Rights in Action: Access to HIV Services among Men Who Have Sex with Men

The extent to which healthcare providers continue to shame, humiliate, or chastise men who have sex with men is the degree to which MSM will avoid prevention, care, and treatment services.

— Access to HIV Prevention and Treatment for Men Who Have Sex with Men[1]

The next five years are critical to achieving the accelerated HIV prevention, care, and treatment goals set by UNAIDS — that is by 2020, 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90 percent of all people receiving antiretroviral therapy will have viral suppression.[2] However, to optimize the benefits of antiretroviral medications and HIV diagnostics, we must mitigate ongoing structural barriers that complicate access to and utilization of HIV services.

We must also sufficiently and strategically target our efforts to populations shouldering disproportionate HIV disease burden. This includes strengthening and tailoring HIV service delivery models for men who have sex with men (MSM), involving a combination of safe community-based agencies and competent health care providers of clinical services.

When compared with the world's general population, MSM are more likely to be HIV-positive but less likely to have access to safe and competently delivered HIV services.[3] It is also known that HIV responses at the country level are most effective when they are strategically targeted, comprehensive, and tailored to the needs of the communities for which they are intended.[4] Yet, national HIV prevention and treatment programs still struggle to tailor and deliver services to MSM,[5] and programs led by and intended for MSM are severely under-resourced.[6] The reasons behind these realities include substandard technical capacity and limited political will to openly address the sexual and reproductive health needs of MSM.

Indisputable evidence about the health benefits of antiretroviral medications initiated early and prophylactically (also known as treatment as prevention, or TasP, and as pre-exposure prophylaxis, or PrEP) is rapidly advancing the global response to HIV.[7] Centralized government procurement of antiretroviral medications has made access to treatment immediately following HIV diagnosis a real possibility for more people living with HIV.[8] In addition, global procurement for diagnostics is enabling virological monitoring of treatment efficacy.[9]

WHAT MSM HAVE TO SAY

"I went to hospital and the nurse pulled out a bible to lecture me about being gay."

"The doctor brought in other doctors to see 'the gay man,' as if I were a spectacle for show. I will not go back."

*Quotes by anonymous participants in focus groups of MSM. From Access to HIV Prevention and Treatment for Men Who Have Sex with Men.[1]

As promising as access to antiretroviral medications may be, MSM still face discrimination, criminalization, and violence on a daily basis. For MSM, access to basic HIV prevention, testing, and treatment services is undermined by negative social attitudes about homosexuality within mainstream society, including among health care providers.[1]

GLOBAL MEN'S HEALTH AND RIGHTS STUDY

In 2014, the Global Forum on MSM & HIV (MSMGF) conducted the third biennial

LINKAGES, a five-year cooperative agreement funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Agency for International Development (USAID), is the largest global project dedicated to key populations. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill. The contents of this document do not necessarily reflect the views of PEPFAR, USAID, or the United States Government.

MSMGF (The Global Forum on MSM & HIV) is an advocacy and technical support network dedicated to the sexual health and human rights of all men who have sex with men (MSM) worldwide. MSMGF currently supports programs in 15 countries.

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SURVEY METHODOLOGY

From August to November 2014, MSMGF recruited a global sample of MSM to complete a 30-minute, anonymous, Internet-based survey, available in Arabic, Chinese, English, French, Portuguese, Russian, and Spanish. Survey participants were recruited via MSMGF's network of more than 4,000 members representing more than 1,500 community-based organizations in more than 150 countries. MSMGF and its partners used email, social media, and social networks to promote the survey.

The survey collected information on individual-level socio-demographics, accessibility and experiences of services, and HIV-related clinical characteristics. Country income levels, stratified by World Bank classifications, were also investigated for their potential impact on access to services.

Based on prior published research, MSMGF's Research Advisory Group identified structural, community, and individual-level factors that can affect perceived access to HIV services for MSM and hypothesized their role (i.e., as barriers or facilitators). These factors were measured in the survey using multiple-item scales ranging from 1 to 5. Cronbach's alphas were calculated to assess the internal consistence of scales, overall, and by survey language and by participant's region of residence.

Access to HIV-related services was dichotomized as "completely accessible" versus otherwise for each relevant service. Bivariate and multivariate regression analyses were conducted to understand associations between access to HIV-related services and hypothesized barriers and facilitators. Numerous factors were examined, including demographics (e.g., region, economic status) and experiences of discrimination from health care providers. Generalized linear mixed methods were used to account for response clustering and to control for unmeasured contextual variables that occur at the country level. Analyses were adjusted for potential confounders.

Global Men's Health and Rights Study (GMHR) — an international, multilingual online questionnaire. MSMGF administers the survey to shine a spotlight on the barriers and facilitators of HIV service utilization for MSM. The survey also places HIV services in the broader context of the sexual health and lived experiences of MSM. The data are used to help support advocacy, technical assistance, and program development.

Data from the 2014 GMHR will be presented in a series of briefs, each focused on specific challenges and opportunities that affect efforts to scale up coverage and quality of services for MSM across diverse regional contexts. This brief is dedicated to understanding access to HIV services among MSM and the implications for strengthening the global HIV response.

DEMOGRAPHICS

Among 5,871 men who started the survey, 2,312 (39 percent) from 154 countries were included in the analysis (**Figure 1**). Participants who recorded incomplete responses to questions or scales of interest were excluded.

ACCESS TO SERVICES

Overall, access to HIV prevention and treatment services was unacceptably low. Half or fewer of MSM perceived that condoms, lubricants, HIV testing, and HIV treatment were easily accessible (**Figure 2**).

When access was examined by region and country income level, several disparities emerged. For example, MSM in North America and Western Europe reported the highest levels of access to HIV prevention and testing services but MSM in North America reported the lowest levels of treatment access. Access to HIV treatment was highest among participants in Western Europe, where 78 percent of participants perceived HIV treatment to be easily accessible (**Figure 3**). Access to all services was highest in high-income countries, with the exception of treatment access, which was highest in upper-middle-income countries. There were also significant differences by age groups, with younger men generally reporting lower access to HIV services across service type.

BARRIERS AND FACILITATORS

In bivariate analyses, age was statistically significant in predicting access to HIV prevention programs and HIV testing. Odds of access were lowest among MSM under 30, increasing among each successive age group.

FIGURE 1

Survey Participants

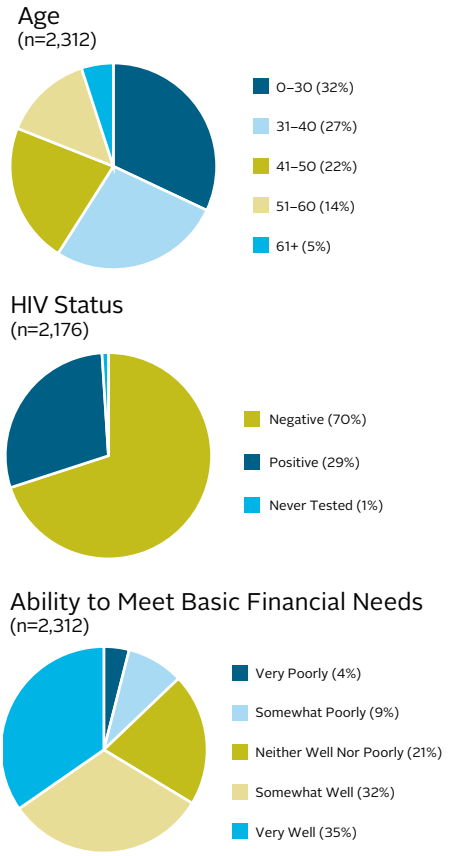
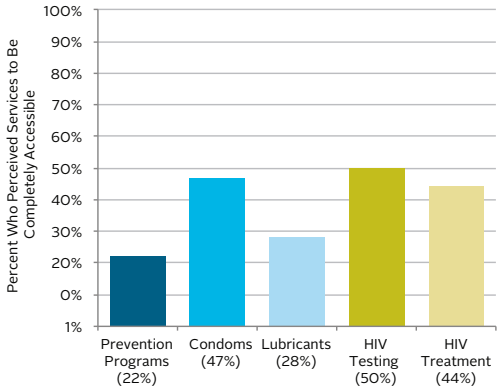


FIGURE 2

Overall Access to HIV Services

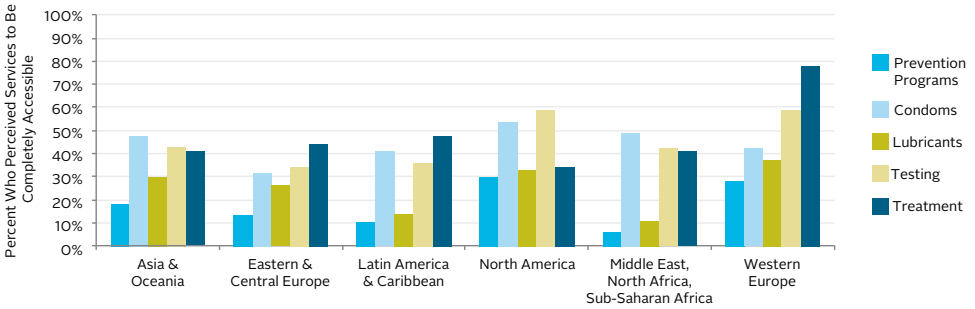
(n=2,312)



Men reporting unstable housing and men with a slower Internet connection reported less access to condoms, lubricants, prevention programs, and HIV testing. Experiences of homophobia, discrimination from health care providers, and fear of others' reactions to one's homosexuality were each negatively associated with perceived accessibility of condoms, lubricants, prevention, testing, and treatment services.

FIGURE 3

HIV Service Access by Region



MSM who reported greater ability to financially meet their basic needs were twice as likely to report greater access to condoms, lubricants, prevention programs, and HIV testing. Meaningful engagement with gay communities was also positively associated with access to each service type. All associations were statistically significant.*

In multivariate regression analyses that controlled for demographic and other variables, provider discrimination and fear of others' reactions were independently associated with decreased access to HIV prevention services, condoms, lubricants, and testing. Conversely, community engagement was associated with increased access to all five service categories, including HIV treatment (**Figure 4**).

LIMITATIONS

The results of the GMHR offer a noteworthy snapshot of experiences related to access to HIV services among a global sample of MSM. However, the study used an online convenience sample, creating a selection bias toward MSM who were more likely to have access to the Internet and other financial or service-related resources and who were more likely to be socially connected. In addition, the cross-sectional design prevented the identification of any causal relationships. Given these limitations, data from the sample may be overestimating levels of access to HIV services. Also, similar to other observational studies, there may be unmeasured factors affecting access to services.

IMPORTANCE OF PERCEIVED ACCESS

How individuals perceive the quality of services provided, including their accessibility, can have a direct impact on their utilization of those services.[10] Improving those perceptions for MSM globally will require a concerted effort to raise the level of provider competence and sensitivity in addressing the needs of MSM.

Many MSM report negative experiences when they attempt to access health or social programs or know others who do.[11] Consistent with this, the 2014 GMHR found an association between provider discrimination and lower access to HIV prevention and testing services. Utilization of HIV testing and treatment services may be improved to the extent that experiences with basic HIV services foster positive engagement with the health service delivery system.

HIV prevention and testing programs, including accessible condoms and lubricants, represent the earliest and perhaps the most important entry points to a comprehensive HIV services continuum. This early engagement is critically important for MSM who may justifiably distrust or be apprehensive about utilizing health care services when they most need them.[12,13] Engagement in the gay community and access to the Internet can play important roles in facilitating safe access to information and services.

As health and community leaders work to improve service coverage toward achieving the UNAIDS 90-90-90 goals, it is critical that specific barriers and facilitators that affect service utilization among MSM be identified and addressed. Increasing accessibility of HIV services is an important first step. This will require proactive efforts to address homophobia, discrimination, and technical competence, particularly among health care providers. Access to basic HIV services for MSM must be improved across all regions, at all country income levels, if we are to reach the goals set by UNAIDS. Special attention should be given to eliminating barriers to access among MSM who are younger or lack the financial resources to meet their basic needs.

* Bivariate statistical tables are available upon request.

KEY RESULTS

- With a few important regional differences, perceived access to HIV prevention and treatment services was unacceptably low among MSM, particularly younger MSM.
- A slow Internet connection, discrimination from health care providers, homophobia, and fear of others' reactions to one's sexuality were associated with lower perceived access to HIV prevention and testing services.
- Ability to meet basic financial needs and community engagement were associated with higher perceived access to HIV services, including treatment.

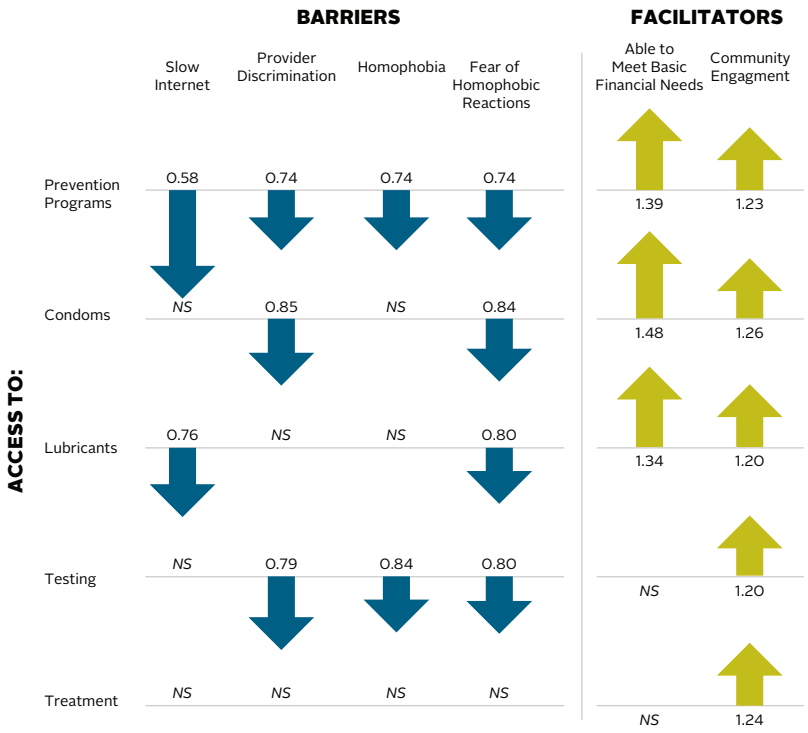
THE TIME TO ACT IS NOW

The following actions can be taken to proactively address the barriers and bolster the facilitators identified in this brief:

1. **Expand professional development, sensitivity training, and technical assistance for health care personnel** at all levels. This includes reception staff, community health workers, laboratory personnel, nurses, doctors, and health care students.
2. **Consult and support MSM experts to plan and deliver training for health care professionals.** First-person accounts of discrimination will help focus technical assistance efforts.
3. **Engage local communities of MSM in the development and evaluation of HIV services.** MSM involvement will help with community validation of local programs.
4. **Hire MSM (including young MSM) to deliver services within local HIV service programs.** MSM should serve not only in the role of outreach worker but at all levels within the programs. MSM are more likely to perceive programs as accessible if they see other MSM in leadership roles.
5. **Create safe spaces where MSM can congregate** for mutual support, affirmation, and connection.

FIGURE 4

Barriers and Facilitators of Access to HIV Services†



† Each statistic is an adjusted odds ratio significant at p<0.05. NS indicates a non-significant finding. The height of the arrow indicates the strengths of the associations. Arrow height corresponds to the logarithm of the odds ratio. Multivariate statistical tables are available upon request.

HELPFUL RESOURCES

HIV Prevention, Diagnosis, Treatment, and Care for Key Populations: Consolidated Guidelines (WHO, 2014)

A Code of Conduct for HIV and Health Professionals: Strengthening Human Rights Approaches to Health (IAS, 2014)

Brief Sexuality-related Communication: Recommendations for a Public Health Approach (WHO, 2015)

Implementing Comprehensive HIV and STI Programs with Men Who Have Sex with Men: Practical Guidance for Collaborative Interventions (UNFPA, MSMGF, et. al., 2015)

6. **Assist MSM in obtaining access to reliable Internet connections.** The Internet can facilitate confidential access to information about HIV services and financial resources among MSM.

7. **Continuously update, refresh, and develop new HIV service approaches.** New research findings, normative guidance from the World Health Organization, and information shared through community consultations with MSM can be used to accomplish this goal.

8. **Mitigate the stigma, discrimination, and violence that MSM experience.** Integrating educational, legal, and support services into local HIV responses will strengthen the responses by making them more comprehensive.

9. **Provide services for young MSM and MSM who are struggling financially.** Tailoring programs to these groups is important, as their needs may be different from those of the larger MSM community.

10. **Support grassroots community empowerment and mobilization efforts** designed to raise awareness and link MSM to services. Community empowerment programs can also contribute to positive self-esteem, peer norms, and trust.

FUNDING

GMHR 2014 was made possible through funding from the Ministry of Foreign Affairs of the Netherlands Development Cooperation through Bridging the Gaps.

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CONTRIBUTORS

George Ayala, PsyD[1], Keletso Makofane, MPH[1], Tri D. Do, MD, MPH[2,3], Glenn-Milo Santos, PhD, MPH[3,4], Jack Beck, BA[1], Ayden I. Scheim, BA[5], Patrick Pato Hebert, MFA[1], Sonya Arreola, PhD, MPH[1,6]

[1] MSMGF, Oakland, CA

[2] API Wellness Center, San Francisco, CA

[3] University of California, San Francisco, San Francisco, CA

[4] San Francisco Department of Public Health, San Francisco, CA

[5] Department of Epidemiology and Biostatistics, The University of Western Ontario

[6] California Institute of Integral Studies, San Francisco, CA