INTER-AGENCY WORKING GROUP ON KEY POPULATIONS

HIV AND YOUNG MEN WHO HAVE SEX WITH MEN: A TECHNICAL BRIEF

DRAFT

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The technical briefs were written by James Baer, Alice Armstrong, Rachel Baggaley and Annette Verster.

Damon Barrett, Gonçalo Figueiredo Augusto, Martiani Oktavia, Jeanette Olsson, Mira Schneiders and Kate Welch provided background papers and literature reviews which informed this technical series.

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Definitions of some terms used in this technical brief

Children are people below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier.[1]

Adolescents are people aged 10–19 years.[2]

Young people are those aged 10–24 years.[2]

While this technical brief uses age categories currently employed by the United Nations and the World Health Organization (WHO), it is acknowledged that the rate of physical and emotional maturation of young people varies widely within each category.[3] The United Nations Convention on the Rights of the Child recognizes the evolving capacity of young people under 18 years of age to make important personal decisions for themselves, depending on their individual level of maturity (Article 5).

Key populations are defined groups who due to specific higher-risk behaviours are at increased risk of HIV, irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The five key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people.[4]

MSM (men who have sex with men): In this technical brief, MSM refers to all males – of any age – who engage in sexual and/or romantic relations with other males. The words "men" and "sex" are interpreted differently in diverse cultures and societies, as well as by the individuals involved. Therefore, the term "men who have sex with men" encompasses the large variety of settings and contexts in which male-to-male sex takes place, across multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with particular community or social groups.

For the sake of clarity, the abbreviation "MSM" is used throughout this technical brief to avoid the confusion that would arise by spelling out "men who have sex with men" in the frequent references to males under the age of 18 years.

Homosexuality refers to an enduring tendency to form emotional, romantic and/or sexual attractions to people of the same sex.[5] The term **gay** is sometimes used to refer to people with a homosexual orientation.

Homosexual sex or **same-sex behaviour** refers to sexual behaviour between people of the same sex, regardless of their sexual orientation.

INTRODUCTION

Young people aged 10–24 years constitute one-quarter of the world's population,[6] and they are among those most affected by the global epidemic of human immunodeficiency virus (HIV). In 2013, there were an estimated 5 million people aged 10–24 years were living with HIV, and young people aged 15–24 years accounted for an estimated 35% of all new infections worldwide in people over 15 years of age.[7]

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations – or who engage in activities associated with these populations – are made especially vulnerable to HIV by widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These factors increase the risk that they may engage – willingly or not – in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

Governments have a legal obligation to support the rights of those under 18 years of age to life, health and development, and indeed, societies share an ethical duty to ensure this for all young people. This includes taking steps to lower their risk of acquiring HIV, while developing and strengthening protective systems to reduce their vulnerability. However, in many cases, young people from key populations are made more vulnerable by policies and laws that demean or criminalize them or their behaviours, and by education and health systems that ignore or reject them and that fail to provide the information and treatment they need to keep themselves safe.

The global response to HIV largely neglects young key populations. Governments, international agencies and donors fail to adequately fund research, prevention, treatment and care for them. HIV service-providers are often poorly equipped to serve young key populations, while the staff of programmes for young people may lack the sensitivity and knowledge to work specifically with members of key populations.

Among young MSM, high rates of HIV infection are due in part to unprotected anal sex with an HIV positive partner, but the social and structural factors already noted also play an important role. Use of drugs or alcohol and selling sex[i] contribute to HIV risk and represent overlapping vulnerabilities that some young MSM share with other young key populations. Young MSM are often more vulnerable than older MSM to the effects of homophobia – manifested in discrimination, bullying, harassment, family disapproval, social isolation and violence – as well as criminalization and self-stigmatization. These can have serious repercussions not only for their physical health and their ability to access HIV testing, counselling and treatment, but also for their emotional, social, educational and economic well-being.

i In this series of technical briefs, "selling sex" is used as an umbrella term to refer to young people aged 10–24 years. It therefore includes children/adolescents aged 10–17 years who sell sex, who under the United Nations Convention on the Rights of the Child (CRC) are defined as sexually exploited, and young adults aged 18–24 years, who are recognized as sex workers. For further information, please see *HIV and young people who sell sex: A technical brief* (Geneva: WHO, 2014).

This technical brief is one in a series addressing four young key populations. It is intended for policy-makers, donors, service-planners, service-providers and community-led organizations. This brief aims to catalyse and inform discussions about how best to provide services, programmes and support for young MSM. It offers a concise account of current knowledge concerning the HIV risk and vulnerability of young MSM; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs; and approaches and considerations for providing services that both draw upon and build to the strengths, competencies and capacities of young MSM.

Community consultations: the voices, values and needs of young people

An important way to better understand the needs and challenges of young key populations is to listen to their own experiences. This technical brief draws upon insights from the research and advocacy of young MSM. It also incorporates information from consultations organized in 2013 by the United Nations Population Fund in collaboration with organizations working with young key populations, including young MSM, in eastern Europe, southeast Africa and South America.[8] Reference is also made to consultations conducted with members of young key populations in the Asia-Pacific region by Youth Voices Count[9] and the Youth Leadership, Education, Advocacy and Development Project (Youth LEAD);[10] and regional and country consultations in Asia with young MSM, conducted by the HIV Young Leaders Fund.[11] Since these were small studies, the findings are intended to be illustrative rather than general. Representative quotations or paraphrases from participants in the consultations are included so that their voices are heard.

Where participants in the consultations were under the age of 18 years, appropriate consent procedures were followed.

YOUNG MSM

The HIV epidemic among young MSM is not well defined. There is a lack of global data on the number of young MSM, their levels of risk for HIV and their protective behaviours. This is due in part to a lack of research and surveillance, and also to the difficulty of reaching young MSM who may fear disclosing their same-sex behaviour.

Estimates of lifetime prevalence of sex between males in some low- and middle-income countries range from 3–20%.[12] However, virtually no data is available for all of Africa, the Middle East, and the Caribbean. Similarly, isolated studies indicate wide variation in the reports of same-sex behaviour or sexual orientation among young people, and the glimpse they provide of the numbers of young MSM is not globally representative:

- A study of 857 street children aged 12–17 years in Greater Cairo and Alexandria, Egypt, found that among the sexually active street boys, 44.2% reported having had sex with a male partner in the previous 12 months, and 15% reported being raped by a male partner.[13]
- In Canada, a study of 11 000 secondary-school students in three grades (aged about 12, 14 and 16) found that up to 1.7% of the boys reported being attracted exclusively to the same sex, and up to 3% to both sexes.[14]
- In New Zealand, of 8 000 secondary-school students (of both sexes) surveyed anonymously, 0.9% reported exclusive attraction to the same sex and 3.3% to both sexes.[15]

One of the challenges in reaching young MSM with sexual health education and other services is the stigmatization of same-sex behaviour. MSM may have sex with other males in secret and may be reluctant to disclose such activity to others. Some MSM are married to or partnered with women. A further factor is that some young people, particularly adolescents, have fluid and changing understandings of their sexual identity and behaviours and may not accept the categories used by research and surveillance, particularly if they perceive these as stigmatizing within their particular social context.[16,17]

Nevertheless, it is clear that young MSM are often at greater risk of acquiring HIV than young heterosexual males or older MSM.[18,19,20,21] Despite this, there is relatively little funding for HIV prevention and treatment programmes specifically targeting this population.[20]

Where data are available, HIV prevalence and incidence are consistently found to be higher among MSM than in the general population, especially in some urban areas. In much of Central and South America and in multiple settings in high-income countries, sex between males is the predominant mode of HIV transmission, but even in contexts where the epidemic is driven primarily by heterosexual sex or by injecting drug use, HIV prevalence among MSM may also be high.[22]

Data also indicate that young MSM have a greater HIV risk than heterosexual young people and older MSM:

- In the Russian Federation, HIV prevalence among young MSM in 2010 was 10.79%.
- In China, a meta-analysis of studies published between 2006 and 2012 estimated the HIV prevalence among young MSM to be 3.0–6.4%.[23]
- In urban sites in the Democratic Republic of Congo, HIV prevalence among MSM aged 15–19 years in 2012 was 4.5%.[24]
- In Bahamas, HIV prevalence among young MSM in 2010 was 24%.[25]
- Among adolescent males aged 13–19 years in the USA, 92.8% of all diagnosed HIV infections in 2011 were attributed to male-to-male sexual contact.[26,27]

Data on sexual orientation and sexual behaviours are generally less well correlated with other sexually transmitted infections (STIs) than with HIV, but available data suggest high rates of some STIs among MSM. For example, MSM account for nearly three-quarters of all syphilis cases (among both sexes) in the USA, and incidence rose from 1.3 cases per 100 000 MSM (aged 15–19) in 2003 to 6.0 cases in 2009.[28] Rates of syphilis, gonorrhoea and chlamydia among MSM in Africa, Latin America and Asia are much higher than in the general population.[29] For example, in a study in four cities in China, 8.4% of MSM aged 16–20 years were infected with syphilis,[30] and at a sexual health clinic in Bangkok, Thailand, syphilis prevalence was 10.4% among MSM aged 15–21 years.[31]

Since syphilis facilitates transmission of HIV and there is evidence that gonorrhoea may also do so, rising infection rates among MSM are of particular concern. MSM diagnosed with rectal gonorrhoea are more likely to be HIV-infected, use recreational drugs, and have partners whose sero-status is unknown to them.[32]

MSM are also at increased risk of viral hepatitis. Some studies suggest high prevalence of hepatitis B virus among MSM.[33] Similarly, rates of human papillomavirus, which can cause anal carcinoma, are high among MSM,[34,35] but prevalence among young MSM is not known.

HIV RISK AND VULNERABILITY

Compared to their age peers in the general population, and to older MSM, young MSM are often more vulnerable to HIV. This is due to numerous individual and structural factors that are linked to specific risk behaviours – inconsistent condom use and greater use of drugs or alcohol.

Unprotected sex: Transmission of HIV is 18 times more likely to occur through unprotected receptive anal sex (between MSM or between heterosexuals) than through unprotected vaginal intercourse.[36] Frequency of unprotected sex increases risk of exposure to HIV, and some younger MSM are more sexually active than their older counterparts. For example, in Cairo, Egypt, 25.9% of MSM aged 15–25 years reported having sex more than once per day, compared to 6.7% of MSM aged 25 years and above.[37] Young MSM have also been found to be more likely than older MSM to report unprotected anal intercourse with partners of unknown HIV status.[38]

The community consultation revealed that many young MSM remain unaware that unprotected anal sex can transmit HIV and other STIs, and do not know the importance of condom-compatible lubricants in HIV prevention.[9] A study of MSM and transgender persons in northern Thailand found low rates of consistent condom use in both insertive and receptive anal sex (33.3% and 31.9%, respectively).[39] Community consultation participants in Albania noted that condoms and lubricant were not always available.[8] In other places, cost prevents some MSM from obtaining them.

Drug and alcohol consumption: Adolescence may be a time of experimentation with alcohol and drugs. Some MSM seek out social spaces such as gay-identified bars, clubs or private parties to socialize without fear of being subjected to homophobia. Such environments may also tolerate or normalize the consumption of alcohol or drugs, which can lower sexual inhibitions and affect risk perception.[40] Young MSM who are uncertain about their sexual orientation may be more likely to use alcohol or drugs during sexual contact with men.[17] Use of stimulants, inhalants, cocaine or hallucinogens by adolescent males studied at clinical care sites in the USA was found to be a direct predictor of sexual risk behaviour.[41] A study in Los Angeles found that MSM using crystal methamphetamine were three times more likely to have HIV than non-drug-using MSM.[42] In Thailand, the use of amphetamine-type stimulants by MSM during their most recent sexual encounter increased from less than 1% in 2003 to 5.5% in 2007.[43]

Changes during adolescence: Adolescence is a period of rapid physical, psychological, sexual, emotional and social development. It is often a time of experimentation, which may involve alcohol or other drugs, and the period when sexual activity with other people may begin. The development of the brain in adolescence influences the individual's ability to balance immediate and longer-term rewards and goals, and to accurately gauge risks and consequences.[44]

Sexual orientation is often clarified and articulated during adolescence. For some young MSM, the awareness of an attraction to people of the same sex may be disconcerting and confusing,

especially if they do not see their same-sex attraction modelled or reflected in positive ways in the wider culture. Regardless of their sexual orientation, adolescent males may also be vulnerable to sexual abuse or exploitation by other males, and therefore potentially to HIV. This is especially true for those who lack stable and supportive family environments. In United Republic of Tanzania, consultation participants said they want the police to arrest political and religious leaders who take advantage of them sexually.[8]

Homophobia, stigma and discrimination: Stigmatizing attitudes towards homosexuality, and discriminatory behaviour towards people with a homosexual orientation, are major obstacles affecting the lives and health of young MSM, particularly when reinforced by criminalization and violence. Most school-based sex education programmes do not acknowledge or address issues of sexual orientation.[22] Sexual minority stigma is associated with high-risk sexual behaviour by young MSM,[45] who may also be discouraged from seeking voluntary HIV testing and counselling and other essential prevention, care and treatment services.

Stigmatization related to being HIV positive can be an additional burden: a study of 40 young MSM living with HIV found that those who experienced high levels of HIV stigma were significantly more likely to engage in unprotected sex while high or intoxicated.[46]

Young MSM are often aware of incomprehension and hostility around issues of same-sex behaviour. Understandably, many choose to keep their sexual behaviour or orientation hidden from others, but this may reduce their access to guidance and information about HIV and the risks of unprotected sex – especially if they fear stigma and discrimination from health-care providers – and may make them more likely to engage in risk-taking behaviours.[47]

Studies in a number of countries show that young people are more likely to experience homophobic bullying at school than in the home or the community.[48] This can have serious psychological repercussions and also undermine learning opportunities, educational achievement, and therefore access to employment opportunities.[49,50]

Anxiety, loneliness, and fear of rejection affect the self-perception and sense of worth of young MSM and can lead to self-stigmatization – feelings of depression, low self-esteem and anger, or self-harming acts.[9] Self-stigmatization is also linked to HIV risk behaviour.[51] However, in many countries few services are available to address the mental-health needs of young people. In the consultation in Pakistan, several young MSM said that friends of theirs had committed suicide because of the stigmatization from their families or communities, especially after their identity as MSM who sold sex was disclosed by health-care providers.[11] Consultation participants in Cambodia said they often felt lonely and needed a place where they could meet to enjoy recreational activities with their peers.[11]

Research shows that men who accept their sexual orientation are more psychologically healthy, have higher self-esteem, are more likely to disclose their HIV status with casual sex partners and are less likely to engage in sexual risk-taking. [52] However, for those who identify as gay, the decision to come out can be a stressful one, and the process of doing so may bring a

mixture of responses ranging from acceptance and support to severe social and legal censure. They are more likely than heterosexual youth to face family disapproval, bullying, harassment, social isolation, discrimination and violence, including sexual violence. [53,54,55,56]

> *"Nobody recognizes me as MSM, as I don't show any sign that links me with gay behaviour. However, if outside of this room I behave differently, then opinion about me and my life would change dramatically."*
>
> Young MSM, Albania[8]

> *"Young MSM 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."*
>
> Young MSM advocate, Jamaica[57]

Lack of information and misconception of risk: There is evidence that young MSM begin having sexual intercourse at an earlier age than previous generations of MSM.[58,59] Many are unaware of the risks of infection and of how to protect themselves.[60] Sex education in schools often provides inadequate information about HIV and generally does not address sexual health risks relevant to MSM.[22] Objective information related to same-sex behaviour is usually not available from family or friends.

In Mozambique, consultation participants said that many young MSM were unaware of the risks of unprotected anal sex and did not know the importance of water-based lubricants in HIV prevention. They wanted specific sexual and reproductive health information provided through the media, health services and peer educators; easier access to prevention commodities; and informed, friendly health-service providers.[8]

Young MSM in Albania said that their main sources of information about safe sex, HIV and STIs were textbooks, but these were mostly in foreign languages and hard to understand. Information about HIV in the media was often incorrect. None of the consultation participants in Albania had received information on STIs from public institutions, but some had received clear information through NGOs serving MSM. [8]

Uptake of HIV testing and counselling is particularly low among young MSM. Many who do not realize they are infected believe they are at low risk for HIV, making them more likely to engage in behaviours that could transmit HIV to their partners.[61] For example, in a study of 122 MSM in Togo, where the average reported age of first sex with another male was around 17 years, about one-third reported having two or more concurrent partners. Only about half said they had been tested for HIV, and only one-fifth reported regular condom use with their regular male partner. Some thought that HIV infection could be transmitted only through sex with women, not with men.[62]

We are virgins because we've never slept with women, so we cannot catch the sickness [HIV].

Young MSM, Togo[63]

By contrast with such misconceptions, in contexts where HIV risk is widely understood and there is easy and affordable access to antiretroviral therapy, MSM may feel less concerned about the risks and consequences of HIV infection, and thus may increase their risk behaviours. This effect may be greater in countries where the worst period of the epidemic lies too far back for young MSM to remember, especially if they are unaware of having known anyone with HIV.[64]

Relationship status: MSM, like heterosexuals, practise unprotected intercourse more often in steady than in casual relationships,[20] and this trend is particularly pronounced among young MSM: in one study, considering the relationship to be "serious" was associated with a nearly eightfold increase in the rate of unprotected sex.[65] Where there is a high turnover of primary partners, the risk of HIV transmission is even higher.[66] Younger MSM are also significantly more likely than older MSM to engage in unprotected anal intercourse with casual partners while also being in a steady sexual relationship.[67]

Some young MSM in the Asia-Pacific consultation reported unprotected sex as a way to express their love for their boyfriend or partner (as well as for increased sexual pleasure).[9] Not using a condom was seen as an act of trust in the other person, even if their HIV status or relationship history was unknown.[9] Young MSM in relationships with older partners are more likely to have unprotected sex than those in relationships with partners of the same age,[68] and are more likely to be HIV positive.[69] Some young MSM with older partners said they sometimes lacked the confidence to insist that their partner use a condom.[9]

Selling sex: In some contexts of social marginalization a significant proportion of young MSM engage in selling sex. A 2001 study in St Petersburg, Russian Federation, found that 22.7% of MSM reported selling sex.[22] In Paraguay, 29% of MSM (median age 21 years) indicated that they were currently engaging in selling sex, and more than half of these reported having begun to do so when they were younger than 18 years.[70] Among MSM, selling sex is often associated with an increased likelihood of being younger, unemployed, having less education, using drugs, engaging in high-risk sexual practices and being raped, compared to MSM who do not sell sex.[22,71,72,73,74]

Selling sex can lead to higher rates of HIV among young MSM. A study among MSM and transgender people aged 15–24 years in Thailand found that HIV prevalence was 13% for the group as a whole, but even higher (15%) among those that sold sex. Among males aged 15 years and above engaged in selling sex in Ho Chi Minh City, Viet Nam, those aged 15–24 years were less likely than older MSM to understand sexual and reproductive health, reduce their risk behaviours or take an HIV test.[74]

"Clients are too ashamed to purchase a condom and we are too scared to buy a condom."
Young MSM who sells sex, Pakistan[11]

Loss of basic social protections: Young MSM are more vulnerable than older MSM to the negative consequences of stigma and discrimination because they depend on family and educational institutions for housing and other resources.[57] Young MSM who are disowned and thrown out of the family home may end up living or working on the streets. Loss of stable housing makes it harder to access health and other services and is associated with increased vulnerability to violence, including sexual violence, as well as to HIV risk behaviours including unprotected sex and selling sex.[75,76]

Forced displacement and refugee settings can increase the pressure on young people to exchange sex for material goods or protection. This is frequently a direct consequence of gaps in assistance, failures of registration systems or family separations.[77]

Migration: Some adolescent males who migrate from rural to urban areas in search of work may sell sex to other males for economic survival, regardless of their sexual orientation. For example, among 237 young male migrants from villages to Shanghai, China, who were selling sex to other males, about one-fifth of the group self-identified as non-gay and the rest as gay. More than half had left home before the age of 20 and many before the age of 15, suggesting initiation of same-sex behaviour at a young age. The gay-identified group was more likely to engage in anal sex and less likely to use condoms. There was a high prevalence of depression among the young MSM and low knowledge about HIV, and only half of them had ever been tested for HIV, even though free testing was available.[78]

Racial and ethnic marginalization: Ethnic and racial disparities in HIV infection rates among young MSM have been noted in some countries. More research is needed to understand the reason for these disparities, though it has been suggested that the social isolation and discrimination suffered by some ethnic-minority youth may be linked to lack of knowledge about HIV prevention, lack of easy access to health services, and drug and alcohol use.[79]

Among MSM aged 13–24 years diagnosed with HIV in the USA in 2011, an estimated 58% were African American and 20% were Latino, far higher than their proportion of the overall population.[80] Another US survey found a strong correlation between being African American or Latino and not knowing that one was HIV positive. One in five young Roma, Ashkali and Egyptian men in Podgorica, Montenegro – many of whom are refugees from Kosovo – reported having had sex with men, typically unprotected and sometimes involving rape. Most had their first anal intercourse before age 18.[79]

LEGAL AND POLICY CONSTRAINTS

The United Nations Convention on the Rights of the Child (CRC, 1989) is the global treaty guiding the protection of human rights for people under 18 years of age.[1] One of its key principles is that the best interests of the child should guide all actions concerning children (Article 3), also taking into account children's evolving capacity to make decisions regarding their own health (Article 5). The CRC also guarantees the rights to non-discrimination (Article 2), life, survival and development (Article 6), social security (Article 26), an adequate standard of living (Article 27) and protection from all forms of exploitation and abuse (Article 34). Article 24 stresses "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health".

In practice, significant legal and policy constraints limit the access of young MSM to information and services affecting their health and well-being. In some countries, legal discrimination against MSM is reinforced or encouraged by conservative religious institutions or attitudes or by laws criminalizing same sex behaviour.[81,82] The rights of young people under 18 years to life and health under the CRC are contravened when they are excluded from effective HIV prevention and life-saving treatment, care and support services.

Criminalization of same-sex behaviour: As of January 2014, 78 countries had criminal penalties for homosexual acts between consenting adults (or anal sex more generally) or prosecuted such behaviour under other laws.[83] In seven of these countries, such acts are punishable by death. The criminalization of homosexuality or homosexual sex pushes young MSM further underground and makes it difficult for them to obtain condoms, lubricants and much-needed counselling, and for service-providers to provide services and commodities. In regions like the Caribbean, it has been documented that countries with such laws have significantly higher rates of HIV among MSM.[84,85] Research suggests that MSM with a history of arrest and incarceration are more likely to engage in high-risk sexual behaviours.[86]

In some countries, laws against sexual violence do not criminalize the sexual assault of men and transgender individuals. The community consultation with young MSM in United Republic of Tanzania revealed that the police often do not respond to complaints of abuse or violence affecting MSM.[8]

> *"There should be some changes in the law so that people like us can be saved from abuse and torture."*
>
> Young MSM, Pakistan[52]

In some jurisdictions where homosexuality or homosexual sex is not illegal, the age of consent for homosexual sex is higher than for heterosexual sex.[87] This makes younger MSM more vulnerable to arrest for their sexual behaviour than their age peers who engage in heterosexual sex.

In Lebanon, advocacy by medical experts and psychologists has recently succeeded in ensuring that laws criminalizing "unnatural sex" are no longer applied to homosexual sex.[88]

Young MSM in Uruguay said that the promotion of human-rights activities and campaigns, including laws approved recently on the recognition and protection of LGBT people's rights and citizenship, must be implemented at the community level and in educational settings.[8]

Police enforcement: In countries where homosexual sex is criminalized, MSM have no recourse to the police if they are the victims of sexual violence. Young MSM may also be targeted by the police for arrest, extortion or sexual abuse, sometimes in the guise of enforcing laws against "public nuisance" or obscenity.[87] Even in countries where homosexual sex is not illegal, the threat of exposure gives police tremendous power over young MSM, many of whom have no awareness of their legal rights. Participants in the Asia consultation pointed out that community members doing prevention outreach work, for example, distributing condoms, may also be targeted for harassment and arrest.[11]

Legal obstacles to outreach to young MSM: Laws that criminalize homosexual sex make it extremely difficult for organizations offering services for sexual health and HIV prevention, treatment, care and support to do effective outreach to young MSM, since their work can bring them into conflict with laws banning same-sex behaviour or underage sex.

While the United Nations Secretary-General has explicitly stated that human rights apply to all people, including people who identify as lesbian, gay, bisexual or transgender,[89] sexual orientation and gender identity are not explicitly a protected status in any binding international human-rights instrument. Some states have incorrectly justified the criminalization of homosexual sex by claiming that they are fulfilling their obligations under Articles 6 and 34 of the CRC (the right to grow up healthy, and the protection of children from sexual abuse and exploitation). National laws banning specific sexual acts between members of the same sex may be used to effectively shut down public-health campaigns targeting MSM or to prevent health workers and others from providing relevant information to young MSM.[87]

Restricted access to services: The access of legal minors to sexual and reproductive health and other services, including harm reduction for those who use drugs, may be restricted by laws and policies requiring the consent of parents or guardians for testing or treatment. This is a particular problem for minors who live away from their parents. The principle of the evolving capacity of people under 18 years (Article 5, CRC) is not always observed, even though this is particularly important for "mature minors" – a term used in some national policies to describe those under 18 years who are living independently, have no parents/guardians or no contact with them, or have abusive parents/guardians. Parental consent is a particular concern for MSM under the legal age of majority who fear disclosing their sexual behaviours or orientation to their parents.

> *One of the biggest barriers we face while accessing health services is that the doctors demand that we bring our guardians, which is not possible for us.*
>
> Young MSM, Pakistan11

Employment discrimination against MSM: Many countries provide no legal protections against discrimination in hiring, or against dismissal from employment, on the basis of actual or perceived sexual orientation or HIV status. This has the potential to increase the economic vulnerability and dependence of young MSM, and lack of income is a predictor of HIV infection.[57] The International Labour Organization has ruled that there should be "no discrimination against or stigmatization of workers, in particular job-seekers and job applicants, on the grounds of real or perceived HIV status or the fact that they belong to regions of the world or segments of the population perceived to be at greater risk of or more vulnerable to HIV infection,"[90] and its supervisory bodies have interpreted this clause as applying to key populations.

SERVICE COVERAGE AND BARRIERS TO ACCESS

There are limited data on the proportion of young MSM reached by HIV prevention, treatment and care programmes. Mean coverage of prevention programmes reported by 20 countries in 2012 for all MSM was 54%. However, one international review concluded that globally, fewer than one in ten MSM receive a basic package of HIV prevention services.[91]

Availability and accessibility: In a 2012 survey, MSM under the age of 30 years reported significantly lower levels of access to low-cost STI testing and treatment, MSM-focused sexual health education and HIV educational materials, and risk-reduction programmes for MSM.[57,92] There is frequently a disparity between services available in urban and rural areas.

- Young MSM in the community consultation in United Republic of Tanzania reported that clinics that provided services were often too far from home to reach easily.[8]
- In Albania, consultation participants said that sexual health clinics in public hospitals were cramped and not private, unfriendly to MSM, and did not provide prevention commodities.[8]
- It was reported that young MSM in Laos PDR sometimes cannot find condoms. Some young MSM in Nepal were unaware of the benefits of lubricants, and in many cases did not know where to obtain lubricants.[9]

"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. Young MSM need access to information and services to keep themselves healthy."

Young MSM advocate, Lebanon[57]

"We do want to participate and attend the institutions and services [that are provided] for all the people; we do not want specific things because we´re LGBT. That's why we need a real homophobia-free dynamic. Without that there is no effective social integration."

Young MSM, Uruguay[11]

Funding: Recent reports indicate that less than 2% of global HIV prevention funding is directed towards MSM.[93] International funding vastly outweighs domestic spending on focused prevention services for MSM globally, including in all regions except the Caribbean.[94] Funding for HIV prevention services for MSM is especially limited in East Asia, the Middle East and North Africa, and across sub-Saharan Africa.[94] In response, outreach in some of these regions is led primarily by civil-society organizations rather than the government. While this means that they can apply international guidelines to their outreach, finding adequate support and legal coverage for their work is challenging.

Uptake of HIV testing and counselling: Perceived low risk for infection is one of the reasons that young MSM delay testing. In a survey of MSM aged 15–22 years in seven metropolitan areas of the USA, almost 6 out of 10 respondents thought they were at low risk of being infected.[61] However, low uptake of testing can also be because those who do perceive themselves at high risk of HIV fear learning that they are HIV positive.[95] Many young MSM

delay getting tested for HIV until they become symptomatic.[96] Migrants face obstacles to getting tested if services are available only to country nationals.

Uptake of antiretroviral therapy (ART): Young MSM living with HIV are more likely than older MSM to be identified later in the course of their infection and to delay entry into clinical care.[97,98] In one study of 126 MSM living with HIV below 30 years of age, more than 40% did not know their viral load or could not access viral load testing, only 56% of those who met the WHO's guidelines for recommended treatment reported taking ART, and only 38% were virally suppressed, compared to 73% of older MSM living with HIV.[57] Reasons for delaying or forgoing entry into mainstream services may include self-stigma and shame, fear of disapproval and discrimination from health-care providers, lack of health-care insurance, or poor service availability, accessibility and affordability.[99,100]

The limited data that exist suggest that adherence to ART among young people is poor, although the reasons are not well understood. In one study among MSM aged 17–25 years living with HIV in Chicago, USA, HIV stigma and discrimination by peers and family emerged as important factors driving non-adherence: of the respondents, 50% indicated that they had skipped doses because they feared family or friends would discover their seropositive status. Participants also described depressive symptoms as barriers to taking medications consistently.[101]

Lack of services targeted to young MSM: Sexual health counselling provided by clinicians frequently addresses only heterosexual behaviour, in part because training curricula do not include issues around same-sex behaviours and homosexuality. A survey of paediatricians in the USA found that while most discussed sexual activity during preventive care visits, they rarely or never discussed homosexuality (82%) with their patients. Only about 30% prescribed condoms, and just 19% provided condom demonstrations.[102] Among young MSM in New York City, USA, who had received a general sexual health screening in the prior six months and who reported any receptive anal sex in their lifetime, just 16% had ever had a rectal screening. A combination of linked factors (e.g., provider discomfort with talking about same-sex behaviours, and the patient's discomfort about revealing these behaviours) may be responsible.[103] Young MSM in the consultation in Albania said that public-health facilities were often cramped, offered little privacy, and did not provide condoms and water-based lubricants.[8]

Stigma and discrimination by service-providers: Insensitivity or discrimination on the part of health-care providers, exacerbated by lack of training and awareness, can deter young MSM from seeking not only HIV testing and counselling but also treatment for other STIs, especially if they feel they will need to disclose their same-sex behaviour to service-providers.[91] This reluctance may be especially strong for MSM who do not identify as gay.[104] Young MSM may fear that revealing their HIV status to family and friends will also mean disclosing their sexual orientation.[105] In the consultation with young MSM in Albania, half the respondents mentioned that despite being aware of public-health services, they did not

make use of them because of discrimination from health-care providers and fear of being "outed" as gay.[8] Young MSM in Asia reported judgmental attitudes from doctors or nurses, who suggested they should "stop" their sexual behaviour. This contributed to feelings of low self-esteem and discouraged them from returning to health services.[9] In the consultation in Pakistan, more than half of the young men who sold sex said that they had been raped by a health-care provider when they went to seek services.[8]

> *"One day with a friend of mine I went for general health check-up in a public hospital. At first everything was fine. Once my friend started to explain his problems (I guess the doctor realized that he is gay), then [the doctor] started smiling, making inappropriate jokes about [being] gay and his health problems."*
>
> Young MSM, Albania[8]

Service-providers also often fail to recognize that as adolescents living with HIV grow up, sexual orientation and sexual practices must be addressed as part of the support offered around sexual and reproductive health and HIV. Often paediatricians are unprepared to discuss same-sex relationships or to provide appropriate comprehensive information, commodities and services for adolescents living with HIV as they become sexually active.

Competing priorities: For many young MSM, taking care of their health is not always their top priority. The need to find shelter, food, alcohol or drugs may take precedence over seeking out services for sexual health, particularly if those services are inadequate or discriminatory. The lack of provision for basic social needs is thus a barrier to accessing sexual health services.

SERVICES AND PROGRAMMES

Around the world, programmes with young MSM are being implemented by governments, civil-society organizations and organizations of MSM themselves. Relatively few have been fully evaluated, but the elements of a number of promising programmes are presented briefly here, as examples of how the challenges in serving young MSM may be addressed. These examples are illustrative and not prescriptive. They may not be adaptable to all situations, but they may inspire policy-makers, donors, programme-planners and community members to think about effective approaches to programming in their own contexts.

Youth-led education to increase sexual and reproductive health awareness among young MSM

Egyptian Family Planning Association (EFPA)

EFPA uses outreach by young volunteer educators to engage young people most at risk of HIV in its clinical services, by providing comprehensive, gender-sensitive, rights-based sexual and reproductive health (SRH) education. Each clinic has two male and two female educators aged 18–25 years who are trained in comprehensive SRH education, HIV and other STIs, and communication skills. They are supervised by clinic staff and by EPFA's reproductive health officer and youth officer. Of EFPA's 56 educators, 30 have been trained to work specifically with young key populations, and some are themselves members of key populations.

The young educators conduct outreach sessions with young people under 18 years, primarily at government institutions for street children and orphanages. The sessions are offered at a location away from the clinic so that the participants will not appear to be seeking clinic services. The educators explain the services offered at the clinics, encourage the young people to attend and distribute condoms. Outreach is also done with young key populations who are not connected to specific institutions, such as truck and minibus drivers. In 2012, 81 youth-to-youth sessions reached almost 2 300 people, one-third of whom were MSM or young people who inject drugs.

Website: www.efpa-eg.net/en/home.php

Low-threshold services and linkages to care

New York State Department of Health, USA

The Test, Connect & Treat programme of the New York State Department of Health recruits high-risk adolescents and young adults (aged 13–24 years) for HIV testing. Young MSM are the population with the majority of new HIV diagnoses in the state. The programme emphasizes low-threshold services. Those who are HIV-positive are immediately linked to care, while those who are HIV-negative are provided with risk reduction and prevention information and referrals to community services.

The programme is run through 14 Specialized Care Centres across the state, where multidisciplinary staff teams provide comprehensive and coordinated HIV and primary health care, mental health and supportive services on-site. Clinic services are made as accessible as possible through evening and/or weekend hours and walk-in appointments. Services are provided regardless of the young person's ability to pay, and those without health insurance are assisted to apply for benefits and enroll in a managed care plan. For those who have eligibility through their parents, providers work to ensure services are confidential.

If a young person tests positive for HIV, they are given a medical appointment and linked to social work and medical case management. The programme has formed partnerships with youth-friendly clinical-care and social-services providers. Case management assessments focus on the young person's strengths and self-management skills, including his or her ability to attend medical appointments and adhere to treatment. This has been found critical for positive health outcomes.

Website: www.health.ny.gov

Strengthening risk reduction among young MSM through community engagement

YouthCO HIV and Hep C Society, British Columbia, Canada

YouthCO's Mpowerment project targets young gay men through a community engagement model in which educational programming on HIV, sexual health and harm reduction is provided within a wider context of social events. This approach aims to engage young MSM to think of themselves as part of a community and to strengthen community norms for sexual health, coping with stigma, and risk reduction.

Social events provide a calmer environment than bars and clubs for young gay men to learn from each other and make friends. Events are publicized through social media, and between 10 and 20 men typically attend. Film viewings can be used as a springboard for discussion about community values and experiences. Alongside films, games and picnics, discussions are held on topics such as healthy relationships, experiences with shame, and HIV prevention. Through these events young men are invited to attend YouthCO workshops that support their education around HIV, safer sex and sexual well-being.

Young gay men are the core organizers and leaders of all Mpowerment events, backed up by YouthCO staff, who are themselves under 30 years of age. The project has successfully reached hundreds of young gay men throughout British Columbia by empowering volunteers to become leaders within their own social networks. As the project also relies on staff to tap into their own social networks, it can be hard to maintain personal and professional boundaries, and YouthCO has found it important to support staff in their own self-care to avoid burnout. Mpowerment has also learned the importance of an accessible and youth-friendly community space (with condoms and lubricants freely available) where participants feel welcome and accepted.

Website: www.youthco.org

Using information and communication technology to reach young MSM

Save the Children Fund, Thailand

Save the Children uses information and communication technologies to enhance HIV prevention outreach to young MSM and transgender people in Chiang Mai, Thailand. The city is a major destination for sex tourism and has large numbers of migrants from minority ethnic groups and from Myanmar. The project provides information on HIV prevention, treatment, care and support by tapping into social media most commonly used by MSM. These include Facebook, Line (a mobile phone application) and other websites and forums frequented by young MSM.

The project's research indicated that non-HIV related content such as personal grooming, religious instruction and topical news would be an effective way to engage young MSM. Content is devised by project staff based on discussions with volunteers and other members of the MSM community, and is changed regularly to keep it fresh and topical. Outreach workers promote Mplus Chat, an app developed by a local NGO working with MSM groups, and this is subsequently used by the educators to establish a relationship with the young MSM. The project provides outreach workers with tablet computers, which help to engage the attention of young MSM and makes communication easier in noisier environments like bars and clubs. The tablet is used to show the young MSM the project's website. It provides content for discussion and can be used to record contact details for later follow-up.

After initial contact is established, the outreach workers continue to use ICT platforms to disseminate information on HIV prevention, treatment, care and support. Young MSM value continued online contact as a way to establish a trusting relationship with a counsellor while maintaining a degree of anonymity. This relationship enables outreach workers to promote accompanied referrals to free HIV testing for young MSM.

Website: www.savethechildren.org/site/c.8rKLIXMGIpI4E/b.6234243/k.C392/HIVAIDS.htm

Online and telephone counselling

menZDRAV Foundation, Russian Federation

In partnership with Phoenix Plus and six other NGOs, menZDRAV Foundation offers services to young MSM aged 18–25 years living with HIV in six regions of the Russian Federation. Many young men are reluctant to attend support groups for fear of having their sexual orientation or HIV status publicly identified, so the Positive Life programme offers individual counselling via phone, social media and Skype.

In each of six cities a hotline with a publicized number is staffed by counsellors from the young MSM community. Depending upon the resources available, calls are answered from morning until late evening, or 24 hours a day. Counselling is also offered via Skype, and young men can send questions to counsellors via e-mail, Facebook, or via the counsellor's profile on gay websites.

There are around 80 trained community counsellors, including project staff members and volunteers. All Positive Life counsellors take part in a centralized training. They receive further training and supervision at the programme's regional offices, as well as from central project staff who take field trips to the regions. Counsellors offer callers information on sexuality, safe sex, STIs, adherence to antiretroviral therapy, side-effects and disclosure of HIV status to sexual partners. Callers are informed about project services and are encouraged to visit the project office for assessments or referrals. Those who are reluctant to visit for fear of being identified can be referred to one of 20 medical specialists across six regions who have been sensitized to the specific needs of MSM living with HIV and will provide services without stigma or discrimination. In 2013, almost 1,900 phone consultations and 1,350 online consultations were provided by Positive Life counsellors.

Website: www.menzdrav.org

Considerations for programmes and service delivery

In the absence of extensive research on specific programmes for young MSM, a combination of approaches can be extrapolated from programmes deemed effective for young people or for key populations in general. It is essential that services are designed and delivered to take into account the differing needs of young MSM according to their age, specific behaviours, the complexities of their social and legal environment and the epidemic setting.

Overarching considerations for services for young MSM

- Acknowledge and build upon the strengths, competencies and capacities of young MSM, especially their ability to articulate what services they need.
- Give primary consideration to the best interests of young people in all laws and policies aimed at protecting their rights.[1]
- Involve young MSM meaningfully in the planning, design, implementation and evaluation of services.
- Make the most of existing services and infrastructure, e.g., services for youth, and add components for reaching and providing services to young MSM.
- Make programmes and services integrated, linked and multidisciplinary in order to ensure they are as comprehensive as possible and address the overlapping vulnerabilities and intersecting behaviours of different key populations.
- Partner with youth and MSM community-led organizations to make use of their experience and credibility with young MSM.
- Build monitoring and evaluation into programmes to strengthen quality and effectiveness, and develop a culture of learning and willingness to adjust programmes.

Implement a comprehensive health package for young MSM as recommended in the WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*:[4]

- **HIV prevention** including condoms with condom-compatible lubricants, post-exposure prophylaxis and pre-exposure prophylaxis in settings where is it being offered for MSM (providing support for adherence and re-testing)
- **Harm reduction** including sterile injecting equipment through needle and syringe programmes, opioid substitution therapy for those who are dependent on opioids and access to naloxone for emergency management of suspected opioid overdose
- **Voluntary HIV testing and counselling** in community and clinical settings, with linkages to prevention, care and treatment services
- **HIV treatment and care** including antiretroviral therapy and management
- **Prevention and management of co-infections and co-morbidities** including prevention, screening and treatment for tuberculosis and hepatitis B and C

- **Sexual and reproductive health services** including screening, diagnosis and treatment of sexually transmitted infections
- **Routine screening and management of mental health** disorders including evidence-based programmes for those with harmful or dependent alcohol or other substance use.

Make programmes and services accessible, acceptable and affordable

- Offer community-based, decentralized services, through mobile outreach and at fixed locations.[4] Differentiate approaches to reach those young MSM who do not identify with a "gay community" as well as those who do.
- Ensure that service locations are easy and safe for young MSM to access.[106]
- Integrate services within other programmes such as youth health services and drop-in centres.[4]
- Provide services at times convenient to young MSM and make them free of charge or low-cost.[106]
- Provide developmentally appropriate information and education for young MSM from an early age, focusing on skills-based risk reduction, including condom use during anal sex and education on the links between use of drugs (including types of drugs and route of administration and unsafe sexual behaviour. Information should be disseminated via multiple media, including online, mobile phone technology and participatory approaches.[106,107]
- Provide information and services through peer-based initiatives, which can also help young people find role models. Ensure appropriate training, support and mentoring to help young MSM reach their community to support them in accessing services.[108]
- Address issues of parent/guardian consent for services and treatment, considered in the context of the best interests of the young person under 18.[87]
- Engage young MSM, including those under 18 years of age, in decisions about services, recognizing their evolving capacity and their right to have their views taken into account.[1]
- Train health-care providers and other staff to ensure that services are non-coercive, respectful and non-stigmatizing, that young MSM are aware of their rights to confidentiality and that the limits of confidentiality are made clear.[3,4]
- Train health-care providers on the health needs of young MSM, as well as relevant overlapping vulnerabilities such as selling sex or drug use.[3,4]

Address the additional needs of young MSM, including:

- Primary health-care services
- Trauma and assault care, including post-rape care
- Immediate shelter and long-term housing

- Food security, including nutritional assessments
- Livelihood development and economic strengthening, and support to access social services and state benefits
- Support for young MSM under 18 years to remain in education, and fostering return to school for out-of-school young people, where appropriate
- Psychosocial support through counselling, peer support groups and networks, to address self-stigma, discrimination, coming out (where appropriate) and other mental health issues[9,106]
- Counselling to families, including parents of young MSM – where appropriate and requested – to support and facilitate access to services, especially where parent/guardian consent is required[9,109]
- Legal services for advocacy and assistance, including information for young MSM about their rights, and reporting mechanisms and access to legal redress.[87]

Considerations for policy, research and funding

Supportive laws and policies

- Work for the decriminalization of same-sex behaviour,[ii] sex work and drug use, and for implementation and enforcement of antidiscrimination and protective laws, derived from human-rights standards, to eliminate stigma, discrimination and violence against young MSM based on actual or assumed HIV status, sexual orientation or gender identity, or same-sex behaviour.[4,87,110]
- Work toward developing non-custodial alternatives to the incarceration of young people who engage in same-sex activity, use drugs or sell sex. Work for the immediate closure of compulsory detention and "rehabilitation" centres.[111]
- Prevent and address violence against young MSM, in partnership with MSM-led organizations. All violence – including harassment, discriminatory application of public-order laws and extortion – by representatives of law enforcement, should be monitored and reported, and redress mechanisms established.[4,87]
- Examine current consent policies to consider removing age-related barriers and parent/guardian consent requirements that impede access to HIV and STI testing, treatment and care.[3]
- Address social norms and stigma around sexuality, gender identities and sexual orientation through comprehensive sexual health education in schools, supportive information for families, training of educators and health-care providers and non-discrimination policies in employment.[48]
- Advocate for removal of censorship or public order laws that interfere with health promotion efforts.[87]

ii Same-sex behaviour may be criminalized under laws against homosexuality, anal sex, "sodomy", "unnatural sex" or other terms.

- Include relevant programming specific to the needs of young MSM in national health plans and policy.

Strategic information and research, including:

- Population size, demographics and epidemiology, with disaggregation of behavioural data and HIV prevalence by age group [iii]
- Research into health interventions and programmes for young MSM and the effectiveness of their delivery, especially services offered by MSM-led organizations[3]
- Research into the impact of laws and policies upon access to health and other services[87]
- Involvement of young MSM, including those under 18, in research activities to ensure that they are appropriate, acceptable and relevant from the community's perspective.[112]

Funding

- Increase funding for research, implementation and scale-up of initiatives addressing young MSM.
- Ensure that there is dedicated funding in national HIV plans for programmes with young MSM, and for programmes that address overlapping vulnerabilities.
- Recognize overlapping vulnerabilities of key populations in funding and delivery of services.

iii In some circumstances, determining population size estimates or mapping key populations can have the unintended negative consequence of putting community members at risk for violence and stigma by identifying these populations and identifying where they are located. When undertaking such exercises, it is important to ensure the safety and security of community members by involving them in the design and implementation of the exercise. For more information see *Guidelines on Estimating the Size of Populations Most at Risk to HIV* by the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance (Geneva: World Health Organization, 2010).

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