everyone has had a turn.

- Make up two groups. The facilitator writes the name of each person from the first group on a separate piece of paper and folds it. They then ask each participant from the second group to choose a piece of paper and introduce themselves to the person named on it.
- Form an inner and outer circle and play some music. Those in the outer circle walk around to the sound of music until it stops. Then they introduce themselves to the person facing them in the inner circle. Repeat the exercise a few times.
- Participants sit in small groups and introduce themselves to each other. Each group is given a name or title and draws their interests on a piece of paper. They then present themselves and their interests to another small group.

C: Personal skills

The facilitator should be someone who is:

- well versed in the topics they want to present and capable of managing a training workshop
- competent in using active learning methods and techniques so as to engage participants and promote learning
- able to communicate in front of a new group of people and to use language tailored to the group
- confident and committed.

They should:

- understand their specific duties
- respect the customs and traditions of the group they are working with
- have no preconceived opinions, or at least be able to acknowledge their own prejudices and opinions and not let them interfere with participants' learning
- be able to analyse, negotiate and give constructive feedback
- accept being assessed and be objective in their reporting of the training experience.

As a facilitator, you should be mentally prepared for your sessions. Before starting, ask yourself:

- Am I ready to undertake this assignment?
- Do I respect the various groups I have to train?
- Do I have all the technical information relevant to the topics of the workshop?
- Am I open to seeking assistance from experts in the field?

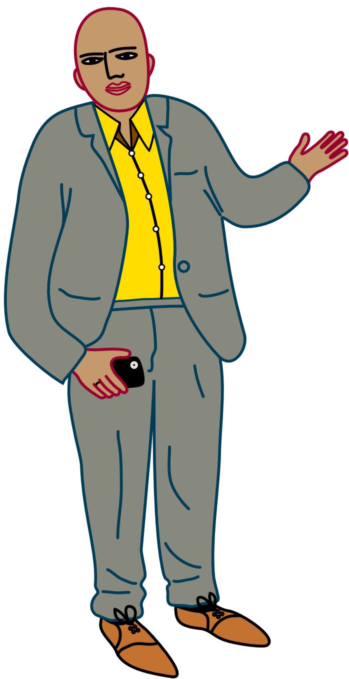
The facilitator should aim to:

- build mutual trust among participants
- create a positive learning environment

- encourage group work
- set the workshop rules
- emphasise the importance of active listening
- encourage participants to list their expectations from the training workshop and compare them to the workshop's objectives.

Preparing for the session

- Prepare the theoretical content associated with the exercises.
- Read the exercises and the theoretical content, and prepare the relevant resources.
- Keep the manual handy for quick reference.
- Refer to the toolkit and other references in preparation for questions.
- Practise the tools and sessions ahead of the session.
- Prepare the materials needed for the exercises.
- Note down observations, questions and participant feedback.
- Have photocopies of the annexes, pictures, cards, etc.



Guest speakers

It can be helpful to invite guest speakers to training courses as they can provide insights and share experience that can be valuable to participants. Ensure that the speaker understands the objectives of the training and the expected outcomes well in advance. It is also useful to share a short biography of the speaker before they start to speak.

Running the session

Although you will encounter all sorts of questions and situations, it is important to allow participants to ask questions and freely express themselves as this will enhance the sessions' productivity. Prepare yourself for times when you may experience:

- a lack of participation in the discussions
- sarcasm and unnecessary jokes from some of the participants when discussing certain topics.

Get familiar with the active learning methods and training materials, and make sure you understand how to use the manual.

D: Active learning approaches based on adult learning principles

As we have already discussed, for participants to be active rather than passive learners the training must be participatory, interactive and based on adult learning principles.

It is important for the trainer using the information in this manual to apply adult learning principles to how they conduct the training.

The active learning methods and techniques used in this manual to facilitate the sessions include:

Brainstorming

Ask a question or present an idea about a subject that could raise strong feelings or that could lead to the expression of a number of viewpoints. This allows you to present the general idea and to determine participants' capacity and analytical skills before going into details. All ideas are accepted and written down: there are no right or wrong answers – although it would be useful at the end of the training to check whether anyone has changed their view as a result of the training.

Role-playing

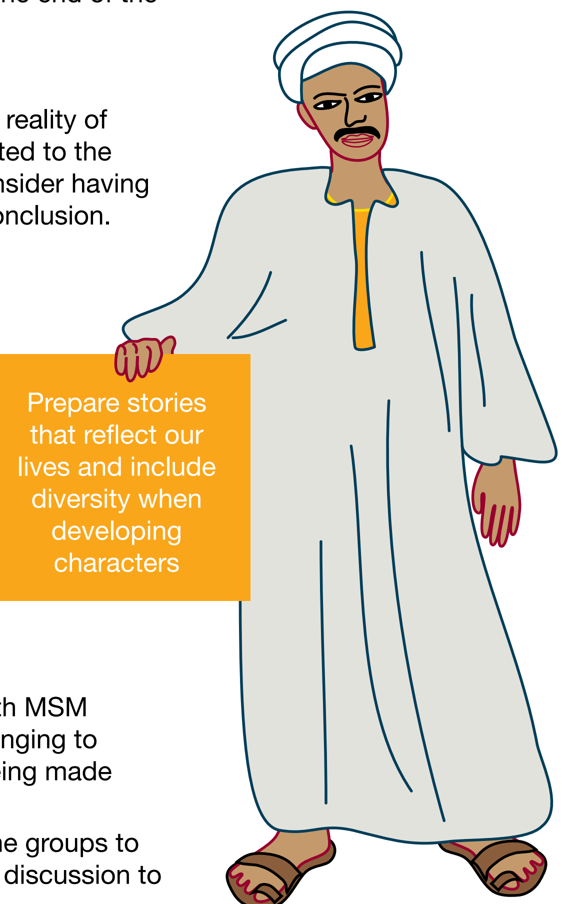
When doing role-plays, encourage the use of real-life scenarios that could be based on participants' own painful and personal situations, although these do not have to be acknowledged openly. By using imaginary characters, participants can present challenging or taboo subjects. Props can help participants to get into character.

Participants should reflect on the challenges faced by the characters in their role-play and come up with solutions. Through this, they are enabled to reflect on their own attitudes, prejudices and areas where they may need to develop their skills further. You could also ask the other participants to discuss what they observe in the role-play and try to predict what might happen before the end of the performance.

Case studies

As facilitator, prepare stories in advance of the training that reflect the reality of working with MSM in their own context. The stories should be presented to the group with questions for participants. When preparing the stories, consider having an introduction, a number of characters, a plot and an open-ended conclusion. Participants should be able to:

- relate to the circumstances of the characters
- suggest what can be done to support them
- name the key issues and challenges raised in the story
- identify the obstacles and think of solutions suitable for the particular culture, needs and capabilities of the characters.



Group work and storytelling

Some exercises require working in groups of four to six. It is often easier to discuss sensitive or challenging issues in small groups. Approaches to working in small groups can include:

- asking a small group to discuss a sensitive issue and then presenting the content of the discussion to the larger group
- introducing a topic in the large group that is relevant to working with MSM through outreach activities, and that may be controversial or challenging to some participants; e.g. an MSM not using condoms or an MSM being made homeless as a result of family rejection
- first discussing an issue briefly in the large group, then asking all the groups to discuss the same issue, and finally feeding back a summary of the discussion to the larger group.

Illustrations and wall journals

Ask participants to illustrate issues or topics, rather than simply relying on discussions. Getting images from newspapers or magazines can be a useful way of stimulating thought. Participants could also draw images or a symbol to represent an issue. Similarly, the facilitator could prepare wall journals with questions or brief exercises that could be analysed in different ways. Participants can walk around individually or in groups and write down their answers.

The "buzz" technique

Ask participants to discuss a question in pairs or to gather as many answers as possible to a particular complex question. They may move around the room to collect the answers or sit opposite one another. Encourage participants to move around, and to express themselves quickly and effectively. The discussion is over once the "buzz" of conversation stops.

The cards brainstorming method

Give the participants cards with questions written on them related to the training and ask them to think how they would answer. You could create a competition among participants to answer as many questions as possible, or give out different cards to each participant.

Discussion and debate

Choose topics with conflicting points of view and ask participants to stand or sit facing each other to discuss them. They should observe certain rules such as listening to each other and not repeating arguments. This encourages everyone to express their thoughts, as well as to think about how others think and feel about an issue. It is an effective way of learning from each other, as well as a way of trying to influence others. Discussions could be around common expressions about MSM, or how society thinks about a particular issue related to the subject of the session.

An alternative approach could be to choose a belief or attitude for participants to debate with each other based on their own experience and observations. Ask participants to back up their arguments for the belief or attitude with either scientific facts, common beliefs or tradition.

If working in small groups, the group may choose one person to represent them in the debate or have each person in the group present a different section of the discussion. This may generate some chaos – and some strong feeling. As facilitator, you must pay attention and ensure that the session is lively and enthusiastic, while at the same time making sure that participants remain respectful of each other.

Short presentation

Prepare a short presentation with pictures/illustrations to summarise the content. People's attention span is usually no more than 20 minutes, so make your presentation 10–15 minutes long.

E: Dealing with different personalities

Understanding the different characters in the group and learning how to deal with them will enable you to run an active training session where all participants can be engaged. The table on the next page presents the types of personalities and sub-personalities that facilitators can encounter during training.

General advice

- Listen and correct misconceptions by providing scientific information to counter myths.
- Encourage everyone, especially those who do not speak much, to participate and to ask questions.
- Rephrase ideas for those who do not easily comprehend in depth and try not to complicate matters.
- Do not be afraid to show conflicting aspects of the topic and allow discussion.
- Avoid evaluating participants' attitudes, values and beliefs, and instead respect their cultural backgrounds and help them understand the content of the sessions.

PERSONALITY	CHARACTERISTICS	HOW TO DEAL WITH THIS MSM
Inquirer (asks a lot of questions)	■ May want to embarrass you ■ Is pleased when his answer matches yours ■ Seeks your approval	■ Let participants answer him ■ Do not take sides
Troublemaker	■ He wants to hurt the feelings of others, or ■ Has valid issues that he complains about	■ Focus on the positive ■ Keep him on track ■ Use questions ■ Get participants to give their opinion when he causes trouble ■ Discuss with him further outside of the session
Non-conformist/ critic	■ Enjoys objecting for the sake of it, possibly because he is dealing with some personal problems or finds it difficult to discuss the issue	■ Try to direct his attention to the main topic and ask his opinion ■ Show respect for his personal experience and explain your position to the group ■ Explain what he does not understand
Opinionated	■ Refuses to listen to you or to the participants ■ Thinks he does not need to learn anything new	■ Encourage the group to debate with him and avoid taking anything personally ■ Explain to him that he has to consider the opinions of the rest of the group, and you can then discuss his point of view
"Know-it-all" expert	■ Wants to impose his opinion ■ May be more knowledgeable or just wants to talk	■ Interrupt his interactions by asking him direct questions ■ Raise the confidence of participants so he is not in control (e.g. Say, *"What you are saying is interesting but let's ask what the others think"*)
Quiet one	■ Indifferent ■ Thinks that he is either above or below what is being discussed	■ Address him personally ■ Remember his name ■ Ask his opinion
Affable/ supporter	■ You do not need to convince him, he is always on your side	■ Great helper in debates ■ Ask for his input ■ Address him frequently ■ Thank him
Talkative	■ Talks about everything except the topic being discussed	■ Interrupt him (e.g. Say, *"Don't you think we have drifted away from the topic?"*) ■ Look at your watch and gesture to hint that he has gone on for too long ■ Suggest he continues the discussion in the break
Shy	■ Has his own point of view but finds it hard to express it	■ Ask him easy questions ■ Support him ■ Raise his self-confidence ■ Give attention to his valuable input
Obstinate	■ Always goes back to the same ideas ■ Talks non-stop ■ Is insensitive	■ Be patient with him ■ Let the group ignore him ■ Promise that you will discuss his issues privately ■ Apologise about the limited time for further discussion

PERSONALITY	CHARACTERISTICS	HOW TO DEAL WITH THIS MSM
Distracted	■ Unfocused ■ Has difficulty following	■ Go back to the topic ■ Make use of the new ideas ■ Try to understand him ■ Treat him gently ■ Tell him your will ask for a summary of what has been discussed at the end of the session ■ Keep sessions short and focused
Arrogant	■ Treats others with a superior attitude	■ Do not criticise him ■ When he is at fault, say, “Yes ... but …” ■ Acknowledge his point of view and encourage him to acknowledge others

F: Tips for the facilitator

Respect participants’ privacy and appreciate what they have to say. Write down their ideas, understand their needs and time all discussions.

It is important, at the beginning of any training, to set up and facilitate an introductory session to present the learning objectives of the training, understand and manage expectations of participants, and set basic ground rules to allow a smooth and respectful interactions.

Sample set of ground rules

- Everyone participates
- Each participant is important in the training and his input is essential
- All ideas are accepted and respected
- Effective listening
- Respect allocated time
- Try not to deviate from the core subject
- Maintain confidentiality about the subjects and ideas being presented
- Turn off cell phones

Sample preliminary session

Exercise: *Ahlan wa Sahlan* or Check-in (10 minutes)

Expectations of participants (first day only) (10 minutes)

Ground rules (first day only) (10 minutes)

Pre-evaluation form (10 minutes) (see template in Module 3, Appendix 5)

Use the training manual to help you to:

- develop an outline of each session
- select the necessary resources
- choose an *Ahlan Wa Sahlan* exercise with which to start the session
- summarise the key learning and discussions from previous sessions

- encourage participation
- be systematic in presenting the topics
- provide documentation
- complete a pre- and post-evaluation form
- write the training report for the person who requires it (e.g. the funder, your manager, participants).

After the session, check that you have presented all the prepared subjects and assess the level of participation.

G: Evaluation

Self-assessment

- Did you perform your role appropriately?
- What did and did not work, and what were the reasons? What could you improve?

The learning environment

The exercises are an essential part of the training and facilitation.

- Did you keep the momentum going throughout the training?
- Did you pace the sessions to the capacity of participants?
- Did you explain the exercises clearly so participants were able to follow the instructions? If not, what would you do next time to correct this?
- Did you provide enough time for participants to discuss?
- Did you listen to their input and needs?

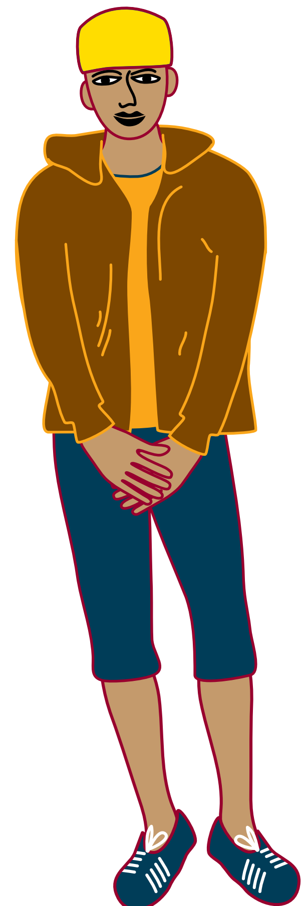
Ask all participants to evaluate the topics, the exercises, the methods and the training atmosphere.

Pre- and post-assessment forms

There are a series of closed questions for each session that you can use to help you to assess any changes in the level of participants' knowledge or attitude changes. For a template, go to Module 3, Appendix 5.

Ask participants to fill out an anonymous questionnaire using the individual code that you should have provided to them at the beginning of the training. This enables each participant, and you, to compare the pre- and post-training results.

If you only wish to measure the group performance as a whole, it is not necessary for them to include their code on the form.



Results

- Ask participants to fill out a form at the beginning and end of the workshop.
- Give each participant a code (e.g. 1/A to 20/N) to use on their form. Ask them to keep it until the end of the session and use the same symbol again on their post-evaluation form.
- Where the form is filled out in small groups, use a group symbol and use the same one again for the post-evaluation form. Results can also be compared in this way.

Daily evaluation form

These are simple questions to find out what participants have learnt and gained, and what most impressed them. For a template go to Module 3, Appendix 1.

Module evaluation

Participants fill out the form at the end of each module with complete objectivity. This can be done at group or individual level. Alternatively, ask questions, or ask participants to raise their hands to indicate whether they agree or disagree with the question. You could also ask them to stand on one side of the room or the other to show whether they are for or against. Evaluation should be expressed freely and without pressure. The main aim is purely educational as well as to improve future training. For a template got to Module 3, Appendix 2.

Report writing for each module and lessons learnt

At the end of each module, review some of the exercises and modify them as necessary, noting any changes in the module report. This helps you, as facilitator, to monitor and analyse your own competence, and can provide direction for any area that needs improvement.

MODULE 1
CORE KNOWLEDGE

Overall timing

21 hours 35 minutes

Objectives

This module covers the core knowledge necessary for people undertaking outreach with MSM:

- Issues related to biology, sex and identity (and common misconceptions)
- Characteristics of MSM, including sexual practices
- Policies and other factors affecting MSM
- The impact of stigma and discrimination
- Basic knowledge about STIs, HIV and prevention
- New recommendations on early initiation of ART, PrEP and "treatment as prevention"
- Issues related to sex work and drug use
- Characteristics and attitudinal issues related to peer educators

SESSIONS IN MODULE 1	
TITLE OF THE SESSION	DURATION
Session 1: Sexual practices among MSM – facts versus cultures	2 hours 40 minutes
Session 2: MSM in their social, health, cultural, religious and legal context	1 hour 40 minutes
Session 3: Challenges facing the MSM population	1 hour 30 minutes
Session 4: Stigma, discrimination and vulnerability	2 hours
Session 5: Overcoming the challenges to accessing this population	1 hour
Session 6: The male and female reproductive systems	2 hours
Session 7: HIV and other STIs	3 hours
Session 8: Sexual practices and preventing HIV and other STIs	1 hour
Session 9: Using antiretroviral drugs to prevent HIV	1 hour
Session 10: False beliefs about STIs	1 hour
Session 11: Drugs and prevention	1 hour 30 minutes
Session 12: Sex work	1 hour
Session 13: Health education and harm reduction in the field	1 hour 30 minutes
Session 14: The peer educator	1 hour
Session 15: Attitudes and beliefs	45 minutes

Session 1

Sexual practices among MSM – facts versus cultures

Time

2 hours 40 minutes

Objectives

At the end of this session, participants will be able to:

- identify characteristics of MSM and the challenges they face
- use scientific terminology related to homosexuality, and correct any misconceptions
- determine the characteristics of sexual partners, clients and peers.

You will need

- Flipchart, paper, markers
- List of myths and misconceptions
- A copy of the Kinsey scale
- Copies of the Klein Sexual Orientation Grid
- Handouts (one per participant) of:

  Annex 1: Understanding MSM

  Annex 2: The Kinsey scale

  Annex 3: The Klein Sexual Orientation Grid

  Annex 4: Correcting common misconceptions

Overview

This session allows participants to discuss sexual relationships among MSM, express their concerns, and talk about what they already know about the subject.

Participants may need some clarification about common misconceptions related to MSM. Your role is to give them the opportunity to ask questions, so preparation is crucial. If you lack confidence, you may wish to invite an expert to facilitate this first session.

Don't hesitate to go into detail. Allow participants to talk about what they know and what they think they know about MSM, including sub-groups.

Remember, this is just the beginning of the training workshop, and there will be many more opportunities to dispel myths and misconceptions related to sexual orientation, and chances for you to correct any negative attitudes.

Activity: Understanding the MSM population – creating a life-like story

Step 1: Preparing the stories (30 minutes)

1. Ask participants to think about a man who has sexual relationships with other men.
2. Draw an image of the man in middle of a large sheet of paper and give him an identity: name, age, sexual orientation, social status, friends, family, type of work, culture, country, region, etc. Describe his life, needs and sexual partners. Note any risky behaviours he may have, such as drug use or sex work. Also discuss the relationships between him, his family, peers and partners.

   All this information will enable other participants to identify the challenges he faces and those barriers that may be encountered in reaching him.

   Participants could use symbols and colours to indicate the quality and strength of relationships he has with each person and the level of risk he may have from his lifestyle.

Step 2: Sharing MSM profiles (30 minutes)

3. Ask each participant to share the profile of their imaginary MSM and encourage questions. During the discussions, the facilitator may identify discriminatory attitudes. If other participants do not challenge them during the discussions, they need to be noted down and addressed later in the training.

Step 3: Explaining terms associated with MSM (30 minutes)

4. Ask participants a question related to terms associated with MSM, such as:
   - *What does [term] mean to you?*
5. Affirm correct answers and correct misunderstandings by sharing the correct answer.

   Terms to be discussed can include those related to biological identity, homosexuality, gender identity, sexual orientation, gender/social roles, transgender people and transsexuals (Annex 1).

Step 4: Kinsey scale (20 minutes)

6. Introduce participants to the Kinsey scale, explaining that it was developed to help to describe actual human experience and behaviours rather than a simplistic understanding of human sexuality as either heterosexual or homosexual. Share the scale with participants and encourage them to discuss their reaction to the scale (Annex 2).

Step 5: Klein Sexual Orientation Grid (20 minutes)

7. The Klein Sexual Orientation Grid is a different approach to helping to describe human sexual experience. Using the account of it in Annex 3, explain to the group why it was developed and distribute copies of it. If there is sufficient time, encourage participants to fill in the form and/or ask them to complete it later.
8. You could ask them later to share their feelings about the scale. It is important to explain to participants that they have the right to keep personal information confidential and should only share information if they feel comfortable to do so.

Step 6: Misconceptions (30 minutes)

9. Discuss the beliefs provided in Annex 4. Present each common misconception to the group and investigate what the group thinks about it. Correct the misconceptions using the information in Annex 4.
10. Talk about how sexual minorities are particularly affected by these misconceptions.

    This introduces participants to MSM identity without going into too much detail, thereby setting the scene for the next exercise.

Hassan is a 22-year-old MSM

Hassan is a MSM who likes drag. When he was young he liked he liked to dress in girls' clothing. His school friends used to tease him that he looked more beautiful than a woman. After trying to change him, his parents gave up and chased him out of the house. He moved to the city where he met a taxi driver called Anis, a 28-year-old MSM. They fell in love, developed a strong sexual relationship and moved in together.

Aymen is a 40-year-old married man

People sometimes gossip that Aymen has “effeminate gestures”, but everyone sees him as a happily married man. In reality, he loves to have sex with men in secret, and often meets with male sex workers. He regularly buys services from a sex worker named Salim. Salim only has sex with men for money. He is sexually attracted to women, and in the future hopes to get married to his girlfriend.

Annex 1: Understanding MSM

Why use the term "men who have sex with men"?

"Men who have sex with men" (MSM) is a concept developed in public health to describe sexual behaviour between men. It is a label used to describe behaviour and not identity. While some men who have sex with men will define themselves as homosexual/gay or bisexual, many will not because it does not reflect their perception of their own identity. For instance, sex between men can take place in single-sex only environments such as prisons and the military, and those men who have sex with other men in that context will do so because their preferred sexual partner, a woman, is unavailable. Likewise, some married men may have sex with other men while still enjoying active and satisfying sexual relations with their wives. Other married men may prefer to have sex with men but for family and societal reasons will live in a traditional heterosexual marriage.

What is sex?

It is important also to understand what kind of sexual behaviour is covered by the term "sex". Some people think that only penetration (anal or vaginal) constitutes sex, whereas others define sex as a catch-all term for any activity that results in sexual pleasure and orgasm; for example, mutual masturbation, oral sex and sensual massage. Not all men who have sex with other men have or enjoy penetrative sex.

Among those who do have anal sex, some are only active (the person who penetrates), some are only passive (the person who is receptive) and some men are versatile (sometimes they are receptive and sometimes they are the active partner).

When it comes to developing HIV prevention guidance and support, it is important for programmers to know how local MSM define sex and what are common sexual practices.

This distinction between behaviour and identity is particularly important in the MENA region, where sexual identity is differently understood from many European and Western-based countries. For instance, scholars* have argued that there is no concept of homosexuality within Arab history despite many descriptions of sexual expression between men, and between older and younger men/boys, in poetry and literature. While there are a number of countries within the region that have a recognised homosexual (gay) community, in other countries sexual behaviour between men will be much more hidden and secret.

The reality is that despite protestation and denial by some, historical and contemporary evidence shows that sex between men has existed throughout history and in all civilisations. Within the MENA region, it is referred to in Arab stories, novels, poems and songs, and it exists among all age groups, social classes, educational backgrounds, marital statuses, races, colours, nationalities and ethnicities.

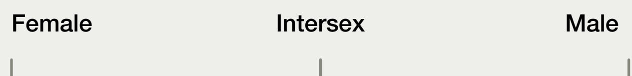
Biological sex, gender identity and sexual orientation

To deepen our understanding of human sexual behaviour and its association with HIV risk, it is important to understand how biology, gender and identity interact as they refer to MSM. Definitions are not always straightforward, and yet understanding them is vital to inform a basis for and development of meaningful HIV prevention and care services.

Our **biological sex** refers to our physical biology at birth defined by our genitalia. Predominantly, the human race is born either female or male, with a small percentage (between 0.1% and 1.6%) who have ambiguous genitalia or both. These people are normally described as "intersex".

The spectrum of human biology and anatomy

Female | Intersex | Male



Intersex

Historically, people who are intersex were known as hermaphrodite. Most were assigned a gender identity (male/female) by doctors and/or family, and sometimes underwent surgery to make their genitalia match their assigned gender identity. Empirical evidence has shown that children born intersex often suffered greatly from being assigned an identity that did not necessarily match how they felt about themselves. Over recent years, many people who are intersex have come to define themselves as a third sex and do not want to be assigned a male or female identity. They do not feel that they need to be changed in any way from how they were born.

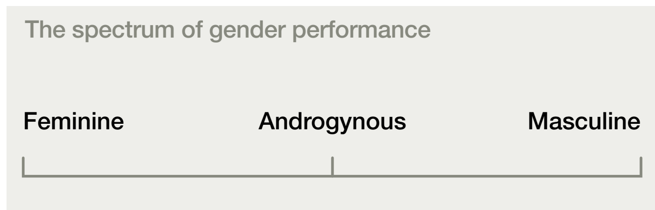
* El-Rouayheb K (2009), *Before homosexuality in the Arab–Islamic world, 1500–1800*, University of Chicago Press.

Annex 1: Understanding MSM

There are also a number of people who from the earliest age feel that their genitalia do not reflect how they experience their gender; i.e. someone with female genitalia may feel that they are a man and vice versa. People who feel this way are known as transsexual.

Our **gender presentation** refers to the way that we outwardly express ourselves in how we dress, behave and identify. Normally this is heavily informed and framed by cultural and social norms. Feminine identity is associated with being a woman and masculine identity is associated with being a man. In reality, this is not so defined and there are woman who may display characteristics that would be commonly described as masculine and vice versa.

The spectrum of gender performance



If a man expresses traits traditionally associated with femininity, this does not necessarily mean that he is homosexual, and a woman who expresses traits traditionally associated with masculinity is not necessarily a lesbian. In fact, gender norms are changing and evolving, and this is demonstrated by what is acceptable now for men and women regarding clothes, hairstyles, professions and so on compared to what was acceptable in the past.

The term **transgender** describes someone who dresses, acts as and wishes to be (or is) recognised as a member of the opposite sex to their biological sex at birth. It includes those people who identify as transsexual and transvestite.

A **transsexual** is someone who feels they are in the wrong biological body and wants to change it – or has changed it through hormone treatment and sometimes surgery. This is known as gender reassignment. Once a person has gone through gender reassignment, they often identify as the other sex from the one they were born as. However, changing their body does not mean that they necessarily change their sexual orientation. Therefore, someone who was a biological man who loves women prior to reassignment will continue to love women post reassignment, and vice versa.

A **transvestite** is someone who dresses and makes themselves appear outwardly as the opposite gender. It does not mean that a man who dresses as a woman wants to have sex with men, or vice versa. There can be many reasons why people dress as the opposite sex, including for enjoyment, relaxation, sexual pleasure, sex work, entertainment work (dancer, singer) or sometimes for ritual purposes.

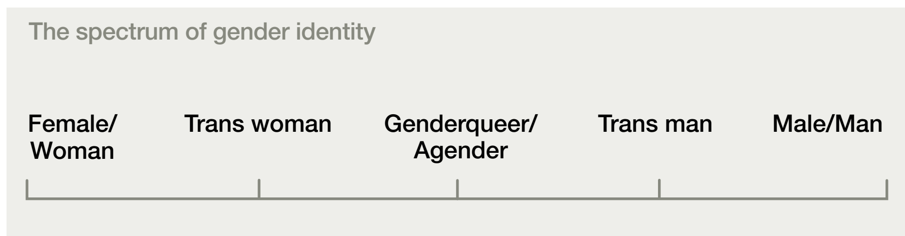
Sexual orientation refers to sexual attraction; i.e. who arouses our sexual feelings and who we want to express our sexual feelings with through sexual and other forms of intimacy.

The spectrum of sexual orientation

- Someone who is **heterosexual** seeks sexual intimacy with someone of the opposite sex.
- Someone who is **homosexual** seeks intimacy with someone of the same sex.
- Someone who is **bisexual** seeks intimacy with both men and women.

Over a lifetime, people may not feel they are so clearly defined by these labels. Who they primarily have sex with when they are young may be different from who they have sex with as they get older.

The spectrum of gender identity



Annex 2: The Kinsey scale

In 1948 the American scientist Alfred Kinsey developed a scale system to help to classify the spectrum of human sexual orientation. He devised this because his research had suggested that sexual orientation is more subtle than is indicated by the heterosexual–bisexual–homosexual continuum. For instance, men may be predominantly heterosexual but have occasional sexual contact with other men and not define themselves as bisexual. He developed a six-point scale that people can use to position themselves along the spectrum from heterosexual to homosexual. The rating is what the person themselves thinks best reflects their experience.

THE KINSEY SCALE	
RATING	DESCRIPTION
0	Exclusively heterosexual
1	Predominantly heterosexual, only incidentally homosexual
2	Predominantly heterosexual, but more than incidentally homosexual
3	Equally heterosexual and homosexual
4	Predominantly homosexual, but more than incidentally heterosexual
5	Predominantly homosexual, only incidentally heterosexual
6	Exclusively homosexual
X	No socio-sexual contacts or reactions

Annex 3: The Klein Sexual Orientation Grid

Researchers, while fully acknowledging Kinsey's pioneering research, have observed that his scale does not take into consideration issues such as how orientation can change throughout a person's lifetime and also how a person expresses their sexual orientation emotionally and socially rather than just sexually. In 1978, Fritz Klein developed a more refined tool called the Klein Sexual Orientation Grid (KSOG) that takes into consideration other factors that may relate to sexual orientation, such as a person's fantasy life, emotional attraction and their own self-identification.

The KSOG uses a seven-point scale to assess seven different dimensions of sexuality at three different points in an individual's life: past (from early adolescence up to one year ago), present (within the last 12 months), and ideal (what you would choose if it were completely your choice). To complete the grid, the person uses the scoring guidance that is given after the grid.

THE KLEIN SEXUAL ORIENTATION GRID				
VARIABLE		PAST (UP TO LAST YEAR)	PRESENT (LAST 12 MONTHS)	IDEAL (IF YOU HAD A CHOICE)
A	Sexual attraction. To whom are you sexually attracted?			
B	Sexual behaviour. With whom have you had sex?			
C	Sexual fantasies. About whom are your sexual fantasies?			
D	Emotional preference. Who do you feel more drawn to or close to emotionally?			
E	Social preference. Which gender do you socialise with?			
F	Lifestyle preference. In which community do you like to spend your time? In which do you feel most comfortable?			
G	Self-identification. How do you label or identify yourself?			

Scale to measure variables. Starting with the past, individuals choose a number that most corresponds to their situation based on the guidance scale below. The process is then repeated for the "present" and "ideal" boxes, bearing in mind that there are no right or wrong numbers.

Scale to measure variables A, B, C, D and E of the KSOG

1	2	3	4	5	6	7
other sex only	other sex mostly	other sex somewhat more	both sexes equally	same sex somewhat more	same sex mostly	same sex only

Scale to measure variables F and G of the KSOG

1	2	3	4	5	6	7
heterosexual only	heterosexual mostly	heterosexual somewhat more	heterosexual/ homosexual equally	homosexual somewhat more	homosexual mostly	homosexual only

Annex 4: Correcting common misconceptions

Use Annex 3 to back up the clarifications in this section. It also would be helpful for facilitators to become familiar with the content of the NGO MSM project orientation manual, as the information there will help you to address some of the common misconceptions about MSM.

MISCONCEPTIONS	CLARIFICATIONS
Is homosexuality a disease or deviant behaviour?	Homosexuality is simply one sexual orientation; heterosexuality (men and women) is another. It is not a disease, nor is it abnormal or deviant behaviour. It exists in all societies.
The behaviour of MSM is against our traditions, customs and local culture. How can we accept them?	It is true that sexual activities among people of the same sex are considered to be deviant in some societies, and many MSM face harassment and discrimination in communities where it is thought to be against local customs and cultures. However, customs and culture change with new learning and knowledge. As people begin to accept that homosexuality is not a disease or a choice, attitudes will slowly change. Likewise, both national and international laws across the world protect the rights of MSM and consider discrimination towards MSM to be a crime. This is not true in all countries, but there is a shift across the world towards a growing international consensus regarding the acceptance of MSM.
What are the reasons that make someone engage in a sexual relationship with another person of the same sex?	There are no reasons – just as there are no reasons for someone wanting to have a sexual relationship with someone of the opposite sex or for having different sexual fantasies. Please see the section *What influences or helps to explain sexual orientation* in Chapter 2 of the NGO MSM project orientation manual.
Is homosexuality just a phase that goes away?	For most people, sexual orientation is not something that changes, even if the way they express their sexuality changes over a lifetime. For instance, a person may be bisexual but only have sex with a person of the opposite sex, or a man who is homosexual may live in a heterosexual marriage because of local customs. For some people, accepting their sexual orientation may be so difficult that they will suppress it until they feel they are ready to express it, and this can sometimes be in later life.
Is there a cure for homosexuality?	Homosexuality not a disease, so there is no “cure”.
It is wrong for a person to be homosexual or bisexual?	We cannot classify the person as “wrong” and “right” in the same way as we cannot say that it is wrong for someone to be heterosexual.

Session 2

Time

1 hour 40 minutes

Objectives

At the end of this session, participants will be able to:

- describe the social (family, community, peers), health, cultural, religious and legal contexts of MSM
- discuss common myths, misconceptions, prejudices and negative attitudes about MSM
- discuss the impact of these on MSM and their families
- identify existing laws and policies regarding MSM and which of them are actually applied in everyday life.

You will need

- Flipchart, large sheets of paper, Post-it notes and masking tape
- List of questions and attitudes relating to the steps in the exercise
- Handouts (one per participant) of:

  Annex 5: Taking a holistic and multi-sectoral approach to working with MSM

  Annex 6: Perceptions about homosexuality

MSM in their social, health, cultural, religious and legal context

Overview

This session explores the reality of the lives of MSM.

Encourage everyone to participate and share real-life experiences. Be mindful that this may include negative attitudes they have experienced from family and close friends, or experiences of threats, rejections, abuse, prosecution and even prison.

Each of the four steps of this session tackles a different topic. It may be useful to reiterate some of the challenges brought up in Session 1.

Activity: Correcting misconceptions about MSM environments

Step 1: Designing a holistic and multi-sectoral approach (15 minutes)

1. Use Annex 5 to explain the link between the individual and their environment. Ask your group to give examples of the relationship between MSM and their immediate environment (e.g. family, community), as well as their wider context (e.g. the media, law, religious values and leadership).

Step 2: Group work (25 minutes)

2. Brainstorm the idea that any intervention with MSM should start with a better understanding of the environment that has the most significant impact on their lives and how that connects to HIV prevention.
3. Ask them to divide into working groups and identify the challenges that affect this target group. Ask each group to discuss the range of attitudes of a particular group of people or institutions towards MSM:
   - **Group 1:** Parents (towards a son having sexual relationships with men)
   - **Group 2:** Society in general (work, educational institutions, health and social services)
   - **Group 3:** Religious leaders
   - **Group 4:** Media
   - **Group 5:** Legal systems and government
4. Ask each group to present their work back to the main group for discussion, raising questions such as:
   - *What are the misconceptions that your group or institution often displays about this population?*
   - *What are their attitudes towards this group?*
   - *Give examples of common attitudes and prejudices towards them? What might be the reasons behind these beliefs and attitudes?*

5. Discuss the difference between existing policies (if applicable) and unjust and unfair community practices not based on law. Ask for real-life examples.
6. Sum up by reiterating how myths, misconceptions and prejudices reinforce negative attitudes towards MSM.

Step 3: Ideas on Post-it notes (30 minutes)

7. Ask the group to write on Post-it notes common negative attitudes expressed by different sections of society that peer educators will have to confront while undertaking their work. Then stick them on to the following sheets:
   - **Sheet 1:** from parents
   - **Sheet 2:** from the local environment (law, media, religious leaders, community)
   - **Sheet 3:** from a sexual partner of an MSM
   - **Sheet 4:** addressed to the parents of the MSM group
   - **Sheet 5:** from the legal system or as a result of misinterpretation of policies
8. Then stick the sheets on to the wall panels.
9. Ask participants to walk around the room to read all the comments on the different sheets, or ask each participant to read out their comment as they stick their Post-it note to the sheets of paper.

Step 4: Discussion and comments (30 minutes)

10. Conclude the session by reinforcing the learning about the negative impact of policies based on myths and misconceptions. Explain how important it is for peer educators and programme planners to understand the contextual factors affecting MSM, and to address their impact in outreach programmes.

    It would also be useful for participants to reflect on the differences between how policies, laws and doctrines are defined and the actual day-to-day realities of how those policies, laws and doctrines are implemented or observed.

Bassem is a 32-year-old student and peer educator with ATL in Tunisia

"I now feel that with the group that I joined we are stronger. There is this feeling of belonging that I have and which is very important, now that we are a strong and solid group and we can stand up for our rights."

Bilel Mahjoubi from ATL

"The greatest success of this programme according to me is the fact that MSM who were mobilised on the ground have become peer educators, trainers, activists, have founded NGOs working for MSM rights and, above all, skilled programme managers."

Jamil is a peer educator with SIDC in Lebanon

"This prevention and mobilisation work with the community and key actors in the HIV response has led to deep changes. Now if, for example, an effeminate gay man presents himself to any service, he won't be turned down. There is still a lot of work to do. However I believe that we have made great strides.

This work boosts my self-confidence; I became more confident to address sensitive topics. I learned from this experience to deal with information related to HIV and to communicate them to others. I was afraid that people would discover my positive status and I was reluctant to participate in the outreach work, but this work transforms me positively."

Annex 5: Taking a holistic and multi-sectoral approach to working with MSM

Like all human beings, MSM live in a context that includes the stage they are at in their own life and beliefs, as well as the beliefs of their family and loved ones, social and religious beliefs, cultural norms, national laws, public attitudes and the media. Sometimes, HIV prevention programmes only focus on the risks associated with sexual behaviour, and do not situate that behaviour holistically in the context of the person's whole life to understand all the factors that influence it. At the individual level, it is important that people working on MSM outreach programmes approach MSM holistically as human beings, not just people who may be at risk of being infected with HIV.

Likewise, addressing the complex needs of MSM in any society demands a multi-sectoral response, as the health and wellbeing of MSM is dependent on many different factors and not just health. These include issues related to education; social norms; religious values, norms and the public attitudes of religious leaders; the behaviour of the police and the position of MSM within the national legal system; as well as the portrayal of MSM in the media.

Programme planners and policymakers involved in intervention programmes for the MSM population must take into account all the needs of the target group. We cannot expect someone to look after his health, to protect himself and to maintain a risk-free quality of life unless his basic needs are being met: from food, shelter and clothing through to safety, love and a sense of belonging.

Such basic needs may be at risk when MSM are threatened and expelled from their homes because of their behaviour, or experience discrimination because of their sexual orientation and gender identity.

Any interventions should therefore:

- take into account the group's lifestyle and gender-related issues
- consider the impact on the lives of this target group
- be effective and adopt both a holistic and multi-sectoral approach to prevention, care and treatment
- focus on the context and underlying influencing risky behaviours in order to promote behavioural change and reduce potential harm
- strengthen and diversify services and preventive actions, and facilitate their access.

Interventions should also aim to impact on both the immediate and wider context of MSM. For instance:

- Families may struggle to accept the reality that their son is "different" (and may push their children to change their sexual orientation or behaviour with varying degrees of coercion). Interventions may well be hindered unless the family is included and involved.
- Existing customs, traditions and culture can prevent MSM from accessing services and reinforce their negative attitudes about themselves.
- Poverty, war, conflict, violence and migration all increase MSM vulnerability and trauma, limiting access to education, employment and services for sexual and reproductive health.
- Media reflects the local environment, and may spread misconceptions or help to discredit them. It is therefore important to involve the media in these programmes to help to sway public perception of the MSM group and the risks they encounter.

A holistic multi-sectoral approach considers all of the factors that influence and have an impact on an individual, such as parents, peers and the community in general. By employing advocacy, empowerment, partnerships and supportive policies and regulations, this approach can target relevant ministries, religious leaders, legal authorities, the media and all stakeholders to create an environment that is more open and receptive to MSM.

Annex 6: Perceptions about homosexuality

Culture is a set of habits, traditions, values, beliefs and rituals adopted by a group of people over a period of time. People sharing the same culture tend to perceive things and behave in similar ways. Generally, individuals who conform to a society's cultural values are judged positively, while those who do not share the same values are judged negatively. We tend to marginalise those who do not "fit in".

However, since cultures across the world are all very different and all cultures tend to evolve over time, how is it sensible to consider one culture to be better than another? Talking about MSM – whether about homosexuality or issues related to sex – is still offensive and distasteful for many people in MENA communities. These attitudes are further reinforced by false beliefs about "unacceptable" sexual behaviour and preconceptions about MSM: e.g. that all homosexuals are also paedophiles, or are predatory or spread disease. Despite the overwhelming evidence that this is not true, these kinds of prejudices can prevent individuals from discussing their own situation openly, except in places where they feel comfortable and safe. It also contributes to some MSM having strong feelings of guilt and shame that can affect their mental health and wellbeing.

FALSE BELIEFS AND MISCONCEPTIONS ABOUT GAYS AND LESBIANS
There are no gays or lesbians in the Arab world/the Middle East/North Africa
Homosexuality is purely a sexual behaviour
Sexual orientation is a choice
Sex between men is a sexual deviation
Sex between men is an infection that can be stopped
Homosexuals act as they do because they do not have any morals
Sexual orientation can be changed and therefore homosexuals can be changed too
Homosexuals are effeminate and lesbians have masculine traits
Homosexuals are paedophiles who lure children
Homosexuality is a mental illness caused by a mental disorder
Gay men rape children
A man becomes homosexual when he starts hating women
A girl becomes a lesbian when she starts hating men
Homosexuals are cursed by God and that is why they got HIV/AIDS
Homosexuals have strong urges for sex
Homosexuals cannot commit to long-term relationships
Homosexuals do not have values and ethics
Homosexuals are heretics
Homosexuality is the reason behind the spread of HIV/AIDS
Homosexuals are all alike and share the same hobbies and interests

Session 3

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- determine the impact of negative behaviours and the problems they create in the lives of those affected, their partners and their families
- classify the challenges faced by this population according to their seriousness, frequency and ways to deal with them.

You will need

- Large sheets of paper, coloured markers, coloured cards, masking tape
- A drawing of the Problem Tree
- Handouts (one per participant) of:

  Annex 7: The Problem Tree

Challenges facing the MSM population

Overview

This exercise is pivotal to the training workshop and you can use it to develop related activities. It may take more time than planned: use your own judgment based on the flow and the quality of the discussions.

Make sure that the discussion is objective and remains on track. Keep the Problem Tree illustration hanging up on the wall throughout the workshop. If you are conducting this session together with the programme planners, it is important to base the programme strategies on this exercise.

Activity: The different problems and their impact on the lives of MSM

Step 1: Preparing the Problem Tree (30 minutes)

1. Draw a tree (Annex 7) and ask participants to put on the trunk the kind of problems (forms) faced by MSM.
2. Ask participants to think about the underlying causes of these problems based on earlier exercises (e.g. legal, religious, society and media). Place these causes at the level of the roots. Then on the branches they should place the effects of these challenges, drawing on previous discussions about the environment, law, community, media and religious leaders. At the end of the exercise, display the drawing with the result of their analysis.

Step 2: Identify challenges (30 minutes)

3. Split the group into three and ask them to list 10 challenges faced by the MSM population. Ask the first group to prioritise these in order of seriousness, the second in order of frequency and the third in order of both seriousness and frequency. Give them examples to start with.

Step 3: Presentation and discussion (30 minutes)

4. Ask participants to share their findings and discuss:
   - *What are the types of challenges that you listed?*
   - *What sexual health problems occur among MSM and not among other groups? Why?*
   - *What are the reasons that make some sexual health problems risky (dangerous) among MSM and not others?*
   - *Are these problems the same for all MSM? Do they differ and why?*
   - *Is the degree of severity the same among MSM? Do they differ and why?*
   - *Is it important for this group of men to recognise these sexual health problems that may affect them? Why?*

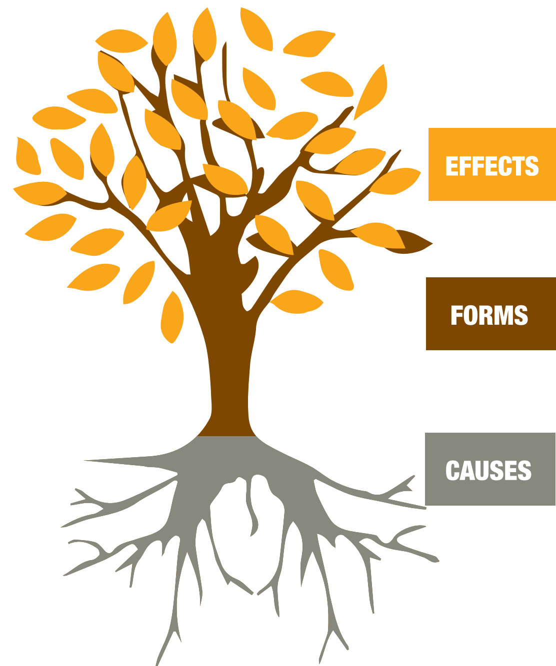
Annex 7: The Problem Tree

The Problem Tree: examples of the forms, causes and effects of stigma from the MENA stigma training workshop

Causes: judgments; blaming; lack of confidence in own sexuality; conservative religious beliefs; fear of infection; ignorance; poverty; belief in myths; moral judgments.

Forms: being chased from home; not welcomed at the clinic; rejected by family; finger-pointing; name-calling; being attacked; violence; losing your job; mistreated by police; blackmail; loss of inheritance; devalued.

Effects: isolation; loss of dignity; viewed as an object; suicide; depression; loneliness; going into hiding; increased HIV infections; increased risk-taking; breakdown of family relations; low self-esteem; loss of family honour.



ABOUT VULNERABILITY AND NEEDS: SUMMARY OF FINDINGS OF A PARTICIPATORY COMMUNITY ASSESSMENT WORKSHOP IN RABAT		
MSM MAIN SEXUAL HEALTH PROBLEM	INCREASING RATE OF NEW STI AND HIV INFECTIONS AMONG MSM IN RABAT	
Immediate causes	■ No use of condom and lubricants among MSM	■ Lack of health service provision (condoms, lubricants, testing, consultation) adapted to MSM needs
Individual factors	■ Lack of knowledge about STIs ■ Lack of knowledge about HIV/AIDS ■ Belief in recovery from AIDS ■ Rape ■ Ignorance ■ Not using of condom with intimate partners ■ Limited education	■ Self-medication ■ Fear related to disclosure of HIV status ■ Perception of homosexuality as a mental illness ■ Discrimination against HIV-positive MSM by peers ■ Discrimination against HIV-positive MSM by other MSM
Vulnerabilities related to services	■ Location of health services in poor neighbourhoods ■ Remoteness of institutions/centres offering sexual health services for MSM ■ Lack of informal sources of sexual health services ■ Condom and lubricant shortages ■ Lack of quality health services for MSM	■ Lack of provision of condoms and lubricant ■ Afraid to identify himself as having an STI or HIV ■ Stigma and discrimination by healthcare workers ■ Fear of heterosexual doctors ■ Lack of psychological support
Vulnerabilities related to social context	■ Sexual exploitation ■ Body exploitation	■ Stigma ■ Hatred ■ Resentment of the family towards MSM ■ Resentment of heterosexuals toward MSM ■ Failure to respect the right to benefit from public health services

Session 4

Time

2 hours

Objectives

At the end of this session, participants will be able to:

- analyse the impact of stigma and discrimination on the lives and rights of MSM and on the health of society in general
- understand homophobia and other stigmatising terms
- analyse the link between vulnerability and risk-taking, and the nature of the target group in the intervention programme
- identify terminology associated with stigma and discrimination.

You will need

- Paper, markers, masking tape
- Camera
- Handouts (one per participant) of:

  Annex 8: Stigma and discrimination

  Annex 9: Increased risks and vulnerability

Stigma, discrimination and vulnerability

Overview

This exercise is very sensitive as it asks participants to share personal experiences. An experienced and skilled trainer/counsellor is recommended to facilitate this exercise. Encourage them to talk about situations resulting from stigma and discrimination, but set ground rules regarding respect and privacy.

Activity: My knowledge helps me to "move" and to "face"

Step 1: Group work (1 hour)

1. Organise four groups, each to discuss one of the following categories of MSM:
   - gay
   - bisexual
   - transgender
   - sex worker who uses drugs.

   These are suggested groups, however there are other possible categories and risk factors within the diverse MSM community. The facilitator may choose other groups to highlight risks and vulnerabilities depending on the specific context of the workshop.
2. Ask them to imagine a day in the life of their subject. Ask them to prepare a scenario with real-life scenes or cartoon-like storyboards. Imagine the places their subject frequents and what they do in those places. Discuss what behaviours and words others may use to describe them. Think about how these might affect them and how they might react to the different situations they encounter.

Step 2: Presentation of group work (30 minutes)

3. Ask each of the groups to present their stories in turn to the large group.

Step 3: Discussion and summary (30 minutes)

4. End with a discussion about how stigma and discrimination can lead to risky behaviour. Explain the difference between risky behaviour and vulnerability. Risky behaviours are actions that the person does that increase their risk of HIV transmission or being infected with an STI, whereas vulnerability is a set of factors – personal and non-personal – outside of the control of the person, limiting their capacity to protect themselves.
5. Discuss the impact of stigma and discrimination, and ask the group to define homophobia. Explain how individuals who have not yet come to terms with their sexuality ("come out of the closet") may display homophobic attitudes towards themselves (self-stigma) and others. Ask participants to share examples of people who have harmed themselves, including possibly committed suicide or attempted to commit suicide, people who have taken their lives as a result of labelling and homophobia.

Annex 8: Stigma and discrimination

Stigma

Stigma is a set of negative beliefs that a society or group holds about an individual or group of people.

Types of stigma

- Society's stigmatisation of MSM
- Self-stigmatisation by MSM themselves
- Using derogatory terms when referring to homosexuals, such as deviant, abnormal, diseased, spreads diseases, faithless, not a real man

Discrimination

Discrimination is unjust and destructive behaviour adopted by a person, community, institution or state towards people because of their affiliation or their possible association with a certain group.

Types of discrimination

- Refuse admittance to or expulsion from an educational institution
- Expulsion from work
- Failure to respect the privacy and confidentiality of others
- Denying health, psychological or social care services

Stigma and discrimination against this group is found around the world and is a violation of the human rights not only of MSM but also their families and communities. It can prevent individuals from accessing information and services, which contributes to the spread of HIV and engagement in risky behaviours.

The impact of stigma and discrimination on MSM and their families

MSM fear how they are perceived by the community and wonder:

- Will my family be shocked if they find out?
- Will I be kicked out of my home?
- Will my sister stop loving me?
- Will people act differently with me?

Families of MSM have questions and misconceptions:

- What have I done to deserve a gay son/daughter?
- I know my son pretty well and he cannot be like others.
- I will take them to the doctor for treatment.
- Homosexuality is a scandal and I have to do something about it.
- Had I known before it was too late I would have helped them.
- If they love their parents, they would stop these practices.

Attitudes that have a negative impact on the affected individual

Heterosexism

This is an ideology that considers relationships between people of the opposite sex as the norm and superior. It denies and stigmatises any behaviour, identity, relationship or society that is not heterosexual. It considers that homosexuality should remain concealed and, if present, should be condemned.

Homophobia

Homophobia presents itself as strongly negative feelings and rejection of the behaviour, way of thinking and lifestyle of individual lesbian, gay, bisexual, transgendered and intersex (LGBTI) people, as well as the wider LGBTI community. These feelings and prejudices are often expressed through extreme anger, resentment, violence, threat of expulsion, persecution, condemnation and even killing. Homophobia is often rooted in traditions, cultures and, sometimes, religious doctrine.

Internalised homophobia

Society's perception of homosexuality can often cause gay men/lesbians to have negative feelings about their own sexual orientation, resulting in feelings of anxiety, fear and disgust. Internalised homophobia can have a negative impact on a person's health and social relationships:

PSYCHOLOGICAL CONSEQUENCES OF HOMOPHOBIA	SOCIAL IMPACT
■ Guilt ■ A crisis of identity ■ Lack of self-esteem, self-loathing or inflated self-image ■ Self-destructive behaviour: risky sexual relationships, drug abuse ■ Poor body image ■ Anxiety ■ Depression ■ Insecurity ■ Confusing sexual behaviour with love ■ Loneliness and isolation ■ Suicidal thoughts and feelings, sometimes resulting in suicide	■ Loss of friends ■ Risky behaviours (addiction/unsafe sex) ■ Fewer chances for self-fulfilment ■ Lower productivity and fewer employment opportunities ■ Poor communication with close relations ■ Limiting social activities and relationships to gay/lesbian groups

Annex 9: Increased risks and vulnerability

MSM are considered to be one of the populations most at risk of getting HIV and other STIs. In many countries, some MSM have sexual relations with women or get married, and this contributes to the spread of the virus among the general population. Feeling vulnerable and the experience of being stigmatised and discriminated against can sometimes diminish a person's capacity to reduce the risk of getting HIV by practising safer sex.

This group's vulnerability is usually physical and is linked to the nature of the sexual relationship:

- Unprotected anal sex carries a much higher risk of HIV transmission than vaginal sex due to biological factors. The receptive (passive) partner is more at risk of HIV transmission than the active partner, although partners may exchange positions.
- Unprotected sexual relationships with multiple partners increase the risk of exposure to HIV and other STIs.
- Certain methods of rectal douching prior to sexual intercourse can inflame the anal mucous and make it more prone to infections. Only tepid water should be used.
- Oral sex is considered less harmful than anal sex, although it is not risk free, particularly if there are sores in the mouth or if there is gum disease. It is advisable to reduce risk by using a condom and avoid ejaculation into the mouth.
- Using psychotropic substances and drugs, steroids, hallucinogens or alcohol raises the risk of unprotected sex.
- Exchanging or sharing needles carries a high risk of HIV, and hepatitis B and C transmission.
- Sharing sniffing tools can increase the risk of hepatitis C transmission.
- Regular condom use among sex workers varies and can be influenced by many factors, including the sex worker experiencing sexual violence, not using condoms with regular partners, clients paying more money to have unprotected sex, and drug use that may reduce a person's perception of risk and the likelihood of condoms being used all the time.

Stigma, discrimination and punitive laws all contribute to reducing the chance of MSM seeking necessary help and health and other services. Past bad experiences with health service providers refusing treatment also influences uptake. For instance, unsympathetic healthcare services can lead to transsexuals taking hormones or undergoing costly sex reassignment surgery without appropriate medical and psychological support and expertise.

Risk factors that increase the vulnerability of this group

- Being young and sexually active
- Having multiple sexual partners
- Being poor or in financial need
- Difficulty in accessing various health services
- Sex in exchange for money or drugs (i.e. both formal and informal sex work)
- Verbal and physical abuse
- Stigma and discrimination
- Low level of education
- Lack of appropriate preventive and therapeutic healthcare services

UNAIDS classifies MSM as a "key population" (those most likely to be exposed to HIV or to transmit HIV). While this label affords this group a pivotal role in prevention and awareness processes, it does not lessen the risk factors.

Annex 10: Examples from stigma training workshops in Beirut and Tunisia

Beirut

Waiting area: Patients gossip about other patients while sitting on the bench. Stigma is directed towards people they suspect have HIV. They give hostile looks about the way you dress and walk.

University campus: In the library people won't sit next to you if they know you are an MSM. There is gossip and isolation in the hostels. Lecturers make homophobic comments in front of students.

In the barracks: Being told to act like a "real man". Being segregated if people suspect you are homosexual. Drinking too much when you get isolated.

Tunisia

School and university: Malicious gossiping; contempt; need to hide sexuality; rejection; reluctance to be in the same class as MSM; isolation; physical attacks; beatings; verbal attacks; hurtful and shocking words shouted at MSM; intolerance.

Cafés, bars and nightclubs: Violence; MSM are victims of beatings and injuries; denied access to nightclubs and bars; insulted when we try to enter; fingers pointed at us wherever we go because of the way we are dressed; contempt; sometimes insulted by the same people who would like to get involved with us; yelling; some people are reluctant to greet us or even to sit next to us; sometimes sex workers are the ones who gossip about us; aggressive looks.

Family: Assumptions; malicious words about us; rejection; isolation; denigration; lack of respect; hostile looks; contempt; insults; violence; brutalisation; giving us work that in our culture is traditionally assigned to women; repercussions on other family members; mothers get blamed for son's behaviour.

Mosque or church: Gossiping; prejudice; banning; taboo (sex is taboo in religious and/or traditional families); punishment; exclusion; puritanism; *haram* (not allowed by religion); guilt; inciting intolerance; accusing gay men of being sinners; judgments about immoral behaviour.

Clinic: Received in an unfriendly way (looks, gestures) at reception; rejection – we feel like we are not wanted in the clinic; overprotection; our sickness is not taken care of by health workers; we are kept waiting or given another appointment; contemptuous looks by health workers; we are examined with disdain and contempt; bitter words about how we are dressed; we are asked to come another day; some medical doctors do not accept MSM in their clinics; treated like we have a psychological condition that can be cured.

Session 5

Overcoming the challenges to accessing this population

Time

1 hour

Objectives

At the end of this session, participants will be able to:

- map out and analyse the challenges and opportunities in reaching MSM
- discuss human rights and public health approaches
- list the rights and responsibilities of MSM.

You will need

- Flipchart, large sheets of paper, markers, masking tape
- Handouts (one per participant) of:

  Annex 11: The human rights approach

  Annex 12: Specific rights and responsibilities of MSM

  Annex 13: The public health approach

Overview

This session is about exploring the factors that can help or hinder peer educators from reaching MSM. It also explores the role of others in reaching MSM to ensure they get the services they need.

The session also introduces participants to human rights and public health approaches.

Activity: Benefits of human rights and public health approaches

Step 1: Discussion (15 minutes)

1. Begin the discussion by asking:
   - *What challenges do you experience in accessing MSM?*
   - *Who and what make it difficult to reach MSM?*
   - *Who and what can help you to reach MSM?*

   Write down responses on the flipchart and reiterate that while it is difficult to reach this group, it is crucial to give MSM support in light of the many problems they experience.
2. Then ask: *What are the implications for individuals and wider society of not reaching MSM with the services they need?*

   Summarise responses on a large sheet of paper for all to see.

Step 2: Questions and answers (30 minutes)

3. Encourage participants to raise any remaining questions and invite the group to help you to answer them.

Step 3: Collecting ideas (15 minutes)

4. Using the challenges identified on the Problem Tree, ask:
   - *What are the common responses of MSM to the challenges identified?*

   Brainstorm answers in plenary and write them on the flipchart.
5. Write down four questions, each on a different sheet of paper (see below). Then form four groups and ask the groups to move from sheet to sheet, writing their responses to:
   - *Who are the actors who can address the needs of MSM?*
   - *What are the types of services that need to be offered to MSM?*
   - *What are the facilitating factors that could help MSM gain access to the services they need?*
   - *What are the challenges in the community likely to obstruct access by MSM to the assistance they need?*
6. At the end of the exercise, list existing challenges and supportive factors, and highlight the importance of interventions for this group using human rights and public health approaches, giving examples.

Annex 11: The human rights approach

When discussing effective and efficient responses to HIV and AIDS, United Nations agencies and international organisations emphasise the importance of using approaches that are based on:

- human rights
- accurate scientific evidence.

They also recommend adopting a participatory approach to ensure the full participation of those infected and affected by HIV and AIDS, as well as decision-makers and those working on gender equality.

Human rights principles

The concept of "human rights" refers to the universal and fundamental rights to which every human being is entitled, without distinction. The human rights approach is based on involvement, freedom and accountability.

Countries signed up to the Universal Declaration of Human Rights are responsible for promoting and protecting the rights of their citizens, who in turn have a responsibility to protect others. In reality, human rights are not always enforced or respected by national governments.

Adopting a human rights approach to the HIV response in a systematic and deliberate way helps to promote access to prevention, care, treatment and support. This means using this approach when planning, implementing, evaluating and monitoring programmes and policies.

The basic principles of the human rights approach include:

- Every human being is entitled to universal rights with no exception.
- There is no distinction – all human rights are of equal value.
- All rights are closely interlinked. The right to health does not override the right to privacy; the link between sexual violence and HIV/AIDS is a violation of the right to liberty and security.
- Equality and non-discrimination – equal rights to all, with priority given to the vulnerable and most at risk.
- Participation and inclusion – strengthening the capacity of target groups and those most at risk will enable them to participate in the improvement of their health (including decision-making, planning and implementation of programmes and activities, and access to training).
- Accountability and the rule of law – since nations and officials are responsible for the promotion and observance of human rights, the individual has a duty to hold the authorities accountable for this.

Human rights principles related to HIV/AIDS include:

- Non-discrimination
- Confidentiality and privacy
- Health – the right to access quality available services
- Education
- The right to work in a discrimination-free environment

In communities where MSM behaviour is regarded as "undesirable" or "offensive", taking an explicit human rights approach can limit resistance to the provision of services. This is because the human rights approach stresses the importance of the unalienable rights of all human beings, and combined with the public health approach, situates the provision of services for MSM within a wider understanding of the impact on society of not providing those services (see Annex 13).

Annex 12: Specific rights and responsibilities of MSM

Wellbeing: physical, social, psychological, and relationships

The right to enjoy good health and an infection-free life, together with a positive self-image. Basic needs (food, shelter, clothing, education, work) are met, alongside spiritual, psychological and social needs.

The right to maintain sexual health

This includes behaviour and practices necessary to enjoy healthy sexual relations, a healthy body free from STIs, and access to relevant information and services. This brings with it a responsibility to respect the health of others and not subject them to violence or sexual exploitation.

The right to reproductive health

This was defined at the International Conference on Population and Development (Cairo, 1994) as a state of complete wellbeing of the reproductive system and its functions (physical, psychological and social) and not merely the absence of disability or disease.

The right to acceptance of sexuality and social roles or gender

Helping MSM to feel comfortable, safe and confident can help to ward off risks and unhealthy behaviours, and will enable them to make informed decisions free from social pressures. To achieve this, they need support and acceptance in order to be able to address the challenges facing them and to access the information and services they need.

The right to information/education

This concerns access to comprehensive, up-to-date, accurate, appropriate and unambiguous information on health issues. This kind of awareness-raising material should be simple, attractively packaged and available in health centres.

The right to access services

Services have to be available and accessible at reasonable prices and in the right places. To achieve this, they should be free from exclusion derived from gender-based stigma, sex, social status, ethnicity, race, nationality and sexual orientation.

The right to safe services

Safe services require service providers with skills in preventive information and an ability to combine theoretical knowledge with practical know-how. They should also be able to identify and manage the complications associated with this group, be they physical or psychological.

The right to privacy and confidentiality

The right to privacy and confidentiality while receiving services also includes confidentiality of medical records.

The right to continuity of care

The right to continuity of services, supplies, follow-up and referral.

The right to dignity and freedom of speech

The right to be treated with respect and understanding of personal circumstances. Service providers should ensure friendly services and encourage users to express themselves and their views freely, particularly if the service provider holds divergent views.

The right to make informed decisions

Decisions should be made with an understanding of all the available options and their repercussions. An individual who is reluctant to take a particular decision is free to do so, but should be made aware of the possible consequences for their health.

The right to develop skills and attitudes

Building up life skills can help to foster:

- social responsibility – advocating for rights while not accepting stigma and discrimination
- ability to analyse the consequences of actions and to distinguish between contradictory messages (what was learnt as a child versus changing social attitudes)
- leadership and entrepreneurial skills (adopting positive and healthy attitudes)
- a healthy lifestyle (acquiring new healthy habits and making suitable choices).

Responsibilities of men who have sex with men

- Self-protection and protection of others.
- Acquiring life skills (decision-making and facing peer pressure), good behaviours and effective communication with others.
- Improving self-confidence, planning and analytical thinking; being responsible and not feeling frustrated when failing.
- Staying away from verbal and physical violence and abuse to oneself and to others.
- Adopting healthy social and sexual behaviour and using preventive measures when needed.
- Having regular check-ups, especially if engaging in unprotected sex; accessing relevant information and getting immunisation against certain types of STIs (hepatitis B, syphilis).

Annex 13: The public health approach

The World Health Organization (WHO) defines public health as all organised measures used to prevent disease, promote health, and prolong life among the general population. It aims to address the determinants of ill health and disease, and create conditions in which people can be healthy and thrive, not just be free from disease. Public health efforts are focused on entire populations and communities rather than on individual patients. A public health approach recognises that we are all interdependent, and that the health or lack of health of one person can affect the health of another.

The three main public health functions are:

- Assessing and monitoring the health of communities and populations at risk to identify health problems and priorities.
- Formulating public policies designed to solve identified local and national health problems and priorities.
- Ensuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

Some of the main areas of public health interventions include vaccination campaigns, such as for polio; safer workplace policies; control of infectious diseases, such as tuberculosis and HIV. They also include addressing the enormous increase in non-communicable diseases such as cardiac disease and obesity. STIs and HIV are communicable diseases and require a public health response to manage them effectively.

In the MENA region, those most at risk of HIV and other STIs are sex workers, people who inject drugs, MSM and their sexual partners – people who are often marginalised by society and consequently can experience a greater deal of isolation and discrimination. As a result, members of these key populations are often reluctant to seek medical support and services as they fear being discriminated against. For these reasons, they can also be difficult to reach.

In this context, if medical and social services focused only on each individual living with HIV or an STI, it would be impossible to address some of the underlying factors that make MSM and other key populations particularly vulnerable to STIs and HIV.

Therefore, while a human rights approach is essential to protect the rights of every individual MSM, the public health approach complements it by trying to address the key factors that render a community vulnerable to infection and disease. In the response to HIV, human rights and public health intertwine to ensure that effective measures are taken to reduce the burden of HIV infection in communities through:

- MSM-friendly STI and HIV counselling and testing services
- providing access to quality and tailored education and information, particularly oriented towards young people at risk
- ensuring access to quality condoms and lubricants
- monitoring the dynamics of HIV infection through surveillance and analysis of data to inform planning (the kinds of questions this work seeks to answer are: Who is infected? How many? Where? How? What are the factors that contribute to vulnerability and risk?)
- ensuring that there are public policies in place to provide an enabling environment for responding to the public health threat of HIV. This includes ensuring that the human rights of those at risk of infection and those living with HIV are fully respected and upheld, and that discrimination is confronted and managed
- key population user-friendly services and effective outreach prevention, care and support services, with particular access to young people at risk.

Session 6

Time

2 hours

Objective

At the end of this session, participants will be able to:

- assess their knowledge about the male and female reproductive systems and correct any misinformation.

You will need

- Flipchart, large sheets of paper, coloured markers
- Drawings of the male and female reproductive systems, without labels (see Annex 16)
- Names of the different anatomical parts
- Questions for managing the discussion
- Handouts (one per participant) on:

  Annex 14: Cards explaining the functions of the female reproductive system

  Annex 17: Puberty and the functions of the reproductive system

The male and female reproductive systems

Overview

This session helps participants to develop a good understanding of the male and female reproductive systems. The session can be quite sensitive, so encourage everyone to participate even if they feel a little embarrassed or shy at times. This is essential information that they need to know. If they are embarrassed while talking about sexuality in training, then they will really struggle to do outreach work with MSM. An ability to discuss issues related to sex and sexuality is a prerequisite for anyone wanting to work in this area.

If for any reason participants are reluctant to discuss the female reproductive system, remind them that some MSM have female sexual partners, so it is important to understand the female body and reproductive health system.

Activity: Functions of the male and female reproductive systems

Step 1: Naming the different parts (45 minutes)

1. Divide participants into two groups: one to draw the male reproductive system and one to draw the female reproductive system. Give each group a list describing the functions of each part (Annexes 14 and 15) and ask them to place it next to the appropriate anatomical part.

Step 2: Presenting the drawings (15 minutes)

2. Then ask the two groups to present their drawings to the big group.

Step 3: Discussion and corrections (1 hour)

3. Bring out the prepared drawings of the male and female reproductive systems (Annex 16) and compare them to what was produced by the group. *Are there any differences?*

   You could ask further questions about how the body works (physiology), such as:

   - *What are the two main ingredients of semen and where are they produced?*
   - *What fluid can leak from the penis before ejaculation? Does this fluid present a risk for HIV transmission?*
   - *What are common names in the local language for semen?*
   - *What factors can cause a man to lose or fail to maintain an erection?*
   - *What factors may limit a woman's enjoyment of sexual stimulation and intercourse?*

4. Use Annex 16 to help to correct misinformation.

Annex 14: Cards explaining the functions of the female reproductive system

Refer to this table to prepare the cards, ensuring that the size of the card is appropriate for the size of the drawing.

THE FEMALE REPRODUCTIVE ORGANS	THEIR FUNCTIONS
Ovaries	Located in the lower part of the abdomen and responsible for producing eggs and secreting hormones.
Fallopian tube	The tube that carries the egg to the uterus (womb). Where the sperm meets the egg (fertilisation).
Uterus or womb	Where the fertilised ovum becomes an embryo and develops into a foetus (also called conception).
Pubis	The area above the genitals covered with hair.
Labia majora	Protects the internal genitalia.
Labia minora	Located inside the labia majora and covers the openings of the urethra and the vagina.
Clitoris	Located between the labia minora, it gives a feeling of sexual excitement and pleasure when stimulated and contributes to female orgasm.
Urethra	The canal through which urine is discharged from the bladder.
Vagina	The opening leading to the cervix where penetration takes place during intercourse. It is an elastic, muscular canal that connects the vaginal opening to the cervix. It is lined with a thin membrane of tissue that is able to expand. The Bartholin glands located beside the vaginal opening produce a fluid (mucus) secretion that acts as a lubricant during intercourse.
Cervix	The band of tissue protecting the opening of the uterus.
Hymen	The hymen is a thin piece of tissue covering the opening of the vagina where menstrual blood is released. It usually tears during the first attempt at sexual intercourse, or it may be soft and pliable so no tearing occurs. Breaking the hymen is commonly associated with the loss of virginity in a girl or woman. However, the hymen can also break without penetration or loss of virginity.

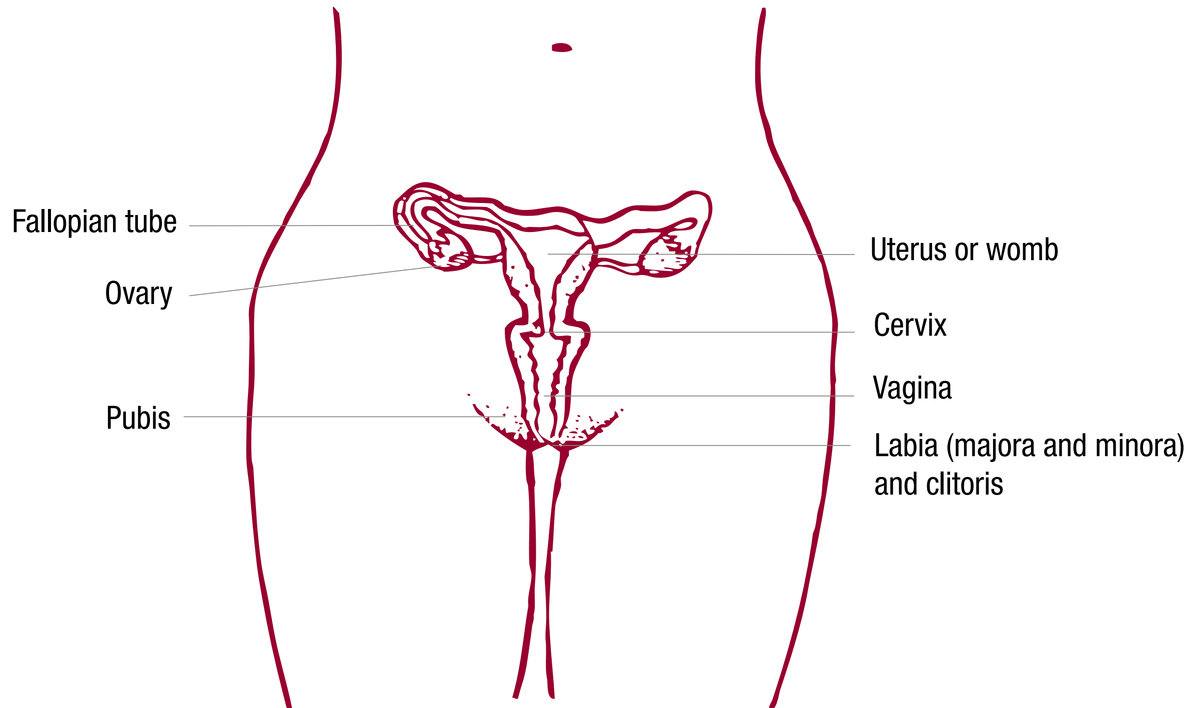
Annex 15: Cards explaining the functions of the male reproductive system

Refer to this table to prepare the cards, ensuring that the size of the card is appropriate for the size of the drawing.

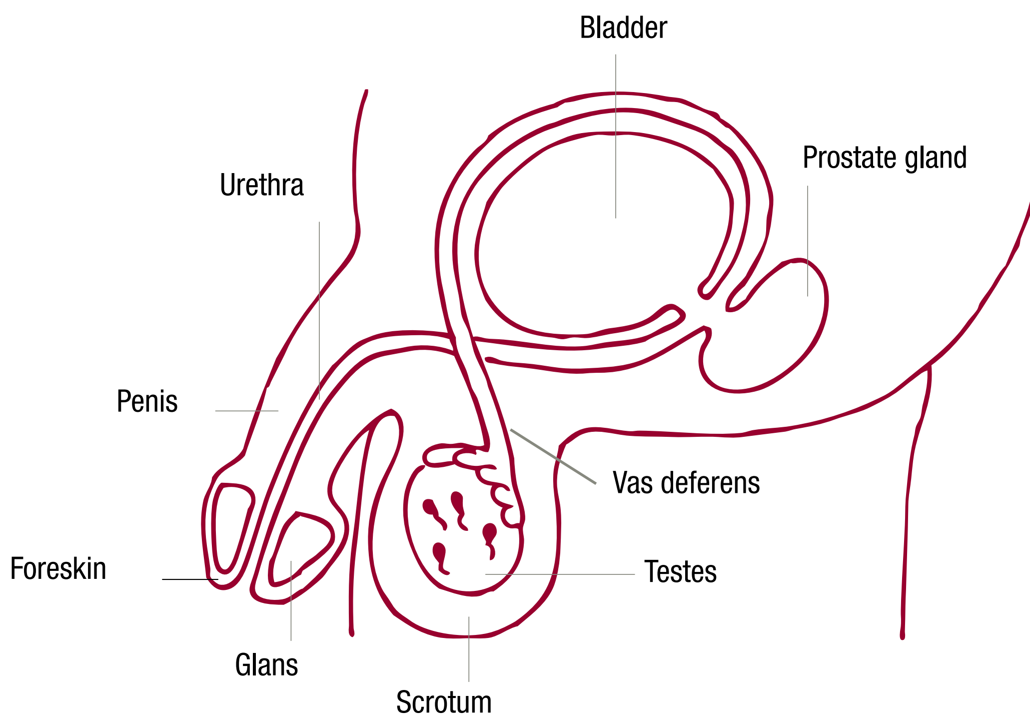
THE MALE REPRODUCTIVE ORGANS	THEIR FUNCTIONS
Vas deferens	Transports mature sperm to the ejaculatory duct in preparation for ejaculation.
Prostate gland	Produces fluid to nourish sperm and help transport it via the ejaculatory duct. Stimulation of the prostate can be very enjoyable for both heterosexual and homosexual men. Stimulation leads to the production of prostatic fluid. The prostate can be stimulated by gently rubbing the prostate gland with a finger, penis or sex toy inside the rectum.
Testicles (or testes)	Responsible for making testosterone (the primary male sex hormone) and for producing sperm.
Ejaculatory duct	A tube that connect the vas deferens to the urethra and passes through the prostate gland.
Urethra	The tube that carries urine from the bladder to outside of the body. In males, it has the additional function of ejaculating semen when the man reaches orgasm. When the penis is erect during sex, the flow of urine is blocked from the urethra, allowing only semen to be ejaculated at orgasm.
Penis	The penis is an external sexual organ made up of the shaft, glans penis and foreskin. It allows the transport of urine and sperm. It reaches its full size during puberty, around the ages of 14 to 17. With stimulation, it becomes engorged with blood and erect, which facilitates penetration into either the vagina or rectum during sexual intercourse.
Glans	This is the bulbous area at the head of the penis and is made from the same tissue as the female clitoris. It is highly sensitive and can contribute to much sexual pleasure.
Foreskin	The skin at the top of the penis that covers and protects the glans. This is removed during circumcision.
Scrotum	The loose pouch-like sac of skin that hangs behind and below the penis. It contains the testes and controls their temperature.

Annex 16: Anatomy of the female and male reproductive systems

Female reproductive system



Male reproductive system



Annex 17: Puberty and the functions of the reproductive system

Puberty for boys and girls starts in their early teens and the physical changes happen quickly. It is the process of physical change by which a child's body matures into an adult body.

The physical changes that happen during puberty are caused by hormones. In girls, puberty starts around the ages of 10 or 11 and is complete by 15 or 16. It is marked by the time a girl starts to ovulate and have periods, which often occurs around the ages of 12 to 13 but can happen sooner or later.

For boys, puberty begins around the ages of 11 to 12 and sexual maturity happens around 16 to 17. During this time, a boy will ejaculate semen for the first time and this normally happens around the age of 13 but can also happen sooner or later. First ejaculation can often happen during sleep and these are commonly known as "wet dreams".

Puberty can be a very challenging time for both boys and girls as their bodies go through so many changes and the surge of hormones can affect their mood. The body shape of both boys and girls changes, and boys' voices lower. It is often a very sensitive time in a person's life, and without education, guidance and support it can be difficult for some young people to navigate. The physical changes and the hormonal release in puberty can have a strong impact on self-esteem, mood and social interaction.

It is important to understand the following about boys:

- **Erections** are the process of the penis filling with blood caused by sexual arousal.
- **Wet dreams** are ejaculation during sleep – a completely normal experience and nothing to worry about.
- **Ejaculation** is the release of semen from the erect penis.
- **Semen** – from puberty, sperm is produced in the testicles under the influence of hormones from the pituitary gland. The sperm comes out through the vas deferens and is transported by the fluid produced by the prostate gland until it reaches the urethra and comes out of the body.
- **Masturbation** is fondling and rubbing the genitals in order to reach orgasm.

Session 7

HIV and other STIs

Time

3 hours

Objectives

At the end of this session, participants will be able to:

- accurately discuss STIs and how they are transmitted
- list at least three STIs
- identify STI symptoms and related complications for both males and females
- list different ways of becoming infected and how to prevent transmission, and know how STIs are treated
- understand the links between HIV infection and other STIs
- list common misconceptions and false beliefs related to HIV and STI.

You will need

- Prepared wall panels (Annex 19), masking tape, coloured markers, Post-it notes
- Handouts (one per person) of:

  Annex 18: HIV, STIs, prevention, treatment and referral

  Annex 19: Wall journals

Overview

In this session participants are asked to talk about their understanding and beliefs about how STIs are transmitted. The first part of the session contains exercises to enable participants to share their existing knowledge. Following that, you as the facilitator will be able to correct any misinformation.

You will need to encourage full participation in this exercise.

Please refer to the supporting documents before you start, and remember to assess participants' reading and writing skills so that you can adjust exercises accordingly (replacing the writing with pictures if necessary or doing both).

Activity: HIV, STIs, transmission, prevention measures and access to services

Step 1: Wall journal exercise (1 hour)

1. Pin up wall panels related to the topic (Annex 19).
2. Take pages from magazines, cut them in half and mix them up. Ask participants to pick a half-page randomly, then to mingle and find the person holding the other half of the magazine page. This person will be their partner for this exercise.

   This exercise works for up to 20 people. If you have more, organise them into threes instead of pairs. If you have less than 20, choose a fewer number of questions but ensure that by the end of the session you have covered all the information.
3. Ask each pair to go to one of the wall panels and write their answers to the questions on the sheet using Post-it notes.

Step 2: Giving the correct answers (2 hours)

4. Once everyone is back in their seats, go to each board and read out the answers. Ask the group whether they think each answer is right or wrong and then correct any misinformation.

Annex 18: HIV, STIs, prevention, treatment and referral

What are STIs?

STIs are a group of infections caused by bacteria, viruses and fungi that get transmitted during intimate sexual relations. They include syphilis, gonorrhoea, chlamydia, herpes simplex virus, genital warts, chancroid, inflammation of the urethra (urethritis) and pubic lice.

STIs affect both men and women, and can cause a great deal of suffering in people's lives. Sometimes a person can become infected with an STI and be unaware of it as they may have no symptoms in the early stage. This can lead to secondary complications that may cause severe health problems. Without treatment, the person can also infect other sexual partners as they are unaware themselves of the infection. A person may also have multiple infections.

Those infections that are caused by bacteria (gonorrhoea, chlamydia, syphilis) can be treated with antibiotics. It is essential that any sexual partner be treated at the same time to avoid recurrence of the infection. It is also essential that the person complete the whole course of antibiotics they are prescribed, as if they do not resistance can develop. Treatment-resistant STIs are becoming increasingly common.

Viral infections – herpes, genital warts, hepatitis B and HIV – cannot be cured with antibiotics. Genital warts can be removed with ointment and cryotherapy (freezing) but they can recur as the virus stays in the body and can reactivate at any time. Herpes is a chronic condition that causes painful sores at the site where the person was infected, and these can recur at regular intervals. The sores can be inside the vagina, anal canal and mouth or the skin around the genitals and mouth. Treatment with antiviral drugs such as acyclovir can suppress the virus and reduce the frequency of outbreaks of painful sores.

Hepatitis B infection can be symptomatic or without symptoms. Some treatments are available, such as antiviral drugs, but it is a chronic infection that can cause lasting damage to the liver. Thankfully, there is a vaccine that can prevent people getting infected with hepatitis B, and all MSM should be advised to get it.

Means of transmission

Some STIs are commonly transmitted during sexual intercourse – vaginal, anal and oral. Infections transmitted this way include gonorrhoea, syphilis, and chlamydia, as well as hepatitis B, genital warts and herpes. Some, such as genital warts, herpes, pubic lice and syphilis, can also be transmitted without sexual intercourse (vaginal, anal or oral) during close skin-to-skin physical contact.

HIV is primarily transmitted during vaginal or anal sex and very rarely during oral sex. HIV can also be transmitted from a mother to her baby during pregnancy, delivery and through breastfeeding. With the right support and treatment, women can reduce their risk of transmitting HIV to their baby to almost no risk. HIV can also be transmitted when people who inject drugs share injecting equipment that contains small amounts of HIV-infected blood. Lastly, a person receiving a blood transfusion can be infected if the blood being transfused was not adequately tested for HIV. Thankfully, with correct screening of donor blood for HIV, the risk of being infected with HIV from a blood transfusion is negligible.

Common STI symptoms (for men and women)

- Burning sensation during urination
- Smelly, coloured secretions and discharge from the sexual organs
- Pain in the lower abdomen
- Ulcers and painful sores on the genitals or mouth. Sores or ulcers caused by syphilis are generally not painful. Sores or ulcers caused by herpes can be very painful
- Itchiness around the genital and perianal area
- Fever – either a high fever or a low-grade fever
- Pain during sexual intercourse
- Skin rashes

Remember: Some people infected with an STI may have no symptoms but can still pass the infection on to a sexual partner.

Complications of untreated STIs (for men and women)

- Infertility, particularly in women
- Irreversible damage to vital organs in the body (heart, brain, nervous system, liver)
- Miscarriage or ectopic pregnancy (women)
- Cervical cancer (women)
- Death – HIV, syphilis and hepatitis B

Prevention approaches

- Wearing the male condom for penetrative sex offers important protection against STIs despite the fact that it does not give complete protection against sexual infections (because the condom does not cover the whole genital area that is prone to infection).
- The female condom does cover the external female genitalia. It can also be left in place for a few hours if the couple wants to have sexual intercourse more than once. It can also be used for anal intercourse.

Annex 18: HIV, STIs, prevention, treatment and referral

SOME FALSE BELIEFS AND MISCONCEPTIONS ABOUT STIs	
Only women get STIs	**Not true:** both men and women can be infected with STIs.
Having sexual intercourse with an underage girl cannot transmit an STI	**Not true:** infection is transmitted through intercourse with an infected person, regardless of age, sex and colour. Sex with an underage girl can cause lasting damage to the girl as she is still developing physically and emotionally. In most countries, it is also illegal.
The use of contraception will protect a woman from STIs	**Not true:** hormonal contraceptives offer no protection against STIs. However, the female condom is very effective at reducing the risk of infection as it not only protects the vaginal wall but also the external genitalia. The male condom also offers some protection against STI transmission.
Herbal therapy is the best remedy for STIs	**Not true:** there is no evidence about their effectiveness, whereas there are tried and tested treatments that health professionals can prescribe to treat STIs (see the information above).
Good hygiene is the best prevention for STIs	**Not true:** cleanliness is important but it does not protect from STIs.
Cleanliness heals infections	**Not true:** however, at the early stage in syphilis when it common to have a painless ulcer called a chancre or when sores are present from herpes, cleanliness can prevent the sores/ulcer from getting secondarily infected with bacteria that can cause more pain.

- Reducing the number of sexual partners reduces the risk of being exposed to someone who is infected with an STI.
- Avoid having sex during the period when a person is being treated for an STI and make sure that all sexual partners of someone diagnosed with an STI get examined and treated.
- It is important not to share razors and injecting equipment.

Treatment

- If someone suspects that they have an STI, they must seek medical help to get screened and treated. Remember, untreated STIs can lead to serious consequences, so getting early treatment is essential to protect health and wellbeing.
- MSM peer educators or peers within the MSM community may know of healthcare services and workers who are particularly friendly and welcoming to MSM and who also know how best to examine and treat them. It is not common for men who only have sex with women to have swabs taken from their throat or anus, but for MSM who have had oral and/or anal sex, this is very important.
- Ensure that all treatments are taken as prescribed otherwise the infection can recur.
- Attending STI services with a sexual partner is ideal as both can be treated at the same time. However this is not always possible, particularly when sex was with a casual partner. The commitment of both partners is important for treatment success.
- STIs can be passed from a mother to her baby and therefore pregnant women and their partners should be tested for STIs such as syphilis. Women and their partners/husbands should also be offered HIV testing.
- Where a woman is living with HIV and is pregnant, she will need specialised support and treatment to minimise the risk of HIV transmission to the baby.
- If a person suspects they have pubic lice, they should avoid sharing bed linen, towels or clothing until they have been fully treated.

What is HIV?

HIV is the abbreviation for **human immunodeficiency virus**. HIV attacks the immune system of the body and its functions. As a result, the immune system becomes weakened and unable to fight infections, and this includes normal bacteria that usually live quietly in the body without causing any problem to their host. With time, the body develops opportunistic infections (bacteria and other germs that take advantage of the opportunity offered by a weakened immune system to infect the body) and cancers that without treatment can cause death.

Annex 18: HIV, STIs, prevention, treatment and referral

What is AIDS?

AIDS is the abbreviation for **acquired immune deficiency syndrome**. Acquired means it is caused by infection and comes from outside of the body. **Immune deficiency** means the infection causes the immune system to weaken and not perform its normal functions. **Syndrome** means that HIV does not cause one illness but rather a collection of different infections, cancers and illnesses.

With advances in treatment, most infections and illnesses caused by HIV can be successfully treated if diagnosed early and the correct therapy is available. Most importantly, ensuring that the person who has illnesses caused by HIV is prescribed and takes antiretroviral treatment (ART) is essential to restoring them to health. ART suppresses HIV and thereby stops it from weakening the immune system. ART allows the body to recover its normal immune function. Without treatment or ART, the person with AIDS will die.

Where does the virus live inside the body?

HIV can be found in all the body fluids listed in the box below. However, it is only the fluids in bold letters in the box that have sufficient quantity of HIV to enable the transmission of HIV to another person through unprotected sex, blood transfusion, sharing injecting equipment or from a mother to her baby. It is not possible to get HIV from being in contact with the sweat, tears, saliva or urine of a person living with HIV.

Blood	Tears
Semen	Urine
Breastmilk	Sweat
Vaginal fluid	Saliva

What happens when the virus enters the body?

Once HIV invades the body, among other things it starts to destroy the white blood cells that help to protect us from infections and some cancers. The particular white blood cells that HIV targets are known as T lymphocytes or CD4 cells. As HIV begins to replicate and multiply, it destroys more CD4 cells and weakens the immune system.

Does the virus survive outside of the body?

HIV does not survive for outside of the body for a long time. For instance, it only survives for 45 minutes in open air and for 15 minutes at a temperature of 60 degrees.

How can HIV be transmitted?

The table on page 48 provides a summary of the different ways that HIV can be transmitted and the ways that it cannot.

The stages of HIV infection

Stage 1: Seroconversion About three to six weeks after infection, many people develop flu-like symptoms (fever, swollen glands, sore throat, rash, muscle and joint aches and pains, fatigue, and headache). This is because HIV is rapidly multiplying in the body and the immune system has not yet produced antibodies to fight the infection.

The amount of HIV in the blood is called the HIV viral load. When the viral load is very high, there is a high risk of HIV transmission, whereas when the viral load is low, the chances of HIV transmission are much lower. During the period of seroconversion, the viral load is very high. In fact, many people get infected during this time from a person who does not know they are infected with HIV.

If the person tests for HIV during the first two or three weeks after possible infection, it is highly likely that the result will come back negative even if the person is actually infected with HIV. This is because the HIV test most commonly used for screening looks for antibodies to HIV and not HIV itself. Until the body has produced antibodies, the result of this particular test will come back negative.

After infection, the body starts to produce antibodies to HIV within four weeks. If a person tests for HIV at this stage it is likely that the test will pick up the presence of HIV antibodies and the test will be positive for HIV. Usually it is advised to wait for four weeks after the time when infection might have occurred to take the HIV antibody test. At this point, research suggests that 95% of HIV infections will be picked up by the test. If a person tests at four weeks and is found to be HIV negative, they will still need to repeat the test at four months as in some people antibodies will not be produced until after four weeks.

Stage 2: The asymptomatic or latency period Post initial infection, the body is normally able to suppress HIV because it still has a strong immune system. During this time, a person can feel well and have few or no health problems that may indicate infection with HIV. Asymptomatic means that they are without symptoms. If the person has not tested for HIV, it is likely that they will not know that they are infected. This stage could last anywhere between three and

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HIV IS TRANSMITTED THROUGH	YES	NO
Insect bites?		✔
Unprotected penetrative sex with someone infected with HIV?	✔	
Sharing eating and cooking utensils?		✔
Breathing?		✔
From an untreated infected pregnant mother to the foetus/baby during pregnancy, delivery and during breastfeeding?	✔	
Blood transfusion with blood infected with HIV?	✔	
Coughing?		✔
Hugging?		✔
French kissing?		✔
Kissing on the cheek?		✔
Sharing underwear?		✔
Masturbation?		✔
Being tattooed with unsterilised equipment infected with HIV?	✔	
Sharing unsterilised injecting equipment and related paraphernalia?	✔	
Daily life: shaking hands, sharing food and drink in public places?		✔
The use of clean and sterilised surgical instruments?		✔
Mutual masturbation and non-penetrative sexual stimulation?		✔

ten years. Slowly during this time HIV is destroying the immune system to the point where it begins to destroy the body's natural defences. By the end of the asymptomatic period, the viral load increases and the person begins to have illnesses caused as a result of a weakened immune system.

Stage 3: AIDS By this stage the patient shows clinical symptoms and develops life-threatening illnesses that can include opportunistic infections and cancers. Without ART, this stage can last between a few months and several years. However, if ART is started as soon as symptoms occur, it is highly probable that the medication will help lower the viral load and this will allow the immune system to recover. Without treatment, the person living with AIDS will die.

Who should get tested and the benefits of early diagnosis?

- Anyone who would like to know their HIV status
- Anyone who thinks they may have been exposed to HIV through unprotected sex
- A person who injects drugs who has shared needles and syringes
- A person in prison who has been exposed to HIV through unprotected sex with another inmate or who is the victim of sexual violence
- Anyone who has been sexually violated and raped. This should happen at the time of the rape and then again three months later
- Anyone wishing to have unprotected sex with a new sexual partner, either because they are getting married, want to start a family and have children, or because they are in a long-term monogamous relationship
- Someone who is about to undergo major medical procedures, such as surgery, dialysis or treatments for cancer
- Children born to an infected pregnant mother. In these circumstances, it is normal to wait for up to 10 to 12 months before doing the antibody test as a baby's immune system is not well developed and it can take many months for antibodies to develop. If feasible, it is better to do an antigen test, which tests for the virus itself, as this can be performed much earlier.

Annex 18: HIV, STIs, prevention, treatment and referral

Early diagnosis with HIV has many benefits. Not least, it means that the person living with HIV can get ongoing support and health screening from healthcare workers, and early signs of immune damage can be treated. Research has clearly shown the benefits of starting ART before a person gets sick. A person living with HIV on ART is expected to have a nearly normal life span, yet sadly many people still die from being infected with HIV because they were not diagnosed or diagnosed too late, or ART was not available to them.

Although there are many benefits from knowing your HIV status, the reality of getting an HIV diagnosis is not easy, and it can take time and a lot of support from family, loved ones and friends to come to terms with living with HIV.

Voluntary counselling and testing (VCT) Research has also shown that the way someone finds out that they are infected has an impact on how they are later able to manage and deal with being HIV positive. Prior to being tested, a person needs to understand what they are doing, what the test will and won't tell them, and know what support might be available to them if they test positive. Even for the person who tests negative, being tested for HIV can affect their subsequent behaviour and often leads them to not want to repeat the situation that led them to be tested in the first place. It is for all these reasons that it is recommended that a person undergoing the test is given the opportunity to talk through their concerns and find out the information they need to know during a pre-test counselling discussion. VCT is performed by people trained to provide support throughout the testing process.

In line with the "treatment as prevention" approach, the strategy referred to as "test and start" involves screening people and immediately initiating ART for anyone who is diagnosed positive, irrespective of CD4 cell count or WHO clinical stage. It is an effective strategy for improving health among HIV positive MSM and interrupting transmission of HIV, particularly in concentrated epidemic areas.

The different types of tests

Antibody tests The most common HIV tests look for HIV antibodies in the body rather than looking for HIV itself. The ELISA (enzyme-linked immunosorbent assay), the rapid test and the Western blot all detect HIV antibodies in the blood.

Antigen tests Antigen tests test blood for HIV itself and not just antibodies. Therefore, they can be used shortly after infection (between one to three weeks) rather than wait a couple of months for antibodies to develop. The PCR (polymerase chain reaction) technique, for example, detects the genetic material of HIV itself and can identify HIV in the blood within two to three weeks of infection.

Antiretrovirals to prevent infection

Applying a combination prevention approach means that prevention services should include the use of antiretrovirals therapy (ART) by people who are uninfected to prevent them from acquiring HIV.

Combination antiretroviral treatment can be used both pre-exposure and post-exposure to prevent HIV infection.

By lowering the amount of virus in blood and body secretions, ART also prevents the transmission of the virus from HIV positive people to non-infected sexual partners. WHO now recommends that all people living with HIV should be offered ART regardless of disease stage or CD4 cell count.

Pre-exposure prophylaxis (PrEP) is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are also used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injecting drug use, these medicines can work to keep the virus from establishing a permanent infection.

When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently.

PrEP is a powerful HIV prevention tool and can be combined with condoms and other prevention methods to provide even greater protection than when used alone. But people who use PrEP must commit to taking the drug every day and seeing their healthcare provider for follow-up every three months.*

Post-exposure prophylaxis (PEP) is when a person who is not living with HIV fears they have been exposed to HIV and wants to prevent infection. ART must be taken within 72 hours of the exposure and taken for three months. If a person has had unprotected sex and fears they may have been infected with HIV, waiting two to three months before testing for HIV antibodies can be agony. Research

* Centers for Disease Control and Prevention, *Pre-Exposure Prophylaxis* (PrEP) [online]. Available at: www.cdc.gov/hiv/prevention/research/prep/

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has shown that it is possible to reduce the risk of a person who has been exposed to the virus by treating the person with ART. In many countries, ARVs is also usually offered to victims of sexual assault immediately following the rape to try to prevent them becoming infected with HIV. Unless the rapist is known or arrested and tested for HIV, it is normally impossible to know whether they were infected with HIV. Therefore it is better to treat all victims with ART to minimise risk.

Is there a cure or a vaccine and how is HIV treated?

Currently, no preventative vaccine exists to lower the risk of an uninfected person becoming infected with HIV, nor is there a cure. However, ART is a very effective at suppressing the virus. As a result of the viral suppression HIV viral load is reduced, and when it is at undetectable levels, the risk of the person transmitting HIV to a sexual partner is extremely low. With effective ART, a person living with HIV can expect to have a near normal life expectancy.

However, ART is not without problems:

- The combination of drugs that make up ART all have different side effects and some of them are potentially dangerous. Regular monitoring by healthcare workers is essential to ensure that a person can continue on ART for as long as they need it.
- If ART is not taken every day as prescribed, resistance can develop and it will cease to be effective. Adherence to any medication can be challenging and this is also the case with ART. Sometimes people also have to hide the medication from their family and loved ones, and this can impact on their ability to take ART consistently.
- Another challenge is the cost. In many countries, first- and second-line ART is provided free of charge, but this is not the case in all countries. The MENA region is one of the least-served regions in terms of access to ART.

Apart from ART, good nutrition and paying attention to psychological and spiritual needs is also essential for health and wellbeing.

The link between HIV and STIs

- The majority of HIV infections globally are transmitted sexually – HIV is an STI.
- The ways that HIV and STIs are transmitted are similar in many respects, and the ways to prevent them are also similar.
- The presence of wounds and sores on the genitals as a result of an STI increases the risk of HIV transmission.
- Having multiple sexual partners increases the risk of exposure to HIV and other STIs.
- There is a high correlation, or relationship, between people being infected with syphilis and also being infected with HIV.

FALSE BELIEFS	ANSWERS
A sexual relationship with an underage girl or boy cures AIDS	Having a relationship with an underage girl or boy does not cure nor protect against HIV. HIV does not discriminate against age, sex, etc. The only treatment is ART
AIDS does not exist in our society	All countries have HIV cases
The only way to get HIV is through sexual relationships between men	Any unprotected sexual relationship with a partner living with HIV is risky, whether between people of the same sex or opposite sex
Prevention is possible by avoiding sexual penetration or interrupted penetration (withdrawal before ejaculation)	Any contact of the genitals or actual penetration in the vagina or anus without ejaculation is risky. Oral sex is also risky, especially when ejaculating in the mouth or if there are sores in the mouth

Annex 19: Wall journals

Sheet 1: List the names of all the STIs that you have heard of. Group them into STIs caused by bacteria and those caused by viruses

Sheet 2: How can you tell (whether you are a male or female) if you have been infected with STIs? What are the symptoms?

Sheet 3: True or false – ways of transmitting STIs

STIs ARE TRANSMITTED THROUGH …	TRUE	FALSE	WHICH STIs CAN BE TRANSMITTED THIS WAY?
Unprotected sexual intercourse with an HIV-positive person			
Being exposed to HIV-infected blood through a blood transfusion or sharing injecting equipment			
Unprotected oral sex			
Mutual masturbation			
Sneezing			
Sharing sheets/towels and underwear			
Mother-to-child HIV transmission			
Being treated with unsterilised surgical instruments that were used immediately after treating someone living with HIV			
Toilet seats			

Sheet 4: What are the long-term consequences of untreated STIs and HIV? How can you prevent these long-term consequences developing?

Sheet 5: True or false – beliefs related to STIs

COMMON BELIEFS	TRUE	FALSE	WHY
Infections affect only women			
Cleanliness heals infections			
A high level of genital hygiene is the best prevention			
Herbal therapy is one way of treating STIs effectively			
Having sexual intercourse with an underage girl is risk-free from getting an STI			
The use of contraception will protect a women from sexual infections			

Sheet 6: What is the usual treatment for STIs caused by bacteria? What is the usual treatment for STIs caused by viruses?

Sheet 7: What is AIDS? Put these words in the right order:

- syndrome
- acquired
- immune
- deficiency

Sheet 8: What is HIV? Put these words in the right order:

- deficiency
- virus
- human
- immuno

Annex 19: Wall journals

Sheet 9: HIV and AIDS symptoms Place the right word in the right box:

The appearance of	**Severe**	**High**
....	....	....
Opportunistic	**Nightly**	
....	....	

- infections
- sweats and fatigue
- lymphatic glands
- temperature
- diarrhoea

Sheet 10: An MSM thinks he may be at risk of HIV infection through unprotected sex with a person of unknown HIV status. What HIV prevention options might be available him? What tests might he need to have and when?

Sheet 11: False beliefs

FALSE BELIEFS	TRUE	FALSE	WHY
Having sexual intercourse with an underage girl is a cure for HIV			
AIDS does not exist in our society			
HIV can only be transmitted between MSM			
HIV infection can be prevented if there is no penetrative sex			
Withdrawing the penis before ejaculation is a safe way of limiting the risk of HIV transmission			

Sheet 12: List a few local places where you can go to test for HIV or other STIs, and put a tick next to the ones that are MSM-friendly.

Session 8

Sexual practices and preventing HIV and other STIs

Time

1 hour

Objectives

At the end of this session, participants will be able to:

- have a good understanding of the range of sexual practices enjoyed by MSM and assess them in terms of their risk of HIV and STI transmission
- outline STI prevention strategies.

You will need

- Flipchart, large sheets of paper, coloured markers (red, orange, green), masking tape
- Flyers
- A drawing of the male anatomy
- Handouts (one per participant) on:

  Annex 20: Examples and classification of common sexual practices

Overview

Some people may find the next exercise a little embarrassing if it is hard for them to discuss sexual behaviour and practices. It is important to address this issue in the training. It is essential that peer educators working with MSM are able to talk about sexual practices in detail if they are going to be effective in discussing a person's risk of HIV or other STIs and in assessing their current behaviour against the risk the practice may involve.

Humour and laughter can really help this session flow. Remember, it is important to not to judge or castigate others for the kinds of sex they enjoy so long as it is not harming another person.

Activity: Sexual practices among MSM and associated risks

Step 1: Identifying the male erogenous zones (30 minutes)

1. Ask participants to draw the outline of a man, including the face, nipples and genitals. Ask them to mark on it the erogenous zones across the whole body. Ask them if erogenous zones are just the genitals or other parts of the body too.
2. Ask them to list the sexual practices that they know that MSM enjoy. What are the most common? What practices do people think bring the most amount of pleasure? What might be considered more of a fetish? Are there any practices that some people feel ashamed about enjoying?

   Sexual pleasure is not just about anal or oral sex. It can include many other things: hugging; caressing the head, chest and ears; kissing on the lips or neck; licking and biting the nipples; licking the thigh, testicles, head of the penis and anus (rimming). They may add other practices.

Step 2: Presentation of drawings and discussion (30 minutes)

3. Get the participants to share their lists and indicate on one drawing whether the practice is risky or not risky by classifying each practice as follows:

   Red dot = high risk

   Orange dot = low risk

   Green dot = no risk
4. Get them to add other practices for discussion. Refer to Annex 20, which lists these practices.
5. Round up the session by correcting any false information, and allow participants to discuss where they originally got their information from about sex, their sexual life, the age when they started experimenting and so on. Focus on the scientific information, and explain that these workshops are the best place to obtain accurate information for them to use later in the outreach programme.

   Reiterate the importance of condom use in preparation for the next session.

Annex 20: Examples and classification of common sexual practices

SEXUAL PRACTICES	RISKY OR NOT RISKY (IN TERMS OF HIV AND STIs)
Anal sex without using a condom	High risk
Active partner (the person who penetrates/the "top") having unprotected sex with another male	Medium-to-high risk
Passive partner (receptive, the "bottom") having unprotected sex with another male	High risk
Active and passive man using protection during sex	Low risk
Unprotected penetrative sex within a group encounter (orgy)	High risk
Licking the genitals of the sexual partner	Not risky for HIV transmission
Swallowing the semen of the sexual partner	Risky but better to swallow immediately than leave in the mouth as the stomach acid destroys the virus. Any sores or gum disease in the mouth increases risk
Licking the anus of the sexual partner then washing the mouth with soap and water	Not risky for HIV transmission but risk of hepatitis A, genital warts and herpes
Inserting finger into the anus of the sexual partner	Not risky unless there are sores on the finger and bleeding
Use condoms every time for anal or vaginal intercourse	Low risk for HIV transmission if used properly, and there are no tears and the condom does not come off. Male condoms do not necessarily protect a person from infections transmitted through skin-to-skin contact; e.g. herpes, warts, syphilis and genital lice
Use condoms most of the time	High risk
Ejaculates inside partner without using a condom	High risk
Unprotected penetrative sex but no ejaculation	High risk
A head massage	No risk
Caressing/sucking and playing with nipples	No risk
Ejaculating on the body of the partner	No risk

Condom advice

- Use a condom with a valid use-by date, with water-based lubricant.
- Keep it away from sunlight and high temperatures, and do not put it in the back pocket of your pants or in your wallet.
- Use the condom throughout intercourse.
- Use a water-based lubricant to cut down friction and reduce the risk of damage to the lining of the anal canal.
- Use a new condom when changing sexual positions.
- Hold on to the condom while withdrawing to prevent leakage of semen.
- The condom should be used only once. Tie a knot in it, and wrap it in tissue and dispose of it in the bin **not** the toilet.
- Wash the penis with water and soap.
- If you suspect an infection, immediately contact a doctor. You may be eligible to take ART to reduce the risk of HIV transmission.

Session 9

Using antiretroviral drugs to prevent HIV

Time

1 hour

Objectives

At the end of this session, participants will be able to:

- have a good understanding of the relevance and potential benefits of PrEP and PEP in the context of MENA
- recognise that further research is needed before considering introducing PrEP and PEP in MENA
- raise MSM community awareness for PrEP.

You will need

- Flipchart, large sheets of paper, markers
- Handout (one per participant) of:

  Annex 21: Key messages on PrEP

Overview

With the development of pre-exposure and post-exposure prophylaxes (PrEP and PEP), along with advances in HIV prevention and treatment technologies, MSM nowadays have more options for protecting themselves and their partners from HIV transmission. Findings from clinical trials of PrEP have demonstrated safety and a substantial reduction in the risk of acquiring HIV infection for MSM. PrEP is therefore now recommended as a HIV prevention option for sexually active adult MSM at substantial risk of acquiring HIV, as part of a combination prevention approach.

In MENA to date, ARVs are not used for prevention purposes. The objective of this session is to raise awareness among peer educators about the potential benefits and challenges of PrEP and PEP for MSM living in MENA, and acknowledge that sound research, as well as proactive advocacy, is required before widening the range of prevention options made available to the MSM community.

Activity: Understanding the potential benefits and challenges of PrEP and PEP in MENA

Step 1: Q&A on advantages and disadvantages of PrEP and PEP (30 minutes)

1. Start the session by asking participants to brainstorm their understanding of PrEP and PEP.
   - *What do these two acronyms mean? What is the difference between the two?*
   - *What are their potential benefits and risks?*
2. Correct and complete the knowledge of participants using the information on PrEP and PEP in Annex 18 and Annex 21.
3. Sum up by emphasising that although these methods are not yet available in MENA, both WHO and UNAIDS recommend it: WHO in its 2014 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* recommends PrEP for MSM as an additional HIV prevention choice within a comprehensive HIV prevention package, and PEP for all eligible people from key populations on a voluntary basis after possible exposure to HIV. UNAIDS calls for 90% coverage of key populations, including MSM, with combination prevention packages that include condoms, lubricant and PrEP.

Step 2: What does this mean for MENA? (20 minutes)

4. Ask participants to now imagine that PrEP and/or PEP are authorised in their country and made available for MSM through the health services providing ART, and/or the civil

society organisation (CSO) providing prevention services for MSM:

- *Why might someone be interested in taking PrEP?*
- *What would be the advantages and disadvantages?*
- *How would the delivery of PrEP function?*
- *What are the concrete challenges that might arise?*

Write on the flipchart the main challenges and risk that emerge from the brainstorming.

5. Explain that in all settings where PrEP is introduced and tried, communities raise concerns regarding costs, stigma and discrimination, or side effects, among others. There are concrete barriers that must be addressed for PrEP to be effective, and there is debate about what effects PrEP has for prevention messages and counselling (for example, in relation to risk reduction and condom use). WHO and UNAIDS therefore recommend that national programmes interested in PrEP perform small pilots to verify whether scale-up is worthwhile and what needs to be in place to make it effective. A first country in the region, Morocco, is carrying out in 2016 a study to see how PrEP use impacts on MSM.

Step 3: Raising MSM community awareness for PrEP and PEP (10 minutes)

6. Conclude this session by explaining that although PrEP and PEP are not yet available in MENA, the MSM community should be informed about the risks, costs, requirements and benefits of these methods and, if they acquire HIV, about the availability of HIV treatment. CSOs have a critical role to play in ensuring acceptance of PrEP and in increasing demand for this kind of intervention.

7. Since PrEP is a relatively new intervention, informed community discussion and awareness-raising activities are initiated worldwide, they should be initiated in MENA also. MSM should be informed about the existence of PrEP and PEP, their questions and concerns should be addressed sensitively and through the dissemination of factual information, and their expectations managed by reminding that sound research and advocacy is needed before PrEP can be considered in MENA.

Annex 21: Key messages on PrEP

- Pre-exposure prophylaxis (PrEP) is the daily use of ARVs by HIV negative people to prevent HIV acquisition: currently it is a daily oral fixed-dose combination of tenofovir disoproxil fumarate (TDF) 300 mg and emtricitabine (FTC) 200 mg (labelled as Truvada), but it is possible that in the near future, there will be other PrEP options.
- When taken daily as directed, PrEP can reduce the risk of HIV infection by more than 90%. Findings from clinical trials of PrEP have demonstrated safety and a substantial reduction in the risk of acquiring HIV infection for MSM.
- PrEP is therefore recommended as a HIV prevention option for sexually active adult MSM at substantial risk of acquiring HIV, as part of a combination prevention approach:
  - WHO 2014 *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* recommend PrEP for MSM as an additional HIV prevention choice within a comprehensive HIV prevention package.
  - UNAIDS calls for 90% coverage of key populations, including MSM, with combination prevention packages that include condoms, lubricant and PrEP.
- In controlled clinical trial settings, when people take PrEP as directed, it is highly effective at preventing HIV infection. However, demonstration studies to show how PrEP works in real life settings are needed to inform implementation and scale up. The importance of the context in which PrEP is made available should never be underestimated. The geographical, social, economic and cultural context play a key role both in deciding to start taking PrEP as well as in adhering correctly to the prescribed doses.
- Given this uncertainty, WHO recommends that national programmes interested in PrEP perform small pilots to verify whether scale-up is worthwhile and what needs to be in place to make it effective. A first country in the region, Morocco, is carrying out in 2016 a study to see how PrEP use impacts on MSM.
- National AIDS strategy plans in MENA increasingly recognise the heightened HIV risk and vulnerability of MSM. Where PrEP is not available, this may include advocacy for its provision as a HIV prevention option, while also safeguarding the availability of treatment to those who are already living with HIV.
- Although ARVs such as PrEP and PEP are playing an increasing role in HIV prevention in other regions, they should always be used in combination with an appropriate mix of other biomedical, behavioural and structural interventions. Condoms and lubricant remain the most convenient and cost-effective choice, and therefore remain fundamental to any package of HIV and STI prevention, treatment and care services for MSM.

Session 10

Time

1 hour

Objective

At the end of this session, participants will be able to:

- compile, discuss and provide accurate information about HIV and other STIs.

You will need

- Flipchart, large sheets of paper, markers
- Handout (one per participant) of:

  Annex 22: List of misconceptions about STIs with the correct answers

False beliefs about STIs

Overview

This session encourages participants to identify and discuss common myths about STIs, what they are, and what is true and false. Make sure that plenty of time is left for discussion.

Activity: Possible or impossible?

Step 1: Collect and list the information (20 minutes)

1. Ask participants to go into small groups to discuss common beliefs about STIs in their local communities (it could be about diagnosis, methods of transfer and/or treatment).

Step 2: Discussion and corrections (40 minutes)

2. Then ask them to discuss the accuracy of this information within their groups. Following this, each group should share their findings with the larger group. You as facilitator should be able to correct any remaining misconceptions (Annex 22).

Annex 22: List of misconceptions about STIs with the correct answers

MISCONCEPTION	CORRECT INFORMATION
STIs affect MSM because they have unnatural sex	Statistically, MSM have a higher prevalence of STIs than the general population because: ▪ anal sex is much more risky than vaginal sex, particularly for the passive partner ▪ they may have a number of casual sexual partners while also having a long-term partner ▪ some relationships are considered "open"; i.e. the partners have agreed they can have sex with other men (open relationships often have rules like agreeing that they will only have anal sex with each other) ▪ maintaining the use of condoms over a long time can be challenging, particularly in long-term relationships ▪ stigma and discrimination make it more likely that they will not get appropriate education and support, or access to condoms and lubricants ▪ low uptake of HIV testing results in higher levels of HIV and other STIs, and vice versa (research suggests that there is a relationship between HIV testing and the level of HIV and other STIs).
Passive sexual partner is less at risk	**Not true:** in fact they are more at risk. However, talking about the percentage of risk is unhelpful in real life. It is always preferable to have safer sex regardless of whether the person is an active or passive partner.
A sexual relationship between an adult and an underage girl or boy is not risky for HIV and other STIs	**Not true:** unprotected sex is always risky if you are infected with STIs, regardless of age and social or economic status. Older people having sex with underage girls and boys can have a devastating impact on the young person's life and can be considered child abuse.
Herbal therapy is the best treatment for STIs	**Not true:** people with STIs should seek medical help to receive treatment that has been scientifically tested and known to work.
Cleanliness after sex is the best prevention	**Not true:** Cleanliness is very important but does not protect from STIs.
The presence of haemorrhoids increases the risk of HIV and other STIs among MSM	**True:** it does increase risk if unprotected sex occurs and there is bleeding.

Session 11

Time

1 hour 30 minutes

Objective

At the end of this session, participants will be able to:

- consolidate/update their knowledge about drug use
- make the link between drug use and HIV and other STIs.

You will need

- Flipchart, large sheets of papers, markers
- List of questions for the exercise
- Handout (one per participant) on:

  Annex 23: Drug use and the risks of HIV and other STIs

Drugs and prevention

Overview

This session has some useful information about drugs and drug taking, so it should be of particular relevance and interest to participants. You may want to invite a specialist in this field to present the session if you do not think you have sufficient experience to train participants about drug use, HIV and MSM.

This is an important subject to understand as participants are highly likely to come across MSM who use drugs and may be at increased risk of HIV as a result of their drug use.

It is useful to share any national and local data about drug use patterns among the population in general and MSM in particular, if known.

Research facts about the country where the workshop is taking place and focus on the type of drugs used locally by MSM. However, this should not prevent you from also listing all types of drugs, their effects and associated risks.

Activity: Drug use and prevention

Step 1: Q & A (30 minutes)

1. Start off with the following questions:
   - *Why do we need to talk about drugs?*
   - *What is the link between drug use and HIV/AIDS?*
   - *What do you know about MSM and drug use?*
   - *What kind of drugs do MSM use?*

Step 2: Brainstorming, group work and information correction (30 minutes)

2. Initiate a brainstorming session by talking about the different types of drugs and their effects. Then get everyone into small groups to talk about the effects of different drugs (Annex 23).

Step 3: Discussion, Q & A and information correction (Annex 23) (30 minutes)

3. Ask the group to discuss:
   - the reasons why people use drugs, including alcohol
   - the difference between recreational drug use and drug addiction
   - the different ways of taking drugs, such as smoking, drinking, eating, injecting
   - risks associated with drug use, such as behavioural inhibition, infection, overdose, HIV
   - what treatments are available for opiate addiction, such as maintenance therapy (medically supervised opiate treatment).

Example

Nabil is 20 years old and studying foreign languages at the university

Nabil loved modelling and enjoyed dressing up in the latest fashion. Nabil's mother died when he was young, and he lived with his father, Mohammed, and grandmother, Fatima. Fatima did not approve of the way Nabil looked and dressed. She was always criticising him and worrying about what their neighbours might think. One day when Nabil came home with a new hairstyle, Fatima shouted at Mohammed, saying he needed to control his son. He was bringing dishonour to the family because he acted and dressed in a feminine way. Mohammed told Nabil that he needed to change the way he looked or he would have to leave home.

The situation deteriorated and Nabil decided to move in with a friend. He started to spend more time in bars but he didn't have a job to pay for his lifestyle. One day Nabil agreed to have sex with a man in exchange for money. He began to sell sex more and more in order to pay for his studies and living costs, since his family no longer supported him. He also started drinking more because clients bought him drinks as they got to know him. Nabil started to miss classes and knew that he was getting into trouble. He missed his family but was scared to return home. He did not know how to get out of his situation.

Annex 23: Drug use and the risks of HIV and other STIs

TERM	DEFINITION
Drugs	Natural or manufactured substances that affect the brain and nervous system as they interact with the functions of the human body, affecting the senses, reactions and behaviour. They can be used for medical purposes and recreation.
Drug tolerance	When a person's reaction to a drug is progressively reduced, requiring an increase in concentration of the drug to achieve the desired effect. Someone who has a high tolerance can take amounts that would kill a person who has not been previously exposed to the drug.
Drug use	The intermittent use of substances, not necessarily for medical purposes.
Drug dependency/ addiction	A disorder that occurs when a person needs alcohol or a drug to function normally. Abruptly stopping the substance leads to withdrawal symptoms. Addiction means that a person has a strong urge to use the substance and cannot stop, even if they want to.
Overdose	The act of taking a dose of alcohol or drug resulting in adverse reactions, ranging from mania, hysteria and coma to death.

Types of drugs

Hallucinogens, tranquillisers and stimulants

Hallucinogens are drugs that induce hallucination and produce changes in perception, thought and feelings. Reactions may vary from person to person, ranging from extreme joy to extreme terror. LSD (“acid”) is a commonly used hallucinogen. Hashish (cannabis) is one of the most widely used recreational drugs that can also be a hallucinogen in its purest form.

Tranquillisers are drugs to reduce tension or anxiety. They can have a sedative effect and can lead to dependence with long-term use.

Opioids are painkilling drugs derived from opium poppies (morphine, heroin, methadone, codeine). They can create a feeling of intense euphoria and wellbeing. They also lead to addiction. Side effects include sedation, respiratory depression, severe withdrawal, development of tolerance, and dependence issues.

Stimulants increase the activity of the brain and the nervous system, and give a feeling of euphoria, weaken the appetite, alleviate fatigue and intensify heart rate (which increases blood pressure). Stimulants include nicotine, caffeine, cocaine, amphetamines and ecstasy pills.

Alcohol in low doses can lead to a feeling of euphoria, stimulation and lowered inhibition. In high doses it can lead to drowsiness, slurred speech, emotional volatility, impaired memory, sexual dysfunction and loss of consciousness. Side effects include addiction, depression, liver and heart disease, and overdose.

Recreational drugs

“Recreational drugs” is a term used for substances that are often used in entertainment venues such as nightclubs, bars and dancehalls (raves). These drugs are illegal, but use has increased among young people:

- Cocaine
- Ecstasy
- GHB
- Medicine
- Poppers

Physical side effects

- Dehydration
- Increase in body temperature
- Strong feelings of anxiety or fear
- Unexpected negative consequences when interacting with other drugs (especially alcohol)
- May also lead to behavioural disinhibition, which means doing things – often risky – that they would not do if they were not taking the drug.

Associated risks

- Recreational drugs often contain unknown ingredients.
- Pills may all look the same yet have different ingredients and effects (stimulating, hallucinogenic etc.). Users may confuse one with another, miscalculate doses or simply ignore what they are ingesting.
- The negative effects of mixing drugs – because stimulants raise the heart rate and blood pressure, this may lead to problems with the heart and the respiratory system (unlike sedatives, where there is a decrease in heart rate and blood pressure).

Annex 23: Drug use and the risks of HIV and other STIs

TYPES OF RECREATIONAL DRUGS, THEIR EFFECTS AND WAYS TO REDUCE HARM		
TYPE	SIDE EFFECTS	HARM REDUCTION MEASURES
Cocaine	■ Cocaine is a stimulant that is usually in the form of a white powder that is sniffed or snorted. Although users feel energised after using the drug, its negative effects include loss of appetite and feelings of anxiety and discomfort. Cocaine users can also use injecting drugs and take sexual risks that they would not do if they did not use cocaine. ■ Studies on cocaine users have shown that they have a higher prevalence of HIV largely related to other behaviours – needle sharing, unprotected sex, sex work – and while sniffing powder is not a risk for HIV, other behaviours are.	**Use your own tools and make sure they are clean** Use the snorting method and prepare your own snorting tools: ■ a piece of plastic sheeting, mirror, straw or bank note ■ a clean card for cracking the substance ■ use either a straw or a rolled-up bank note (that hasn't been used by someone else) ■ use a new bank note or straw for every session
Ecstasy pills	■ A synthetic drug that acts as a stimulant. Comes in various shapes, sizes and colours, and is stamped with different designs. ■ Ecstasy pills have an energising and hallucinatory effect. ■ Side effects include increased heart rate, blood pressure, anxiety, nausea and blurred vision. ■ Use can lead to dehydration and collapse.	■ Use only one type and avoid mixing different drugs. ■ Refrain from using different methods in the same session (sniffing, inhaling, injecting), whether for the same drug or several types. ■ Refrain from mixing the drug with alcohol, as this could lead to loss of motor coordination and collapse, disorientation, and loss of consciousness. ■ Avoid reducing the effects of one type of drug by using another. ■ Always keep hydrated while using ecstasy. Drink 500ml to a litre while out dancing. ■ Use a condom during sexual intercourse.
GHB	■ GHB is a sedative and is often used as a liquid even though it is available in powder form. It is also known as the "date rape drug" and is often added to alcoholic drinks to increase its impact. This can cause collapse and loss of consciousness. ■ GHB rape victims are usually unable to consciously consent to sexual acts and often do not remember the act or the offender. ■ Some people use GHB voluntarily. ■ Consuming GHB and alcohol can result in sudden loss of consciousness, difficulty in breathing and, in some cases, death.	■ Hold on to your drink at parties and make sure it is in fact the right drink (juice, soda or alcohol). ■ Should you experience any strange symptoms, stop drinking alcohol and drink plenty of water instead, and find a friend or a trusted person to tell them.
Medication	■ In several MENA countries, medicines such as Tramal, Rivotril, Cemo, Valium, Neocodeine, Xanax are sometimes sold without prescription and used during parties. ■ When they are combined with alcohol, misuse of these medicines that are sold over the counter can be very dangerous and lead to health problems, including overdose and death.	

Annex 23: Drug use and the risks of HIV and other STIs

TYPES OF RECREATIONAL DRUGS, THEIR EFFECTS AND WAYS TO REDUCE HARM		
TYPE	SIDE EFFECTS	HARM REDUCTION MEASURES
Poppers	■ A type of liquid chemical administered by inhalation and sold in small bottles. The side effects of this drug include muscle relaxation and expansion of the arteries. ■ It produces a heightened sense of reality for a short time and a short-lived sense of intimacy and excitement. ■ It is also used before anal sex to help relax the muscles of the anus. ■ Increases the risk of anal bleeding when performing anal sex because of its effect on the arteries. ■ Anal bleeding increases the risk of STIs, such as HIV and syphilis. ■ Causes fainting, dizziness and trembling.	■ Use condoms in all sexual relations (this advice is valid whatever the drug!). ■ Change condom with each change of position during sexual relations.

Ways to use drugs

There are different ways of using drugs according to their type: smoking, inhaling, sniffing, chewing, swallowing and injecting.

Why do people use recreational drugs?

- Their friends are doing it and they don't want to feel left out or not be cool.
- They want to experience “euphoria”.
- Experimentation, being rebellious and taking risks.
- Belief that it increases sexual prowess.
- It makes them feel more relaxed; they can forget their worries and escape from harsh realities.
- A desire to participate, such as at parties.

The risks associated with drug use, and their health, social and legal implications

Drugs may be prescribed to alleviate pain or to treat mental, neurological or psychological illnesses. However, when a drug is not used for medical reasons, and without supervision and/or prescription – and particularly if it is mixed with alcohol or with other drugs – it can lead to chronic health and social problems, as well as to addiction, overdose and death.

People who use drugs are exposed to risks and may experience problems with their community, parents or workplace. This can lead to isolation and marginalisation, and (depending on the type of drug) to prosecution. In addition, drug use can lead to increased risk of HIV infection, viral hepatitis B and C, cancer, ulcers, distress, coma and overdose. In summary:

- **Physical dependency** – the interaction of the body with the drug, so that when without the drug, the person can experience mental and physical dysfunction, accompanied by pain in all parts of the body, muscle spasms, vomiting, diarrhoea and deficiency symptoms.
- **Psychological dependency** – the person having an irresistible craving to find the substance, with a strong desire to relive previous enjoyable sensations. Side effects may include anxiety, stress, depression and withdrawal symptoms.
- **Long-term health problems** – major organ disease (liver, heart, kidneys, lungs); psychological complications; dependency and addiction; infection around injection sites.
- **Long-term social problems**, when not controlled – family and relationship disruption; dependency leading to financial problems, crime and sex work; inability to work.

The link between HIV and drugs

- The HIV virus remains alive in blood contained in syringes for up to four weeks. Sharing contaminated needles among people who inject drugs exposes them to HIV infection and hepatitis B and C.
- Just a small amount of blood in tools such as injection needles can transmit the virus.
- Stimulant drugs affect personal behaviour during sexual relationships; people who use drugs expose themselves to the risk of HIV transmission through unprotected sex and by sharing needles or other injecting tools.

Annex 23: Drug use and the risks of HIV and STIs

Recreational drugs are mostly stimulants and their use can increase the risk of STIs:

- The sense of euphoria caused by these drugs dampens the perception of risk or harm, and diminishes the instinct for self-protection, as well as the ability to use condoms correctly when having sex.

Increased sexual arousal can also lead to a decrease in the perception of risky behaviour.

Prevention during sexual relations under the influence drugs

- Try to avoid penetrative sex when high on drugs.
- Keep condoms and lubes with you at all times.

Prevention while injecting drugs

- Make sure you always use a new/clean needle and syringe. **Never** share needles and syringes!
- Wash your hands before and after injecting.
- Make sure you know the side effects of the drug and don't mix more than one type per session.
- Tend to any wounds and ulcers, especially if there is blood and you are using sharp tools.
- Dispose of used needles responsibly.
- If addicted to drugs and/or alcohol, seek medical help. Substitution therapy may be available to keep you stable and help you live with your drug use in a way that does not affect your mental, physical health and wellbeing in such a damaging way as when it is uncontrolled.

Getting treatment

- Admit that you have a problem and need help.
- Decide to take action today and not tomorrow.
- Visit local centres that specialise in harm reduction.

Treatments for people who use drugs

The global response to drug use is guided by the principles of harm reduction.

Harm reduction is an evidence-based approach that aims to reduce the adverse health, social and economic consequences of drug use for individuals who use drugs, their families and their communities. It is a pragmatic approach to health comprised of interventions that address harms like HIV transmission, hepatitis C transmission, overdose and unsafe injecting. The approach is guided by both public health and human rights principles.

People who have become dependent and/or addicted to drugs and alcohol have several options about managing their situation. These can include undertaking a process of withdrawal and then remaining abstinent from drugs or alcohol; trying to control their drug use and limit the potential harms associated with them; and for people addicted to opiate drugs such as morphine, heroin and other opioid-derived drugs, a treatment option called substitution or replacement therapy. Whatever the approach, it is important to consider the following stages:

- **Stage 1:** understand whether the person themselves sees drug use as being a potential problem in their lives**.** A person's current perception will influence the approach. Those who want to reduce or stop their drug use will need to be referred for support and treatment. For those who do not want to change, it is important to raise awareness of the risks – physical mental, social – associated with drug use, addiction and the wider impact it can have on their own life and the lives of their loved ones.
- **Stage 2:** those who would like to become drug and/or alcohol free may need to register to be part of a rehabilitation and detoxification programme. This process can take anywhere between six months to three years depending on the individual. Detoxification is often started and supervised within a hospital or a specialised centre. The medical treatment involves eliminating physical dependence and can take between five days and three weeks.

  There are many approaches to rehabilitation, including behavioural therapy programmes as an inpatient or an outpatient. Some of these approaches adopt client-focused therapy, motivational interviewing and becoming a lifelong member of a 12-step programme.
- **Stage 3:** for those people who are addicted to opiate-based drugs and feel they cannot go down the abstinence approach, there is a medically supervised programme called opiate substitution or replacement therapy. This involves the person taking a daily dose of an opiate substance such as methadone or buprenorphine prescribed by a doctor. This treatment can control cravings and the destructive behaviours that can accompany drug use. Most people on this treatment are able to maintain work and remain sober. As the therapy is given at predictable times, and at a dose level that will not cause harm, people on this therapy often live quite normal lives and others would never guess that they have ever been dependent on drugs. However, drug replacement or maintenance therapy is not available in all countries, and in some countries it is illegal despite being fully supported by WHO.

Session 12

Time

1 hour

Objective

At the end of this session, participants will be able to:

- analyse their attitudes toward sex work and any related misconceptions.

You will need

- Flipchart and large sheets of paper
- Handout (one per participant) on:

  Annex 24: MSM and sex work – Q&A

Sex work

Overview

This session is about MSM and sex work. It is an important subject for peer educators, particularly in relation to HIV and other STIs.

The session aims to help to dispel myths and correct misconceptions.

It is important to refer to statistics about local experience of sex work, MSM and HIV, if they exist.

Activity: Concepts related to commercial sex and MSM

Step 1: Brainstorming (20 minutes)

1. Start the session by asking participants to brainstorm their understanding of sex work. Who does it? When? How? With whom?

Step 2: Group work (20 minutes)

2. Divide participants into three groups and ask them to stand facing a large sheet of paper on the wall with questions on it taken from Annex 24.

   In Part 1 of the exercise, the groups must answer "Yes" to every question, even if they are not convinced the answer should be a "yes". This is in order to reflect the common beliefs of local communities.

3. In Part 2 of the exercise, the groups move to another sheet and this time answer "No", backing up their answers with evidence.

Step 3: Reading the answers and discussion (20 minutes)

4. In the big group, spend five minutes asking each group to share their answers to Part 1 of the exercise. Then spend 10 minutes sharing the answers to Part 2. Spend the last five minutes answering any remaining questions or concerns about sex work and MSM.

Annex 24: MSM and sex work – Q&A

QUESTIONS	ANSWERS
Are all MSM sex workers?	Of course not. Sexual orientation and sex between men does not constitute sex work. Sex work is an exchange of money, commodities or services for sex; i.e. one person is selling a service (sex) and the other person is buying it.
Would a person offering money/gifts for sex always entice an MSM to have sex with them?	This would be the same answer if the person were heterosexual; i.e. most people do not sell sex for money or gifts, but some do. Some who sell sex are MSM, whereas others are heterosexual men and women. There can be formal sex work as well as informal sex work. For instance, some young people will have sex with older people for items such as cell phones and luxury goods, and this is known as transactional sex.
A homosexual is usually unable to commit to one sexual partner	Commitment to one sexual partner is a personal choice regardless of sexual orientation or sexual behaviour. Some MSM choose to live in "open" relationships, where they have a primary partner but the couple has an agreement that they may have sex with other people. In reality, in some parts of the world like the MENA region, it is difficult for two men to set up home together and be known as a couple. Having to constantly hide who they are and who they love can put a strain on any relationship.

Session 13

Health education and harm reduction in the field

Time

1 hour 30 minutes

Objectives

At the end of this session, participants will be able to:

- understand the concept of outreach programming and how to develop it based on a public health approach
- define health, health education and its components
- identify risk reduction approaches
- explain the importance of peer education and participatory approaches.

You will need

- Large sheets of paper, markers, masking tape
- Handouts (one per participant) on:

  Annex 25: Peer health education based on public health principles

  Annex 26: Risk reduction

Overview

This session contains information about peer outreach and health education. You will need to adapt it so that it is at an appropriate level for your group. This technical information is central to the training, so you must make sure that participants understand it all. Allow time for questions and answers, as this exercise is a preparatory session for subsequent sessions.

Activity: Outreach programming and health education

Step 1: The wall journal exercise (20 minutes)

1. Distribute the following concepts, each written on a small sheet of paper:

health • health education • risk reduction • behavioural change • peer education

2. Distribute the following list of descriptive terms and ask the participants to discuss their understanding of the words and then place the words beside the appropriate corresponding word from the first list. Participants may find that they use a word or phrase more than once. Words to discuss:

inner peace • physical wellbeing • social relationships • information • skills • attitudes • values • renewed enthusiasm • resources • balancing benefits and risks • long term • continuity • risk • similar characteristics • similar age • mutual understanding • creativity • participation • necessity • better future.

Step 2: Summary and correction of information (1 hour 10 minutes)

3. Once this exercise is complete (and displayed on a large sheet of paper on the wall), make any necessary amendments and then summarise the definitions of "health" and "health education". Then explain the process of behavioural change and the elements that support it. Discuss the issue of harm reduction.

4. You should end by summarising the definitions of "health", "health education" and "peer education", and the importance of adopting a participatory approach.

Annex 25: Peer health education based on public health principles

WHO in its constitution of 1946 defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." When we are considering outreach work with MSM in the area of HIV and STI prevention, this holistic understanding of health is extremely important in guiding the nature and focus of any interventions.

Peer education is an approach that employs people of a similar age with similar characteristics to the target group to go out and meet MSM in places where they socialise and live, and provide health and social support. Peer educators who are well trained and supervised can often be extremely effective at building the trust and confidence of MSM. With that trust, they are able to provide MSM-specific health education, active encouragement and support for behaviour change, psychosocial support to those who need it, as well as be trusted providers of condoms and condom-safe lubricant. Peer educators can provide their services to individual MSM as well as to small groups.

It is essential that peer educators are seen to be practising what they preach and remain professional at all times. Those who do not will no longer be taken seriously. Therefore, it is imperative that organisations running peer outreach services provide their peer educators with regular supervision and an opportunity to discuss and share any personal concerns about their own behaviour or challenges, and get the support they might also need.

MSM in the MENA region often live in challenging circumstances, where their rights are neither protected by the laws of the country nor by the communities in which they live. Any outreach programme focused on behaviour change must take into consideration the impact of the context where MSM live on their behaviour, sense of self, and mental and social wellbeing. That is why HIV programmes working with MSM generally provide direct support to MSM, as well as undertake initiatives to help change negative social norms about MSM into something more positive and welcoming. Therefore, peer education programmes working with MSM must fully endorse and promote the basic human rights of MSM, including their right to self-determination.

As part of helping to create a more welcoming and enabling environment, peer educators can be very effective at trying to address some of the issues of stigma and discrimination experienced by many MSM. They can do this by actively working with and supporting healthcare workers, religious and community leaders, and law enforcement agents to be less discriminatory and more supportive of the human rights and the health and social support needs of this population.

It is essential that peer educators get to know local service providers and work with them to provide sensitive and quality health and support services. Peer educators can only do so much, and one of their most important roles is to identify the needs of their clients and, where necessary, make effective referrals to service providers, and then support the client with any follow up.

Peer educators and peer education programmes are a means of ensuring the social inclusion of MSM in society. MSM are often marginalised and treated with contempt as well as intimidation and violence. As a result, they can feel isolated and fearful. By providing sympathetic, compassionate and respectful peer education programmes, MSM can feel respected, that their needs are valid, and that they are deserving of respect from others as well as themselves. Therefore, peer education approaches can help to transform lives.

Peer educators can play a number of roles. Core functions will include:

- providing correct information on health issues such as HIV and other STIs, risk behaviours and prevention
- distributing condoms, lubricants, clean needles and syringes, and other injecting equipment
- providing some direct health services such as VCT, adherence support for HIV-positive men taking ART, and psychosocial support
- facilitating referral – one of the most important roles of a peer educator is to ensure that their clients are referred to the services they need. Peer educators need to follow up any referral to ensure that the person was able to access the service and received appropriate and sympathetic treatment and/or services. Services could include HIV testing, STI diagnosis and treatment, and HIV treatment and psychological support. Sometimes a peer educator will accompany the person to a service provider, particularly if they feel nervous or embarrassed about seeking help.

Annex 25: Peer health education based on public health principles

DEFINITIONS OF COMMON TERMS RELATED TO HEALTH AND PEER EDUCATION	
TERMS	**COMPONENTS**
Health	A sense of psychological and physical wellbeing
Health education	Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes. (WHO)
Behaviour change	A process of addressing knowledge, attitudes and practices associated with a particular behaviour in order to change it. For example, exploring and understanding the level of knowledge, attitudes and practice of someone having unprotected sex to help them change their behaviour to practise safer sex.
Peer education	Teaching and sharing of information by people who have similar characteristics to the target group, such as age, culture, social status and life experiences.
Risk reduction	A process of identifying the risks associated with HIV and other STIs and implementing measures to limit the risk of transmission. These can include direct measures such as condom use, reducing number of sexual partners or only practising safer sex, as well as efforts that address the context of where MSM live and operate; e.g. to make sex work safer by ensuring that all sex workers are protected from violence and have access to condoms and lubricants at all times.

Annex 26: Risk reduction

One of the best-known HIV prevention approaches is the ABC approach: abstinence, be faithful and/or use a condom. In reality, for most people abstinence is not really an option.

MSM are at a higher risk of HIV and other STIs for a number of reasons:

- They have a higher level of exposure to HIV and other STIs because there is a higher prevalence of these infections among MSM than among the general population.
- Some sexual practices such as anal sex carry a higher risk of infection than others.
- Some MSM have not had access to sex education and prevention advice that is relevant to their own lives.
- Maintaining safer sex can be challenging. For instance, a recent study in Lebanon found that over half of MSM surveyed and targeted in an intervention programme between 2007 and 2011 were not using condoms in their sexual relations. Most stated that condoms interfered with their enjoyment of sex and reduced their sexual pleasure. Despite the increased risk of HIV and other STIs, they preferred to take the risk and have a higher level of sexual enjoyment.

Risk reduction is an approach to behaviour change that acknowledges that it is not possible to reduce all risks unless someone becomes totally abstinent. Since this is the case, risk reduction approaches encourage people to reduce their risk of exposure to HIV and other STIs by adopting evidence-based and scientifically validated prevention approaches. These include reducing the number of sexual partners; using condoms and condom-safe lubricant for anal sex; getting STIs treated early; getting tested for HIV and starting ART early to keep HIV viral load low; and limiting the use of alcohol and recreational drugs to reduce the risk of behavioural disinhibition.

Session 14

The peer educator

Time

1 hour

Objective

At the end of this session, participants will be able to:

- identify the job requirements of the peer educator in terms of knowledge, attitudes and skills before implementing street interventions.

You will need

- Large sheets of paper, coloured markers, masking tape
- Handout (one per participant) on:

  Annex 27: Characteristics of the peer educator

Overview

This exercise provides programme planners and field supervisors with a set of core characteristics that will be useful for selecting peer educators.

Activity: The role and characteristics of the peer educator

Step 1: The drawings (15 minutes)

1. Draw an image of a peer educator and ask each participant to provide characteristics that they feel are important for them to be successful; e.g. knowledge, values, attitudes and skills.

Step 2: Presentation (45 minutes)

2. Ask each participant to read out loud the characteristics they have chosen and explain why. Ask the rest of the group if they agree with each characteristic. If not, why not?
3. Once all the participants have shared their characteristics, review the information and add any further characteristics from Annex 27 if they did not come up in the discussions.

Walid, 31, is a student who is single and defines himself as MSM. He is a peer educator with SIDC and Helem in Lebanon

"I am a peer educator in the project and I benefited from all the trainings in terms of information, approaches for conducting peer education, planning my field work and, overall, I benefited from the field work and the practical aspects. I was able to put in practice the theoretical information I learned.

In my position as a PE [peer educator], what has changed is that I met other groups and communities who are different from the people I knew and I have learned how to work with approaches adapted to each of those groups. The way of working, of speaking, the content of the information designed for street youth are different from those used with young people in bars and nightclubs. I am no longer limited in using one single method or approach.

It is during my work on the street that I could feel the difference between the populations I meet with, and I started using two different methods or approaches. This was very important because it makes my interventions more useful and increases my self-confidence and my trust in the quality of the information I am providing. And when I feel that the people I am talking to accept easily, ask more questions and are interested in the issue, this makes my work more significant and more useful."

Bassem, 32, is a student and peer educator with ATL in Tunisia

"Today, I feel responsible for [my] sexual behaviours. I am aware of the importance of prevention and of the risks faced by our community, starting with the high risks of HIV infection since we have a concentrated epidemic in our community."

Annex 27: Characteristics of the peer educator

Peer educators may themselves belong to the target group, and may share some similar characteristics, such as age, social status, culture, religion and experience of being "different" from the dominant norm. This "insider knowledge" means that peer educators often know how and where to reach the target group, and what is the best way to approach them.

Training develops their capabilities and enables them to transfer their skills and knowledge into a health education and promotion context. Their role is to access the group and provide them with educational resources and accurate information about HIV and AIDS. They help MSM to develop an accurate sense of their own risks of acquiring HIV and other STIs by sharing their knowledge on the link between sexual and other behaviours and STIs and HIV. The peer educator promotes prevention by discussing risk and distributing condoms, lubricants, clean needles/syringes and injecting equipment when needed; providing basic health services in the street (whenever possible); and referring MSM to appropriate services such as VCT and STI screening, STI and HIV treatment and counselling, and services for people living with HIV.

Not all fieldworkers will be peers, but those who are not need to demonstrate a positive regard and respect for MSM and not be embarrassed about discussing intimate details about sex between two men. In fact, some MSM may prefer to be contacted by someone who is sympathetic but is not necessarily MSM themselves. In some situations, it may be much easier and safer for peer educators not to be identified as MSM.

Whether the fieldworker is a peer educator or not, he should meet the criteria in the table below. These characteristics are enhanced and developed with appropriate training and self-development.

The success of any outreach programme also requires community mobilisation, and this is best achieved by adopting a participatory approach. Organisations wishing to start a programme should involve the target group at all stages. This will strengthen relationships between MSM and the programme, and over time with the community in general, helping to reduce stigma and discrimination.

CHARACTERISTICS OF THE PEER EDUCATOR	
CORE CHARACTERISTICS	**SKILLS**
■ Aged over 18* ■ Known and respected by peers ■ Respects and values other people ■ Honest ■ Mature and able to keep information confidential ■ Adaptable ■ Welcomes feedback and wants to grow and improve	■ Able to communicate in the "language" of the target group and simplify technical information ■ Good listener ■ Able to make decisions ■ Able to work and operate in places where MSM gather regardless of practices and beliefs. These places can be dangerous ■ Innovative, suggest new and realistic strategies for supporting behaviour change ■ Responsible and well organised
KNOWLEDGE	**ATTITUDES**
■ Has a good understanding of: – HIV and other STIs – what they are, how they are transmitted, treatment and prevention – the impact of the social and economic context on behaviour – drug use, HIV and MSM – sex work, HIV and MSM ■ Has a good understanding of issues related to gender, sexual orientation and identity ■ Is familiar with available local resources	■ Understands and respects the values and principles of the target groups ■ Advocates for their rights and for human rights in general ■ Believes in the work he is doing and its importance ■ Strives to be free from prejudice and actively works against any discrimination towards MSM ■ Available to work in the evenings and weekends

* Programme planners should review local policies relating to street intervention when defining an age range for peer educators. It is best to choose over-18s but this doesn't prevent working with under-18s. This younger group, who may be sexually active, can receive personal awareness sessions, and can be asked to cooperate in bringing their peers for awareness or to be referred to services (especially if there are special protocols for counselling), voluntary testing and information, education and communication material distribution. Programme planners should work within local health policies and, if necessary, get parents' consent, as this is a sensitive moral issue.

Session 15

Time

45 minutes

Objective

At the end of this session, participants will be able to:

- understand and discuss the various attitudes and beliefs, and identify their own.

You will need

- Handout (one per participant) on:

  Annex 28: List of attitudes

Attitudes and beliefs

Overview

This interesting exercise may cause some agitation, so remind everyone about the workshop rules on respecting each other's opinion. Encourage constructive and evidence-based criticism, and let everyone express their views.

You may not get through the whole list of attitudes (Annex 28), so choose those you find appropriate and leave the rest for discussion throughout the training.

Listen to participants' points of view. Take notes and focus on any attitudes that need clarification or encouragement. Do not take sides, but gear the discussion towards the more positive attitudes without imposing them.

Encourage effective listening, as this exercise is a test of participants' openness and effective listening skills.

Activity: For or against

Step 1: Individual exercise (15 minutes)

1. Hand out copies of Annex 28, and ask participants to fill it in individually (without consulting each other), ticking the appropriate box for each answer.

Step 2: Group exercise (30 minutes)

2. Once they have finished, ask participants to stand facing each other holding their sheets and explain the reasons behind the choices they made (for or against). Those who opted for an "against" answer have to stand in the middle and explain their position.

Annex 28: List of attitudes

ATTITUDES	FOR	AGAINST	CORRECT ANSWER AND JUSTIFICATION
Distributing free condoms to MSM will encourage them to engage in same-sex practices			No, MSM have sex in the same way as men who have sex with women, but they have less access to information and condoms. Free condoms not only reduce the risk of HIV and other STIs for MSM, but also for all of society.
Giving free condoms to those under 16 will encourage them to engage in same-sex practices			Encouraging young people to delay having sex is important as research shows that the earlier you start having sex has some influence on the number of sexual partners over a life time. The more sexual partners you have, the more likely you are to get exposed to HIV. The reality is that young people do have sex and get exposed to infection when they do not use condoms. Distributing condoms provides an opportunity for health education and also to find out from the young person whether they are experiencing any problems or have any questions about intimacy, sex and sexuality.
Encouraging MSM to talk about who they are and their lives can help reduce their exposure to risks			Yes, because they feel they are accepted so that builds their trust with a peer educator and encourages them to ask questions. As they open up, their self-esteem will grow as they realise that they are accepted and respected. Increased self-esteem can led to less risk taking and increased use of condoms.
The best way to reduce harm from STIs is to ban/outlaw sexual relationships among MSM			Firstly, banning something doesn't mean that it will not happen. Secondly, stopping consenting adults from expressing their sexuality is contrary to human rights. MSM are just like heterosexual men and women in needing to express their sexuality and enjoy sex. What they need is the knowledge and guidance to be able to do it safely and enjoyably.
People living with HIV and with an undetectable viral load and a high CD4 count can have unprotected sex			Although having an undetectable viral load means the risk of HIV transmission is very low, HIV transmission is still possible. There are spikes in the level of circulating virus during times of illness and stress, and it is not feasible to do the level of screening necessary to observe the changes in viral load. Therefore, it is advisable to continue using condoms.
Encouraging MSM not to mix drugs will reduce their risk of overdose			Yes, it is never a good idea to mix drugs but it is also possible to overdose on just one drug.
Encouraging MSM to reduce their alcohol intake before sex will help them to use condoms			Yes. Even small amounts of alcohol can lead to disinhibition, meaning that people are less likely to use condoms.
Distributing condoms to MSM will encourage them to have multiple sex partners			This has nothing to do with the use of condoms. However, a condom will provide protection to those who want to have multiple sex partners.

www.aidsalliance.org

About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

www.aidsalliance.org

About UNAIDS

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative joint venture of the United Nations family, bringing together the efforts and resources of ten UN system organisations in the AIDS response to help the world prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic. UNAIDS helps mount and support an expanded response to AIDS – one that engages the efforts of many sectors and partners from government and civil society. Cosponsors include UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, UNWOMEN, WHO and the World Bank.

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