FROM RESEARCH TO PRACTICE

HIV/STI Prevention and Young Men Who Have Sex with Men

The vital importance of reaching the nation's most at-risk population

Men who have sex with men (MSM) accounted for more than half of all new HIV infections in the United States in 2008. In fact, 85 percent of HIV infections diagnosed in young men ages 13-24 from 2005-2008 were attributed to male-to-male sexual contact.[1] Young men who have sex with men (YMSM)* are the only risk group in which the number of new infections has increased steadily each year since the 1990s, even as it has decreased among other populations.[2] Thirty years into the HIV epidemic, young men who have sex with men remain at serious risk of acquiring HIV.

Stigma and historical oppression complicate the problem, placing young men of color who have sex with men at even higher risk: the rate of new infections among this group has risen steadily for 20 years, including a 93 percent rise in new infections between 2001-2006. Each day, nine young African American/black men are diagnosed with HIV.

Without culturally-competent, pragmatic, and inclusive prevention strategies, YMSM are left to explore the realm of sex and sexuality uninformed and through trial and error – leaving them at risk.[3] This document explores the barriers to HIV prevention YMSM may face and provides guidelines for creating more effective prevention programs.

MANY YMSM ENGAGE IN BEHAVIORS THAT PUT THEM AT RISK OF HIV/STIS

- Determining the risky behaviors in which YMSM are likely to engage can inform behavioral interventions in communities of at-risk MSM and secondary prevention efforts among those already living with HIV.[4]
- According to the National HIV Behavioral Surveillance System, 89 percent of YMSM reported anal intercourse with a male partner in the past year and 46 percent had unprotected anal intercourse (UAI). Seventeen percent had UAI with more than one male partner.[4]
- Findings from the same study show that compared to young men who had UAI with only one male partner, those who had UAI with multiple male partners were more likely to have engaged in UAI with a casual male partner. Thirty-one percent of all young men participating in the National HIV Behavior Surveillance System reported drug use during sex.[4]
- One study of YMSM found that the odds of HIV infection increased significantly as the age of sexual partners increased – participants with partners 5 or more years older had twice the odds of becoming infected with HIV than study participants as a whole.[5]
- Many YMSM are not aware of their HIV status. In one nationwide study of MSM which included HIV testing, ten percent of YMSM tested positive, with 69 percent of those who tested positive unaware of being infected with HIV.[6]
- Studies have found that because of the existence of medications which can prolong an HIV positive individual's life and prevent the virus from developing into AIDS, some YMSM may be taking more sexual risks, including unprotected sex with untested or known HIV positive individuals.[7]

SILENCE, STIGMA, AND DISCRIMINATION CONTRIBUTE TO HIV RISK AMONG YMSM

- YMSM not only face a lack of information about safer sex, but face strong barriers to developing self-efficacy for safer sex behaviors. Stigma against homosexuality leads to a dearth of information and limited discussion about safer sex and HIV prevention.
- All YMSM experience homophobia, through laws and policies that discriminate against them and harmful cultural messages. Most YMSM students have also directly experienced discrimination in schools: 85 percent of GLBTQ students report being verbally harassed in school, and 40 percent report being physically harassed in school.[8]
- GLBTQ youth are overrepresented among homeless youth – comprising between 20 and 40 percent. These youth are more likely to participate in sex work and drug use and have very limited access to health care, placing them at grave risk of HIV.[9]
- Many students encounter misinformation and/or harmful stereotypes in HIV prevention education and sexuality education. Abstinence-only programs often rely on stereotypical gender roles

** YMSM is defined as men ages 24 and under who have sex with other men. This classification is inclusive of those self-identifying as gay, homosexual, bisexual, heterosexual, transgender, questioning, and queer.*

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and heterosexual relationships as models, not only ignoring GLBTQ youth, but contributing to stigma against those YMSM who don't fit a traditionally masculine ideal.[10] Even otherwise comprehensive sex education may fail to provide instruction on risk reduction for GLBTQ youth.[3]

- Other sources of information about safer sex, like parents and health care providers, may not be available to GLBTQ young people. Their parents may not be accepting of their identity or may not be prepared to discuss safer sex for GLBTQ individuals; and many are concerned their health care provider will not maintain confidentiality.[3]

- HIV-related stigma and homophobia are closely linked due to public perception of AIDS as a "gay disease."[11] One study found that 59 percent of men who had never been tested for HIV had not done so out of fear of negative social consequences.[12] Another found that internalized homophobia was linked to lack of awareness of HIV prevention programs and to a lack of comfort with condom use.[13]

STRUCTURAL BARRIERS PUT YMSM OF COLOR AT HIGHER RISK

- For many YMSM, social and economic factors, including homophobia, stigma, and lack of access to culturally competent health care and health care services may increase risk behaviors or be a barrier to receiving HIV prevention services.[14]

- According to the Centers for Disease Control and Preventin (CDC), sixty-three percent of all HIV/AIDS diagnoses among YMSM aged 13–24 in 2008 were among African American/black youth, even though blacks represented only 17 percent of the population in that age group.[1,15]

- Studies have shown that among men who have sex with men, African American/black men are more at risk for HIV even when they have the same or fewer risk behaviors. An analysis of 53 studies found that black men were not more likely than whites to have unprotected anal sex, engage in commercial sex work, or have sex with a known HIV positive partner; and in fact reported having fewer partners than white men – yet acquire HIV at vastly disproportionate rates.[16]

- A history of oppression of African Americans dating back to slavery, and inequity that continues to the present impact HIV risk for African American youth. Racism contributes to and is intertwined with underemployment and unemployment, decreased access to medical care, and incarceration; these along with social stigma around homosexuality create a strong barrier to sexual health for African American YMSM.[14] For instance:

  - HIV positive black men who have sex with men are less likely than HIV positive white men to be taking ART (anti-retroviral therapy, a group of HIV medications). Because treatment for HIV decreases the viral load, those who are not receiving treatment are more likely to transmit HIV.[16]

  - African American men are four times as likely to be incarcerated as whites; incarcerated men are at risk for unprotected sex and HIV transmission.[14]

  - More than one-quarter of African Americans live in poverty compared to 11 percent of whites.[17] African Americans African Americans are less likely that whites to be insured and more likely to have publicly funded insurance.[18]

- Among YMSM ages 13-24, Latinos experienced 18 percent of new HIV infections in 2008. One study found that cultural expectations play a large role in HIV risk for this population: men who held strong "machismo" (traditionally masculine gender-role) beliefs were more likely to have had multiple partners, while men who had experienced discrimination based on homosexuality were more likely to have had UAI.[19] Latinos are also about twice as likely to have no health insurance as non-Latinos, decreasing their access to health care.[20]

- American Indians and Alaska Natives represent less than one percent of the total number of HIV/AIDS cases reported to CDC's HIV/AIDS Reporting System, but their rate of diagnosis of HIV is higher than that of whites (11.9 cases per 100,000 compared to 8.2).[2] Among males, male to male sexual contact accounted for 61 percent of cumulative HIV cases among American Indians and Alaska Natives in 2005 (the most recent year for which this data is available).[21] Many factors, including lack of reporting and cultural barriers to open discussion of homosexual behavior, make understanding the HIV epidemic among this population a challenge.

EFFECTIVE PROGRAMS, WHICH BUILD SKILLS AND AFFIRM THE VALUE OF YMSM, CAN REDUCE SEXUAL RISK-TAKING

Complex issues are fueling HIV transmission among YMSM—particularly for YMSM of color. In order to address those complexities, interventions must address individual behavior, and the socio-cultural determinants that fuel HIV transmission.

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- Peer-based interventions have been effective with YMSM in reducing risk behaviors.
    - One intervention with gay men significantly reduced sexual risk-taking behavior in four cities by recruiting popular peers and training them to pass on behavior recommendations to friends through conversation. Surveys found that at one-year follow-up, unprotected anal intercourse in the cities decreased between 15-29 percent, condom use increased, and the number of sex partners decreased.[22]
    - One study found that YMSM were most likely to be reached effectively through outreach activities, such as dances, movie nights, picnics, gay rap groups, and volleyball.[23]
    - One program showed 60 percent fewer YMSM reporting unprotected anal intercourse after sustained sexuality-related peer education that combined education sessions with a social support group.[24]
    - One effective program presented a "menu" of risk reduction options over the course of a retreat weekend, delivered by trained peer facilitators. Compared to those who did not receive the study, participants reduced their number of sex partners and instances of UAI, and were 81 percent more likely to have been tested for HIV six months after the program.[25]
- Because of the barriers posed by homophobia and racism, interventions for YMSM of color may need to focus on community-building approaches that reflect cultural nuances as well as on individual behavior change. For example, one study suggests that interventions focus on increasing the collective capacity of African American YMSM to address HIV and on increasing tolerance for YMSM within African American communities.[26,27]
- One study found that programs that promoted positive youth development are paramount to fostering healthy sexual outcomes for youth. The study found that programs that build skills, enhance bonding, strengthen families, engage youth, and empower youth were the most effective at creating behavior change.[28]

The following critical components for HIV/STI prevention are drawn from research.

- **Tailor programs to include YMSM.** Programs developed for all young people should discuss sexuality and should include discussion about anal sex in HIV/STD risk reduction sessions.[29]
- **Involve youth.** Peer support groups provide non-sexual opportunities for YMSM to share their emotions and experiences, ease their feelings of isolation, and build support systems. Involving YMSM in program design and implementation reduces their risky behaviors and fosters their spirit of self-determination and self-worth.[25,30]
- **Utilize peer influence within social networks.** Research has shown that identifying and recruiting peer leaders is an effective way of reaching YMSM with HIV prevention messages.[24,25]
- **Explore new venues, including non-gay-identified ones.** Community gathering places, welcoming churches, barber shops and beauty shops, websites, and bars or coffeehouses should be considered as a means of reaching YMSM with prevention messages.[11]
- **Foster a sense of personal worth.** Prevention must affirm the value of YMSM and create a context that fosters responsible sexual behavior. One-on-one counseling sessions make effective beginnings for such interventions.[3,11,13]
- **Address the needs of youth.** Focus on the needs identified by YMSM, not on those perceived by adults. This may include sponsoring support groups, building dating skills, and providing mentors and other role models.[29]
- **Teach skills.** Programs must teach skills. The ability to use condoms, negotiate safer sex with partners, build relationships, communicate with steady and casual partners, make decisions, and say 'no' strengthens teens in making healthy choices.[29]
- **Incorporate risk reduction strategies.** Programs should include information about partner reduction, gauging one's own susceptibility, the relative risk of specific behaviors (e.g., anal sex vs. oral sex), and other ways to reduce HIV risk beyond abstinence and condom use.[31]
- **Provide sustained support.** Since sustaining behavior change is difficult, populations at high risk require continuing support and reinforcement. To prevent relapse into unsafe behavior, prevention programs must address the changing needs of YMSM as they grow older.
- **Create programs specifically for YMSM of color.** Studies indicate that programs need to address individual, community, and cultural factors pertinent to YMSM. Programs should address racism in the gay, white community

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High infection rates in the community mean that even with equal or fewer risk behaviors, YMSM of color are more likely to acquire HIV.

while simultaneously supporting YMSM of color as they deal with decisions regarding sexuality, gay identity, culture, and race/ethnicity. YMSM also need safe environments for sharing their experiences.[29]

- **Address the needs of marginalized groups such as homeless youth and IV drug users.** Programs must reach out to homeless youth, especially those involved in commercial sex, and those who are IV drug users. One study of homeless adolescents found that one in 14 had been treated for AIDS. An estimated one-third of homeless youth have participated in survival sex or sex work. Homeless youth are also more vulnerable to intravenous drug use (IDU), a risk factor for HIV transmission. And in 2006, thirteen percent of new HIV infections among males were attributed to IDU or male sexual contact and IDU. This highly at-risk population desperately needs outreach programs and basic health care.[1,9]

Importantly, interventions which focus solely on changing personal behaviors are only a part of a successful HIV prevention strategy. Addressing other factors which contribute to the spread of HIV is vital. Recommendations drawn from research include:

- **Support structural interventions (approaches that promote health by changing the environment to one that facilitates health), including ones which work toward:**
  - Condom availability and comprehensive sex education, including risk reduction in schools and other community settings/venues.
  - Population education - educational techniques designed to raise the consciousness of its participants and allow them to become more aware of how an individual's personal experiences are connected to larger societal problems.
  - Harm reduction, including needle exchange legislation and programs for injection drug users.
  - Community mobilization for HIV prevention advocacy and a reduction of stigma against HIV positive individuals
  - Ensuring access to quality education and health care
  - Routine HIV testing
  - Reducing the community viral load through early diagnosis of HIV infection, timely initiation of antiretroviral therapy, and treatment adherence.
  - Supporting policies protecting against hate crimes and employment discrimination based on sexual orientation.[32]
- **Adopt an ecological approach to prevention.** An ecological approach attempts to create more effective and culturally competent programs by examining a young person's entire sphere (their family, community, and societal relationships and influences) and creating peer, group and family-level interventions.[32]

CONCLUSION

HIV remains an incurable and life-threatening disease, and one for which young men who have sex with men are highly at risk. Like all young people, YMSM need culturally-competent, pragmatic, and inclusive prevention messages – as well as programs which address behavioral, cultural, and institutional barriers to sexual health information and services.

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Changing personal behaviors is only a part of a successful HIV prevention strategy. Youth need programs which foster a healthy, empowering environment.

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