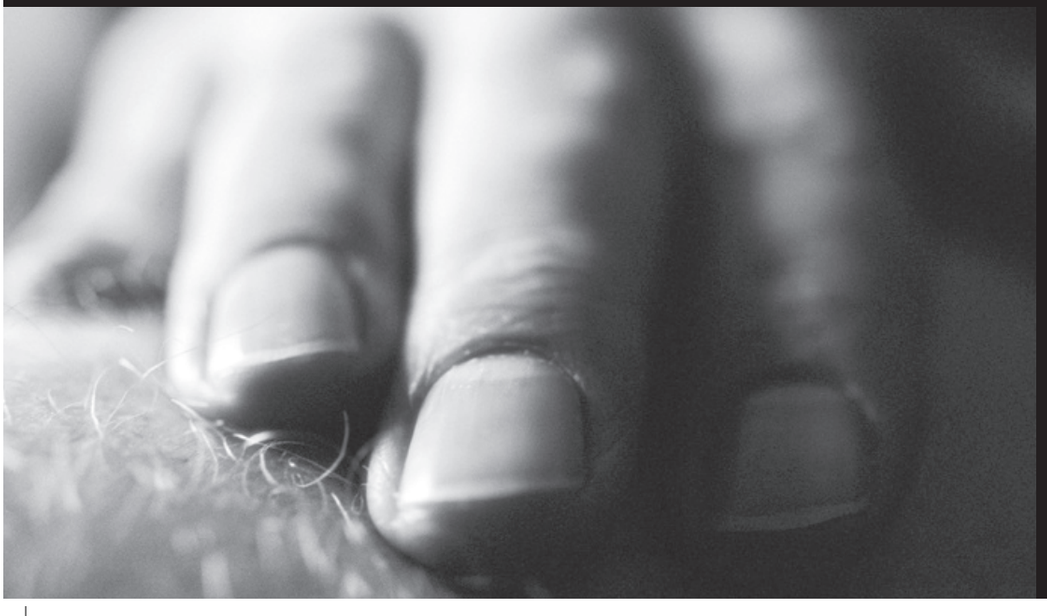
POZ PREVENTION

knowledge and practice guidance for providing sexual health services to gay men living with HIV in Ontario



The Toronto People With AIDS Foundation (PWA) exists to promote the health and well being of all people living with HIV/AIDS by providing accessible, direct and practical support services. For more information: **www.pwatoronto.org** or (416) 506-1400.

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Information published by PWA is not medical advice. We strongly urge people to consult with a qualified medical practitioner before undertaking any decision, use or action of a medical nature.

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A letter to service providers from two gay men living with HIV

September 2008

Gay men framed the AIDS epidemic in Canada and other parts of the world. We articulated safer sex for ourselves, and those beyond. We built our own organizations as the best people to respond to our crisis of care and HIV prevention. We fought for our ongoing self-determination as gay men throughout the AIDS crisis. We resisted all efforts to stop us from being who we are in our fullest ways.

Gay men living with HIV were pioneers in gaining access to treatments, treatment information and payment for HIV treatment in public and private drug plans. We risked public ridicule in fighting stigma and discrimination while protecting our rights to care and treatment and an active sexual life, and the right to services to help us survive. More recently, in light of more effective antiretroviral medications and dependent upon our aspirations and health status, many of us have striven to re-create, build and maintain meaningful, active lives.

Each gay man living with HIV is able to tell the story of how he became infected. In the spirit of self-determination, gay men living with HIV are now translating these stories into HIV prevention.

Until very recently all HIV prevention was directed toward the uninfected. Although this seemed logical, it excluded the involvement of many who are passionate and knowledgeable about HIV transmission within our community. In addition, it resulted in some campaigns and materials that unintentionally contributed to broader stigma and discrimination experienced by people living with HIV/AIDS. We now think it timely for gay men living with HIV/AIDS to be involved and leading in the development of resources, knowledge and programs that will provide HIV-positive gay men with the information, tools and skills needed to maximize our sexual health and impact HIV transmission. Thus poz prevention, or HIV prevention for people living with HIV, is our new horizon.

Like all HIV prevention efforts we need to make poz prevention speak to the individual and community aspirations of gay men and our identities. We want to remove the artificial barrier between positive and negative gay men and fully recognize the leadership and potential that exists within the gay community to care for each other and to educate those who work with us. Gay men have excelled in this and it has shaped us as individuals and as a community. As Poz gay men we are excited to be part of the development of this manual. It is our hope that this will bring energy and new ways for you to also be part of promoting health, in the fullest sense, to all gay men living with HIV/AIDS.

David Hoe

Poz Prevention Working Group

Ontario's Gay Men's Sexual Health Alliance

Murray Jose

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Ontario's Gay Men's Sexual Health Alliance

Executive Director,
Toronto People With AIDS Foundation

1. Providing sexual health services to gay men living with HIV: weaving together the strands of poz prevention

Who this manual is for

People in a position to provide poz prevention programs, including sexual health services, to gay men living with HIV, including:

- Staff and volunteers of AIDS service organizations (ASOs).
- Staff and volunteers of other social service organizations.
- Health care providers, including those who treat sexually transmitted infections (STIs).
- Public health staff.

Defining "poz prevention"

Poz prevention for HIV-positive gay men aims to empower individuals, promote healthy relations with sexual partners and improve conditions to strengthen the sexual health and wellbeing of HIV-positive gay men and reduce the possibility of new HIV infections and other sexually transmitted infections.

- Poz Prevention Working Group, Ontario's Gay Men's Sexual Health Alliance

Who this manual is about: gay men (and MSM)

Self-identified gay men living with HIV. This manual may also assist you when providing services to men who have sex with men (MSM) who do not identify as gay and to gay or queer transmen.

In this manual we use the term "gay" except where the term "MSM" is more accurate (e.g., when reporting epidemiological data or behavioural research specifically about MSM). We recognize the limits of words to reflect people's reality. In reality, most people's identity is much more fluid than the terms "gay" and "MSM" seem to allow. People may identify with different facets of who they are in different settings or at different times in their lives. As a service provider, it is important for you to take your cues from your clients when providing sexual health services, rather than making assumptions about their identity, their behaviours and their needs. It is important to create a space in which clients feel safe discussing their behaviours, motivations, emotions and needs – and safe laying claim to a specific identity if it is important to them to do so.

Identity, self-identity and the words we use: gay and MSM

The term "MSM" was developed in the early 1990s as a more inclusive term than "gay" or "bisexual." MSM describes all men who engage in sexual activity with other men, regardless of their cultural or political identity or how they self-identify. This inclusiveness makes MSM the most accurate term for certain purposes, including sociological discussions in which it is important to acknowledge men who do not identify as gay or bisexual and when collecting and reporting epidemiological data. However, in the context of the HIV epidemic, focusing solely on MSM can obscure or even erase gay men. Furthermore, most self-identified gay, bisexual, queer transmen, or Two-spirited men do not identify with the term "MSM". [2 3]

This manual is primarily about self-identified gay men, rather than all MSM living with HIV because:

- Gay men continue to be the largest group in Canada affected by the HIV epidemic.
- There is anecdotal evidence that the sexual health needs of HIV-positive gay men are not being met.
- The Poz Prevention Working Group of Ontario's Gay Men's Sexual Health Alliance, who conceived of and guided this project, is composed of self-identified gay men, most of whom are living with HIV. These men believed that they could not effectively represent the interests, concerns and needs of all MSM.

- HIV prevention resources developed for a specific, narrowly defined target audience are more effective than resources that attempt to respond to the needs of a general audience.
- The project resources were limited so it was not possible to also develop resources specific to MSM who do not identify as gay.
- While much of the information in this guide will be helpful in providing services to gay or queer transmen, we were unable to gain input from gay or queer transmen living with HIV in the creation of this guidebook. For more information about safer sex for gay and queer transmen read: *Primed: The Back Pocket Guide for Transmen and The Men Who Dig Them*.

Why this manual was written

This manual was written to foster a community of service providers who are able to provide standards-based, culturally competent and client-centred poz prevention programs to gay men living with HIV. This manual recognizes that providing such programs challenges many service providers and organizations. You must navigate a complex web of information and social relations, formed by questions of sex, sexuality, health, disease, illness, death, gender identity, race, culture and ethnicity, behaviour, science, medicine, law, ethics, professionalism, values, principles and standards. To complicate matters, our understanding of HIV transmission, HIV prevention and the criminal law regarding HIV and sex is evolving. Finally, until now there has not been a resource that weaves together the necessary knowledge base with crucial practice guidance.

This manual is intended to help you meet these challenges. Use this manual to empower yourself to provide the best possible poz prevention programs to gay men living with HIV.

What is in this manual: weaving together the strands of poz prevention

This manual will provide you with a **knowledge base** and **practice guidance**.

The **knowledge base** consists of information drawn from the two plain-language guides for gay men living with HIV (see "Who developed this manual," see page 5), supplemented with more in-depth information. The knowledge base will:

- Increase your understanding of the lived experience and sexual lives of gay men living with HIV.
- Identify and analyze preconceptions, attitudes and beliefs that can influence whether and how service providers and organizations provide poz prevention programs, including sexual health services, to a diversity of gay men living with HIV.
- Provide you with up-to-date HIV-related sexual health and legal information relevant to gay men living with HIV.

The **practice guidance** establishes a standards-based model for delivering poz prevention programs, including sexual health services, to gay men living with HIV. This practice guidance draws on:

- The **values and principles of poz prevention.**
- **Professional codes and standards** that seek to ensure that gay men living with HIV receive high quality, standards-based and legally and ethically sound services.
- **Guidelines** for providing sexual health counselling, HIV disclosure counselling and other services to gay men or other people living with HIV.

Wherever possible the manual integrates – weaves together – the strands of the knowledge base and the strands of practice guidance. It is virtually impossible to communicate in words the manifold connections between these strands. So we developed a graphic representation, "Weaving together the strands of service provision."

See next page ▶

HIV and AIDS among MSM in Ontario and Canada

In Canada and Ontario, MSM make up a clear majority of both new and cumulative HIV infections, AIDS cases and deaths due to HIV disease.

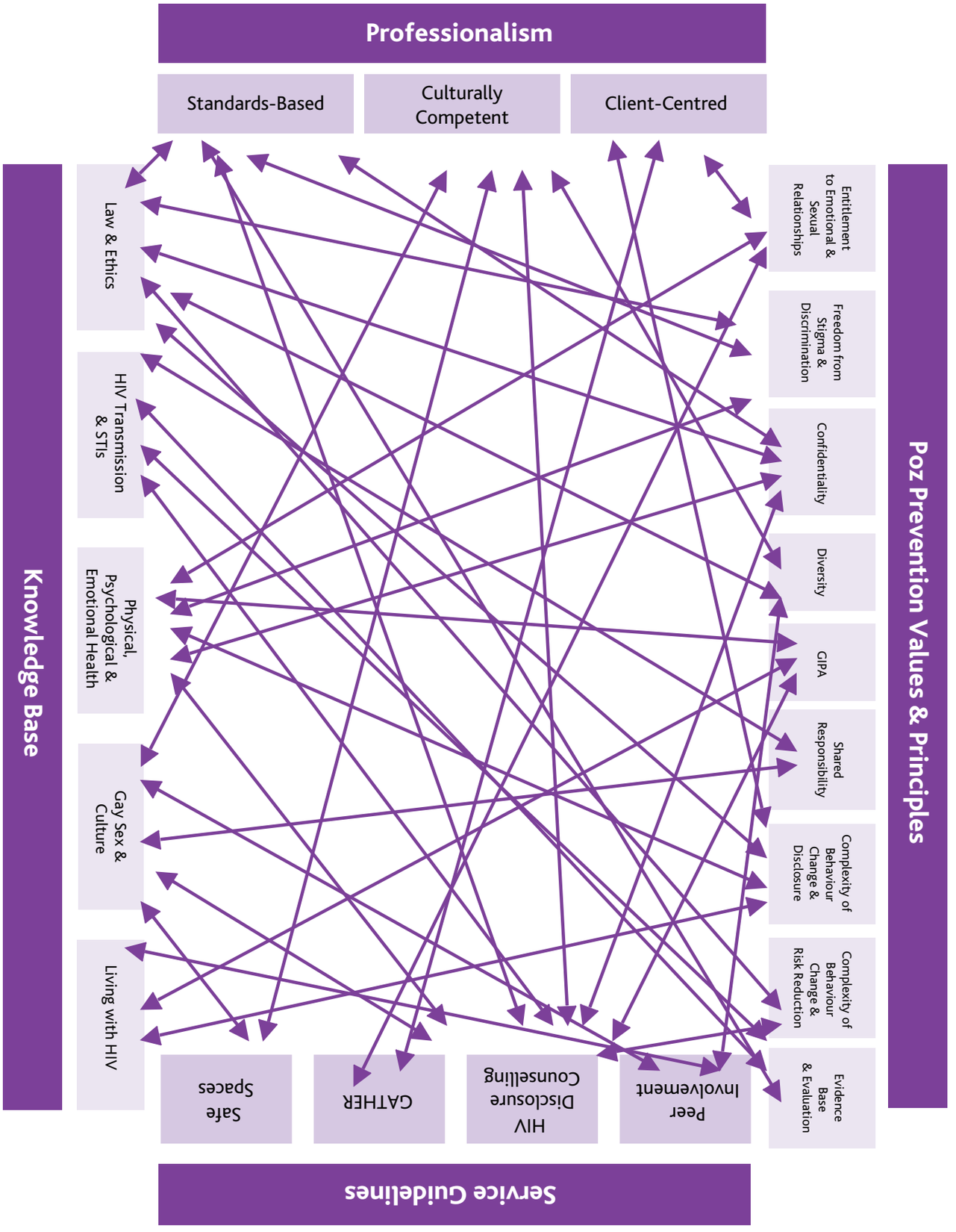
Canada: [4]

- MSM account for the largest number of reported HIV and AIDS diagnoses.
- MSM have accounted for 68 percent of positive HIV tests among adult males since testing began in 1985.
- In 2005, estimated new HIV infections among MSM increased slightly compared with 2002.
- MSM account for 76 percent of cumulative reported AIDS cases among adult males.

Ontario:

- As of 2006, an estimated 16 percent of MSM in Ontario were living with HIV.[5]
- Data collected in 2002 found an overall HIV prevalence rate of 6.4 percent among gay and bisexual men surveyed, as assessed by saliva antibody testing. [6] However, close to 29 percent of the men in the survey did not provide a saliva sample.
- At the end of 2006, MSM constituted 59 percent of the estimated 26,355 people living with HIV.
- From 2001 to 2006, the number of new HIV infections among MSM increased by 26 percent.
- MSM have accounted for 70 percent of reported AIDS cases since monitoring began.[7, 8]

Weaving together the strands of poz prevention



The manual also includes:

- **Key points**, at the beginning of each section.
- **Quotes** throughout from gay men living with HIV, service providers and people with particular knowledge about HIV and gay men.
- **Key references for more information**, at the end of each section.
- **Links to documents and resources for clients**, at the end of each section.

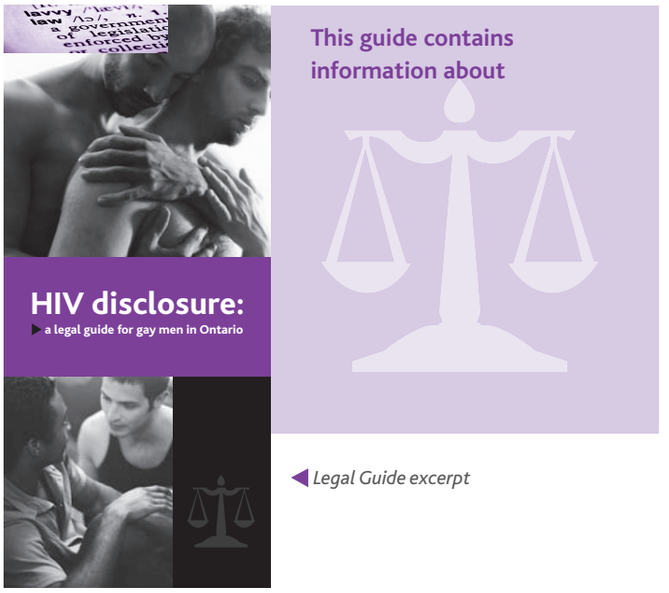
Who developed this manual

The Toronto People With AIDS Foundation (PWA), with input and advice from a subgroup of the Poz Prevention Working Group of Ontario's Gay Men's Sexual Health Alliance. This manual addresses topics identified by PWA, the subgroup of the Poz Prevention Working Group and service providers (volunteers and staff from AIDS service organizations and other community organizations, clinical nurses, social workers in clinics, and public health nurses in Ontario) surveyed in spring 2008.

This manual is one of three resources. The others are plain-language guides primarily for gay men living with HIV:

- **HIV disclosure: a legal guide for gay men in Ontario** [published by the HIV & AIDS Legal Clinic (Ontario)].
- **Pozitively Healthy: a gay man's guide to sex and health in Ontario** (published by the Toronto People With AIDS Foundation).

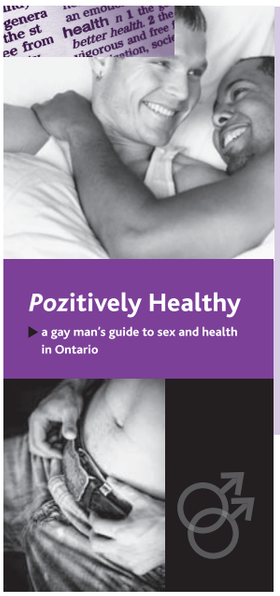
All three resources are meant to promote HIV-positive gay men's sexual health, while addressing the need for HIV prevention among gay men.



◀ *Legal Guide excerpt*

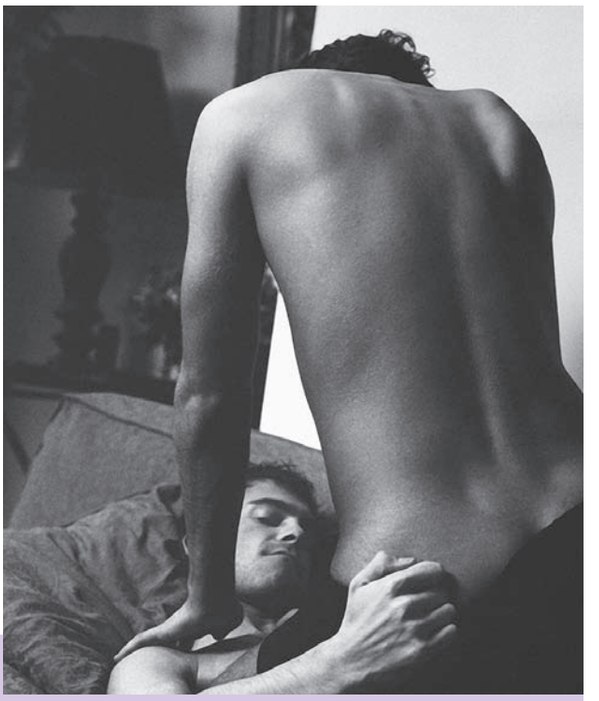
This guide contains information about:

- Who wrote this guide and why?
- HIV, sex, dating and relationships
- Laws that protect you from discrimination
- What the criminal law says about sex and HIV
- Figuring out if you have a legal duty to disclose your HIV infection before sex
- Other important information about criminal law, sex and HIV
- If you have sex with someone who is also HIV positive
- For guys who have HIV but have not tested HIV positive
- Reducing your risk of criminal charges and convictions
- Don't assume he knows you are HIV positive
- If you are going to disclose, make it count
- How to protect yourself against guys who might lie
- What does public health law have to do with you?
- Public Health Section 22 Orders
- Who can disclose your HIV infection without your permission?
- Do you have to disclose – work, insurance, landlords, travel and immigration?
- Who to contact for more information and legal advice



The information in this guide and where to find it

◀ *Sexual Health guide excerpt*



This manual along with the legal guide and the sexual health guide are meant to promote HIV-positive gay men's sexual health, while addressing the need for HIV prevention among gay men.

The information in this guide and where to find it:

- This guide is for you
- Your sexual health "Top 10"
- Pozitively hot: being an HIV positive gay man
- Your sexual health, from top to bottom
- An HIV positive guy's guide to safer sex
- You and him talking about sex and HIV
- Handling "no'" while staying positive and proud
- Positives attract ... sex between HIV positive guys
- Sex, drugs and recreation
- STI information for HIV positive guys
- For more information

Ontario's **Gay Men's Sexual Health Alliance** is a provincial coalition of gay men and their allies from community-based HIV/AIDS service organizations, the HIV research community, public health and policy makers. The Alliance is interested in strengthening our capacity as a community to reduce rates of new HIV infections and support the health and wellbeing of all gay, bisexual and other men who have sex with men across Ontario.

Notes:

[1] R.M. Young and I.H. Meyer, "The trouble with "MSM" and "WSW": Erasure of the sexual-minority person in public health discourse," *American Journal of Public Health* 95, 7 (2005): 1144-1149.

[2] Ibid.

[3] B. Ryan, *A new look at homophobia and heterosexism in Canada* (Ottawa: Canadian AIDS Society, 2003).

[4] See "HIV/AIDS among MSM is Canada." In Public Health Agency of Canada, *HIV/AIDS Epi Updates, November 2007* (Ottawa: Public Health Agency of Canada, 2007). Available at: www.phac-aspc.gc.ca/aids-sida/publication/epi/epi2007-eng.html.

[5] R. Remis, "Epidemiologic trends in HIV infection among men who have sex with men in Ontario: The situation in 2007," Toronto, 1 February 2007, Ontario Gay Men's HIV Prevention Summit. Available at: www.phs.utoronto.ca/ohemu/doc/Msm2006.pdf.

[6] T. Myers et al., *Ontario Men's Survey*. (Toronto: University of Toronto HIV Studies Unit, 2004). Available at: www.mens-survey.ca or http://cbr.cbrc.net.

[7] R.S. Remis et al., *Report on HIV/AIDS in Ontario 2006* (Toronto: Ontario Ministry of Health and Long-Term Care, March 2008). Available at: www.phs.utoronto.ca/ohemu/doc/PHERO2006_report_final.pdf.

[8] R.S. Remis et al., "Trends in HIV incidence among men who have sex with men in Ontario: update from the Laboratory Enhancement Survey (LES)," *Canadian Journal of Infectious Diseases* 18 (Supplement B) (2007): 41B. Available at: www.pulsus.com/journals/JnlSupToc.jsp?sCurrPg=journal&jnlKy=3&supKy=417.

Notes

2. Establishing poz prevention as a standard

Key Points

- You should strive to provide client-centred, culturally competent and standards-based services to your clients. By doing so you demonstrate professionalism and respect for your clients.
- Poz prevention is an emerging concept and field. It is important to establish a standard for poz prevention programs, including sexual health services, for gay men living with HIV.
- In Ontario, gay men developed a definition of "poz prevention," and established the values and principles that should guide poz prevention work.
- Poz prevention programs should focus on empowering gay men living with HIV to share with all gay men the responsibility for preventing new HIV infections and transmission of other STIs.
- Gay men living with HIV are entitled to equality and freedom from discrimination in the provision of medical and social, including sexual health, services.
- Gay men living with HIV are also entitled to full, satisfying and healthy emotional and sexual relationships.
- Gay men living with HIV have an important role to play in HIV prevention efforts, as people living with HIV and members of the gay community.

Professionalism and standards-based service provision: why you owe it to your clients

Professionalism is not necessarily about the formal training or education you have or the letters you have after your name. It is essentially about how you do your job, the relationship between you and your clients and whether you give your clients the respect they deserve.

If you are a registered professional you are duty-bound to provide services in accordance with your profession's guidelines, standards and codes. They are easily accessible on the internet. And all self-regulating colleges have advisory services that members can consult for advice about practice situations. If you are not a member of a registered profession, you can still look to professional guidelines, standards and codes to guide you in your work. See the textbox, "Standards of selected Ontario professions."

A note on terminology:

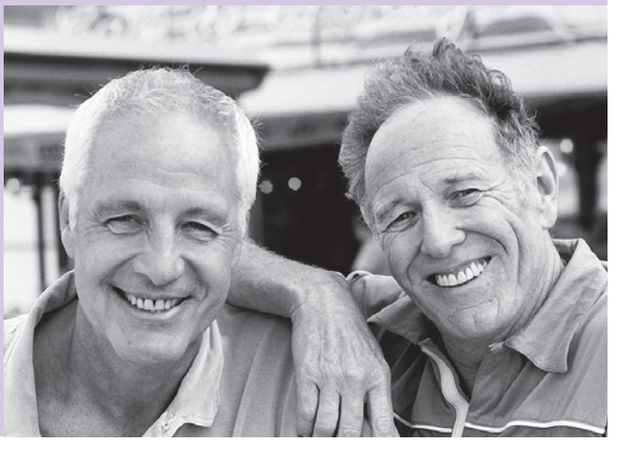
In Ontario, the Poz Prevention Working Group has defined the term "poz prevention" for gay men living with HIV. In other contexts, HIV prevention initiatives for HIV-positive people are referred to as "prevention for positives," "prevention with positives" or "positive prevention," and include all people living with HIV.

In this section we set out why "poz prevention" should be the standard you follow when providing sexual health services to gay men living with HIV in Ontario.

The Gay Men's Sexual Health Alliance recognized that effective HIV prevention must include sexual health work developed by and of relevance to HIV-positive gay men.

Standards of selected Ontario professions

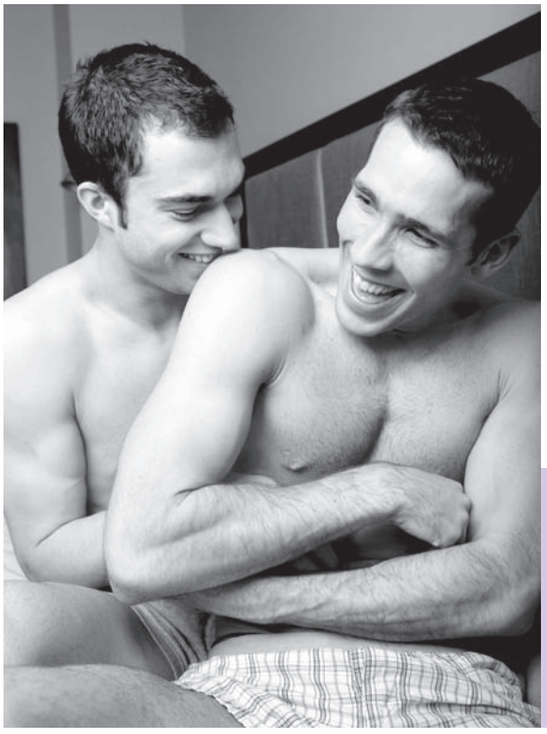
- College of Nurses of Ontario. *Compendium of Standards of Practice for Nurses in Ontario*. 2nd ed. Toronto: College of Nurses of Ontario, 2005. www.cno.org/pubs/compendium. html
- College of Physicians and Surgeons of Ontario. *The Practice Guide: Medical Professionalism and College Policies*. Toronto: College of Physicians and Surgeons of Ontario, September 2007. http://www.cpso.on.ca/Policies/PracticeGuideSept07.pdf
- Dieticians of Canada and College of Dieticians of Ontario. *Professional Standards for Dieticians in Canada*. College of Dieticians of Ontario, 1997. www.cdo.on.ca/en/pdf/publications/ProfessionalStandardsforDietitians.pdf
- Ontario College of Pharmacists. *Standards of Practice*, 2003. Effective 1 January 2003. www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Standards+2003/$file/Standards+2003.pdf
- Ontario College of Pharmacists. *Code of Ethics for Members of the Ontario College of Pharmacists*. December 2006. www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Code+of+Ethics/$file/Code+of+Ethics.pdf
- Ontario College of Social Workers and Social Service Workers. *Code of Ethics and Standards of Practice Handbook*. 2nd ed. Toronto: Ontario College of Social Workers and Social Service Workers, effective 1 July 2008. www.ocswssw.org/sections/pdf/Standards_of_Practice_Final.pdf



Poz prevention as developed by HIV-positive gay men in Ontario

In order to define what poz prevention means for HIV-positive gay men in Ontario, we need to take a step back and explain how and who developed it. Poz prevention originated with leadership from gay men. Gay men and their allies first developed and implemented an Ontario Gay Men's HIV Prevention Strategy in 2004, sponsored by the AIDS Bureau of Ontario's Ministry of Health and Long-Term Care. The primary purpose of the Strategy is to reduce the transmission of HIV between a diversity of gay/MSM living in Ontario. The Strategy recognizes a broad range of social determinants of health influence the risk of gay/MSM for HIV transmission and their capacity to access HIV-related services. The Strategy operates on the basis of an anti-oppression framework, which acknowledges that racism, homophobia, heterosexism, socio-economic status, mental health and gender norms are also determinants of risk for gay and other MSM. In 2008, the Strategy changed its name to the Gay Men's Sexual Health Alliance.

The Alliance recognized that effective HIV prevention must include sexual health work developed by and of relevance to HIV-positive gay men. The Alliance, being committed to the full inclusion of HIV-positive gay men, established a Poz Prevention Working Group. The Poz Prevention Working Group developed a definition of "poz prevention," and established the values and principles that should guide poz prevention work among gay men in Ontario. The Alliance's Provincial Advisory Body approved the definition, values and principles.



HIV positive people and HIV prevention

Sexual Health guide excerpt

HIV positive people and HIV prevention

We can reduce the spread of HIV in the gay community if all of us – HIV negative, untested, and HIV positive – take responsibility for our sexual health. Most HIV prevention messages are aimed at people who don't have HIV. But people living with HIV also play an important role in HIV prevention. Many of us know a lot about HIV. Many of us educate other people about HIV, including the guys we have sex with.

You can take better care of your sexual health when you have useful information about sex, communicating with sex partners, and HIV and other sexually transmitted infections (STIs). We hope that the information in this guide will help you make decisions that are right for you. We hope that you can use the information to have a fulfilling emotional life and a hot and satisfying sex life. And to help reduce the spread of HIV and other STIs.

Poz prevention is a conceptual framework and strategic model that recognizes HIV-positive people as people, rather than simply as potential sources of new HIV infections.

Poz prevention: rationale, definition, values and principles

Most HIV prevention efforts focus on HIV-negative people, with the objective of keeping them HIV negative. Poz prevention is a conceptual framework and strategic model that recognizes HIV-positive people as people, rather than simply as potential sources of new HIV infections.

As service providers, you should use the definition, values and principles of poz prevention as the foundation for providing professional and standards-based services to HIV-positive gay men. Services should not be "hit or miss" or vary in quality depending on where, when, or by whom services are being provided. Within an organization and across a sector services should be based on standards that are widely accepted, implemented and acted upon. The definition, values and principles of poz prevention provide standards for providing services to HIV-positive gay men.

Defining "poz prevention"

Poz prevention for HIV-positive gay men aims to empower individuals, promote healthy relations with sexual partners and improve conditions to strengthen the sexual health and wellbeing of HIV-positive gay men and reduce the possibility of new HIV infections and other sexually transmitted infections.

- Poz Prevention Working Group,
Ontario's Gay Men's Sexual Health Alliance

Values for conducting poz prevention work

As gay men with HIV we value:

- **Full, satisfying and healthy emotional and sexual relationships.**

  Historically, people living with HIV/AIDS were seen as needing support services to help them manage a fatal disease. As HIV/AIDS mortality has declined, there have been some shifts in service provision that acknowledge that HIV has become a life-long, manageable disease, yet rarely if ever have the sexual health needs of those with HIV been acknowledged. Gay men with HIV need programs and services that support their ability to have fulfilling emotional and sexual relationships.

- **Living free from stigma and discrimination.**

  Stigma, discrimination, shame and fear can be internalized by HIV-positive gay men, contributing to marginalization and disempowerment, particularly in relation to sexuality. Similarly, stigma and discrimination foster an environment in which communication related to sex and safer sex is inhibited, making it more difficult for gay men to disclose their HIV status and to practice safer sex.

- **The confidentiality of all medical information, including HIV status and information specific to their sexual health.**

  Programs that work to support the sexual health of HIV-positive gay men must recognize the right to self-determination of HIV-positive gay men over all aspects of their sexual health, including disclosure of their HIVstatus to sexual partners, service providers, and any other individuals in their lives.

- **The importance of acknowledging the diversity of men, our cultures, communities and self definitions.**

  Not all gay men with HIV are the same. To be effective, programs must acknowledge the diversity of lived experiences amongst gay men with HIV. For example, issues facing men who have been newly diagnoses might vary considerably from those who have lived with HIV for some time.

- **Involvement in the planning, design, delivery and evaluation of programs in support of their sexual health.**

  As with the development of any prevention or health promotion program, to ensure that programs are responsive, relevant and appropriate, the target population(s) must be involved in all aspects of program development and implementation.

- **The development of new prevention technologies that meet the needs of gay men with HIV and are consistent with their sexual lives.**

  Currently, condoms remain the only technology available to gay men to avoid HIV transmission during anal sex. Yet, condoms may be an unrealistic technology for many gay men for whom condoms affect their ability to maintain an erection, create barriers to intimacy and pleasure, or signify emotional distance within a relationship. It is vital that new prevention technologies increase the options available to gay men, to enable more gay men to have fully intimate sexual and emotional relationships with other men while avoiding HIV transmission.

Gay men with HIV need programs and services that support their ability to have fulfilling emotional and sexual relationships.

Principles for conducting poz prevention work

Shared Responsibility for Prevention:

- Developing prevention programs for, and inclusive of, HIV-positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people with HIV. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of HIV prevention programming.

Complexities of behaviour change – addressing social determinants of health:

- Prevention work must take into account the complexities underlying behaviour change. This includes, but is not limited to the interplay of individual life experiences, personal perspectives on sexuality and HIV and any social, economic and cultural conditions. In addition, recognition must be given to the influences of stigma and discrimination on community environments and personal decision-making.

Health promotion and risk/harm reduction:

- Coercion and criminalization are not the solution to the risk-taking activities of gay men with HIV, and certainly are not the first answer. This approach creates a climate in which trust and honest engagement of people, cornerstones of effective HIV prevention, are unlikely. Rather, programs rooted in health promotion and risk/harm reduction will ensure that individuals and communities are actively engaged.

Disclosure of HIV status – a life long process:

- Disclosure is not always the answer and is not a magic solution to HIV transmission. There is no single HIV prevention intervention or solution that will work for all people in all circumstances. Disclosure does not guarantee safer activities. Disclosure must be considered within an environment of stigma and discrimination; it may result in both risks and benefits to people with HIV. Helping people assess their readiness to disclose and developing the skills to do so is different than telling people they must disclose.

Sexual health and wellbeing:

- Poz prevention programs can best support a reduction in new HIV infections by ensuring that the sexual health and wellbeing of HIV-positive gay men is a primary focus of the work.

Evidence must inform actions:

- Poz prevention programs should be evidence informed, timely, and relevant to HIV-positive gay men, they should be evidence-informed.

Programs should be evaluated:

- All HIV prevention programs should be evaluated to ensure that they are having the intended outcomes for gay men with HIV. Evaluations should consider both the intended and potential unintended impacts that HIV prevention programs can engender. For example, HIV prevention campaigns may have the unintended impact of not being relevant to HIV-positive gay men if they do not include messages relevant to those who already have HIV.

Diversity of needs must be addressed:

- Gay men with HIV have the right to sexual health programs that address their unique needs, while recognizing that HIV-positive gay men are a heterogeneous group.

A culture of shared responsibility that encourages communication and equality in relationships should be a goal of HIV prevention programming.

Poz Prevention Programs in Ontario

Black CAP Poz Prevention Project (416-977-9955)

The Black CAP Poz Prevention Project is being developed to better equip people who are HIV positive from the African and Caribbean community to help them to reduce the risk of HIV re-infection and STI co-infection and also to reduce the risk of HIV and STI transmission to their sexual partners through increased knowledge and stregthening their negotiation skills.

The resources that are being developed are as follows: MSM and Heterosexual booklet, poster, webpage from the main Black CAP site and podcast.

The Poz Prevention Project aims to recognize and empower the sexuality and sexual health of people from the African and Caribbean community living with HIV/AIDS. It also will encourage and foster the involvement of people living with HIV/AIDS in all aspects of health promotion and prevention strategies. And to help develop health communication and prevention strategies targeted specifically to people living with HIV/AIDS.

Positive Prevention Program, AIDS Committee of Guelph and Wellington County (www.aidsguelph.org/positive-prevention)

The program is designed to help empower people living with HIV, promote healthy relationships with sexual partners, strengthen the overall wellbeing of HIV-positive people and reduce the possibility of new HIV infections and other sexually transmitted infections.

The program consists of two components: one-on-one positive prevention education sessions and an educational workshop series.

A focus group of six clients living with HIV took a leading role in identifying needs and content of the educational workshops. Topics include: strategies to reduce risk taking behaviours (e.g., negotiating safer sex practices), where to find coordinated services and support, strategies for HIV disclosure, self-esteem and confidence building, HIV treatment, and HIV education and transmission. The workshops take place at a regional HIV and hepatitis C clinic.

"Prevention with positives" interventions in the U.S.

There are examples of poz prevention programs beyond Ontario. In 2003, the U.S. Centers for Disease Control (CDC) introduced new guidelines for HIV prevention, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. One of the new prevention strategies was "prevention with positives," based on the CDC's "Recommendations for Incorporating HIV Prevention into the Medical Care of Persons with HIV Infection." The CDC has funded numerous initiatives and demonstration projects and participated in the Diffusion of Effective Behavioral Interventions (DEBI) project, a national strategy to provide training and on-going technical assistance on selected evidence-based HIV/STD interventions to HIV/STD program staff.

Several reviews and meta-analyses have found that interventions offered by health care providers can significantly reduce risk behaviours in gay men (and others) living with HIV. One recent review and meta-analysis of found that such targeted "prevention with positives" interventions with gay men reduced self-reported unprotected sex by, on average, 17 percent more than standard HIV prevention and 27 percent more than minimal or no intervention.[1] Another review and analysis (not specific to MSM) found reductions of 20 to 60 percent.[2]

Project Enhance[3]

- This behavioural intervention was developed at Fenway Community Health in Boston, Massachusetts. Fenway serves the LGBT community and is the largest HIV care clinic in New England. The program, developed in collaboration between Fenway staff and gay community members, focuses on holistic interventions to reduce unsafe sex practices among HIV-positive MSM.
- The team developed a set of learning modules consisting of interactive information sessions accompanied by workbooks. All participants complete the core module, Having Sex. Participants then choose the other modules they want to work on: Party Drugs, Managing Stress, Sexual Triggers, Disclosure, Getting the Relationships You Want, and Cultures, Communities and You.

SUMIT (Seropositive Urban Men's Intervention Trial)[4, 5]

- SUMIT was a controlled trial of a behavioural intervention, conducted between 2000 and 2001 in San Francisco and New York City.
- The trial compared a single, one and a half to two hour "community forum" style information session, in which local experts presented information on HIV transmission and safer sex practices, with a peer-led series of six weekly three hour intervention sessions that addressed sexual relationships, HIV and STI transmission, drug and alcohol use, disclosure, and assumptions about partner status.
- Preliminary results show that the extended intervention did not lead to sustained reductions in risk behaviour. The team speculate that more integrated, tailored services might be more effective than this stand-alone, "one-size-fits-all" approach.

A case-based, online prevention for positives module for service providers

The Northwest AIDS Education and Training Center and the University of Washington developed *Prevention for Positives: A case-based, online training module* (http://depts.washington.edu/hivaids/prevent/index.html). Learning takes place using five case studies.

Key references for more information

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- UNAIDS. *Policy brief: The greater involvement of people living with HIV (GIPA)*. March 2007. http://data.unaids.org/pub/Report/2007/jc1299-policybrief-gipa_en.pdf
- U.S. Centers for Disease Control. *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. www.cdc.gov/Hiv/topics/prev_prog/AHP/default.htm
- U.S. Centers for Disease Control, Center on AIDS & Community Health (COACH) at the Academy for Educational Development (AED). *Diffusion of Effective Behavioral Interventions (DEBI)*. www.effectiveinterventions.org.

Documents and resources for clients

- HIV & AIDS Legal Clinic (Ontario), *HIV disclosure: a legal guide for gay men in Ontario*. Toronto, HALCO, 2008. www.haclo.org
- Toronto People With AIDS Foundation. *Pozitively Healthy: a gay man's guide to sex and health*. Toronto: PWA, 2008. www.pwatoronto.org
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- British Columbia Persons With AIDS Society. *Sex Positive Guide*. 1st ed. Vancouver: BCPWA, 2004. www.bcpwa.org/articles/sex_positive_reader.pdf
- National Association of People with AIDS. *Principles of HIV prevention with positives*. Silver Spring, Maryland: NAPWA, www.napwa.org/pdf/PositivePrevention.pdf
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Notes:

[1] W.D. Johnson et al., "HIV intervention research for men who have sex with men: a 7-year update," *AIDS Education and Prevention* 17,6 (2005): 568-589, 2005.

[2] N. Crepaz et al., "Do prevention interventions reduce HIV risk behaviours among people living with HIV? A meta-analytic review of controlled trials," AIDS 20 (2006):143-157.

[3] R.O. Knauz et al., "Developing an HIV-prevention intervention for HIV-infected men who have sex with men in HIV care: Project Enhance," *AIDS and Behaviour* 11 (2007): S117-S126.

[4] R.J. Wolitski, J.T. Parsons, and C.A. Gómez, "Prevention with gay and bisexual men living with HIV: rationale and methods of the Seropositive Urban Men's Intervention Trial (SUMIT)," 19 (2005): S1-S11.

[5] R.J. Wolitski et al., "Prevention with HIV-seropositive men who have sex with men: Lessons from the Seropositive Urban Men's Study (SUMS) and the Seropositive Urban Men's Intervention Trial (SUMIT)," *Journal of Acquired Immune Deficiency Syndromes* 37 (2004): S101-109.

Notes

3. Developing your cultural competence

Key Points

- Everyone has a culture.
- Many self-identified gay men belong to gay culture, with practices, habit patterns, customs, values and structures that are related to a common experience.
- Yet, at the same time, culture is individual. Each gay man's culture might be influenced by race, gender identity, religion, place of birth, ethnicity, socio-economic status, sexual orientation and life experience.
- For many gay men, living with HIV has infused gay culture with additional common experiences.
- Cultural competency is a set of congruent behaviours, attitudes and policies that come together to enable service providers and organizations to achieve cultural diversity and to work effectively in cross-cultural situations.
- Sex and sexual expression figure prominently in gay culture. Despite the challenges associated with living with HIV, most HIV-positive gay men remain sexually active.
- Sexuality is an inherent part of being human. Sexual decision-making and behaviour are not driven solely (or perhaps not even predominantly) by rationality. The importance of pleasure also needs to be recognized.
- In order to properly engage gay men living with HIV in poz prevention programs, including sexual health services, service providers and organizations should ensure they are able to provide culturally competent services.
- It is as important to normalize and encourage healthy sexual behaviour in HIV-positive gay men. This involves supporting gay men in maintaining their sexual health while encouraging them to protect sexual partners from becoming infected with HIV.
- It may also involve engaging gay men living with HIV in discussions about homophobia, heterosexism, transphobia, racism, immigration experiences, HIV-associated loss, HIV stigma and self-stigma, sexual risk assessment and risk behaviours, substance use and addiction and HIV disclosure. And pleasure.

Culture, competency, diversity

Culture:

Practices, habit patterns, customs, values and structures that are related to a common group experience. Culture can include ethnicity, language, religion or spiritual beliefs, race, gender, geographic origin, group history and life experiences.

Cultural Competency:

A set of congruent behaviours, attitudes and policies that come together in a system, agency or profession that enables that system, agency or profession to achieve cultural diversity and to work effectively in cross-cultural situations.

Cultural Diversity:

Differences in race, ethnicity, language, nationality or religion among various groups within a community, organization or nation. A city is said to be culturally diverse if its residents include members of different groups.

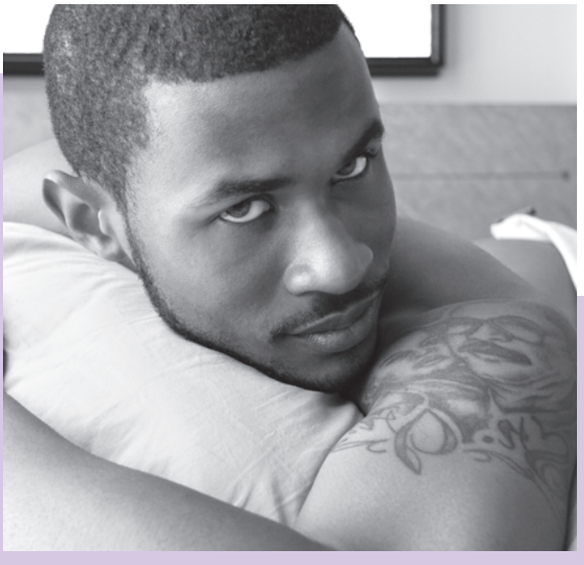
- adapted from Van Ngo, H. *Cultural competency: a self-assessment guide for human service organizations*. Calgary: Cultural Diversity Institute, 2000.

Recognizing gay culture, homophobia and heterosexism

Gay men have a culture. In the past, many aspects of Canadian and Western gay male culture were organized in response to the dominant heterosexual culture and the various ways in which gay men were marginalized in that culture. Today, in Canada, gay men enjoy greater social acceptance than ever before, especially gay men who live in urban centres. Overt homophobia and state-legitimized discrimination against gay men have become markedly less common during the past decade. A wide range of laws has been amended to reflect the rights to equality and freedom from discrimination for gay men (and lesbians). These legal changes echo larger social changes, including the fact that a majority of Canadians find discrimination on the basis of sexual orientation unacceptable.

The terms **homophobia** and **heterosexism** are often used to describe a continuum of anti-gay bias and discrimination. While definitions vary and sometimes overlap, homophobia is often reserved for more overt or visceral repugnance toward homosexuals, while heterosexism describes a more widespread bias, including the feeling that heterosexuality is superior to, and/or more natural than, homosexuality. Heterosexism can manifest as often-unexamined assumptions about what kinds of beliefs and behaviours – especially sexual – are "normal", "decent" or "acceptable."

"Cultural competence" should go beyond the absence of homophobia or discrimination. Taking into account people's differences is an important principle of equality and non-discrimination – treating people equally does not necessarily mean treating everyone the same. Service providers should recognize some unique social, cultural and behavioural characteristics of gay men and how these characteristics relate to the service provider's culture. This involves recognizing (and acting on) the knowledge that standards and values espoused by the general population (or the service provider) may not necessarily be espoused by gay men. Gay culture can view sexual activity and sexual relationships quite differently than mainstream culture. Since sexual attraction is at the core of gay male culture, the way we act on and view our sexuality is part and parcel of gay male culture.



Taking into account people's differences is an important principle of equality and non-discrimination – treating people equally does not necessarily mean treating everyone the same.

Anti-oppression, racism, homophobia, heterosexism and transphobia

What does it mean to work from an anti-oppression framework?

- Actively working to acknowledge and shift power towards inclusiveness, accessibility, equity and social justice.
- Ensuring that anti-oppression is embedded in everything that you do by examining attitudes and actions through the lens of access, equity and social justice.
- Being conscious and active in the process of learning and recognizing that the process as well as the product is important.
- Creating a space where people are safe, but can also be challenged.

- *Involve Youth 2: A guide to meaningful youth engagement*. Toronto: City of Toronto, September 2006.

Racism

- Prejudice that one race is superior to other races.
- Discrimination or abusive behaviour and action towards one or more races.
- The idea that beliefs or doctrines that are different among races mean the superiority of some races.
- A policy or a system that promotes racism.
- Intolerance of one or more races.

- National Anti-Racism Council of Canada, Chinese Canadian Council, and Urban Alliance on Race Relations, *Newcomer Anti-Racism Brochure*, 2007.

Homphobia:

Research into negative attitudes towards homosexuality and gay and lesbian persons has increased in the last thirty years. ... Many studies label all negative attitudes to homosexuality as homophobia. Others believe that the term "homophobia" should only be used to refer to fear, aversion, and distaste. Weinberg has called homophobia "the dread of being in close quarters with homosexual". MacDonald defines homophobia as an "irrational, persistent fear and dread of homosexuals". All other anti-homosexual reactions have been termed "homo-negativism" by Hudson and Richetts. Fyfe has said that we need to differentiate between a socio-cultural bias against gays and lesbians of "homonegativism", and "phobic reactions to homosexuals as a particular individual's experience of excessive discomfort and avoidance when confronted with an anxiety-provoking stimuli".

- B. Ryan, *A new look at homophobia and heterosexism in Canada* (Ottawa: Canadian AIDS Society, 2003). References omitted.

Heterosexism:

Is ...a "heterosexual bias that values heterosexuality as superior to, and/or more natural than, homosexuality".

- S. F. Morin, Heterosexual bias in psychological research on lesbianism and male homosexuality. *American Psychologist*, 32 (1997): 629-637.

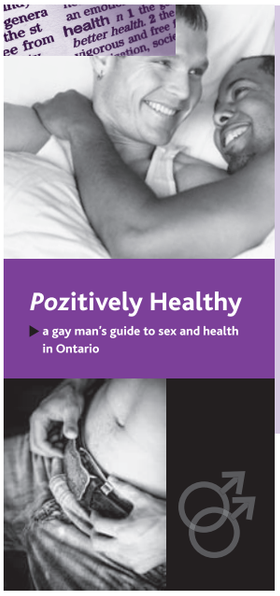
Transphobia:

In the collective opinion of mainstream society, transgendered people cross too many gender boundaries and as a result experience gender-based discrimination, or transphobia.

Because of the unyielding dominance of our society's rigidly constructed two-gender model, members of the transgendered community have many negative experiences in common...transphobia is at its most basic the fear of a transgendered person and the hatred, discrimination, intolerance, and prejudice that this fear brings. Transphobia is manifested as harassment, threatened safety, disgust, ridicule, restrictions on freedom of movement, restrictions on access to resources (housing, employment, services etc), and violence to name a few.

- S. Laframboise and B. Long. *An introduction to gender, transgender and transphobia*, High Risk Project Society, undated. http://mypage.direct.ca/h/hrp/gendertr.html

Though gay or queer transmen are part of the gay men's community, they experience transphobia from other gay men. It is important to understand the impact of this marginalization when providing sexual health services to gay or queer transmen.



Pozitively hot:
being an HIV positive gay man

Sexual Health guide excerpt

Pozitively hot: being an HIV positive gay man

Sex positive, HIV positive

When we talked to gay men about living with HIV and having sex, many of them said HIV brings a lot of responsibility. There is no cure for HIV. So many of us will take HIV medications for the rest of our lives. And there is a risk that we will pass on HIV during sex.

But your life didn't stop when you got your HIV diagnosis. Like many of us, you were probably shocked and stressed out for a while after you found out you had HIV. Maybe you even felt some shame or guilt. But you went on living. Your sex life can go on too.

What is "sexual health"?

Sexual health means having sex and sexual relationships that are as hot and satisfying as possible. Sexual health also means taking care of your health and the health of your sex partner(s). To be sexually healthy you will probably need to take care of your body, your mind and your emotions. It is important for gay men, including gay men living with HIV, to have the information we need to make informed decisions about our sexual health.

Living positively and gay

Homophobia, AIDS-phobia and sex-phobia can affect how we think, feel and behave. Sometimes people direct their phobias and negative attitudes at us. At other times these phobias and negative attitudes might bubble up from inside us. No matter how thick-skinned or "out" we are, these negative attitudes can make us feel ashamed or guilty. Or can cause us to suffer from low self-esteem.

Those of us from minority ethnic and racial communities may feel guilt, shame and low self-esteem more intensely. We may have experienced racism and hostility towards our culture on top of homophobia, AIDS-phobia and sex-phobia.

Society also judges what it means to be a "normal" man or a "normal" woman. So guys who are effeminate or transmen are judged harshly and may have a hard time feeling good about themselves and their sexuality.

You may not always realize how these negative attitudes and feelings affect your health and the decisions you make. But it is important to recognize and deal with the negative effects of homophobia, AIDS-phobia and sex-phobia. This can help you live a proud life and have a fulfilling emotional and sexual life.

Three examples of professional standards and a self-assessment

The **College of Nurses of Ontario**'s "Culturally Sensitive Care" practice guideline recognizes that culture is a broad concept and that the culture of both the service provider and the client affect the service provider-client relationship. The practice guideline sets out a number of assumptions that form the core tenets of providing care that is culturally appropriate:

- **Everyone** has a culture.
- Culture is individual. Individual assessments are necessary to identify relevant cultural factors within the context of each situation for each client.
- An individual's culture is influenced by many factors, such as race, gender, religion, place of birth, ethnicity, socio-economic status, sexual orientation and life experience. The extent to which particular factors influence a person will vary.
- Culture is dynamic. It changes and evolves over time as individuals change over time.
- Reactions to cultural differences are automatic, often subconscious and influence the dynamics of the nurse-client relationship.
- A nurse's culture is influenced by personal beliefs as well as by nursing's professional values. The values of the nursing profession are upheld by all nurses. (See the Ethics practice standard.)
- The nurse is responsible for assessing and responding appropriately to the client's cultural expectations and needs.

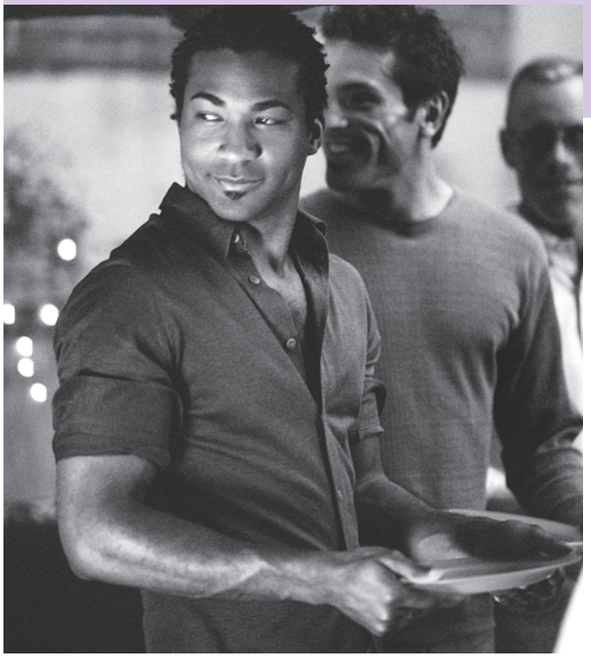
According to the **College of Physicians and Surgeons of Ontario**, physicians should demonstrate:

- cultural sensitivity in their communication with patients and families.
- an awareness of their own values and how their values relate to or differ from those of patients and families.

The **Ontario College of Social Workers and Social Service Workers** recognizes under the principle of "integrity" that their members are in a position of power and thus have a responsibility to all clients. Care must be taken to ensure that clients are protected from the abuse of such power during and after the provision of professional services. This includes the following standard:

> College members promote social justice and advocate for social change on behalf of their clients. College members are knowledgeable and sensitive to cultural and ethnic diversity and to forms of social injustice such as poverty, discrimination and imbalances of power that exist in the culture and that affect clients. College members strive to enhance the capacity of clients to address their own needs. College members assist clients to access necessary information, services and resources wherever possible. College members promote and facilitate client participation in decision making. (2.2.9)

It is important (perhaps more important) to recognize the influence of the other cultures to which gay men and MSM belong.



So as a starting point, think of behaviours rather than identities – what people do rather than what they "are." Let your client identify with a particular sub-culture or identity if it is important to them to do so.

The **Cultural Competency Self-Assessment Instrument**, developed by the Calgary Diversity Institute, offers a structured format to address major issues in the delivery of culturally competent services. The instrument specifically enables organizations to:

- Recognize the impact and relevance of cultural competency in their administrative and direct service functions.
- Evaluate whether their existing policies, programs and practices are designed to achieve and promote cultural competency.
- Identify the areas in decision making, policy implementation and service delivery where cultural competency is essential.
- Assess progress in culturally competent service delivery.
- Identify what changes are needed and who should assume responsibility for those changes.
- Develop specific strategies to address cultural competency issues.

See the "Key references for more information" to find out where to download the self-assessment.

Importance of cultural competence "beyond" gay culture

Dominant gay culture, like the dominant Canadian culture, can at times be unwelcoming to people from other cultures. Ideals of male beauty, masculinity, and racial or ethnic stereotypes can lead many guys to, at times, feeling or being discriminated against within spaces that are meant to be a haven for gay/MSM from a homophobic society. At the same time, individual gay/MSM living with HIV may not closely identify with or may feel conflicted about dominant gay culture or aspects of it because for them, dominant gay culture may be incompatible with other cultures with which they identify. For example, men who identify strongly with a conservative religious community or men from a racialized or minority ethnic community may or may not identify with aspects of more dominant gay male culture. Each client is, first and foremost, an individual, and the community of gay/MSM is highly heterogeneous. It is important to recognize the influence of the many cultures and communities to which an individual belongs.

The African and Caribbean Council on HIV/AIDS In Ontario (ACCHO) has published *HIV Prevention Guidelines and Manual: A Tool For Service Providers Serving African and Caribbean Communities in Canada*. It provides population-specific guidelines for African and African Caribbean "gay men, bisexual men and men who have sex with men," recognizing the different perceptions and needs that must be addressed for effective HIV prevention among these groups of men. The Black Coalition for AIDS Prevention (www.black-cap.com) is developing positive prevention resources for people with HIV from African and Caribbean communities including gay/MSM.

Some transmen like sleeping with other men – transmen and non-trans – and some identify as gay men. In Ontario, members of the gay or queer transmen's community and collaborators have researched and published sexual health and HIV prevention resources for gay, bi, and queer transmen. *Primed: The Back Pocket Guide for Transmen & The Men Who Dig Them* provides an introduction to transmen culture with a focus on transmen's sexual culture.

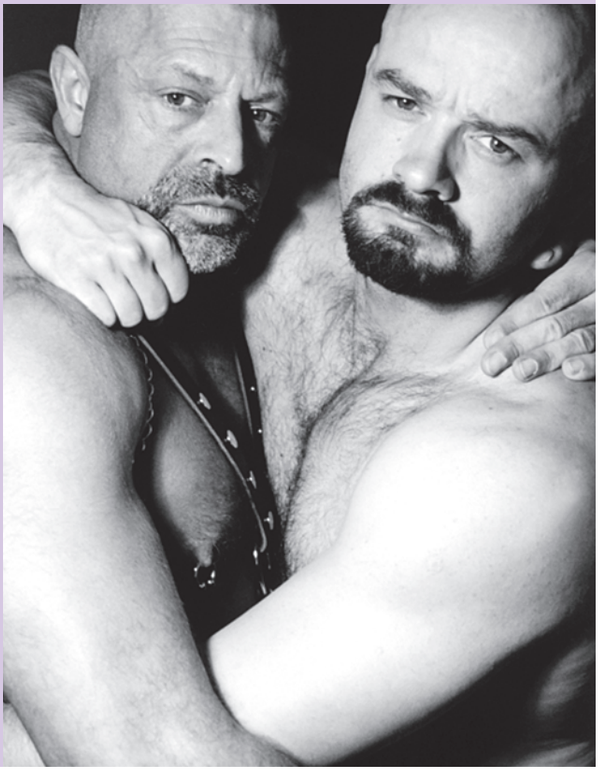
A primer on gay male sexual cultures and behaviours

Gay men span many subcultures, often based on sexual identification and behaviour (including leathermen, jocks, sex pigs, barebackers, twinks, bears, straight-acting, guys next door) or gender identity (drag queens, transvestites, transmen). A comprehensive look at all the facets of gay male culture is beyond the scope of this manual.[2]

Little attention has been paid to HIV-positive gay men's sexuality as people, distinct from their HIV status.[3] The diversity of the gay male community is reflected in the lifestyles, behaviours and sexual repertoires of the men who make up the community. Not all gay men see themselves as part of a particular, definable sexual "subculture." Yet others strongly identify with a particular subculture, which forms a significant part of their identity. Others might identify strongly with a particular role or subculture, without explicitly naming it or articulating it as such. Or they may identify their way of being gay in opposition to stereotypical representations of what it is to be gay (e.g., "straight-acting" or "regular guy-next-door").

Identification with a subculture or identity can be fluid, overlapping, intersect and shifting over time. Some men may invest much of their identity in their sexual behaviour within the gay community. Others may not. So as a starting point, think of behaviours rather than identities – what people do rather than what they "are." Let your client identify with a particular sub-culture or identity if it is important to them to do so.

Relationships between gay men can be just as fluid and diverse as their sexual behaviour and identification. Some men divide relationship status neatly into "single" or "in a relationship." And gay men in Canada can get legally married. Yet some



men in relationships open up their relationship to sexual (and emotional) experiences with men other than their primary partner. Men who do not see themselves as being in a relationship may none-the-less be involved in longstanding arrangements based on sexual attraction, love or friendship: dating one or more people on a regular basis, fuck-buddies, friends with benefits, etc. At the same time these men may also have sex with people they do not know at all, or do not know well. And some men may only have anonymous sex.

Gay sexual and cultural terminology

Gay men can often be blunt and explicit when they talk about sex and sexual activities. While attitudes and comfort levels will obviously vary between individuals, given the appropriate context many gay men will openly talk about their sex lives, about "getting fucked" and "sucking dick". When you are providing sexual health services, this bluntness and explicitness can be very useful. However, for personal, religious and cultural reasons, some gay men may not talk about sex in the same way.

Gay men are also prone to using language in a very playful and inventive way, often with a humorous or "bitchy" edge. People who are unfamiliar with gay culture may at first be surprised, or even offended, by how casually men may refer to each other as "bitch", "slut" or "fisting queen."

The meanings of barebacking

Bareback, barebacking and barebacker can be loaded terms, the connotations of which can vary according to the person saying or hearing it:

- A "barebacker" can mean an HIV-positive man who deliberately chooses to have unprotected sex with other HIV-positive men to avoid exposing HIV-negative men to the risk of infection.
- But a "barebacker" can also mean a person who has unprotected anal sex, regardless of his HIV status or that of his sexual partner.

Some gay men, HIV-positive and HIV-negative, do not use the term "bareback" and have a strong negative reaction to it because, for these men, "bareback" implies amorality and irresponsible sexual behaviour. Other gay men see barebacking as an affirmation of gay or HIV-positive identity and of sexual freedom.

A partial gay sex lexicon

Bareback, barebacking:
unprotected anal sex

Barebacker:
someone who has unprotected anal sex

Bottom:
a man who typically takes the receptive or "passive" role in anal sex; the one who "gets fucked"

Cum, load, jizz, seed:
semen

Dipping:
having unprotected anal intercourse before putting on a condom

Docking:
when one man pulls his foreskin over the head of another man's penis

Douching:
flushing out the rectum with water to clean it before sex

Fisting:
inserting the hand (partially or entirely) into the anus. Typically, the hand is not actually clenched into a fist; rather, the fingers are held together and inserted first.

Fucking:
anal intercourse/front hole (transmen)

Hole, fuckhole, asshole, manhole, pussy, boypussy, or even cunt:
anus, front hole

Play, playing:
having sex

PNP, party 'n' play:
having sex while under the influence of recreational drugs

Poz:
HIV-positive

Queen:
describes a homosexual, particularly if the person is effeminate. It can also be a term of familiarity or endearment. "Queen" can also mean an aficionado of any particular activity; as in "opera queen", "drama queen", "size queen", "fisting queen."

Raw:
unprotected anal sex; see "bareback"

Rimming:
anal/oral contact

Top:
a man who typically takes the insertive or "active" role in anal sex; the one who does the fucking

Toys, sex toys:
dildos, buttplugs, cockrings, etc.

Vanilla:
straightforward sex; including kissing, oral sex and fucking with no particular kinks or fetishes

Versatile:
a man who is willing be the top or bottom during anal sex

Water sports, w/s, golden showers, piss play:
sex involving urine

HIV and gay men's physical health and sexual health

HAART (highly active anti-retroviral therapy) has vastly improved the physical health of, and prognosis for, many gay men living with HIV. Some studies suggest that gay men are more likely to begin treatment earlier and have better treatment outcomes than other groups of HIV-positive people.[4] Some theoretical models have predicted that HIV-positive people who begin treatment in their 20s or 30s may live well into their 70s.[5] But these are just projections.

HIV disease and HAART are associated with a broad array of physical health complications: high cholesterol and triglycerides, cardiovascular disease including risk of heart attack and stroke, diabetes, liver and kidney toxicities, bone disorders, fat redistribution, diarrhea and other gastro-intestinal complications and fatigue. We do not fully understand how and why some of these complications occur – which to attribute to the virus, treatment side-effects or to the interplay between the two.

HIV, stigma and self-stigma

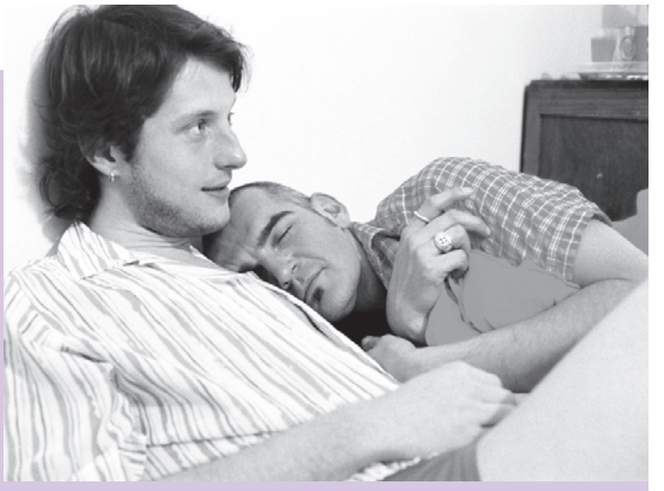
Many HIV-positive gay men are stigmatized by society. Being gay can be stigmatizing. It may sometimes be easy to lose sight of this in present-day Canada where sexual diversity is largely accepted and, for instance, Gay Pride is annually celebrated with great revelry in large and some small cities. Yet homosexuality is still seen as a shame and a failure by many families, cultures, religions and sectors of society. Gay men come from many different ethnic and cultural backgrounds, many of which are traditionally strongly opposed to homosexuality. Many gay men, regardless of racial or ethno-cultural background, still battle homophobia, stigma, denial and discrimination. Discrimination against gay men and MSM has been recognized as a global human rights issue, and a major contributor to the HIV epidemic in gay and MSM worldwide.

Gay men living with HIV can also face stigma based on their HIV status. This stigma can come from society at large, or from the gay community.

Stigma and shame can result in **internalized homophobia**, which can lead to feelings of self-blame and low self-esteem. HIV-positive gay men may also live with internalized AIDS-phobia, and blame themselves for their own infection. The internalization of stigma associated with being gay and living with HIV can be compounded for people who face stigma and discrimination based on other facets of their identity (e.g., gender identity, race, culture).

Gay men living with HIV can also face stigma based on their HIV status. This stigma can come from society at large, or from the gay community.

In the specific context of sexual health services, HIV-positive gay men may feel particularly vulnerable or may be made to feel ashamed. Seeking care for a sexually transmitted infection (other than HIV) may well be seen as an "admission of guilt" – evidence of continuing to engage in unprotected sex and, by implication, exposing others to HIV. Yet unprotected sex by an HIV-positive gay man is not necessarily equivalent to reckless endangerment of others, but may reflect an informed and considered decision on the part of both partners or may reflect a client who is struggling with maintaining safer sex despite their best intentions. More on this later in this section.



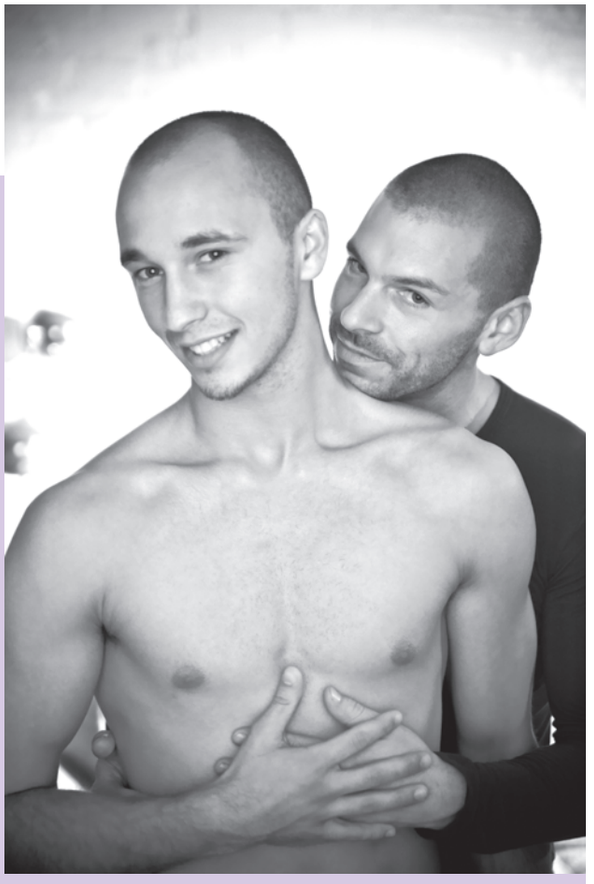
In the specific context of sexual health services, HIV-positive gay men may feel particularly vulnerable or may be made to feel ashamed.

HIV, multiple loss, death and bereavement

Some gay men, especially those who have lived with HIV for many years, have lost a great deal to HIV. They may have lost jobs, careers, income, savings, friends, family, their sense of health and wellbeing, and many loved ones to complications from HIV. Before the advent of HAART, death due to complications from HIV was an ever-present facet of living with HIV and being gay. Since the advent of HAART, HIV-related mortality has sharply declined. Yet it is important to recognize the ongoing effects of loss, multiple loss and bereavement on the lives and sex lives of gay men living with HIV, gay communities and gay culture.

"Anybody who experiences multiple loss can suffer from survival guilt and melancholy or numbness. They may indulge in substance abuse or risky behaviour. There can be an increased sense of fatalism."

- Dr. Allan Peterkin, Clinic for HIV-Related Concerns, Mount Sinai Hospital, Toronto. Quoted in A. Silversides, "Fallout from the plague years: multiple loss and impact on gay men," *Canadian Medical Association Journal* 158, 10 (1998): 1351-1353.



Recognizing and exploring the ongoing effects of multiple loss may be the starting point for working with HIV-positive gay men to change behaviours that negatively impact their health. One approach that has proven successful in addressing multiple loss among people living with HIV is bereavement support. A number of studies have shown that group-based bereavement support improves the health, wellbeing and quality of life outcomes for people living with HIV.

"In short, people who are better connected socially: feel better about themselves and others, will protect themselves and others from harm, and may be more likely to practice and sustain healthy sexual relationships, thus preventing the spread of HIV and STIs."

- C. Leaver, Y. Perreault, and A. Demetrakopoulos, "Understanding AIDS-related bereavement and multiple loss among long-term survivors of HIV in Ontario," *Canadian Journal of Human Sexuality* 17, 1, 1 (2000): 37-52.

The AIDS Bereavement Project of Ontario (ABPO, www.abpo.org) is an Ontario resource that service providers can draw upon. The APBO collaborates with organizations to build worker, agency and community resiliency in the face of AIDS-related multiple loss and transition. The ABPO seeks to mitigate the impact of grief and loss on organizations, staff and volunteers and community members living with HIV by:

- Assisting in assessment and enhancement of individual and agency coping strategies related to loss and transition.
- Developing and delivering agency programs, educational presentations, workshops, retreats and research initiatives incorporating evidence-based knowledge and bereavement expertise.
- Providing innovative training to organizations, staff and people living with HIV to increase communication skills, peer support and community resiliency strategies.
- Ensuring excellence in ABPO work through the development of sustaining, relevant, creative and evolving responses to the changing nature of loss within diverse AIDS-impacted communities.

HIV, mental health and emotional health: depression and addiction

Depression has been identified as a risk factor for HIV infection.[9] And depression is common, under-diagnosed and under-treated in people living with HIV. While estimates vary, the rate of depression among people living with HIV is estimated to be two to six times the rate in the general population.[10] A recent study found that 32 percent of MSM with HIV suffered from depression;[11] other studies have found that up to 50 percent of MSM with HIV had had at least one major depressive incident in their lifetime, and rates of depression tended to increase with the advance of HIV disease.[12]

◀ *Sexual Health guide excerpt*

◀ *Legal Guide excerpt*

Sex, drugs and recreation

Some guys use party drugs when they have sex – or have sex when they are using party drugs. Other guys have strong negative views about party drugs and won't go anywhere near them. Party drugs are sometimes called "recreational" drugs.

Party drugs can affect your health, especially if you take party drugs often or take large doses of them. Party drugs can change the effect of HIV medications. And HIV medications can change the way your body reacts to party drugs. Here are some things to be aware of:

- Protease inhibitors (a type of HIV medication) can really increase the concentration of party drugs in your body. This means that the same amount of party drugs can have a much bigger effect on you.
- Drinking alcohol can increase the level of the HIV medication abacavir (Ziagen) in your body.
- If you are taking ddI (Videx), drinking alcohol increases your risk of developing a dangerous swelling of your pancreas.

If you are not sure what HIV medications you are taking, check with your doctor or pharmacist. Your pharmacist should be able to answer questions about how your HIV medications react with other medications and party drugs.

You can get more information about HIV, HIV medications, party drugs and your health from torontovibe.com and the Canadian AIDS Treatment Information Exchange (CATIE).

Figuring out if you have a legal duty to disclose your HIV infection before sex

The criminal law about sex and HIV is really about the risk of passing on HIV. If there is a **significant risk** that you will pass on HIV during sex, you have a legal duty to tell your sex partner that you have HIV before you have sex.

Usually when we talk about the risk of passing on HIV, we talk about "high risk," "low risk," "negligible risk" and "no risk." These are not the words the law uses. The law talks about "significant risk". But the law has not defined exactly what significant risk means. So sometimes it can be really hard to figure out if you have a legal duty to disclose.

Fucking without a condom

One thing we do know for sure is that sex with a "high risk" of passing on HIV is a "significant risk" in the eyes of the law – so you have a legal duty to disclose.

If you fuck or get fucked without a condom there is a high risk you will pass on HIV. So when you fuck or get fucked without a condom you have a legal duty to disclose your HIV infection to the other guy before sex. ▶

Fucking with a condom, oral sex and other types of sex

When you fuck or get fucked with a latex or polyurethane condom and water-based lube, have oral sex or have another type of sex, **you *may* have a legal duty to disclose** your HIV infection to the other guy before sex. We cannot say for certain whether you have a legal duty to disclose because:

- Canadian courts are still figuring out what "significant risk" means in criminal cases about HIV and sex.
- Your risk of passing on HIV during sex is hard to figure out because it can depend on a lot of things.

Figuring out the risk of passing on HIV during sex

Here are some things to consider when you try to figure out the risk of passing on HIV during sex:

- **Blood, cum, pre-cum and ass fluid**: An HIV positive man's blood, cum, pre-cum and ass fluid can contain enough virus to infect another person with HIV. HIV can be passed on when blood, cum, pre-cum or ass fluid that contains HIV get into a guy's bloodstream. HIV can also be passed on when the cells lining the inside of a guy's ass, piss hole, mouth, nose or eyelids absorb blood, cum, pre-cum or ass fluids that contain HIV.
- **Condoms**: You can decrease the risk of passing on HIV by properly using condoms and water-based lube.
- **Sexually transmitted infections (STIs)**: If you have an STI it is easier for you to pass on HIV. If your sex partner has an STI it is easier for him to get HIV.
- **HIV viral load**: A viral load test measures the amount of HIV in your blood. The higher your viral load the more likely you are to pass on HIV during unprotected sex. **But even if your viral load was "undetectable" in a blood test, you can still pass on HIV because:**
  - You still have HIV in your body.
  - Your cum, pre-cum and ass fluid may contain high levels of HIV.
  - Your viral load might have increased since you had the test.

Remember, when there is a significant risk that you will pass on HIV you have a legal duty to tell your sex partner that you have HIV before you have sex.

For more information about the risk of passing on HIV during sex, see the Canadian AIDS Society's *HIV Transmission: Guidelines for Assessing Risk*.

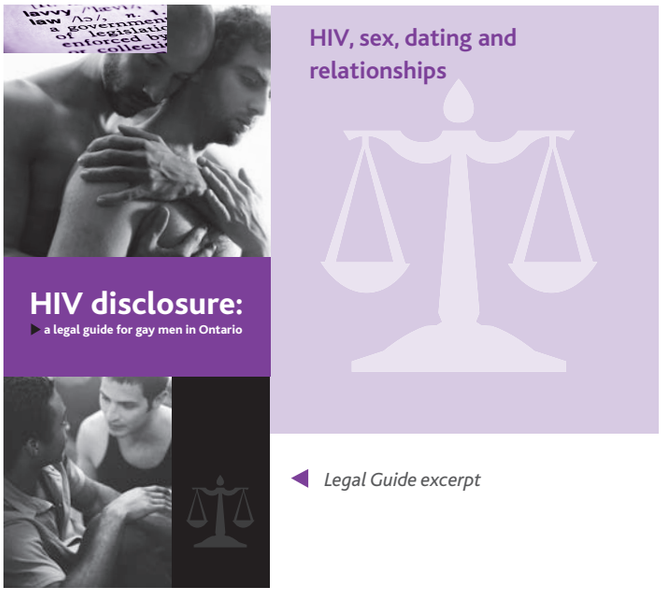
The choice by an HIV-positive man to have sex with other HIV-positive men can be an attempt to protect HIV-negative men.

The challenges of disclosure: why it's not easy to do[13, 14, 15]

Given the potential consequences of failing to disclose one's HIV status, it would seem that the best solution would simply be to disclose to each new sexual partner. This is rarely as easy as it sounds. HIV status is intensely personal information and the act of disclosure can lead to positive or negative results, or a mix of the two. This is why people living with HIV are entitled to have control over this crucial decision, except where the law says otherwise.

The issue of HIV disclosure has been the subject of discussion, debate and deliberation since the beginning of the HIV epidemic. Most of the discussion and debate has been about people who do not disclose their HIV status before they engage in behaviours with a high risk of transmitting HIV. The focus on HIV-positive people who put others at risk of HIV transmission has distorted the discussion and made life more difficult for people living with HIV. It has reinforced the climate of fear, stigma, and discrimination that surrounds HIV infection and has even resulted in violence against some people living with HIV. It has made it more difficult for many people living with HIV to disclose their status.

Many men will disclose their status to some, but not all, sexual partners. Arriving at the decision to disclose (or not) often involves weighing a complex set of factors including the partner's perceived HIV status, the anticipated sexual behaviours and what degree of risk they are thought to pose and the partner's perceived ability to make informed decisions of his own. HIV-positive gay men's disclosure strategies vary. Many men may lack the skills to disclose their status and deal with their partner's potential reactions. Counselling and skills-building around disclosure may be one of the most effective strategies for helping HIV-positive gay men have safer sex. See section 4.



Legal Guide excerpt

HIV, sex, dating and relationships

Living with HIV comes with responsibility. There is no cure for HIV. HIV can seriously harm a person's health and can lead to death. And HIV can be transmitted during sex.

So the law about HIV and sex is very strict.

Because you are HIV positive, the law can affect your sex life. But when you know what the law says, you can make better decisions and avoid legal problems. So knowing about the criminal law can help you have a safer, hotter and more satisfying sex life.

Living with HIV can complicate sex, dating and relationships. Telling another guy you have HIV can be really difficult. You may find that disclosing your HIV status gets easier the more you do it. Or you may never find it easy to disclose. Either way, you can probably figure out ways to prepare yourself to deal with the other guy's reaction to your HIV.

If a guy doesn't want to have sex with you or date you because you are HIV positive, it is his loss. But he is entitled to make that choice. Just like you are entitled to say "no" to guys you don't want to have sex with or date.

HIV-positive gay men and sexual risk-taking

Some gay men – HIV-positive and HIV-negative – continue to engage in behaviours that risk HIV transmission and transmission of others STIs. The reasons are complex, varied and continue to be investigated. An exhaustive discussion is beyond the scope of this manual. Here, we hope to raise some key issues and questions, present relevant research findings and perhaps challenge some assumptions about, and interpretations of, sexual risk-taking by HIV-positive gay men.

For our purposes, "risk taking" refers to sexual behaviour that exposes an HIV-positive man's sexual partners to a high risk of HIV transmission (i.e., unprotected anal sex with a partner whose HIV status is negative or unknown). We will refer to this as "non-concordant unprotected intercourse" (NCUI). Sex between HIV-positive men, while exposing both men to possible STIs and HIV re-infection, does not risk new HIV infection. The choice by an HIV-positive man to have sex with other HIV-positive men can be an attempt to protect HIV-negative men, an issue we will return to later in this section.

Ontario-based researcher Barry Adam has described how HIV-positive men who identify as "barebackers" (i.e., engage in unprotected anal sex) link barebacking behaviour with notions of free will and informed consent. Such choices are guided by the modern, Western, "neoliberal" cultural values of autonomy and free choice, and "justifiable through a rhetoric of individualism, personal responsibility, consenting adults, and contractual interaction." Such men are "nearly always willing to respect partners who prefer to use protection," rarely express any willingness to knowingly infect a partner and tend not to bareback with men they perceive as being incapable (for reasons of "experience", age, knowledge about HIV, etc.) of giving "informed consent."

Similarly, one U.S. study has found that risky behaviour may vary according to HIV-positive gay men's beliefs about who is most responsible for preventing HIV transmission. Men who felt a greater sense of personal responsibility were least likely to have NCUI. Importantly, in this study, men's feelings about their partner's responsibility were distinct and independent from feelings about their own. In other words, believing that a partner had a responsibility to protect himself did not necessary prevent men from having a felt personal responsibility of their own.

A sense of responsibility and evolving protective strategies

"There has been almost no research on how people living with HIV view their responsibility for protecting others or how prevention messages for this population may be received. Only a few researchers have studied issues related to personal responsibility. ... Most of the men [in our study] believed that they had a responsibility to protect their sex partners from HIV infection and had adopted risk-reduction practices that were consistent with this belief... A sense of responsibility for protecting others seemed to be motivated by several factors, including altruism, personal

standards, and self-interest. Tapping these motivations may enable therapists and HIV prevention programs to increase a sense of responsibility among HIV-seropositive gay and bisexual men and reduce transmission risk."

- P.N. Halkitis, C. A. Gomez, and R. J. Wolitski eds., *HIV+ Sex: The Psychological and Interpersonal Dynamics of HIV-Seropositive Gay and Bisexual Men's Relationships* (Washington, D.C.: American Psychological Association, 2005).

How often do HIV-positive gay men have unsafe sex?

Evidence suggests that most HIV-positive people remain sexually active after their diagnosis. There has not been a great deal of research specifically examining HIV-positive gay men's sexual behaviour. Studies in Canada and the U.S. have generally found that:

- Most HIV-positive gay men practice safer sex, or engage in unprotected sex that does not put HIV-negative men at risk (i.e., unprotected sex with a known HIV-positive partner).
- Significant numbers of HIV-positive gay men continue to have unprotected sex with partners of unknown HIV status, or men whom they presume to be HIV-positive.
- A smaller but significant minority continues to have unprotected sex with men they know to be HIV-negative.

Studies have found varying rates of unprotected sex among HIV-positive gay men in North American cities:

- Montreal, 2004 to 2006: 16 to 22 percent had NCUI.[18]
- Toronto, Pride 2005 survey: nearly half (47.5 percent) had NCUI, compared to 14.1 percent of HIV-negative men.[19]
- Los Angeles, Milwaukee, New York and San Francisco, 2000 to 2002: 45 percent had had anal sex without using condoms, but only 15 percent with an HIV-negative partner or a partner of unknown status.[20]
- Seattle, 2005 to 2006: 27 percent had NCUI in the preceding year.[21]
- New York and San Francisco, 2000 to 2001: 34 percent had unprotected anal sex with a casual partner of unknown HIV status; 18 percent with a known HIV-negative casual partner.[22]

While the gay community has accepted condoms as a sexual necessity, many gay men view unprotected sexual intercourse as better, hotter, and more primal, intimate and enjoyable than sex with condoms.

Factors that influence HIV-positive gay men's sexual safety decisions

Gay men, regardless of HIV status, have unsafe sex for many reasons. "There is no 'average gay man' and no single message (or 'magic bullet') that can address the multiple situations and overlapping social and sexual micro-cultures, each with its own vulnerabilities to unsafe sex."[23] However, a few fundamental facts risk being obscured or neglected.[24] For example, we are often guilty of forgetting how non-rational sex and sexuality fundamentally are. Many HIV prevention efforts over the past 20 years have neglected the very essence of sex, treating it as a cognitive and rational construction, controlled solely by a person's mind or rational self. Sex is a complex phenomena best understood in relation to emotional and sociological contexts in addition to cognitive states.

While the gay community has accepted condoms as a sexual necessity, many gay men view unprotected sexual intercourse as better, hotter, and more primal, intimate and enjoyable than sex with condoms. Gay men who have "rediscovered" unprotected sex often use "almost rhapsodic language" in describing the pleasure and connection it brings.

Ontario researchers found that the following factors were likely to influence HIV-positive gay men's sexual safety decisions:[26]

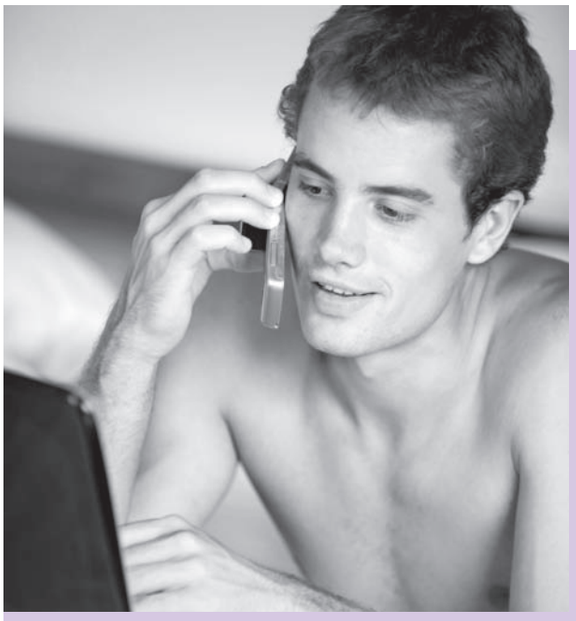
- **Erectile difficulties with condoms.** This does not inevitably lead men to abandon condoms altogether. They may choose to take the "bottom" role, "try again later," or use condoms intermittently or inconsistently.
- **A partner's known or presumed HIV status.**
- **Stress, depression and personal turmoil.** Men who are going through emotionally turbulent or stressful times, or who are depressed, may lapse into an uncaring attitude.
- **Relationships and pressure by partners not to use condoms**. One of the clearest findings from HIV research is that gay men tend to drop condom use as they develop relationships. This may occur even in anticipation of a relationship, as a sign of "seriousness," or as part of the relationship-building process. Mixed-status couples may also agree to forgo condoms.
- **Momentary lapses in judgment.** Men frequently describe scenarios in which "good intentions" are overrun by simply getting caught up in the "heat of the moment". These often involve a partner who is seen as especially attractive and desirable.
- **Use of alcohol and recreational drugs.** Alcohol and recreational drug use can increase sexual desire, lower sexual inhibition and impair judgment.
- **Sexual opportunism.** A small number of men candidly admit to having unprotected sex when the opportunity presented itself, especially in anonymous and public settings.

Don't ignore pleasure

"Most of us don't engage in activities, which have a risky edge because we hate ourselves, are stupid, or seek harm. Humans, by and large, are not guided primarily by the intellect. We do these things because they add something to our lives that we really want -- that we truly value. Instead of bemoaning the failures of young gay men and gay men of color to not follow our use-a-condom-every time dictates, prevention leaders must accept that fact that, for many gay men, HIV risk is no longer the primary factor driving the anal sex practices of gay men. A more complex look at the pleasures and meanings men experience from anal sex might suggest new pathways for prevention."

- E. Rofes, "Facing the third decade of HIV/AIDS: Can we finally Tackle the Real Issues Impacting Gay Men's Sexual Health?" Available at: www.ericrofes.com/books/third_decade.php.

The Pleasure Project (www.thepleasureproject.org) is a U.K.-based educational initiative that promotes safer sex that feels good. Whereas most safer sex and HIV prevention programs are negative and disease-focused, the Project takes a positive, liberating and sexy approach to safer sex. The Project aims to make sex safer by addressing one of the major reasons people have sex: **the pursuit of pleasure.**



Your Sexual Health, from top to bottom

◀ *Sexual Health guide excerpt*

Your sexual health, from top to bottom

You might run into challenges in your sex life. But there are ways to overcome the challenges.

Your sex drive

Sometimes you might not feel very interested in sex. That's not necessarily a problem. Your sex drive is affected by your physical, mental and emotional health. Many of us feel less interested in sex when we're stressed, tired, sick, or just dealing with other things in life. Here are some other things that can lower your sex drive:

- Smoking cigarettes, drinking a lot of alcohol, or taking a lot of party drugs.
- A low level of a male hormone called testosterone.
- Anxiety or guilt about being gay, being HIV positive or having sex.
- Depression or feelings of sadness.
- Feeling bad or uncomfortable about your body.
- Some prescription medications.
- Getting older.

If you are not interested in sex for a long time, and that bothers you, you may want to talk to your doctor. There are probably things you can do to get your sex drive back.

Hard-on, not hard up

If your cock is not getting or staying hard you can do something about it. Prescription medications – like Cialis, Levitra and Viagra – can help you get a hard-on. Only a doctor can prescribe these erection drugs for you. They're pricey and your drug plan may not pay for them.

Be careful when you take erection drugs:

- High doses of erection drugs can damage your cock. Some HIV medications can boost the dose of erection drugs you take. So you may end up getting a higher dose than you actually took. Be especially careful if you are taking the HIV medication called ritonavir (Norvir).
- Avoid poppers. Poppers cause a very sharp drop in your blood pressure. Erection drugs lower your blood pressure too. Combining the two can be dangerous, especially if you have heart or blood pressure problems. Some guys who take erection drugs use poppers and don't have any problems. But your body may react differently.

HIV-positive men and strategies for "attempted safety"

"HIV-positive people (especially gay men) appear to be evolving a variety of strategies other than the maintenance of 100 per cent condom use which aim to inform and protect their partners, at least from the risk of HIV. ... HIV-positive people, it is becoming clear, are evolving a set of 'attempted safety' strategies based on disclosure that have very little to do with conventional 'safer sex' messages."

- G. Cairns. *Positive prevention by positive men: developing positive-led HIV prevention programmes for gay men with HIV.* (London: UK Coalition of People Living with HIV & AIDS, December 2005).

Strategies for attempted safety include:

- Sero-sorting.
- Strategic positioning / sero-adaptation.
- Delayed condom use.
- Withdrawal before ejaculation.
- Using viral load as an indicator of sexual transmission risk.

Gay men may not be aware of the HIV transmission risk associated with delayed condom use.

Sero-sorting is the choice to have unprotected sex with partners of the same HIV status as oneself – either HIV-positive or HIV-negative. For HIV-positive men sero-sorting can be a deliberate strategy to avoid infecting HIV-negative men by confining unprotected sex to other men who are already HIV-positive. However, attempts at sero-sorting can fail due to miscommunication, mistaken beliefs, presumptions or conjectures about the other person's HIV status. For example, an HIV-positive man may mistakenly presume that a partner's consent to "bareback" indicates that the partner is also HIV-positive. While the HIV-negative man may mistakenly presume that the other man is also negative. For this reason, some people refer to sero-sorting as "sero-guessing". There may also be legal implications for failing to disclose HIV status to a sex partner who is also HIV-positive.

Some gay men may believe that there is low or no risk of HIV transmission when the HIV-negative guy "tops" and the HIV-positive guy "bottoms". Or they may understand, correctly,

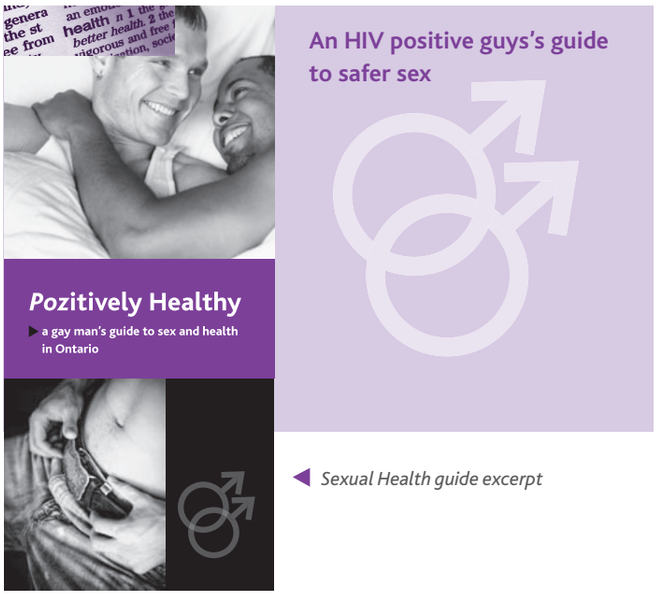
How "attempted safety" strategies can fail and suggested interventions to promote safer sex

Strategy	Underlying assumption	Actual evidence	Suggested intervention
All		High risk of HIV and other STI transmission.	Discuss risk with patients.
All		Risk of HIV re-infection.	Discuss risk with patients.
Strategic positioning.	Top is unlikely to be infected.	Top may be at somewhat lower risk. However, HIV transmission possible whether top or bottom.	Discuss risk with patients.
Delayed condom use/ withdrawal before ejaculation.	Safe(r) as long as ejaculation does not occur inside.	HIV transmission possible (Polaris).	Discuss risk with patients.
Sero-sorting.	Cannot infect another HIV-positive man.	Partner status may be misread.	Foster communication skills.
Assessing viral load.	Undetectable viral load implies safety.	No data for gay men.	Discuss risk; inform patients of lack of data for gay men.

that the risk of acquiring HIV during anal intercourse with an HIV-positive man is lower for an HIV-negative top than for an HIV-negative bottom. So based on their understanding, HIV-positive and negative men may **strategically adopt sexual positions** to reduce their risk of acquiring or transmitting HIV.

Some men **delay condom use** (dipping) or have unprotected anal sex and **withdraw before ejaculation**. The Ontario-based Polaris study has found that "delayed" condom use posed a highly significant risk for HIV transmission.[27] Gay men may not be aware of the HIV transmission risk associated with delayed condom use. Or the risks associated with unprotected anal intercourse even where there is no ejaculation.

Men are using information about **HIV viral load** to make decisions about their likelihood of infecting a sexual partner during sex. Their understanding of the influence of viral load on sexual infectivity is influenced by interpretations of research, discussions about HIV treatment as HIV prevention, and notably the 2008 statement by the Swiss Federal AIDS Commission. The Commission stated that, under certain circumstances, people on HAART with an undetectable HIV viral load should be considered sexually uninfectious. It is not clear how many men are making decisions based in whole or in part on their HIV viral load. There is certainly a significant risk in assuming that an undetectable viral load equals sexual non-infectiousness, as there is no data to support this for gay men. Anecdotally, some gay men with HIV have indicated a strong desire to better understand this information, in part, to gain relief from the pressure of feeling 'infectious' with their sexual partners. The relationship between HIV viral load and infectiousness are discussed in greater detail in section 6.



Sexual Health guide excerpt

An HIV positive guy's guide to safer sex

Many of us worry about passing on HIV or becoming re-infected with a different strain of HIV. That worry might never go away completely. But you can have great sex without passing on HIV or becoming re-infected with HIV. Great safer sex starts with an understanding of the risks involved in sex.

Figuring out the risk of HIV transmission

When experts figure out the risk of passing on HIV during sex, they ask two questions:

1. Is there a **potential** that HIV can be transmitted from one person to another during a sex act?
   - An HIV positive man's blood, cum, pre-cum and ass fluids can contain enough virus to infect another person with HIV.
   - Blood, cum, pre-cum or ass fluids that contain HIV must get directly into the other guy's bloodstream.
   - Or the cells lining the inside of other guy's ass, piss hole or mouth must absorb blood, cum, pre-cum or ass fluids that contain HIV.
2. Is there evidence that HIV has been transmitted from one person to another during that sex act?

Based on the answers to these two questions, experts have developed four different categories of HIV transmission risk for sex:

- High risk sex (**potential** for HIV transmission and **evidence** of HIV transmission).
- Low risk sex (**potential** for HIV transmission and **evidence** of HIV transmission under certain circumstances).
- Negligible risk sex (**potential** for HIV transmission but **no evidence** of transmission).
- No risk sex (**no potential** for HIV transmission and **no evidence** of transmission).

Condoms can prevent HIV transmission

Some gay guys, no matter what their HIV status, are tired of hearing about condoms. But condoms work. When they are used properly, condoms are the single best way to prevent HIV transmission when guys have anal sex or oral sex.

Condoms can also prevent you from becoming re-infected with a different strain of HIV. And condoms can protect you against many other sexually transmitted infections (STIs).

The HIV risk table for HIV positive guys

Use this table to figure out your risk of passing on HIV to a guy during sex.

The information in this table is only about HIV. Most other STIs are spread more easily than HIV. Information about other STIs starts on page [insert page number].

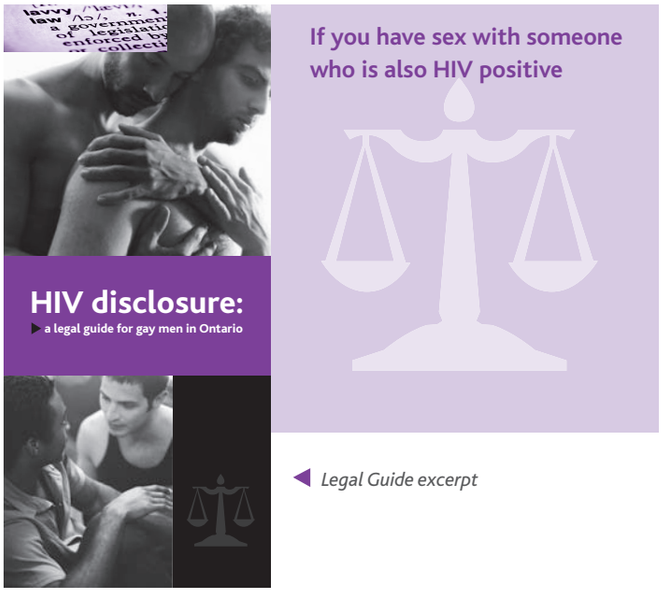
Some of the information in the table will apply to you if you are a gay or queer transman. For more information about safer sex for gay and queer transmen read *Primed: The Back Pocket Guide for Transmen & The Men Who Dig Them*.

For detailed information about your legal duty to disclose your HIV status, sex and the law, read *HIV disclosure: a legal guide for gay men in Ontario*.

The sex	Your risk of passing on HIV	Some important details
You fuck him (anal sex) **without a condom**. You are the top.	High risk	HIV can get into his body through the lining of his ass, even if the lining is not damaged. HIV can get into his ass even if you don't shoot your cum inside him. Your pre-cum contains HIV, and you can leak small amounts of cum before you have an orgasm. So sticking your cock into the other guy's ass just a little, for just a short time (sometimes called "dipping") or pulling it out before cumming is high risk. **Rough sex** can damage his ass and your cock. This increases the risk of passing on HIV.
He fucks you (anal sex) **without a condom**. You are the bottom.	High risk	**Inside your ass there are fluids that contain a lot of HIV.** HIV can get into his body through tiny cuts or open sores on his cock, through his foreskin or through the lining of his piss hole (urethra). **Rough sex** can damage his cock and your ass. This increases the risk of passing on HIV.
You put a **sex toy** in him after it has been in you.	High risk	
You fuck him (anal sex) or **he fucks you** with a **condom on.** If you are the top or the bottom.	Low risk	
He sucks your cock without a condom on it.	Negligible risk	The risk of passing on HIV is increased if he gets **your cum or pre-cum in his mouth.**
You suck his cock without a condom.	Negligible risk	
He sucks your cock with a **condom on** it.	Negligible risk	
You rim a guy's ass, **he rims** your ass, **you finger** his ass, **he fingers** your ass, you stick the head of your cock into his foreskin "docking", he sticks the head of his cock into your foreskin, **cock and ball torture.**	Negligible risk	
You fist a **guy's ass,** or **he fists your ass.**	Negligible risk	
You piss or shit in a guy's mouth or on his damaged skin.	Negligible risk	If there is **blood in your shit or piss** this can increase the risk of passing on HIV to him. Getting **shit** on open skin carries a high risk of **bacterial infection** and can lead to blood poisoning. This is true whether or not the shit comes from someone who has HIV.
You piss or shit on his skin that is not broken or damaged.	No risk	
Kissing, jerking off each other, playing with **sex toys without sharing** them.	No risk	

HIV re-infection is a concern

Many gay men living with HIV are concerned about the possibility of being re-infected with HIV. Re-infection (aka "super-infection") occurs when a person who is already HIV-infected becomes infected with another strain of HIV. Small-scale studies have established that HIV re-infection occurs (including re-infection with drug-resistant virus), but research has not yet determined the prevalence of re-infection. Nor has research conclusively documented the potential health effects of re-infection. The second strain may be distinct enough from the original strain to significantly affect the person's prognosis or clinical condition. A drug-resistant strain or a more virulent strain might lead to faster disease progression.



Legal Guide excerpt

If you have sex with someone who is also HIV positive

Do you have a legal duty to disclose your HIV before sex with another guy who you know has HIV? There is a risk that you might be charged and convicted for not telling him that you have HIV. This type of legal case is based on the theory that someone living with HIV:

- Can be **re-infected** with a different type (also known as a "strain") of HIV; and
- That re-infection with a different strain of HIV can cause serious bodily harm.

Re-infection is hard to study. Only a few dozen medical cases of re-infection have been identified with certainty. Nobody knows how often re-infection happens.

To date, there have been no Canadian court cases where an HIV positive person was criminally charged for exposing another HIV positive person to a **significant risk of HIV re-infection**.

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Notes

4. Providing sexual health counselling to HIV-positive gay men: commit to a client-centred approach

Key Points

The sexuality of HIV-positive gay men is highly stigmatized. For example, some people believe that gay sex is immoral, that HIV-positive people should not have sex, or that having unprotected sex under any circumstances is wrong. This stigma can prevent HIV-positive gay men from receiving the service they need.

- **Providing client-centred services to HIV-positive gay men is essential to overcoming the stigma that can prevent HIV-positive gay men from accessing the services they need.**
- **"Client-centred" describes the relationship between the client and the service provider, in which the needs and wants as determined by the client, not the service provider, are the focus of the client-service provider working relationship.**
- **To be client-centred from a poz prevention perspective means combining the core elements of client-centred service provision with cultural competency as it relates to HIV-positive gay men, and the poz prevention values and principles.**
- **Honest and open communication is critical to engaging clients in services and programs and to ensuring that public health interests are best served.**
- **Behaviours are the result of the complex interplay of individual life experience, personal perspectives on sexuality and HIV, and social, economic and cultural conditions.**
- **Behaviour change may not be easy. It often involves addressing the social determinants of a person's health.**
- **A firm grasp of guiding values and principles, and best practices in sexual health service provision and HIV disclosure counselling, can help you to provide high quality sexual health services to gay men living with HIV.**

In order to provide sexual health counselling services to HIV-positive gay men, service providers need to understand:

- **How to use a client-centred approach appropriate to HIV-positive gay men.**
- **How to identify and analyze the legal issues that arise in providing sexual health services to HIV-positive gay men.**
- **HIV transmission risk.**
- **STIs including HCV.**

This section will focus on using a client-centred approach appropriate to HIV-positive gay men when providing sexual health counselling.

"Below the issue your clients present with, and the counselling goal of safer sex and reduced HIV transmission, is a story. And it is your job to get that story. So there is a lot of work and a lot of listening to be done with that person to figure out who they are and what the story is. Low self-esteem, use of drugs, loneliness may be parts of the person's story. As a service provider you can help that person re-write their story and change how it unfolds. The goal is not necessarily to send them off saying "I will have safer sex" but maybe "I now understand that I need to do something about my depression, about my housing and I have the support to do it."

- Gay man living with HIV, volunteer and activist

Commit to the core elements of client-centred service provision

Why is a client-centred approach important in providing sexual health counselling to HIV-positive gay men? Because the sexuality of HIV-positive gay men is highly stigmatized. Stigma can prevent HIV-positive gay men from receiving the service they need for their health and wellbeing and from doing their part to stop the transmission of HIV. Anecdotally, HIV-positive gay men have reported that they may delay or avoid care or be guarded in the information they share, due to previous negative experiences with service providers, fear of judgment, reprisal or even legal action; in other words because some service providers lack cultural competence in working with HIV-positive gay men and intentionally or unintentionally stigmatize their clients. And HIV-positive gay men may engage in self-stigma, having internalized the stigma that they perceive has been directed at them.

What does client-centred mean? Client-centred is a standard of service provision in which the needs and wants as determined by the client, not the service provider, are the focus of the client-service provider working relationship. The emphasis on the self-determination of the client is a defining element; the service provider works from a foundational belief that the client knows best what they need and supports the client by empowering their problem-solving abilities.

Client-centred is a standard of service provision in which the needs and wants as determined by the client, not the service provider, are the focus of the client-service provider working relationship.

The core elements of client-centred service provision include:

- The service provider and client work in **collaboration**.
- The **client's interests are paramount**.
- The **service provider is a source of information, knowledge and critical thinking** regarding the client's circumstances, all of which are conveyed to the client in a way that he or she can understand.
- The service provider recognizes the **client's autonomy**. The **client is best placed to make decisions** about his or her own life and the **service provider facilitates the client's self-determination** by encouraging them to decide which problems they want to address and how to address them.
- **Professionalism** is at the heart of the relationship. The service provider follows **professional rather than personal ethics and standards** and is **aware of his or her values, beliefs and needs and how these may impact the relationship**.
- Both service provider and client understand and work within the **boundaries** of the client-service provider relationship.

Client-centred service provision from a poz prevention perspective

Different professions have different ways of describing client-centred relationships. To be client-centred from a poz prevention perspective means combining the core elements of client-centred service provision with cultural competency as it relates to HIV-positive gay men, and the poz prevention values and principles. Remember, according to the principles of poz prevention, service providers should respect HIV-positive gay men's rights to:

- Full, satisfying and healthy emotional and sexual relationships.
- Freedom from stigma and discrimination.
- Confidentiality of all medical information, including HIV status and information specific to their sexual health.
- Acknowledgment of their diversity.

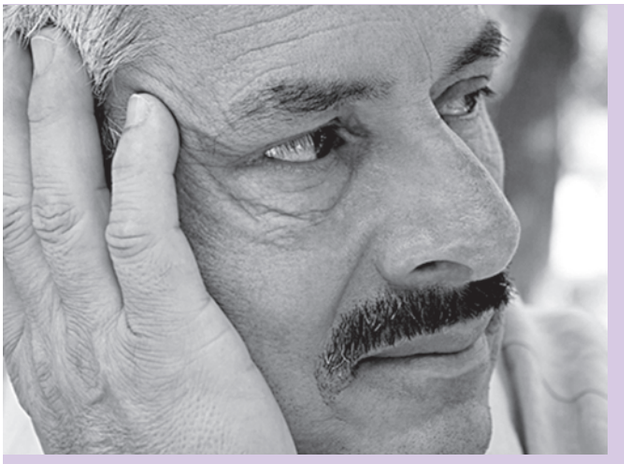
Service providers should also recognize that:

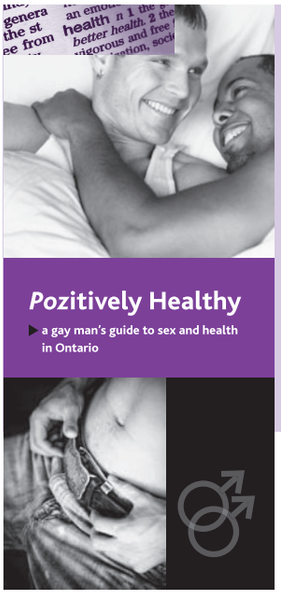
- The sexual health and wellbeing of HIV-positive gay men is a primary focus and is also a means toward reducing new HIV infections.
- The responsibility for preventing new infections is shared between HIV-positive and HIV-negative individuals.
- Behaviour change is complex and can require action on social determinants of health.
- Coercion and criminalization are not the solution to the risk-taking activities of gay men living with HIV. Programs rooted in health promotion and risk reduction are more likely to engage communities and reduce HIV transmission over time.
- HIV disclosure is a challenge for most HIV-positive gay men. Helping them to assess their readiness to disclose their HIV status, and developing the skills to do so, is more beneficial than insisting they must disclose.

Practice guidelines for providing client-centred sexual health counselling to HIV-positive gay men

Sexual health counseling for HIV-positive gay men is most effective when service providers:[1, 2, 3]

- **Are supportive, non-judgmental and acknowledge the challenges of risk reduction while emphasizing and building on client strengths**. Most HIV-positive gay men are eager to protect their sex partners from HIV. Service providers should identify and reinforce this and other client strengths and resiliencies.
- **Recognize that one size does not fit all**. Acknowledge client diversity and individuality. Recognize that behaviours will vary, as will supportive approaches and programs that clients may find helpful.
- **Provide brief, general prevention messages on a regular basis**. Simple, periodic messages, provided within the context of regular care, can reinforce risk reduction as a means to benefit the client's own health, as well as the health of his partner(s).
- **Provide adequate, accurate information about HIV transmission risk factors and risk reduction. Identify and correct misconceptions**. HIV-positive gay men need up-to-date, reliable information about HIV transmission. This information should include not only condom use, but also the influence on HIV transmission of specific sexual acts, STIs, antiretroviral therapy and viral load.
- **Identify and address biomedical risks for HIV transmission**. The risk of HIV transmission can be reduced by treating STIs.
- **Identify behavioural risks and the reasons behind them**. Clients may or may not be engaging in behaviours that put others at risk. If they are, the behaviours and reasons for them may vary widely from person to person.
- **Help clients deal with the challenge of HIV disclosure**. Research has repeatedly identified disclosure to sexual partners as one of the most challenging aspects of risk reduction for HIV-positive MSM. The situation has been complicated by the criminal legal duty to disclose in certain circumstances. Many gay men need support around HIV disclosure.
- **Consider more tailored or intensive programs where appropriate**. Where brief, general messages do not appear to be adequate, interventions tailored to the individual's needs may be more effective. Steps may include client-centred counselling, skills building around disclosure, or specialized services to address issues such as homelessness, addiction or mental illness.





Handling "no" while staying positive and proud

Sexual Health guide excerpt

Handling "no" while staying positive and proud

Every guy has heard "no" when they ask another guy for sex, a date or a relationship. And each of us has probably said "no" to a guy.

Sometimes guys say "no" to us when they find out we have HIV. That's far from certain, but it happens. So you may need to get some skills to handle the "no" while staying positive and proud. It may help you to think about these things:

- Your worth as a person didn't change when you got HIV. Some people say they are stronger and better people because of what they have gone through.
- It is not really about you. His "no" is about him – what he thinks and feels about HIV.
- He may be trying to lower his own risk of getting HIV. And that is his choice to make.
- He may be dealing with other issues and can't handle thinking about HIV right now.
- Lots of HIV negative guys have sex with, date and love HIV positive guys. If this guy isn't one of them, the next guy could be.
- You did what you felt you had to do. You told him you were HIV positive. It was probably not an easy thing to do. You respected yourself and you respected him. No one can take that from you.

Talk with clients about their sexuality

Honest and open communication is critical to engaging HIV-positive gay men in services and programs, **and** to ensure that public health interests are best served. In 2004, the Canadian Federation of Sexual Health published the first Canadian *Sexual and Reproductive Health Counselling Guidelines*. We have adapted these for counselling gay men living with HIV, including the **GATHER** model.

Greet your clients.

Ask your clients why they have come and about their situations.

Tell your clients how you can help them.

Help your clients to make their own decisions.

Explain how to use the methods they have chosen.

Return visits are arranged to see how they are getting on.

This model is flexible and allows you to work your own style of counselling into a discussion on STIs/HIV and safer sex practices.

When starting a discussion on sexuality give the client time to settle into the session before asking specific questions about sexuality issues. Start by asking questions like:

- What brings you here today?
- Where would you like to begin?

Information should be asked in a simple, non-judgmental manner using clear language. Try to do one-to-one education during the conversation, because it can be an important part of the client's health and wellbeing. You should mention to the client that they are not obligated to answer any questions they do not feel comfortable discussing.

Once you and the client feel comfortable, you can ask more specific questions like:

- Can you tell me more about your concerns?
- What is it that worries you?
- What do you think might have put you at risk for STIs, or exposing someone to HIV?
- What activities do you like to do sexually that concern you?
- Do you feel that this relationship puts you at risk of getting an STI or passing on HIV infection? If yes, why do you think that?
- Do you do things to prevent getting STIs or passing on HIV infection? If yes, can you tell me about what things you do and how they keep you and your partners safer?

Try to do one-to-one education during the conversation, because it can be an important part of the client's health and wellbeing.

Guidelines for **counselling clients in relation to HIV disclosure** have been developed by the Canadian AIDS Society and the Canadian HIV/AIDS Legal Network. Chapter 6 of *Disclosure of HIV Status After Cuerrier: Resources for Community Based AIDS Organizations*, entitled "Counselling and HIV Disclosure: Standards and Approaches," includes:

- Counselling goals – encouraging beneficial disclosure.
- Suggested approaches to counselling clients about HIV disclosure issues.
- Client assessment: preventing HIV transmission.
- Acknowledge the client's perspective.
- Disclosure where HIV exposure is not an issue.
- Counselling is part of comprehensive care.

See the "Key references for more information" at the end of this section to find out where to download *Disclosure of HIV Status After Cuerrier*.

Create safe and welcoming environments

Creating a safe and welcoming environment for each client can be challenging, particularly if the environment some clients perceive as "safe and welcoming" is seen by others as offensive or problematic. There are many relatively quick and easy ways to make gay men living with HIV feel welcome. The following suggestions, focused on the physical office environment, are taken from the U.S. Gay and Lesbian Medical Association's *Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients*:

- Post a rainbow flag or other LGBT-friendly symbols or stickers in visible places.
- Display LGBT media, including magazines or newspapers for and about gay and HIV-positive individuals.
- Exhibit posters from LGBT or AIDS service organizations, particularly ones depicting ethnically diverse same-sex couples or transgender people.
- Display brochures about gay health concerns.
- Acknowledge relevant days of observance in your practice such as World AIDS Day, LGBT Pride Day, and National Transgender Day of Remembrance.
- Visibly post a non-discrimination statement stating that equal care will be provided to all patients, regardless of sex, age, race, ethnicity, physical ability, religion, sexual orientation or gender identity.

The involvement of peers can be an essential part of creating a safe and welcoming environment. It is also part of fulfilling the GIPA Principle.

Involve peers to the greatest extent possible

Gay men living with HIV should be encouraged and supported to become involved in designing, delivering and evaluating poz prevention programs, including sexual health services. The involvement of peers can be an essential part of creating a safe and welcoming environment. It is also part of fulfilling the GIPA Principle. See page 41.

There are many examples of successful peer involvement in sexual health services, especially counselling and education-prevention programs, in clinical and community settings. There are also resources that provide guidance about how to encourage and implement peer involvement. See the "Key references for more information" at the end of section 2 and at the end of this section.

The GIPA Principle

GIPA stands for Greater Involvement of People Living with HIV/AIDS. The GIPA principle was developed in 1994 as part of the Paris AIDS Summit Declaration. The Declaration, signed by the 48 nations that attended the meeting, holds that the greater involvement of people living with HIV is essential to strengthen efforts to respond to the HIV epidemic. People living with HIV have a central role to play in HIV/AIDS education and care, and in the design and implementation of national and international policies and programs. The Paris Declaration also acknowledged that people living with HIV need increased support to take on a greater role in responding to the HIV epidemic.

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5. Legal issues in providing sexual health services

Key Points

- Resources exist to guide service providers through some of the difficult legal and ethical issues that can arise when providing services to people living with HIV.
- Service providers should be aware of three areas of law when counselling clients in relation to HIV and STIs: public health law, criminal law and privacy law.
- Service providers have no legal duty under the criminal law to report a client to police when that client's behaviour is placing another person at risk of serious bodily harm.
- In certain circumstances the law gives permission to a service provider to exercise her discretion to breach client confidentiality to protect the client or another person who may suffer harm as a result of a client's actions. This is the so-called "duty to warn."
- "Duty to warn" is not an accurate description, since we do not know of a single Canadian court case where a court has imposed a duty on a service provider to disclose a client's HIV status to prevent harm.

As stated in the previous section, service providers need to understand four elements when providing sexual health counselling to HIV-positive gay men:

- How to use a client-centred approach appropriate to HIV-positive gay men.
- How to identify and analyze the legal issues that arise in providing sexual health services to HIV-positive gay men.
- HIV transmission risk.
- STIs including HCV.

This section focuses on the second topic, legal issues that arise in providing sexual health services to HIV-positive gay men.

Disclosure of HIV Status After Cuerrier: an essential resource for service providers

In 2004, the Canadian HIV/AIDS Legal Network and Canadian AIDS Society published *Disclosure of HIV Status After Cuerrier: Resources for Community Based AIDS Organizations*. It is a detailed resource on the legal, ethical and counselling aspects of HIV disclosure in Canada. It focuses on HIV disclosure issues, rather than on poz prevention and sexual health service provision. You can use *Disclosure of HIV Status After Cuerrier* in conjunction with more up-to-date resources and resources with a broader poz prevention and sexual health focus, where these exist. Fortunately, such resources do exist: the information in this manual and the two companion guides. And HALCO is available to provide you with information and answer your questions about the law.

What you need to know about public health law, criminal law and privacy law

Law is complex. So is life. As a result, sometimes the duties and powers set out in different laws (or ethical codes) come into apparent or actual conflict with one another. But the law (and ethics) can guide service providers and help them analyze and resolve apparent or actual conflicts.

The power you are given, or the duty you have, as a service provider will depend upon the area of law you are considering. Your duty may also depend upon whether you are a registered member of a self-governing profession.

Three areas of law are most relevant to your relationship with clients in the context of providing sexual health services:

- Public health law.
- Criminal law.
- Privacy law.

Public health law

- If you are a **physician, registered nurse, chiropractor, dentist** or **dental surgeon, pharmacist, optometrist** or **drugless practitioner** you have a duty to report to public health authorities known or suspected cases of AIDS.
- If you are a **physician** or a **registered nurse in the extended class** you have a duty to report known or suspected cases of HIV.
- Public health law does not impose any duties on, or grant any powers to, **service providers who are not registered health professionals**.
- **Public health nurses**' powers and duties to prevent the spread of HIV and other STIs are set out in Ontario's *Health Protection and Promotion Act*. Public Health Nurses should be aware of that Act.

Criminal law

- Service providers **do not have a legal duty under the criminal law** to report to police clients who engage in sexual or injecting activities that risk transmitting HIV.
- Therefore, service providers cannot be charged with or convicted of a criminal offence for failing to report a client to police.
- The criminal law related to HIV comes from the *Criminal Code* and court decisions interpreting the *Code*.
- See section 3 for more information about the criminal law duty of HIV-positive people to disclose their HIV status in certain circumstances.

Privacy law

- All service providers have a legal duty to keep client information confidential, **except in well-defined circumstances**.
- Where there is credible and imminent risk of serious bodily harm to an identifiable person or class of persons, **a service provider is permitted to breach client confidentiality to protect** that person or group. **But you have no legal duty to do so**.

Law is complex. So is life. As a result, sometimes the duties and powers set out in different laws (or ethical codes) come into apparent or actual conflict with one another.

- Therefore, the concept of a legal "duty to warn" does not accurately describe Canadian law. The law gives permission to take a course of action; it does not require it.
- If a service provider uses this permission to breach client confidentiality to protect the client or another person, according to the law the service provider must continue to protect a client's privacy interests.
- Privacy law has many sources, including law and codes governing self-regulating professions, the *Canadian Charter of Rights and Freedoms*, Ontario's *Personal Health Information Protection Act*, 2004, and court decisions.

Public health law and the lives of gay men living with HIV

Chapter 5 of *Disclosure of HIV Status After Cuerrier*, entitled "Public Health Laws" and Chapter 7, entitled "Client Confidentiality and Record-Keeping," contain information about HIV and AIDS case reporting under public health laws.

Legal Guide excerpt

What does public health law have to do with you?

In Ontario, Public Health is organized into 36 separate regions, each with their own public health unit. A Public Health Unit in one region may use its powers differently than a Public Health Unit in another region. Public health units are legally responsible for protecting public health by trying to prevent the transmission of various infections, including HIV. In this sense, public health law is different from criminal law. The criminal law is about HIV disclosure. Public health law is about HIV disclosure **and** safer sex, even between HIV positive guys. To prevent transmission of HIV, public health wants you to disclose that you have HIV to every sex partner before you fuck or get fucked, suck his cock or he sucks your cock and **also** wants you to use a condom every time you fuck or get fucked, suck his cock or he sucks your cock.

So Public Health can become involved in your life and your sex life:

- Certain health care providers have a legal duty to inform Public Health when you test positive for HIV or other STIs. For example, the doctor or nurse who gave you an HIV test had a legal duty to inform Public Health when you tested HIV positive (unless you had an anonymous test). If you had an anonymous test, your personal information was not collected and Public Health does not know who you are. However, if your anonymous HIV test is positive, you will be referred to a doctor for treatment. When you access a doctor for HIV care, the doctor is required to do another HIV test on you, and this time, your personal information is collected and must be sent to public health.
- Public Health keeps a database of people who have been infected with HIV or other STIs. The database includes each person's name, date of birth, gender, infection(s) and contact information.
- **If you test positive for HIV or some other STIs, Public Health requires that your sex partners be contacted**. This is known as contact tracing, partner counselling or partner notification. Public Health can ask you for information about your sex partners, including their names. Public Health requires that your known sex partners be contacted so that they can be told that they may have been exposed to a STI and they can be advised to get medical care. Depending on the circumstances, Public Health may let you or your doctor notify your partners. Or, Public Health may do the partner notification directly or may require proof that your partners were notified. Public Health should not disclose your name to your partners, but your partners may figure out that it is about you. (Please note that this also applies to needle-sharing).

Public Health counsels people about sexual health, safer sex and HIV and STI prevention. If you are HIV positive and you test positive for another STI, Public Health will probably assume that you put another person at risk of getting infected with HIV. Public Health may counsel you, might issue a "Section 22 Order" against you, or both.

Client's duty under the criminal law to disclose HIV infection

As set out in section 3 of this manual and in greater detail in the companion guide *HIV disclosure: a legal guide for gay men in Ontario*, people living with HIV have a duty to disclose their HIV status to sexual partners in certain circumstances.

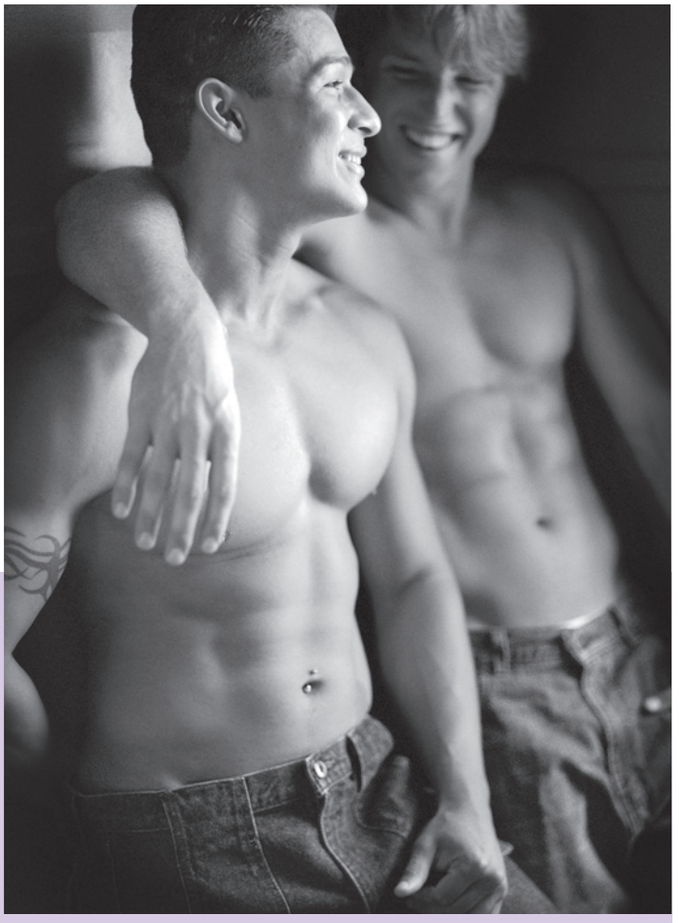
Chapter 3 of *Disclosure of HIV Status After Cuerrier*, entitled "Criminal Law, HIV Exposure and HIV Disclosure," focuses on the Canadian criminal law and the precedent-setting decision of the Supreme Court of Canada in the Cuerrier case and the Williams case. Another reliable source of information on the criminal law and HIV is the info sheets published by the Canadian HIV/AIDS Legal Network. See "Key references for more information" at the end of this section.

Reconciling client confidentiality and HIV prevention: taking steps to prevent harm, or the so-called "duty to warn"

Chapter 7 of *Disclosure of HIV Status After Cuerrier*, entitled "Client Confidentiality and Record-Keeping," includes information on service providers' duty of confidentiality and the limits on the duty of confidentiality:

- Do counsellors have a legal duty to prevent harm?
- Do registered professionals have an ethical duty to prevent harm?
- How to apply the law and ethics to figure out the appropriate course of action where a client may be putting another person at risk of HIV infection.

Because this an issue of great concern to service providers, we have adapted and reproduced the step-by-step approach to decision making when an organization is considering breaching client confidentiality in an attempt to prevent harm to another person.



Disclosure to prevent harm: step-by-step decision making

If your organization has a policy or guideline regarding disclosing client information to prevent harm, then it should be followed unless there is a valid reason not to do so. You might decide not to follow the organization's policy if it is inconsistent with the law or your profession's ethical code. The decision not to follow organizational policy should be taken in consultation with your supervisor.

If your organization does not have a policy or guideline, we suggest that you take a step-by-step approach when deciding whether to breach client confidentiality to prevent harm. The following steps are based on best practices, professional ethics and the law.

Step 1. Seek guidance

Seek guidance from your supervisor if an HIV-positive client is putting an identifiable person at risk of HIV infection and that person is unaware of the risk.

If you are a member of a registered health profession, you can also seek guidance from the practice advisory service of the professional college to which you belong. You probably have legal and ethical obligations that you need to take into account.

Step 2. Start with counselling

Have you thoroughly counselled your client about his legal obligation to disclose his HIV status, and explored issues that may be preventing him from doing so?

- If the answer is "NO," then explore the client's willingness to engage in counselling regarding legal and other aspects of HIV transmission and disclosure. And provide counselling if the client agrees.
- If the answer is "YES," or the client refuses counselling and indicates he is not going to change his behaviour, move to the next step.

Step 3. Apply the public safety exception

Apply the legal test, known as the "public safety exception." It is an "exception" to the duty you owe to a client to keep his information confidential.

Ask yourself:

1. Is an identifiable person or group of persons at risk?
2. Is the risk a significant risk of serious bodily harm or death? (According to the Supreme Court of Canada in the 1998 Cuerrier case, becoming infected with HIV is a "serious bodily harm.")
3. Is the serious bodily harm (i.e., HIV infection) or death imminent?

- If the answer to ANY of these questions is "NO", then there is no legal basis to take action to prevent harm (i.e., to disclose confidential information without your client's permission).
- If the answer to ALL of the questions is "YES", move on to the next step.

Step 4. Weigh ethical and practical considerations

Weigh the following factors to see whether they tip the balance in favour of disclosing:

a. Any obligation you may have under a professional ethical code or practice guideline.

b. The potential harm that will result if client confidentiality is breached. Consider potential harm to the client, to the counselling relationship and to the ability of your organization to carry out its mandate.

c. The potential harm that will result if client confidentiality is not breached. Consider potential harm to the client's partners and to the ability of your organization to carry out its mandate.

If you decide not to breach client confidentiality, continue to engage the client in counselling about issues and challenges related to disclosure if the client agrees to do so.

If you decide to breach client confidentiality, move to the next step.

Step 5. Before you breach client confidentiality

If you decide to breach client confidentiality you should consider the steps you will take. You should:

- Decide who you are going to contact, when and what client information you are going to disclose.
- Give the client reasonable advance notice and discuss the procedure you are going to follow and the information you are going to disclose.
- Help the client develop a plan to deal with potential negative consequences associated with your disclosure.

Step 6. Continue to protect your client's privacy interests

You are in a position to disclose client information without the client's consent. When doing so, remember:

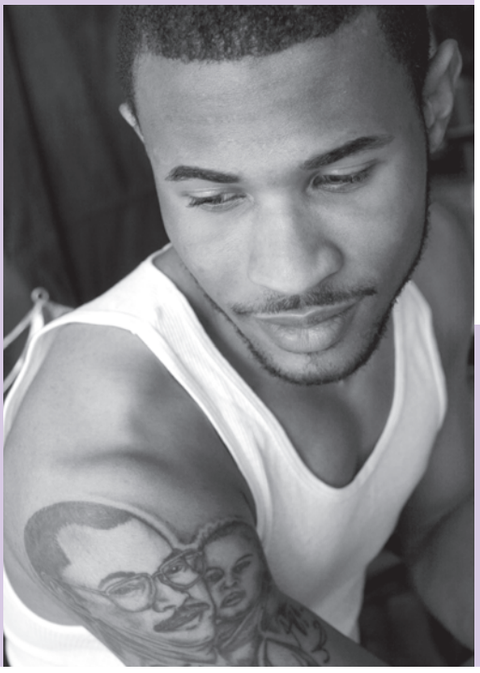
- You owe an ongoing legal duty of confidentiality to your client. Disclose as little confidential information as possible to accomplish the goal of preventing harm.
- Never reveal the client's identity directly to his sexual or injecting partner. Satisfy yourself that the person or people to whom you are disclosing client information also understand the importance of continuing to protect your client's confidentiality.

Key references for more information

- Canadian HIV/AIDS Legal Network. *Criminal Law and HIV – Infosheets*. Toronto: Canadian HIV/AIDS Legal Network, 2008. www.aidslaw.ca/publications/publicationsdocEN.php?ref=847.
- Canadian HIV/AIDS Legal Network. *HIV/AIDS and the Privacy of Health Information – Infosheets*. Toronto: Canadian HIV/AIDS Legal Network, 2004. www.aidslaw.ca/publications/publicationsdocEN.php?ref=187.
- Canadian HIV/AIDS Legal Network. *Privacy Protection and the Disclosure of Health Information: Legal Issues of People Living with HIV/AIDS in Canada*. Toronto: Canadian HIV/AIDS Legal Network, 2004. www.aidslaw.ca/publications/publicationsdocEN.php?ref=189
- Canadian HIV/AIDS Legal Network and Canadian AIDS Society. *Disclosure of HIV Status After Cuerrier: Resources for Community Based AIDS Organizations*. Ottawa: Canadian HIV/AIDS Legal Network and CAS, 2004. www.aidslaw.ca/publications/publicationsdocEN.php?ref=36 or www.cdnaids.ca/web/repguide.nsf/pages/cas-rep-0196.
- Information and Privacy Commissioner / Ontario. *A Guide to the Personal Health Information Protection Act*. Toronto: IPC/O, December 2004. www.ipc.on.ca/images/Resources/hguide-e.pdf.
- "Persons who fail to disclose their HIV/AIDS status: conclusions reached by an Expert Working Group." *Canada Communicable Disease Report* 31, 5 (2005): 53-61. www.phac-aspc.gc.ca/publicat/ccdr-rmtc/05pdf/cdr3105.pdf

Documents and resources for clients

- Canadian HIV/AIDS Legal Network – Infosheets. See "Key references," above.
- Information and Privacy Commissioner / Ontario. *Frequently Asked Questions: Personal Health Information Protection Act*. Toronto: IPC/O, February 2005. www.ipc.on.ca/images/Resources/hfaq-e.pdf



6. HIV transmission risk

Key Points

Sexual health choices should be understood in the context of other risks we face in our lives.

- Research continues to provide more information about factors that can affect HIV transmission risk, including sexually transmitted infections (STIs) in either partner, the presence of HIV in rectal secretions, HIV disease stage and HIV viral load.
- The relationship between HIV viral load and potential infectiousness is complex. It is important to critically analyze existing and forthcoming information and to be able to clearly explain the significance of viral load so clients have accurate information to make decisions.
- Viral load and circumcision have yet to be comprehensively evaluated as factors affecting HIV transmission among gay men.
- The majority of "safer sex" information explicitly or implicitly targets an HIV-negative audience. This makes sense if the basic message of safer sex information is "how to stay uninfected".
- When providing poz prevention programs, including sexual health services, to gay men living with HIV it is important to understand risk from an HIV-positive gay man's perspective.

As stated in the previous section, service providers need to understand four elements when providing sexual health counselling to HIV-positive gay men:

- How to use a client-centred approach appropriate to HIV-positive gay men.
- How to identify and analyze the legal issues that arise in providing sexual health services to HIV-positive gay men.
- HIV transmission risk.
- STIs including HCV.

This section focuses on the third topic, HIV transmission risk.

Put HIV risk in perspective

Sexual health choices should be understood in the context of other risks we face in our lives. We negotiate risk in our lives every day and make decisions, both consciously and unconsciously, about the levels of risk we are willing to accept. Every time we ride a bicycle, walk on a city sidewalk, eat foods capable of harbouring bacteria, drive a car or take an airplane, we are taking a risk with our health. We hear a great deal about the health risks of smoking cigarettes, drinking alcohol and eating fast food — risks that may eventually shorten our lives. Yet a great many of us continue to smoke, drink and eat fast food.

Risk reduction information should acknowledge the options that can be exercised. For many people some level of risk is probably either acceptable or unavoidable, making it necessary to include a broad range of risk reduction choices in HIV prevention education.

Understand population-level versus individual HIV transmission risk

In interpreting information about HIV transmission risk, it is important to make the distinction between population-level and individual risk. An intervention can reduce HIV transmission across a population, without providing a guarantee (or even a definite estimate of the probability) that a specific person will not transmit or become infected with HIV.

Take condoms, for instance. Condom use is still considered the most reliable and effective way to prevent HIV transmission among sexually active people. A recent meta-analysis found that condoms are able to reduce HIV exposure roughly 10,000-fold even under "worst-case" conditions, and that consistent condom use has resulted in nearly 100 percent prevention of HIV transmission in some studies of heterosexual couples. However, the largest-scale reviews have shown that condoms result in an 80 percent reduction in HIV incidence in heterosexuals. This does not mean that a condom is only 80 percent effective at preventing HIV transmission when a sero-discordant heterosexual couple has intercourse. The 80 percent effectiveness reflects large-scale, population-level effects of human error (i.e., the failure to use condoms properly and consistently).

Whether or not the person passes on HIV to their sexual partner during sex will depend upon the people involved and what they do. Human error (including mistaken presumptions and misunderstandings) factors into the analysis of risk. This makes it very challenging to translate the results from large-scale, epidemiological HIV prevention studies into clear and concrete advice for clients. Ultimately, it is up to each person to assess their own risk – of getting or passing on HIV – in light of what they know about the effectiveness of HIV risk reduction strategies. Providing clients with accurate, comprehensive and easy to understand information about HIV transmission risk will put them in a better position to make decisions about the risks they are willing to take.

HIV sexual transmission risk: the CAS guidelines

The Canadian AIDS Society (CAS) document, *HIV Transmission: Guidelines for assessing risk*, recognizes five essential conditions, all of which must be present, for a person to become infected with HIV:

- There must be a **source of infection**. Semen, vaginal fluid, blood and breast milk can contain sufficient quantities of HIV to cause HIV infection.
- There must be a **host susceptible to infection.** All humans are considered susceptible to HIV infection.
- There must be a **means of transmission**. A break in the skin, direct access to the bloodstream, absorption through mucosal membranes (mucosa) or through some disruption to the mucosa, allowing for an **appropriate route of entry** (sexual, blood-to-blood, or mother-to-child) by which HIV can reach susceptible cells.
- There must be a sufficient quantity of virus to cause infection.

There is one significant omission from the CAS Guidelines. Based on recent evidence, **we now know that rectal tissue and rectal secretions contain high concentrations of HIV – enough to be infectious – and thus can infect a top during unprotected anal sex**. These "fluids" from the rectum are not mentioned in most public education resources. This is an inconsistency that many gay men find confusing, which may lead to misperceptions about the level of risk for the top partner during anal sex.

We negotiate risk in our lives every day and make decisions, both consciously and unconsciously, about the levels of risk we are willing to accept.

In defining the degrees of risk of various activities (sexual or otherwise), the CAS Guidelines consider two factors: the potential for transmission (based on the above five conditions), and the actual observed evidence for transmission. Based on these factors, four categories of risk are defined:

- **No risk**: no potential for transmission, no documented cases of transmission.
- **Negligible risk**: potential for transmission (due to exchange of body fluids), but under conditions such that the likelihood of transmission is expected to be greatly diminished, and with no confirmed, documented cases of transmission.
- **Low risk**: potential for transmission, and a small number of reports of infection due to these activities (usually with certain identifiable conditions – e.g., poor dental health in conjunction with oral sex).
- **High risk**: potential for transmission and widely documented cases of transmission.

Providing clients with accurate, comprehensive and east to understand information about HIV transmission risk will put them in a better position to make decisions about the risks they are willing to take

Other factors in sexual transmission risk and implications for gay men: STIs, circumcision, viral load and disease stage

STIs

Untreated STIs can increase the risk of HIV transmission – whether in the HIV-positive or HIV-negative partner. This includes syphilis, genital or anal herpes, chlamydia and gonorrhea: [1,2,3]

- STIs (such as herpes and syphilis) can cause breaks, lesions or inflammations in the genital, anal or oral skin or mucous membranes, through which HIV can be more readily transmitted.
- Several STIs, such as herpes, can induce greater HIV shedding in the HIV-positive partner, also increasing the chance of transmission. [4]

Implications for gay men

- STIs in either sexual partner can increase the risk of HIV being passed from one partner to another.

Circumcision

Evidence from three large-scale clinical trials in Africa suggests that **uncircumcised** men are at increased risk of HIV infection because cells in the tissue underneath the foreskin are more susceptible to infection. Uncircumcised men were roughly twice as likely as circumcised men to become infected with HIV through unprotected, penetrative, vaginal intercourse with an HIV-positive woman .

Implications for gay men

- Few studies have been conducted in gay men thus far, and they have shown conflicting results as to whether circumcision protects gay men from HIV infection. [6,7,8,9]
- Nearly all the discussion and analysis to date has involved male-female transmission. Apart from a few preliminary studies and theoretical models, there is next to no evidence as to what "treatment as prevention" might mean for gay men. Since anal sex is generally a higher-risk activity than vaginal sex, treatment may have a smaller impact on reducing infectiousness between men.
- There is no scientific consensus that HAART and an undetectable viral load render people uninfectious when engaging in vaginal intercourse.
- For gay men, evidence-based advice about viral load and its effect on infectiousness are premature.
- Gay men appear to be making decisions about sex based on viral load. Information about viral load and infectiousness needs to be clearly and consistently communicated.
- The current "bottom line" is that HIV-positive people on HAART with an undetectable viral load in their blood can still transmit HIV.

Viral Load

HIV-positive people with a higher **HIV viral load** have repeatedly been shown to have a higher chance of infecting their sexual partners than people with a lower viral load. From a population-level perspective, researchers have argued that reducing HIV viral load using HAART treatment could lead to a reduction in the number of new infections. [10] This is sometimes referred to as "treatment as prevention" or "treatment as an aid to prevention."

The effect of HIV viral load on a person's sexual infectiousness has been hotly debated. Two key questions can help you analyze the debate and its relevance to clients:

- How well does blood plasma HIV viral load correspond to levels of sexually transmissible virus (i.e., in the semen, rectal and vaginal fluids and tissues)?
- Does it matter whether the potential route of HIV transmission, and location of HIV-infected tissues and secretions, is a rectum rather than a vagina?

Implications for gay men

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For gay men, evidence-based advice about viral load and its effect on infectiousness are premature.

Disease Type

Sexual transmission of HIV is much more likely both in very early and very late stages of HIV disease. [21] People with primary infection have extremely elevated viral loads. Many studies have shown that primary infection, despite being relatively brief in length, causes a disproportionate number of new infections.[22] And late-stage HIV disease is characterized by uncontrolled HIV replication, resulting in a very high viral load.

Mini literature review on viral load and HIV transmission

- Numerous studies, all in heterosexual couples, have linked higher plasma viral loads with increased likelihood of sexual infectiousness,[11] and provision of HAART to decreased HIV incidence.[12, 13]
- Decreased HIV incidence has been observed in several populations after HAART became widely available, but these studies do not demonstrate a direct causal link.[14, 15]
- A number of studies have demonstrated that between 5 and 10 percent of men with an undetectable HIV viral load in their blood has detectable virus in their semen.[16]
- In 2008 Swiss Federal AIDS Commission, based on a recommendation from an expert panel, stated that HIV-positive individuals on effective antiretroviral therapy (with viral load less than 40 copies/ml for at least 6 months) and without other sexually transmitted infections are sexually non-infectious.[17]
- The statement of the Swiss Federal AIDS Commission has been widely challenged, refuted and debated.[18] A systematic research review presented at the 2008 International AIDS Conference found that the Swiss statement could neither be confirmed nor disproved.[19]
- Next to no research has thus far addressed the effect of HAART and viral load on HIV sexual transmission among gay men.
- In August 2008, a man was reported to have transmitted HIV to his regular male partner despite taking antiretroviral treatment and having an undetectable viral load in his blood. The report authors believe that this is the first recorded instance of an individual with an undetectable viral load infecting a sexual partner with HIV. [20]

Awareness of HIV status

It is estimated that, as of December 2006, 37 percent of HIV-infected persons in Ontario were unaware of their HIV status. MSM made up just over half (54 percent) of these undiagnosed people.[23] Studies have found that people who are aware of their HIV status are only half as likely to have unprotected anal or vaginal sex as people who are unaware of their HIV infection. People who are unaware of their HIV infection are an estimated 3.5 times more likely to pass on HIV than people who are aware they have HIV. [24]

Post-exposure prophylaxis (PEP)

Gay men may not know about PEP. Yet it is an important tool that can help keep sexually active gay men HIV negative. Knowing about PEP can give HIV-positive gay men the ability to further contribute to reducing new HIV infections. See below.

Slip-ups, mistakes and condom breaks

Sexual Health guide excerpt

Key references for more information

- Canadian AIDS Society. *HIV Transmission: guidelines for assessing risk*. 5th ed. Ottawa: CAS, 2005.
- WHO and UNAIDS. *WHO/UNAIDS joint statement. Antiretroviral therapy and sexual transmission of HIV*. 1 February 2008. www.who.int/hiv/mediacentre/080201_hivtransmission_en.pdf

Documents and resources for clients

- Information on safer sex and HIV transmission risks is available from local public health departments and online from community-based organizations including www.actoronto.org and www.catie.ca.

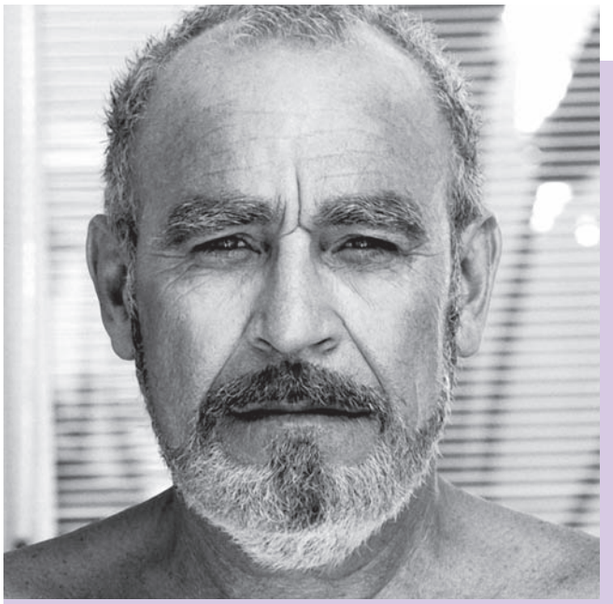
Slip-ups, mistakes and condom breaks

Condoms sometimes break or slip off when we are fucking. And some of us might fuck without a condom, even though we didn't intend to and afterwards we wish we hadn't.

An HIV negative guy who is exposed to HIV can take HIV medications to try to stay uninfected. This medical treatment is called PEP – short for "post-exposure prophylaxis." Scientists believe that PEP reduces the risk that someone will become HIV positive after being exposed to HIV.

A doctor must prescribe PEP. Go to a hospital emergency department. But doctors and other staff at medical clinics and emergency rooms may not know about PEP. Or they may not have a clear policy on who can get PEP. If a guy has problems getting PEP he should insist on seeing an infectious disease specialist doctor.

If you're on HIV medications, you may think it is a good idea to give the guy some of your medications. That's not recommended. Your HIV medications may not be an effective PEP treatment. And it may leave you short on medications later on.



Notes:

[1] W.E. Stamm et al., "The association between genital ulcer disease and acquisition of HIV infection in homosexual men," *Journal of the American Medical Association* 260 (1988): 1429–1433.

[2] Public Health Agency of Canada, *Canadian Guidelines on Sexually Transmitted Infections* (Ottawa: Public Health Agency of Canada, 2006). Updated January 2008. Available at: www.phac-aspc.gc.ca/std-mts/sti_2006/sti_intro2006-eng.php.

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

[4] N. Nagot et al., "Roles of clinical and subclinical reactivated Herpes Simplex Virus type 2 Infection and human immunodeficiency virus type 1 (HIV-1)–induced immunosuppression on genital and plasma HIV-1 Levels," *Journal of Infectious Diseases* 198 (2008): 241–249.

[5] K. Alcorn, "Two circumcision studies halted after circumcised men's risks halved," *aidsmap* 13 December 2006. Available at: www.aidsmap.com/en/news/376EF102-A6E5-408F-A671-789D7B325CCD.asp.

[6] D.J. Templeton et al., "Circumcision status and risk of HIV seroconversion in the HIM cohort of homosexually active men in Sydney," Sydney, Australia, 2007, Fourth International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention: Abstract no. WEAC103.

[7] G.A. et al., "Circumcision status and HIV infection among Black and Latino men who have sex with men in 3 US cities," *Journal of Acquired Immune Deficiency Syndromes* 46, 5 (2007): 643-650.

[8] J.K Kreiss and S.G. Hopkins, "The association between circumcision status and human immunodeficiency virus infection among homosexual men," *Journal of Infectious Diseases* 168, 6 (1993): 1404-1408.

[9] S.P. Buchbinder et al., "Sexual risk, nitrite inhalant use, and lack of circumcision associated with HIV seroconversion in men who have sex with men in the United States," *Journal of Acquired Immune Deficiency Syndromes* 39, 1 (2005): 82-89.

[10] A. Anema, E. Wodd, and J. Montaner, "The use of highly active retroviral therapy to reduce HIV incidence at the population level," *Canadian Medical Association Journal* 179, 1 (2008) 13-14.

[11] J. Castilla et al., "Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV," *Journal of Acquired Immune Deficiency Syndromes* 40 (2005): 96–101.

[12] C.-T. Fang et al., "Decreased HIV transmission after a policy of providing free access to highly active antiretroviral therapy in Taiwan,". *Journal of Infectious Diseases* 190, 5 (2004): 879-885.

[13] V.D. Lima et al., "Expanded access to highly active antiretroviral therapy: a potentially powerful strategy to curb the growth of the HIV epidemic," *Journal of Infectious Diseases* 198, 1 (2008) 59-67.

[14] Fang C-T. *Decreased HIV transmission after a policy of providing free access to highly active antiretroviral therapy in Taiwan*.

[15] Lima VD et al. *Expanded access to highly active antiretroviral therapy: a potentially powerful strategy to curb the growth of the HIV epidemic*.

[16] S.C. Kalichman, G. Di Berto, and L. Eaton, "Human Immunodeficiency Virus Viral Load in Blood Plasma and Semen: Review and Implications of Empirical Findings," *Sexually Transmitted Diseases* 35, 1 (2008): 55-60; A.-G. Marcelin et al, "Detection of HIV-1 RNA in seminal plasma samples from treated patients with undetectable HIV-1 RNA in blood plasma," *AIDS* 22 (2008): 1677 – 79, 2008; P.F. Barroso, Paulo F et al, "Adherence to Antiretroviral Therapy and Persistence of HIV RNA in Semen," *Journal of Acquired Immune Deficiency Syndromes* 32, 4 (2003): 435-440.

[17] P. Vernazza et al., "Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitment antirétroviral efficace ne transmettent pas le VIH par voie sexuelle," *Bulletin des médecins suisses* 89, 5 (2008): 165-169. Available at: www.saez.ch/pdf_f/2008/2008-05/2008-05-089.PDF

[19] Australasian Society for HIV Medicine, National Centre in HIV Epidemiology and Clinical Research, Australian Federation of AIDS Organisations and National Association of People Living with HIV/AIDS, *Australasian statement on HIV antiretroviral therapy and infectiousness*. 18 July 2008. Available at: www.ashm.org.au/news/334/11/; S. Attia et al., *Can unsafe sex be safe? Review of sexual transmissibility of HIV-1 according to viral load, HAART, and sexually transmitted infections*, Mexico City, AIDS 2008 - XVII International AIDS Conference: Abstract no. THAC0505.

[20] M. Sturmer et al., "Is transmission of HIV-1 in non-viraemic serodiscordant couples possible?" *Antiviral Therapy* 13 (2008): 729-732.

[21] Hollingsworth TD, Anderson RM and Fraser C. HIV-1 transmission, by stage of infection. *Journal of Infectious Diseases* 198 (2008):687–693.

[22] See for example, B.G. Brenner et al., "High rates of forward transmission events after acute/early HIV-1 infection," *Journal of Infectious Diseases* 195 (2007): 951-59, 2007.

[23] R.S. et al., *Report on HIV/AIDS in Ontario 2006*. (Toronto: Ontario Ministry of Health and Long-Term Care, March 2008). Available at: http://www.phs.utoronto.ca/ohemu/doc/PHERO2006_report_final.pdf.

[24] Quoted in Remis, *Report on HIV/AIDS in Ontario 2006*.

7. Sexually transmitted infections, including HCV

Key Points

- Sexually active gay men are exposed to a wide range of sexually transmitted infections (STIs) as well as HIV.
- Several STIs may result in more severe disease, or may require more aggressive treatment, in men living with HIV.
- Certain STIs, including syphilis, gonorrhea and genital herpes, make HIV more transmissible (both to and from the person with the STI).
- Gay men living with HIV are at risk of hepatitis C virus (HCV) infection.
- Gay men living with HIV are more likely to develop anal cancer from infection with certain strains of human papillomavirus (HPV) than other people infected with HPV.

A note on terminology: Many gay men are more familiar with the term "sexually transmitted disease" (STD) than "sexually transmitted infection" (STI).

As stated in the previous section, service providers need to understand four elements when providing sexual health counselling to HIV-positive gay men:

- How to use a client-centred approach appropriate to HIV-positive gay men.
- How to identify and analyze the legal issues that arise in providing sexual health services to HIV-positive gay men.
- HIV transmission risk.
- STIs including HCV.

This section focuses on an element of the fourth topic, STI transmission, including HCV.

A brief epidemiological overview of STIs in MSM

MSM have higher reported rates of STIs than the general population.

General Population [1]

- genital chlamydia: 0.18 percent.
- gonorrhea: 0.03 percent.
- syphilis: 0.003 percent.

STIs reported among Ontario MSM (previous 12 months):[2]

- genital or anal warts: 1.8 percent.
- penile gonorrhea: 1.6 percent.
- chlamydia: 1.4 percent.
- oral gonorrhea: 0.8 percent.
- genital herpes: 0.7 percent.
- hepatitis B: 0.7 percent.
- hepatitis C: 0.7 percent.
- rectal gonorrhea: 0.6 percent.
- hepatitis A: 0.5 percent.
- syphilis: 0.4 percent.

How STIs can affect gay men living with HIV

Common STIs among gay men are (some are less common than others):

- chlamydia.
- gonorrhea.
- syphilis.
- genital herpes.
- human papillomavirus (HPV), genital warts and anal cancer .
- hepatitis A, B and C.
- non-specific urethritis (NSU).
- intestinal parasites and infections (e.g., shigella, , giardia, amoebiasis).

The *Canadian Guidelines on Sexually Transmitted Infections* provides expert guidance on the etiology, diagnosis, and treatment of STIs. This regularly updated reference from the Public Health Agency of Canada in on the internet. See "Key references for more information."

Special information for HIV positive guys

◀ *Sexual Health guide excerpt*

Special information for HIV positive guys

HIV positive guys don't get chlamydia or gonorrhea any easier than HIV negative guys. And the treatment for chlamydia and gonorrhea – antibiotic pills – is the same whether you have HIV or not.

But HIV positive guys (compared to guys without HIV) may:

- Have to take three times the normal dose of antibiotics to cure early stage syphilis.
- Have more frequent or severe outbreaks of genital herpes.
- Suffer more significant damage to the liver when they are infected with the virus that causes hepatitis C disease. And it can be harder to treat hepatitis C disease in people who have HIV.
- Be more likely to get anal cancer from HPV.

If you have an STI that has not been cured it is easier for you to pass HIV to your partner during unprotected sex. This is true even if all your symptoms are gone. Just because your symptoms are gone it doesn't mean the STI is cured.

HIV-positive gay men are more likely to be HCV infected than HIV-negative gay men.

Pay attention to hepatitis C

Injection drug use remains far and away the major source of new HCV infections in Canada. However, in the past several years, evidence has established that HCV can be sexually transmitted. And HIV-positive gay men are more likely to be HCV infected than HIV-negative gay men. Outbreaks of HCV infection among gay men living with HIV have been reported in Canada, the U.S., and some European countries. In Canada, there has not been enough community education for gay men about the risks of HCV infection.

The mechanisms of HCV sexual transmission are not yet fully understood. Higher levels of HCV have been found in the semen of HIV-positive men. Rougher sex that can involve exposure to blood (even in minute amounts), unprotected anal intercourse and multiple sex partners have been associated with increased HCV risk.

Recognize the link between HPV and anal cancer [4, 5]

There are more than 100 subtypes of human papillomavirus (HPV). Some HPV subtypes can cause skin, genital and anal warts. Others can lead to abnormalities in infected cells that may eventually progress to cervical and anal cancer.

Many subtypes of HPV are sexually transmissible, fairly widespread and cause genital warts (known as condylomata acuminata) in infected tissue. Warts can usually be treated fairly easily by freezing or with topical treatments. However, certain subtypes of HPV are risk factors for cervical and anal cancers. HPV infection can lead to pre-cancerous changes (called dysplasia) in infected cells. Over time, these cellular abnormalities can progress. In the worst cases it can progress to invasive cervical or anal cancer.

HIV-positive MSM are 50 to 150 times more likely to get anal cancer than the general population.

People living with HIV are at a significantly higher risk of HPV-related cancers. HIV-positive MSM are 50 to 150 times more likely to get anal cancer than the general population. A study of HIV-positive gay men conducted at the Immunodeficiency Clinic of Toronto General Hospital found: [6]

- At least one potentially oncogenic (cancer-causing) strain of HPV in 89 percent of participants.
- Abnormal anal Pap smears in 66 percent.
- High-grade pre-cancerous cellular abnormalities in nine percent.
- Overt anal cancer in 1.7 percent.

Cancer lesions require surgical removal. However, if detected, pre-cancerous cellular abnormalities can very often be successfully treated with less invasive laser or trichloroacetic acid treatment.

There are currently no Ontario or Canadian standards for anal cancer screening in men. It is not a routine part of care for gay men living with HIV. The Immunodeficiency Clinic of the Toronto Hospital, University Health Network (www.tthhivclinic.com) offers screening for HPV-related anal cancer to HIV-positive gay men at risk.

Key references for more information

- Public Health Agency of Canada, *Canadian Guidelines on Sexually Transmitted Infections* (Ottawa: Public Health Agency of Canada, 2006). Updated January 2008. Available at: www.phac-aspc.gc.ca/std-mts/sti_2006/sti_intro2006-eng.php

Documents and resources for clients

- Information on STIs is available from local public health departments and online from community-based organizations including www.actoronto.org and www.catie.ca.

Notes:

[1] Public Health Agency of Canada. *Reported cases of notifiable STI from January 1 to December 31, 2006 and January 1 to December 31, 2007 and corresponding rates for January 1 to December 31, 2006 and 2007*. Available at: www.phac-aspc.gc.ca/std-mts/stdcases-casmts/cases-cas-08-eng.php.

[2] T. Myers et al., *Ontario Men's Survey*. (Toronto: University of Toronto HIV Studies Unit, 2004), Table 32. Available at: www.mens-survey.ca or http://cbr.cbrc.net.

[3] See generally: "Hepatitis C - overview," *aidsmap*. Available at: www.aidsmap.com/cms1032587.asp.

[4] I. Salit, "Anal cancer: a sexually transmitted disease," Toronto, 1 February 2007, Ontario Gay Men's HIV Prevention Summit.

[5] See "Genital Human Papillomavirus (HPV) Infections." *In Public Health Agency of Canada, Canadian Guidelines on Sexually Transmitted Infections* (Ottawa: Public Health Agency of Canada, 2006). Updated January 2008. Available at: www.phac-aspc.gc.ca/std-mts/sti_2006/sti_intro2006-eng.php.

[6] I. Salit et al. Anal cancer screening: an update of the TRACE study. Montreal, 2004, Canadian Association of HIV Research Conference: Abstract no. 202. Available at: www.cahr-acrv.ca/english/resources/abstracts_2004/abs/abs202.htm.

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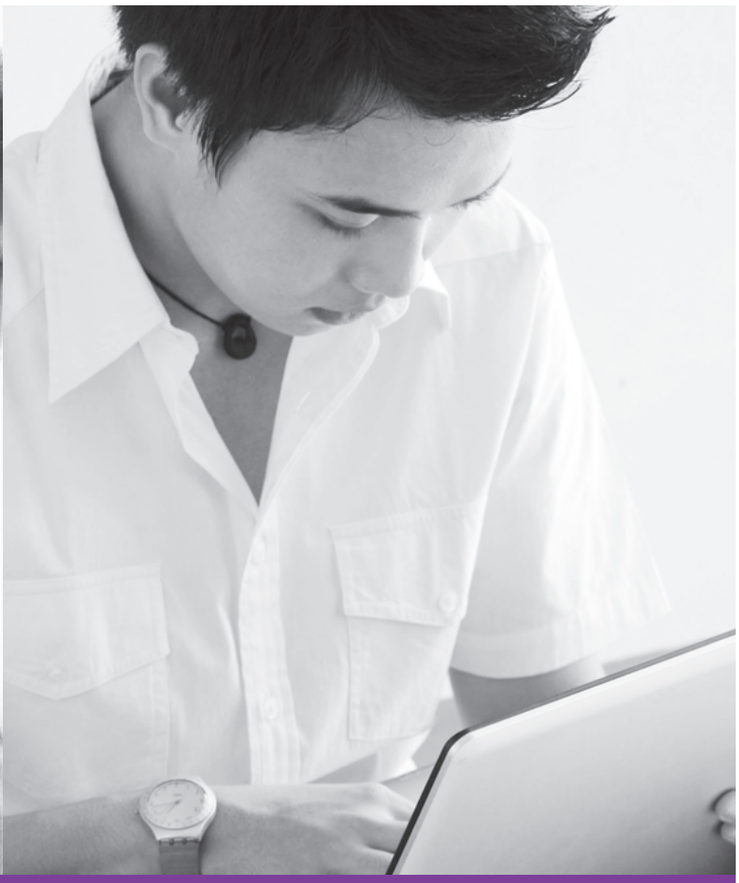

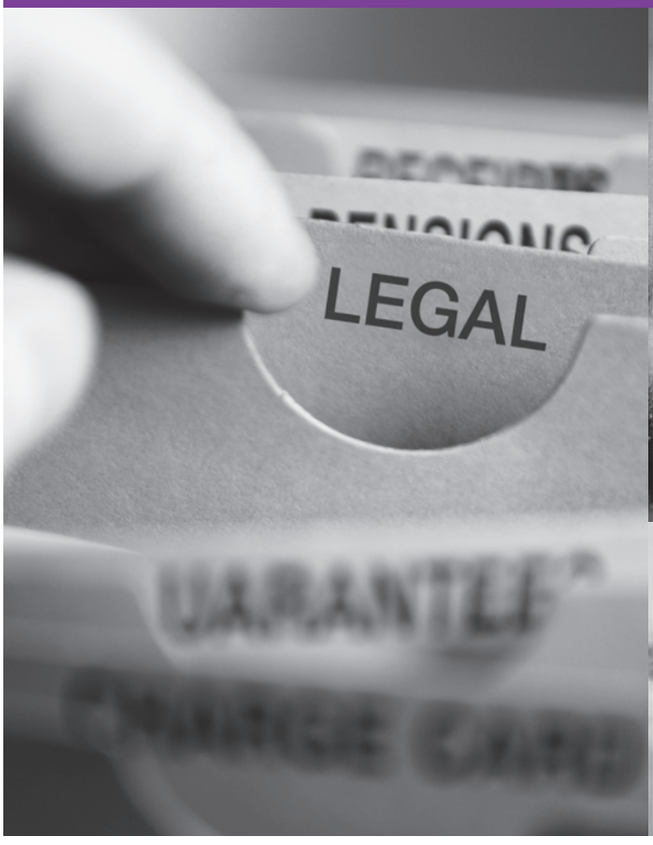

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