

Gauteng STI news



NHLS

Improving men's sexual health: a challenge for Gauteng



NICD

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National Institute for Communicable Diseases (NHLS)*

We, at the STI Reference Centre, are delighted to bring to you this second issue of Gauteng STI News. This quarter's issue has a theme focused around the sexual health of men. As we all know, men are often the key to the successful management of STIs. How do we best engage them?

It is perhaps worth taking a moment to reflect on some of the important issues that need to be considered by those working with male patients in the sexual health field. These include the need to acknowledge men's macho attitudes and masculinity, men's embarrassment at having to reveal their genitals to female nurses, men's pride, men's concerns over clinic confidentiality and mistrust of professionals, men's perceptions as to whether sexual health services are geared towards them or more towards women, misinformation given to men about services from peers and the fact that men's health seeking behaviour often differs from that of women.

In addition, projected attitudes from clinical staff towards men may be less than ideal in terms of dealing with boisterous young men presenting in groups, acceptability of the sexual preference among men who chose to have sex with other men (MSM), and the outward presentation of the stereotypical image of men as "the problem" behind STIs.

A key challenge for sexual health services is to increase the number of young men attending with STIs for treatment. It was for this reason that we have initiated a men's STI clinic in Alexandra, supported by community outreach initiatives in conjunction with the City of Johannesburg's Region E HAST department, under the leadership of Mrs. Ncemisa Mehana and her team.



Above: Migrant labourers, for example miners, remain a vulnerable group for STIs and HIV/AIDs.

With syndromic management, those of us working in South Africa do not have the luxury of screening for asymptomatic infections, so many STIs remain undiagnosed in youth.

Even those youth with symptomatic STIs are reluctant to attend STI clinics, and prefer “watch and see”, hoping for their symptoms to resolve; they often do, but these young men remain infectious for many months. South Africa’s public healthcare facilities record basic data on STI attendees. However, these surveillance data are unable to report on those men who do not present to public healthcare facilities. This means that we may under-estimate the number of STIs in our youth simply because they do not attend public clinics and thus avoid being captured in our national statistics.

Negotiating increased condom use with men remains a global challenge. Yet, the male condom remains the most effective way to avoid acquiring STIs, including HIV, among sexually active people.

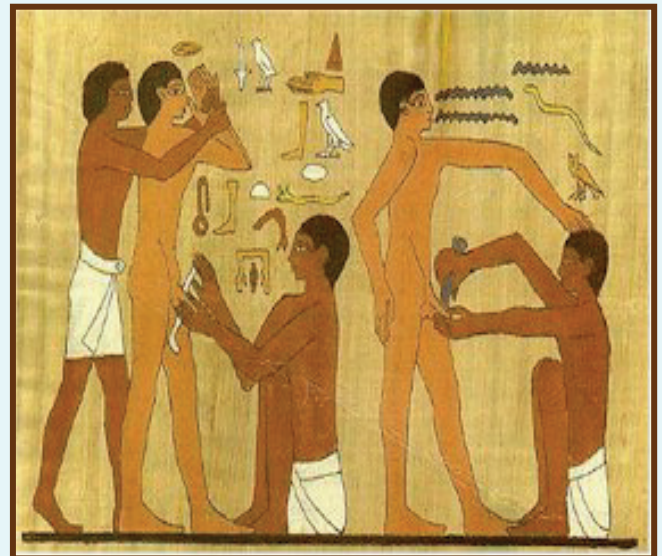
How can we persuade men of the importance of the condom? The key, surely, lies in being honest with our patients about the risk of HIV and other STIs. It means taking those extra few minutes in our daily consultations to emphasise why condoms are helpful in an educational way. Giving men the correct information to make their own informed choice is likely to result in higher uptakes of condom use.

Discussing HIV testing in an enthusiastic way is difficult to do day after day. Yet, as the data from the Alexandra men’s clinic show in this issue, over two-thirds of men attending with STIs have never taken an HIV test. Let’s think again about how we interact with men let’s give them the chance to be responsible for their own health through engaging them with accurate and factual information.

STI/HIV RESEARCH IN AFRICA MALE CIRCUMCISION TRIALS IN AFRICA

The results of two randomized trials assessing the potential of male circumcision to prevent new cases of HIV infection were published in the Lancet in February 2007^{1,2}. Both studies were performed in Africa, one in Uganda and the other in Kenya. The randomized trials come after a number of observational studies which indicated that uncircumcised men had a higher prevalence of HIV than circumcised men³. Importantly, they support the findings of the first randomized controlled trial of male circumcision in 18-24 year old men in Orange Farm, South Africa published by Bertran Auvert and colleagues in 2005⁴. The South African trial was stopped by its data and safety monitoring board when an interim analysis showed a 60% protective effect of circumcision in an intention-to-treat analysis and a 76% protective effect in a per-protocol analysis that adjusted for cross-overs.

The randomized trial in Rakai, Uganda, enrolled 4,996 uncircumcised HIV-negative men (aged 15-49) on the basis of agreement to undergo voluntary counselling and testing for HIV. Men were randomly assigned to receive immediate circumcision (2,474 men) or to have circumcision performed after 2 years (2,522 men). HIV testing was performed again at 6, 12 and 24 months after enrolment and the primary outcome was HIV incidence. Ronald Gray and colleagues based their analyses on a modified intention-to-treat basis.



Full male circumcision has been practiced in some part of Africa for thousands of years, for example among the ancient Egyptians. Studies conducted revealed that male circumcision had 60-76% estimated efficacy in terms of protecting men against new HIV infections.

They found that male circumcision had a 51% estimated efficacy in terms of protecting men against new HIV infection. Sociodemographic, behavioural and STI symptoms did not appear to influence the trend of protection against HIV in the circumcised group. The group reported 84 moderate or severe adverse events (wound dehiscence and infection) in the circumcision group (3.6%) but these all resolved with treatment. The trial was terminated by the NIAID on the basis of efficacy in December 2006.

The randomised trial in Kenya took place in Kisumu among a group of 2,784 men (aged 18-24). As in the previous study, men were randomly assigned immediate circumcision (1,391 men) or delayed circumcision at 2 years (1,393 men). HIV incidence was again the primary outcome in an intention-to-treat analysis and repeat HIV testing took place at 1, 3, 6, 12, 18 and 24 months. As was the case for the trial in Rakai, it was stopped prematurely in December 2006 after a third interim analysis showed efficacy. At 2 years, the HIV incidence was 4.2% (95% CI 3.0-5.4) in the delayed circumcision group versus 2.1% (95% CI 1.2-3.0) in the circumcised group. This translated into circumcision reducing the risk of acquiring HIV by 53% (95% CI 22-72). The authors reported only 21 adverse events and all resolved quickly.

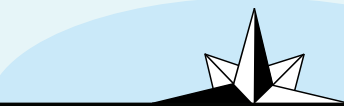
It is thus now clear that circumcision does partially protect men, at least in a randomized controlled trial setting, from acquiring HIV. The data on the protective effects of male circumcision were reviewed by a panel of experts at a WHO/UNAIDS Technical Consultation in March 2007⁵.

This consultation recommended, among other things, the need to develop clear communication strategies to ensure that men opting for the procedure understand that male circumcision is only partially protective and that they therefore need to continue to use other effective methods for HIV prevention, such as condoms. Whether male circumcision is a practical or safe intervention to roll-out across continents such as Africa remains a topic of much debate.

References:

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4. Auvert B. *et al.*. Randomised, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 trial. *PLoS Med*;2:1-11
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**Contribution: Professor David Lewis,
Head of the STI Reference Centre,
National Institute for Communicable
Diseases.**



In order to keep this newsletter going and comprehensive, we would like to hear from you: STI areas of interest, questions and challenges. Keep them coming!

EVALUATION OF ENHANCED RISK REDUCTION COUNSELING IN PATIENTS TREATED FOR SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) constitute a huge health and economic burden in developing countries. The importance of STIs has been more widely recognized since there is good evidence that the control of STIs can reduce HIV transmission. One of the main interventions which could reduce the incidence and prevalence of HIV include voluntary counseling and testing (VCT). Counseling which is aimed at reducing an individual's risk of acquiring STIs including HIV, is an effective primary prevention strategy.

The STI Reference Centre, in collaboration with the Centers for Disease Control and Prevention (Atlanta), plans to carry out a study to evaluate enhanced risk reduction counseling in patients treated for STIs within Gauteng. If a patient presents with STI for medical care, the clinical encounter is an excellent opportunity to encourage HIV testing and to counsel the patient on ways to reduce their future risk of acquiring STIs, including HIV. The person being seen for an STI, whose HIV test is positive can be advised on how to prevent transmitting HIV to others. In addition, early diagnosed HIV infected patients are being referred to various HIV clinical services which includes clinical evaluation, health and prevention education and antiretroviral therapy if applicable. For patients who test HIV negative, risk reduction counseling can be used to discuss realistic steps to discuss ways of reducing the risk of contracting STIs and HIV in the future.

HIV/STIs risk reduction counseling and encouragement of HIV testing has been proven effective in U.S.A in reducing STIs and HIV infections. Strategies to encourage and offer HIV/STI risk reduction counseling and testing to all persons diagnosed with STIs are needed to scale up HIV/STIs prevention efforts. This counseling model is already being applied by a few non-governmental organizations in Gauteng province providing VCT, although not specifically targeting STI patients.

Developing and testing new models to encourage HIV testing and counseling in persons with STIs is important. If such efforts are effective, increased HIV counseling/testing of patients evaluated for STIs will increase the number of people who are aware of their HIV status. This will translate into increased referral of patients to HIV services and reduced onward transmission of HIV to partners.

**Contribution: Stephina Tshelane,
Surveillance Officer, National Institute
for Communicable Diseases**

DETECTION OF ANTI-HUMAN PAMILLOMAVIRUS (HPV) ANTIBODIES AND TYPING OF DETECTED HPV IN HETEROSEXUAL MEN WITH ANOGENITAL WARTS, MALE URETHRAL DISCHARGE AND ASYMPTOMATIC MEN

This study is being conducted by STI Reference Centre and aims to determine the genotypic distribution of HPV among men presenting with anogenital lesions. Valuable information will be gathered with regards to HPV type prevalence, as well as previous exposure to HPV as determined by both oral and serum HPV-specific antibodies, among men in South Africa.

Human papillomaviruses (HPVs) are widespread in general population and more than 120 putative HPV types have been identified.



Above: Genital warts are caused by the human papillomavirus (HPV).

HPV are divided into high risk and low risk types based on their ability to induce malignant transformation. The high risk HPV type infections are among the most important STIs because of their association with anogenital cancers, including cervical cancer in women. Cervical cancer is an important public health concern in resource-poor areas of Sub-Saharan Africa, South and Central America and South and South East Asia.

About 80-85% of global cervical cancer deaths occur in woman from developing countries. The reason for this high percentage of deaths in these countries is lack of access to cervical cancer screening programmes.

Cervical cancer is a leading cause of death among black women in the U.S.A. who are 2.5 at increased risk of acquiring cervical cancer compared to white women. African women within South Africa are also more at risk than women from other racial groups.

Males have been implicated as the vector of HPV and treatment of clinically detectable lesions is advised to prevent the spread of HPV infection to new sexual partners.

Contribution: Etienne Muller, Senior Medical Scientist, National Institute for Communicable Diseases

ESTABLISHMENT OF A SPECIALIST MEN'S SEXUAL HEALTH CLINIC IN ALEXANDRA

In June 2005, the STI Reference Centre of the National Institute for Communicable Diseases established an open access dedicated sexual health clinic for men 8th Avenue clinic, Alexandra. The aims of the clinic were a) to encourage more young men to attend 8th Avenue clinic for STI management, b) to establish a facility in which STI surveillance of both gonococcal resistance and aetiological causes of the main STI syndromes in men could be monitored through laboratory testing of specimens, and c) to inform local health managers of important public health trends relating to STIs in Alexandra's male population.

Services offered at the clinic

The men's clinic offers the following services:

- Syndromic management of STIs
- Wart treatment using cryotherapy and topical podophyllin application
- Culture of gonococci from urethral swabs of men with urethritis
- Screening of urine for urethritis pathogens (*Neisseria gonorrhoeae* [GC], *Chlamydia trachomatis* [CT], *Trichomonas vaginalis* [TV] and *Mycoplasma genitalium*[MG])
- Serological screening for syphilis
- Referral for HIV voluntary counselling and testing
- Discussion of psychological problems

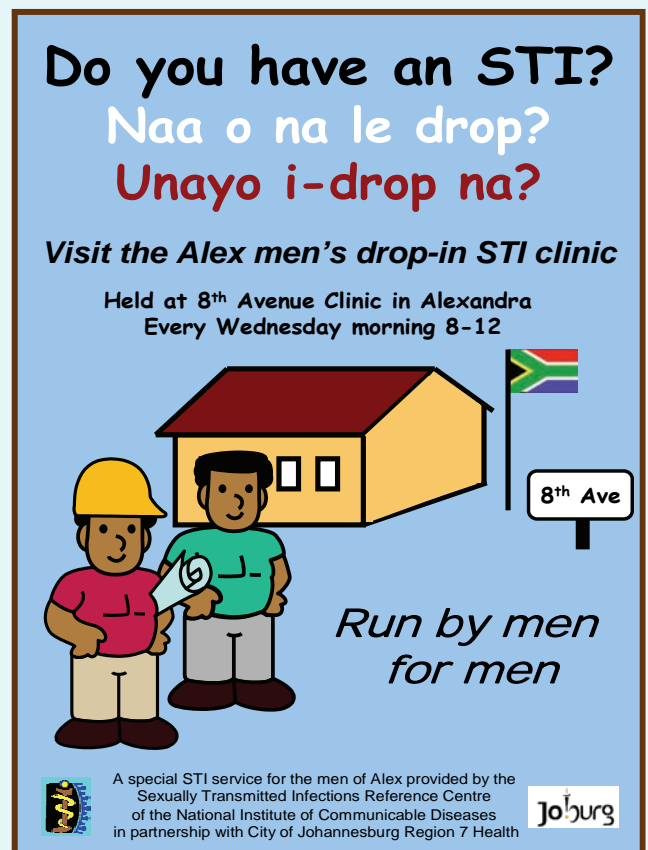


Figure 1: Poster advertising the men's clinic

A number of community initiatives have supported and advertised the men's clinic, namely, distribution of posters (Figure 1) and pocket size cards, talks at local schools and colleges about STIs, liaison with local non-governmental organisations, an open day for stake-holders and youth (Figure 2) and a feature article in the local newspaper (Alex Voice).



Figure 2: Mr. Obed Mohlamonyane discussing the work of the men's clinic at the STI Reference Centre Open Day.

Findings from the first year of the service

In the first 12 months, 182 men attended the service. There were 196 new consultations and 110 follow up visits. The average age of men attending the service was 30 years (range 16-75 years). Age data were available for 176/182 men and showed that the peak age range of attendees was 20-29 years (Figure 3). The main STI syndromes diagnosed are shown in Table 1.

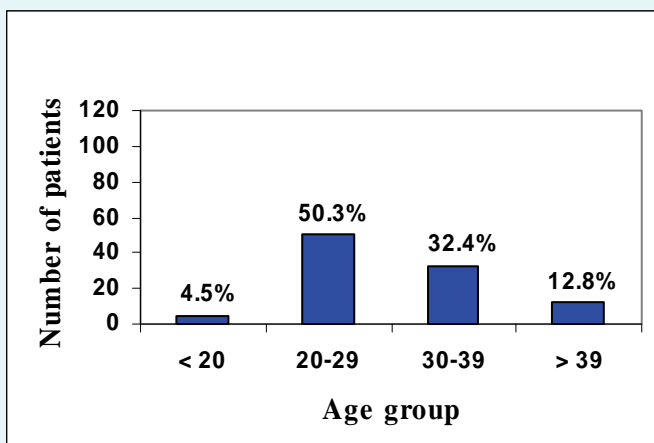


Figure 3. Distribution of age ranges of men attending the service.

Diagnoses	No. of diagnoses	Percentage of total new consultations
Male urethritis syndrome (MUS)	57	29%
Genital warts	51	26%
Burning on micturation (BOM)	24	12%
Genital ulcers syndrome	24	12%
Other STI syndromes	13	7%
STI contact	26	13%
Psychosexual problems	4	2%
Other conditions	11	6%

Table 1: 210 diagnoses were made in 182 men attending for 196 new consultations (12 men re-attended with new problems on two or more occasions).

Laboratory testing for STIs

Laboratory testing detected 40 cases of gonorrhoea, 24 cases of chlamydial infection, eleven cases of trichomoniasis and 18 cases of *M. genitalium* infection. Allowing for syndromic management of MUS and BOM, as well as treatment of contacts of women with pelvic inflammatory disease and vaginal discharge, the syndromic approach would have missed treating one (3%) gonorrhoea case, eight (33%) chlamydial infections and four (22%) *M. genitalium* infections. None of the 11 trichomoniasis cases would be treated under the current national guidelines. Gonorrhoea was resistant to ciprofloxacin in 20% of men.

HIV status of the male patients

Only nine of 182 men asked declined to give details of previous HIV testing. Among the 173 who provided information, 124 had never undergone HIV testing and only 43 reported taking a test (Table 2).

Category	Number of men	Percentage of all attendees	Percentage of those with HIV test results
Never Tested	124	68%	N/A
HIV Negative	29	16%	63%
HIV positive	17	9%	37%
Awaiting Results	3	2%	N/A
Declined to give information	9	5%	N/A

Table 2. Reporting of previous HIV testing by 182 men.

Serological screening for syphilis

Serological screening for syphilis was performed on serum obtained from 139 men presenting with clinically confirmed STIs or as contacts of STIs. No screening was performed on men who had undergone RPR testing within the previous 3 months. Four of the 139 men (2.9%) had a positive RPR.

Conclusions

Untreated asymptomatic chlamydial infections, the rising level of ciprofloxacin resistance in gonococci, the absence of anti-trichomonal cover in the treatment of male urethritis syndrome, poor clinic attendance by youth, and poor uptake of HIV testing by men remain challenges for STI management in South Africa.

References

1. Lewis DA, *et al.*. The 374 clinic: an outreach sexual health clinic for young men. *Sex Transm Infect* 2004; **80**: 480-483.

Contribution: Professor David Lewis, Head of the STI Reference Centre, National Institute for Communicable Diseases



THE BURDEN OF HIV AND SEXUALLY TRANSMITTED INFECTIONS AMONG MEN RESIDING IN INFORMAL SETTLEMENTS NEAR CARLETONVILLE, SOUTH AFRICA

Mobile services for women at high risk (WAHR) of sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infections, have been operating in the Carletonville area on the West Rand in South Africa's Gauteng Province for a number of years. These services have offered a package of sexual health education, condom promotion and provision, syndromic management of women with symptoms of STIs and monthly administration of azithromycin 1g orally (periodic presumptive therapy, or PPT). As a result of the introduction of similar services for WAHR in the Free State, significant decreases in gonorrhoea, chlamydial infection and clinically-diagnosed genital ulcer disease were observed both in the women accessing the service and the miners working in nearby goldmines¹.

The men in the Carletonville area, many of whom work at nearby goldmines and who live in same informal settlements as the WAHR, have frequently requested a mobile service of their own. Few specialist STI services exist for men in South Africa. A men's specialist STI service was commenced in Alexandra Township (Johannesburg) in 2005 (see previous article) and has proven popular with local men, who call it the "man for man" clinic².

Many men who attend that service state that they feel more comfortable discussing men's sexual health problems with other men. Accordingly, a pilot mobile STI and HIV testing service, run by men for men, was initiated to assess the need for and uptake of such a service, over a three month period in 2006. In our study, we wanted to a) assess the uptake of STI and HIV testing by men accessing the mobile service, and b) describe the burden of HIV and other STIs among men residing in informal settlements near Carletonville.

Men voluntarily accessed the mobile STI and HIV testing clinic run by male staff between July and September 2006. Men were encouraged to attend by local peer educators who lived in the same informal settlements and worked with the WAHR clinical service that operated in each of these informal settlements on different days of the week (Figure 1). Ethics approval for the study was obtained from the University of the Witwatersrand. The study was also approved by the Gauteng Department of Health.



Figure 1. Men were encouraged to attend the service through the use of peer educators

The mobile STI service operated four days a week (Mondays to Thursdays inclusive) over the three month period in a number of informal settlements near Carletonville on a two weekly rotational basis. The service was staffed by a male nurse and two male HIV counsellors, and additionally, at the start a male doctor for supervisory and training purposes. The two HIV counsellors worked in small tents, and the male nurse worked both from a van and a larger tent (Figure 2).



Figure 2. The mobile clinic operating in an informal settlement

Men were given the opportunity to have a rapid finger-prick HIV test, and be referred to different HIV programs for treatment, care and support when tested positive. HIV infections were statistically associated with having a past history of urethral discharge and genital ulceration, the presence of genital warts and inguinal lymphadenopathy, as well as sero-positivity for both RPR and HSV-2.

Men were given the opportunity to have a rapid finger-prick HIV test, to have a genital examination by the nurse, to have urine tested for the presence of pathogens that cause urethritis, and to have a blood test for herpes simplex type 2 (HSV-2) and syphilis serology. Condoms were available free of charge from the clinic staff. All clinically symptomatic STIs, including male urethritis syndrome (MUS), scrotal swelling syndrome (SSW) and genital ulcer syndrome (GUS), were treated with syndromic management according to national STI guidelines.

Negative and confirmed positive rapid HIV test results were given to the men on the same day with appropriate post-HIV test counselling. Those men who had a confirmed HIV positive result gave further blood on the first visit for HIV viral load and CD4 cell testing. Men were asked to return in two weeks for the results of the urine-based urethritis screen and their serological screen for HSV-2 and syphilis. If they had tested HIV positive at the first visit, they also received a referral letter to take to their local anti-retroviral (ARV) centre which included copies of their CD4 cell and HIV-1 viral load results.

During the three month period, a total of 309 men accessed the service. Data on men's symptoms were available for 306 men. Most men (90%) were asymptomatic although 10% had STI symptoms and/or signs, most commonly dysuria and/or urethral discharge. Most men (98%) requested screening for urethritis pathogens.

HIV infections were statistically associated with being non-South African, having a past history of urethral discharge and genital ulceration, the presence of genital warts and inguinal lymphadenopathy, as well as sero-positivity for both RPR and HSV-2. Gonococcal and chlamydial infections were associated with single young men, whereas trichomoniasis and RPR sero-positivity were associated with older married men.

The prevalence of infections causing urethritis and the various serology results are presented in Table 1.

Infection	Symptomatic of STIs (n = 27)	Asymptomatic for STIs (n = 274)	Overall (n = 301)
	Prevalence (%)	Prevalence (%)	Prevalence (%)
Gonorrhoea	26%	5%	7%
Chlamydia	4%	9%	9%
Trichomoniasis	22%	18%	18%
S y p h i l i s (RPR positive)	N/A	N/A	7%
HSV-2 antibodies	N/A	N/A	57%
HIV	N/A	N/A	30%

Asymptomatic STI and HIV infection rates were high in this community-based population sample. The study provides insight into the burden of such infections among disadvantaged communities within South Africa. The service proved popular with the men who accessed it, although few men were symptomatic of STIs. Without funds to support an STI screening service, which is costly, such a mobile service operating with syndromic management principles alone will treat few STIs but it is likely to achieve high uptake of HIV testing.

Acknowledgements:

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1. Steen R *et al.*. Evidence of declining STD prevalence in a South African Mining Community following a Core-Group intervention. *Sex. Transm. Dis.* 2000; 27(1): 1-8
2. Mohlamonyane O *et al.*. Unayo i-drop na? Establishment of a specialist men's sexual health clinic in a South African Township. Poster at the 22nd IUSTI-Europe Congress, Versailles, France 19-21 October 2006.

Contribution: Professor David Lewis, Head of the STI Reference Centre, National Institute for Communicable Diseases

KNOW MORE ABOUT ENGENDERHEALTH

Men As Partners (MAP), South Africa

Men As Partners (MAP), South Africa is one of many programmes that are run by EngenderHealth. EngenderHealth is an international non-profit organization that has been working for 60 years to make reproductive health services safe, available, and sustainable for women and men worldwide. Based in New York City, they have 20 offices in the field, and more than 70% of their staff work in countries across Asia, Africa, and the America.

EngenderHealth established its Men As Partners® (MAP) program in 1996. Through its groundbreaking work, this program works with men to play constructive roles in promoting gender equity and health in their families and communities. EngenderHealth works with individuals, communities, health care providers, and national health systems.

MAP Programme Vision

MAP strives to create a society in which men and women can enjoy equitable, healthy relationships that contribute to the development of a just and democratic society.

Objectives of the MAP programme

- To encourage men to reduce their own risk taking behaviours
- To take a stand against domestic and sexual violence
- To become actively involved in reducing the spread and impact of HIV/AIDS

MAP Strategies (Spectrum of change/intervention)

1. Building individual skills and knowledge
2. Promote community education
3. Improve the quality and availability of sexual and reproductive health care services available to men
4. Strengthen organisational capacity
5. Build broad based networks
6. Educating key stakeholders
7. Community mobilisation
8. Advocate for changes in policy and enforcement of progressive legislation
9. Research monitoring and evaluation
10. Use of art to promote constructive male involvement



Men As Partners march against domestic violence (Soweto-Mofolo-S.A)

Some of the themes that are covered by the MAP programme are:

- Understanding or learning about gender (socialisation)
- Sex and sexuality
- Sexual and reproductive health
- HIV and other sexually transmitted diseases
- Gender based and sexual violence
- Relationships

In South Africa, the MAP programme is working in five provinces through other NGO's, CBO's and Tertiary institutions: Gauteng, Western Cape, Eastern Cape, Northern Cape and Limpopo.

In April 2007, MAP South Africa launched a Men As Partners week, which entailed community outreach programs, with the theme "I am Partner...". For more information on this campaign visit www.iapartner.org and to learn more about EngenderHealth, visit their website at www.engenderhealth.org or email nhadebe@engenderhealth.org

INVOLVE US IN THE FIGHT FOR
OUR COUNTRY

**Contribution: Nhlanhla Mabizela,
Programmes Officer, EngenderHealth**

HIV SCHOOLS BREAK NEW GROUND WITH GAY MEN IN GAUTENG

OUT LGBTI Wellness (OUT) is an organization in Tshwane focusing on the sexual health issues of lesbians, gay men, bisexuals, transgender and intersex individuals. In 2006, Lesego Masike from Behind The Mask reported the results of an OUT HIV prevalence survey among men who have sex with men (MSM) in Gauteng Province. The survey was undertaken between 2002 and 2004 and reported that 64% of all MSM tested were HIV positive. HIV was more prevalent among whites (80%) than Africans (50%). According to OUT, existing government anti-HIV/AIDS programme focus primarily on heterosexual health education around HIV prevention.

For the past few years, OUT has run an HIV school project. The HIV schools are held at various locations in Gauteng Province. Speaking at an OUT Quarterly Discussion Forum hosted at the University of South Africa on the 25th June 2005, Toni Kruger, Sexual Health Manager at OUT said that the HIV School is a weeklong HIV/AIDS and STI workshop targeted specifically at MSM from township areas. "We look for an NGO in the township, and then ask for contacts for gay men. We then contact them, tell them the context, and they get interested and hooked and keen to come. Through them we get referrals to more people," said Jay Matlou, one of the peer educators. Twenty men attend each week-long school. Included in the school is a buddy scheme of four buddies to provide social support for behavioural change.

The programme, which is conducted by peer educators, includes transfers of knowledge, personal risk appraisals, drafting of personal risk reduction plans and passing on of skills aimed at self-efficacy. HIV risk-taking issues, such as lack of condom use in casual sexual encounters and patterns of unsafe sex where MSM are disempowered in their relationships with other men, are explored. At the end of the school, participants received a certificate showing they have completed the course. The rationale behind the school is to address the lack of HIV/AIDS prevention work targeting MSM and an acknowledgement that MSM require a different approach in regards to HIV/AIDS and STI prevention efforts.



Some of the key aspects of the HIV schools are that they are peer facilitated and use several local languages (Tswana, Zulu, and English). The buddy support is very important to the whole programme. Within the week participants move from discussing their existing knowledge on STIs and HIV to the final activity where they draft and give a presentation on their personal risk reduction plans. The personal risk reduction plans require a commitment to doing all or some of the actions that can reduce their risk. Thus, at the end of the intervention, it is hoped that participants will fulfill the aims of the intervention which is the use of a personal risk reduction plan, and in particular the use of condoms and lubrication in casual sexual encounters and in relationships.

For further information, please contact:

1. Behind The Mask: 011 403 5566

Email: info@mask.org.za

Website: www.mask.org.za

2. OUT-LGBT Well-being: 012 344 5108

Website: www.out.org.za

Contribution: By Musa Ngubane and Wendy Landau at Behind The Mask (23 June 2005), with permission from Mashilo Mnisi, Managing Editor at Behind The Mask

PROTECTING CHILDREN FROM STIs AND HIV/AIDS

The information below comes from a guide to essential practice {Sexually Transmitted and Other Reproductive Tract Infections by World Health Organization (WHO)}

The celebration of national child protection week (CPW) took place from 28 May to 3 June 2007, under the theme "Renewing our pledge in a national partnership to end violence against children and tackle child poverty."

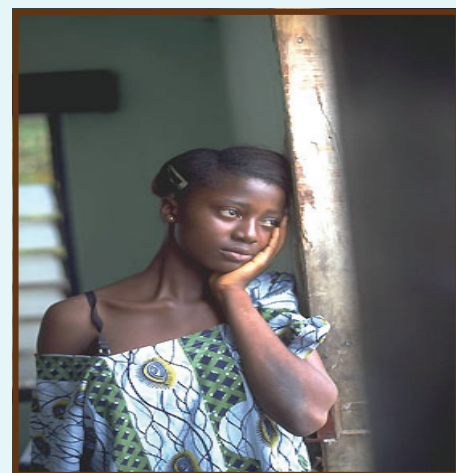
According to WHO, sexual violence is common among children but is frequently not talked about. Studies from different parts of the world have found that the percentage of adolescents who have been coerced into sex can range from approximately 7% to 46% in females and 3-20% in males depending on the country. The Gauteng clinical STI surveillance for the period 2000-2006 revealed that, 363 of 317, 808 new STI episodes were recorded in the age group 0-14 years at sentinel sites. Of these new STI episodes 271 were recorded in females and 92 in males. Health care workers should maintain a high index of suspicion of child abuse. They should discuss with parents the issue of whether sexual abuse may have occurred. Often, but not always, child abuse is associated with a close family members. Many children and adolescents are reluctant to talk directly about abuse, either because they may be ashamed to discuss it or they may be afraid of future violence if the situation is exposed. Often, individuals come to the clinic with other non-specific complaints or request a check-up, assuming that the health care provider will notice anything abnormal that needs treatment.

Sexual violence is defined by WHO as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by a person regardless of relationship to the victim, in any setting, including but not limited to home and work".

- Clinic policies and practice guidelines should be developed locally
- Women or children who have been sexually abused may need shelter and legal protection.
- Psychosocial management includes counselling and supportive services, which should be available on site or by referral
- Medical management includes prevention of pregnancy and infection, in addition to care of injuries. Emergency contraception, STI and post-HIV exposure prophylaxis should be available.
- Referral should be available if services cannot be provided on-site.

Together let us make a concerted effort towards strengthening interventions aimed at:

- Protecting children against sexual violence and human trafficking
- Preventing mother to child HIV transmission
- Preventing neonatal STIs



Photograph of an adolescent from UNICEF child protection photo gallery

**Contribution: S.M Tshelane,
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