

YOUNG MEN WHO HAVE SEX WITH MEN: HEALTH, ACCESS, & HIV

Data from the 2012 Global Men's
Health & Rights (GMHR) Survey

The Global Forum on MSM & HIV (MSMGF)



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Data from the 2012 Global Men's Health and Rights (GMHR) Survey
A Policy Brief

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INTRODUCTION

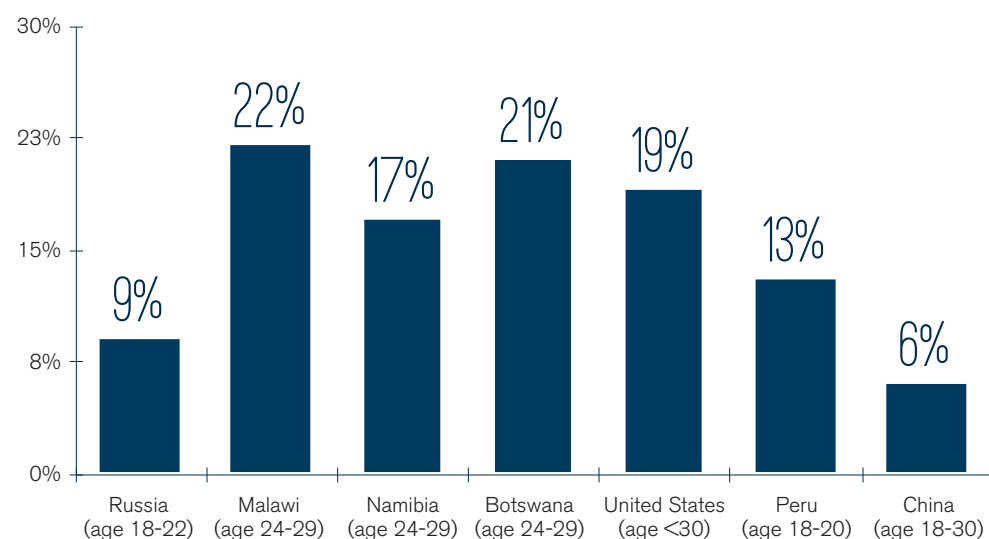
In every world region, men who have sex with men (MSM) face significantly higher rates of HIV than the general population.¹ Young people are also at increased risk for HIV, comprising over 40% of new HIV infections worldwide.²

Young MSM (YMSM) face the heightened risks of both populations, as well as a number of vulnerabilities that are unique to YMSM. Despite the clear need for intervention, YMSM are often left out of research, policy, and programs designed for general MSM, general youth, and the general population. While data on HIV among YMSM are extremely limited, existing studies show high HIV prevalence among YMSM around the world (Figure 1).

This policy brief examines HIV risk factors and access to services among YMSM using data from the Global Forum on MSM & HIV (MSMGF)'s 2012 Global Men's Health and Rights survey (2012 GMHR). The brief concludes with a set of recommendations for addressing the global HIV epidemic among YMSM.

FIGURE 1

HIV Prevalence among YMSM ^{3 4 5 6 7}



METHODS

In March 2012, the MSMGF formed a multidisciplinary research team to develop and implement the 2012 GMHR, a multilingual survey designed to identify and explore barriers and facilitators affecting access to HIV services for MSM at the structural level, community level, and individual level. The survey was conducted online in Chinese, English, French, Georgian, Russian, and Spanish between April 23 and August 20, 2012. A convenience sample of 5779 MSM from 165 countries was recruited through web-based banner ads and direct email outreach to the MSMGF's global networks.

For this policy brief, the 2012 GMHR dataset was used to evaluate HIV risk factors and access to services among YMSM represented in the sample (n=2491), comparing levels of risk and access between YMSM and older MSM. Differences between YMSM and older MSM were calculated using chi-square tests for categorical variables and Wilcoxon rank-sum tests for continuous variables and psychosocial scales.

More information on the 2012 GMHR's methods, measures, and overall findings is available in the MSMGF's 2012 report, ["Access to HIV Prevention and Treatment for Men Who Have Sex with Men."](#)

PARTICIPANT CHARACTERISTICS

For the purposes of this report, YMSM are defined as MSM age 30 and below. Of all participants in the 2012 GMHR, the number of YMSM respondents was 2491.

FIGURE 2

Age of YMSM Surveyed

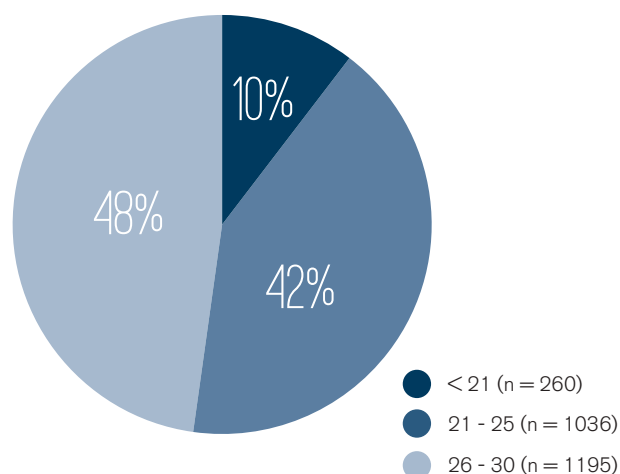


FIGURE 3

HIV Status of YMSM Surveyed

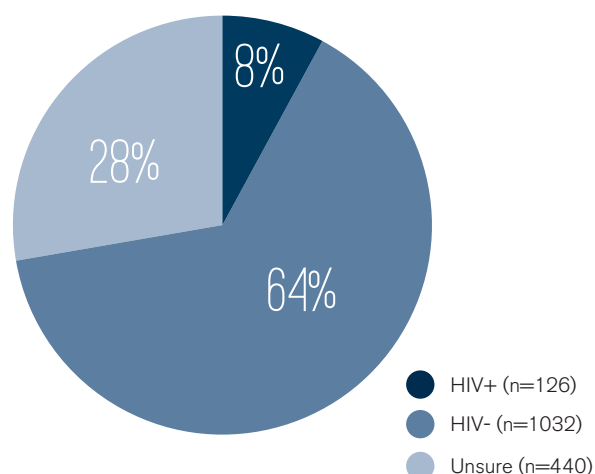
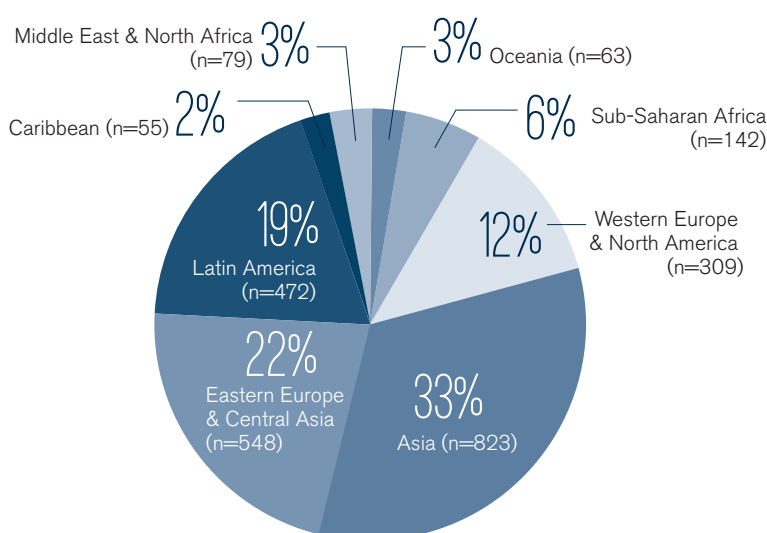


FIGURE 4

Regional Breakdown of YMSM Surveyed



Compared to older MSM, a larger proportion of YMSM were from Asia (33% vs 25%), Eastern Europe (22% vs 12%), and Latin America (19% vs 12%).

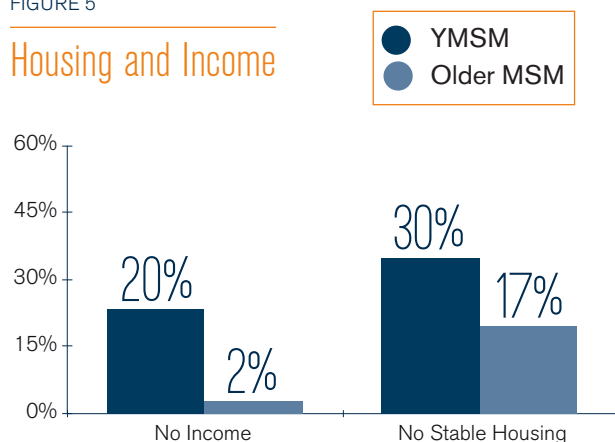
INCOME, HOUSING, & HEALTHCARE

Many YMSM are dependent on family that may not understand or accept their sexuality, putting them at greater risk of losing housing or financial support.

Loss of stable housing has been associated with increased HIV risk behaviors, including exchange of sex for money, unprotected sex, and needle sharing, as well as lower health-related outcomes for people living with HIV.^{8 9 10 11} Additional studies have shown that lack of income is a strong predictor of HIV infection, with people living below the poverty line significantly more likely to be infected.^{12 13 14}

FIGURE 5

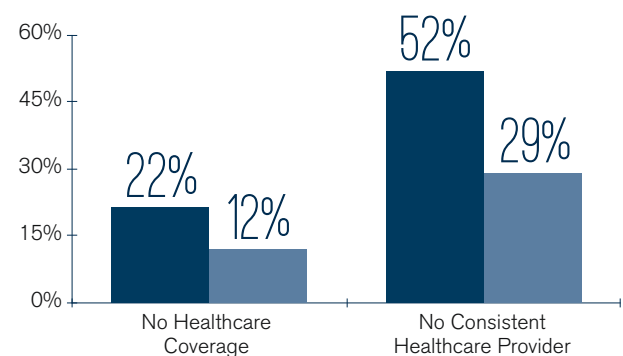
Housing and Income



Among all survey participants, YMSM had significantly higher prevalence of unstable housing ($p<0.001$) and lack of income ($p<0.001$).

FIGURE 6

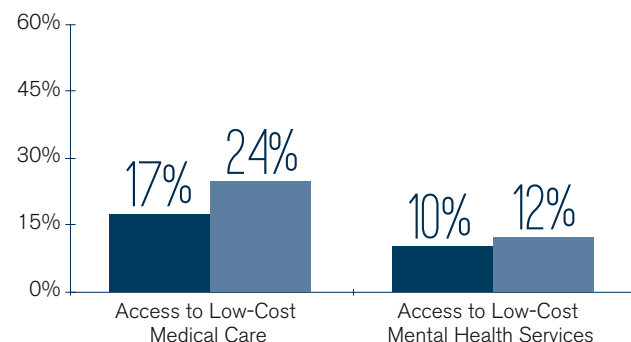
Health Coverage



Survey data also showed that YMSM had lower prevalence of healthcare coverage ($p<0.001$) and that comparatively few had a consistent healthcare provider ($p<0.001$).

FIGURE 7

Access to Healthcare



“YMSM are often unable to respond effectively to homophobia because of their age – they have no income, no employment, and they are dependent on family for housing. If they get kicked out, and they often do, they end up on the street where they may be forced to trade sex for food, shelter, or protection.”

—Daniel Townsend, Jamaica

ACCESS TO HIV PREVENTION SERVICES

The 2012 GMHR examined levels of access to a variety of HIV prevention services, including condoms, lubricants, HIV testing, HIV treatment, MSM-focused sex education, HIV education materials for MSM, and HIV risk reduction programs for MSM. While access to services was low for all MSM, the proportion of YMSM reporting easy access was significantly lower than older MSM across all categories of service measured (all $p\text{-values} \leq 0.01$).

FIGURE 8

Access to Condoms and Lubricants

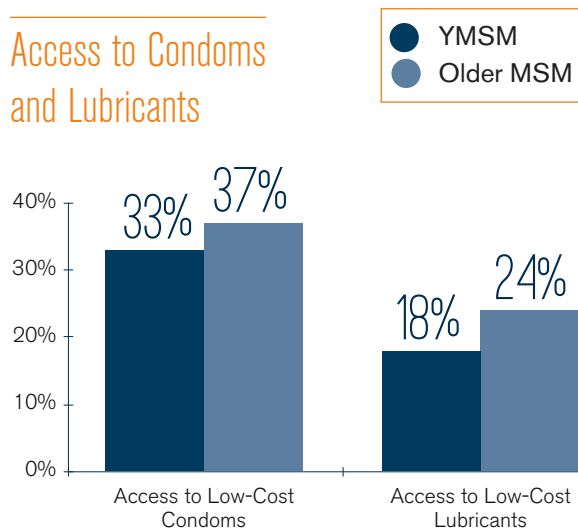


FIGURE 9

Access to STI Testing and Treatment

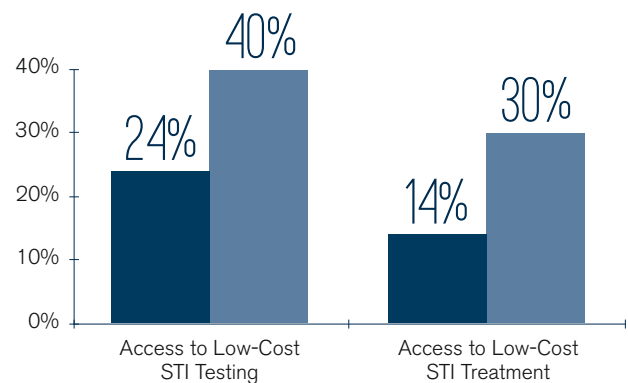
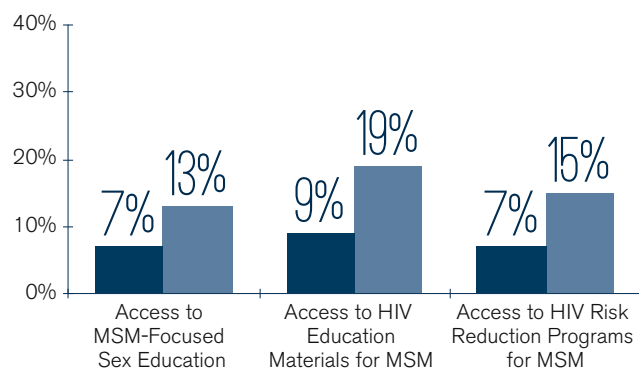


FIGURE 10

Access to MSM-Focused Education and Programs



“There is a severe lack of general sexual health services in the Middle East and North Africa, let alone those which are equipped and sensitized to cater to the needs of young MSM, who do not have the social or financial support to consult a private care provider. YMSM need access to information and services to keep themselves healthy.”

— Johnny Tohme, Lebanon

YMSM LIVING WITH HIV

Effective management of HIV is essential for ensuring the health of people living with HIV (PLHIV) and can greatly reduce the risk of forward transmission.^{15 16} In order to manage HIV effectively, HIV testing must be accessible and those who test positive must be linked with appropriate care, including timely initiation of antiretroviral therapy (ART) and clinical monitoring.

According to the World Health Organization (WHO), PLHIV should begin treatment when their CD4 countⁱ drops below 350.¹⁷ Some governments recommend treatment for all PLHIV.¹⁸ Early initiation of treatment results in reduced viral load, slower disease progression, and reduced risk of HIV-related death and illnesses.¹⁸ Routine monitoring of viral load is essential to proper HIV treatment, and viral load suppressionⁱⁱ can greatly reduce the risk of forward transmission.

Treatment Status of YMSM Living with HIV

FIGURE 11

CD4 Count Among YMSM Living with HIV

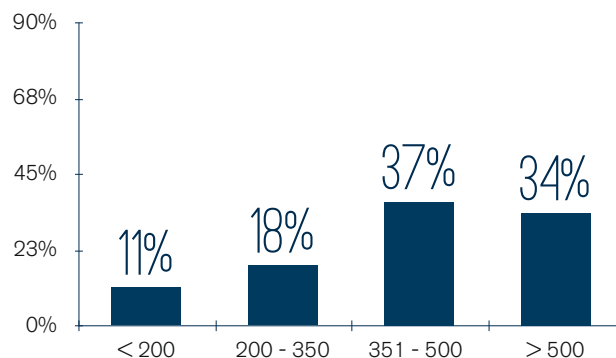
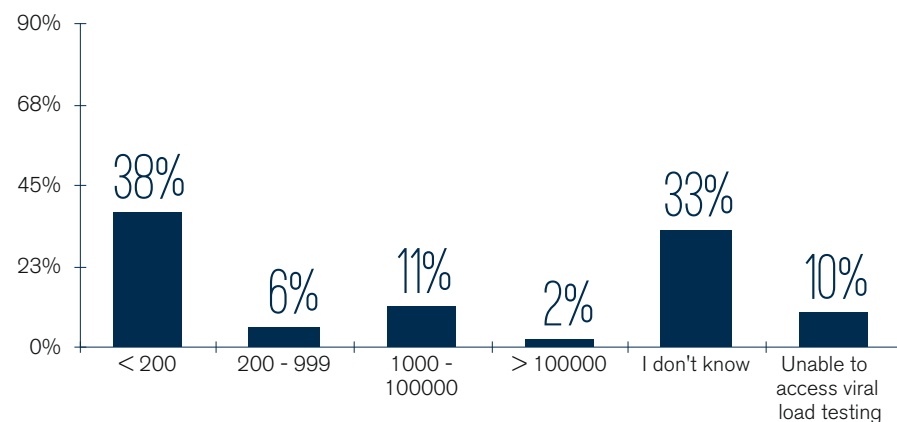


FIGURE 12

Viral Load Among YMSM Living with HIV



“In Asia, many YMSM believe that HIV will not affect young people, and they do not see the need to get tested. Even if they know they have HIV, they often neglect to access treatment. Most YMSM cannot afford the high costs of sexual health services, and they often fear discrimination when seeking these services.”

— Thu Yain,
Singapore

- i. CD4 count refers to the level of CD4+ T lymphocyte cells in the blood, also known as CD4 cells. CD4 cells play a central role in the human immune system, and CD4 count is one indicator to measure HIV disease progression.
- ii. Viral load suppression is defined as reducing the number of HIV copies to <200 copies/mL blood. Viral load suppression and resulting rises in CD4 count are associated with reductions in overall incidence of AIDS-defining malignancies, risk of non-AIDS-defining malignancies, and risk of forward transmission.²³

YMSM Living with HIV Compared to Older MSM Living with HIV

FIGURE 13

Percent of Treatment-Eligibleⁱⁱⁱ MSM Not on ART

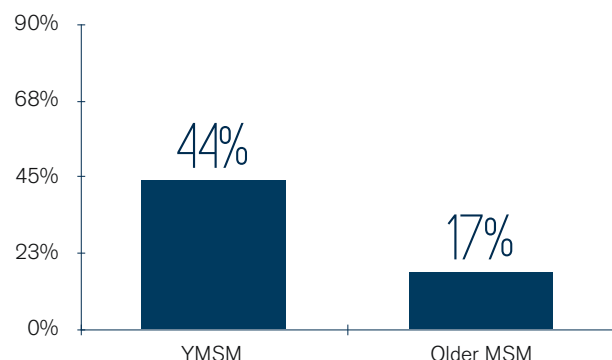


FIGURE 14

Percent of MSM Living with HIV Who Are Viral Load Suppressed

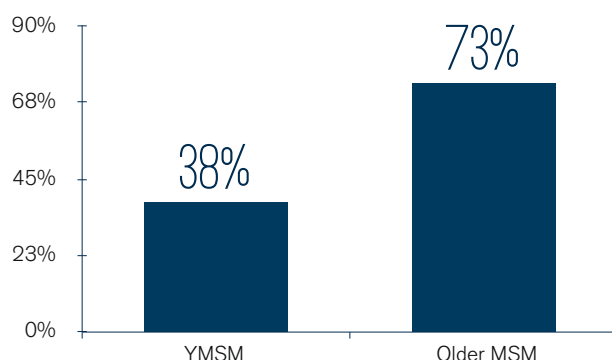
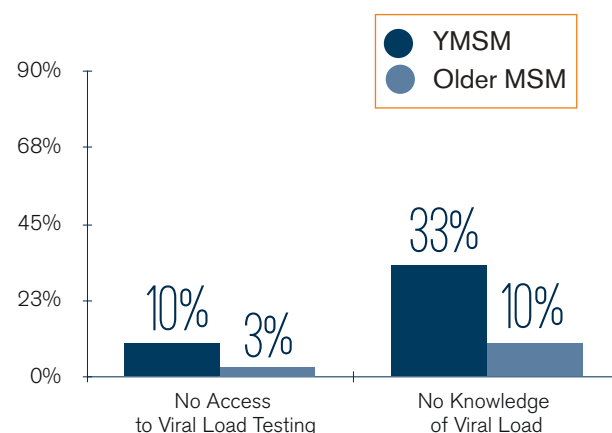


FIGURE 15

Viral Load Testing



iii. "Treatment-Eligible MSM" is defined here as MSM living with HIV who have a CD4 count less than 350, according to the World Health Organization's guidelines for starting ART.

BARRIERS & FACILITATORS

Data from the entire 2012 GMHR survey sample revealed several barriers (factors associated with lower access) and facilitators (factors associated with higher access) that impact the ability of MSM of all ages to obtain condoms, lubricants, HIV testing, and HIV treatment. Barriers and facilitators were measured using multiple-item scales ranging from 1 to 5. Experiences of homophobia were significantly associated with reduced access to services, while community engagement and comfort with health service providers were each significantly associated with increased access to services. More information on the impact of these barriers and facilitators can be found in the full 2012 GMHR report.¹⁹

Age-stratified analyses of the barriers and facilitators revealed by the original analysis on 2012 GMHR survey data indicated that YMSM experienced significantly higher levels of homophobia ($p<0.001$) and violence ($p<0.001$) compared to older MSM. YMSM also reported significantly lower levels of community engagement ($p<0.001$), comfort with service providers ($p<0.001$), and connection to the gay community ($p<0.001$) compared to older MSM.

TABLE 1

Mean Scores for Barriers to Service Access

(STANDARD DEVIATIONS IN PARENTHESES)

	YMSM	Older MSM	Statistical Significance
Homophobia	3.25 (.68)	2.91 (.76)	$p<0.001$
Violence	1.28 (.66)	1.19 (.46)	$p<0.001$

TABLE 2

Mean Scores for Facilitators to Service Access

(STANDARD DEVIATIONS IN PARENTHESES)

	YMSM	Older MSM	Statistical Significance
Community Engagement	1.56 (.58)	1.65 (.55)	$p<0.001$
Connection to Gay Community	3.25 (.86)	3.47 (.85)	$p<0.001$
Comfort with Service Providers	2.86 (.89)	3.31 (1.01)	$p<0.001$

“Homophobia and discrimination are still two of the main issues that YMSM have to deal with every day, and their negative impact on YMSM is strong and far-reaching. Most YMSM are more focused on the challenges of coming to terms with their sexual orientation and identity than they are on their sexual health. We cannot address sexual health for YMSM without acknowledging these issues.”

—Sergio López, Paraguay

RECOMMENDATIONS

This analysis of data from the 2012 GMHR survey shows that YMSM reported significantly less stable housing, less access to medical care, less access to HIV prevention services, lower HIV treatment outcomes, higher prevalence of homophobia and violence, less community engagement, and less comfort with providers, when compared with MSM older than 30. Many of these factors act syndemically,²⁰ fueling each other and leading to poor health outcomes for YMSM.

Targeted efforts are needed to reduce disparities in HIV risk and service access among YMSM. It is incumbent upon national governments, multilateral agencies like UNAIDS, and major global funders like PEPFAR and the Global Fund to recognize that the needs of YMSM must be addressed explicitly and directly. As the world reevaluates goals for the post-2015 development agenda, there are several concrete steps that can be taken to provide crucial support for YMSM health and human rights.

1. Address Housing Stability and Economic Dependence

Due to high levels of homophobia and low levels of economic independence, many MSM are unable to discuss their HIV risk factors with health providers, educators, or family members without risking loss of housing or economic stability. Data from the 2012 GMHR indicate that a high proportion of YMSM have no stable housing, which can increase levels of HIV risk factors, including rates of exchange sex, needle sharing, and unprotected anal intercourse. HIV prevention information and services must be made available to YMSM in a way that does not jeopardize their housing; and HIV prevention, treatment, and care services must integrate resources for YMSM who lack housing or economic support.

2. Provide Comprehensive HIV Prevention Tailored to YMSM

This analysis indicated that less than 10% of YMSM could easily access MSM-focused sexual education or HIV education materials for MSM. EDUCAIDS recommends that HIV education begin before the onset of sexual activity.²¹ However, comparatively few countries offer school-based sexual education and inclusion of issues concerning YMSM is virtually absent. Without access to information tailored to the needs of YMSM, many YMSM misunderstand their own level of risk, how to prevent HIV effectively, and what services may be of help.²² YMSM must have access to sexual education that explicitly addresses sexual practices and sexual health issues relevant to YMSM, including anal sex, substance use, and mental health.

Comprehensive sexual education must be accompanied by efforts to ensure YMSM can access the HIV prevention resources they need. Data from the 2012 GMHR indicate that less than 35% of YMSM could easily access condoms and lubricants, and less than 25% could easily access low-cost STI testing and treatment. Condoms, lubricants, STI testing, and STI treatment must be made available in safe spaces free from homophobia, and they must be delivered in a way that is accessible to YMSM.

3. Improve Treatment and Care for YMSM Living with HIV

Timely treatment and proper monitoring is essential both for the health of PLHIV and for the prevention of forward transmission. Of all YMSM who met the WHO's guidelines for recommended treatment, only 56% reported taking ART. Only 38% of YMSM living with HIV were virally suppressed compared to 73% of older MSM, and more than 40% of YMSM did not know their viral load or could not access viral load testing. It is clear that more must be done to connect YMSM living with HIV to treatment and care services. Efforts are needed to engage YMSM in low-cost medical care and mental health services, where they can learn more about their sexual health needs and HIV risk factors. HIV testing and treatment must be offered in safe spaces free from homophobia, and all services must be promoted directly to YMSM, taking into account existing levels of knowledge, access to services, and confounding factors like unstable housing, limited income, and discrimination.

4. Address Barriers and Facilitators that Impact Access to HIV Services

For MSM of all ages, homophobia is associated with reduced access to essential HIV services. Not only do YMSM experience higher levels of homophobia, but they may also be uniquely vulnerable to its negative effects due to their dependence on family, educational institutions, and other potentially hostile structures for housing and resources. Large-scale efforts are needed to reduce homophobia at the societal level, with a special focus on families, educational institutions, healthcare systems, and HIV service providers. These efforts must be supplemented by the development of structures to support YMSM who have lost housing and resources.

Conversely, community engagement and comfort with health service providers are associated with increased access to HIV services for MSM of all ages. Just as efforts are needed to reduce barriers to service access, it is equally important to support initiatives that bolster facilitators. Organizations focused on MSM and organizations focused on youth should undertake efforts to actively and sensitively engage YMSM in their programs and services, providing a safe space for YMSM to be themselves and interact with other YMSM in their communities. These organizations must recognize the unique needs of YMSM and involve YMSM in efforts to develop, design, and deliver programs that address them.

5. Support YMSM Leadership and Involvement

YMSM are best equipped to define their own needs and should be supported in developing responses to those needs. The global AIDS infrastructure must work to foster leadership among YMSM and support greater involvement of YMSM in the decision-making processes that affect their health and human rights. Deliberate efforts must be undertaken to ensure YMSM leaders and organizations are aware of opportunities to impact policy at regional and global levels, and YMSM leaders and organizations must be given appropriate amounts of time and information to engage in these processes in a meaningful way. Finally, multilateral organizations and global funders should support initiatives developed and delivered by YMSM themselves, increasing availability of and access to effective and appropriate interventions for YMSM globally.

THE MSMGF YOUTH REFERENCE GROUP

This policy brief was developed in collaboration with the MSMGF Youth Reference Group (YRG). Established in early 2010, the YRG is composed of 18 YMSM advocates working for the health and human rights of YMSM in their respective regions around the world. The YRG advises and coordinates the work of the MSMGF on YMSM issues, advocating for the empowerment of YMSM within the global HIV response through skills building, cross networking, and meaningful participation in the decision-making processes that affect YMSM.

- Anthony Adero, Kenya
- Joseph Sewedo Akoro, Nigeria
- Mohamed Alborgi, Egypt
- Oliver Anene, Nigeria
- Thu Yain Pye Aung, Singapore
- Miguel Angel Ceccarelli Calle, Peru
- Stephen Chukwumah, Nigeria
- Daniel Driffin, United States
- Adeshola Fabunmi, Nigeria
- Ashot Gevorgyan, Armenia
- Cathal Kavanagh, Ireland
- Sergio Lopez, Paraguay
- Evans Odiambo Opany, Kenya
- Ifeanyi Orazulike, Nigeria
- Khemraj Persaud, Guyana
- Donte Smith, United States
- Johnny Tohme, Lebanon
- Daniel Townsend, Jamaica

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The Global Forum on MSM & HIV (MSMGF) is a coalition of advocates working to ensure an effective response to HIV among MSM. Our coalition includes a wide range of people, including HIV-positive and HIV-negative gay men directly affected by the HIV epidemic, and other experts in health, human rights, research, and policy work. What we share is our willingness to step forward and act to address the lack of HIV responses targeted to MSM, end AIDS, and promote health and rights for all. We also share a particular concern for the health and rights of gay men/MSM who: are living with HIV; are young; are from low and middle income countries; are poor; are migrant; belong to racial/ethnic minority or indigenous communities; engage in sex work; use drugs; and/or identify as transgender.

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