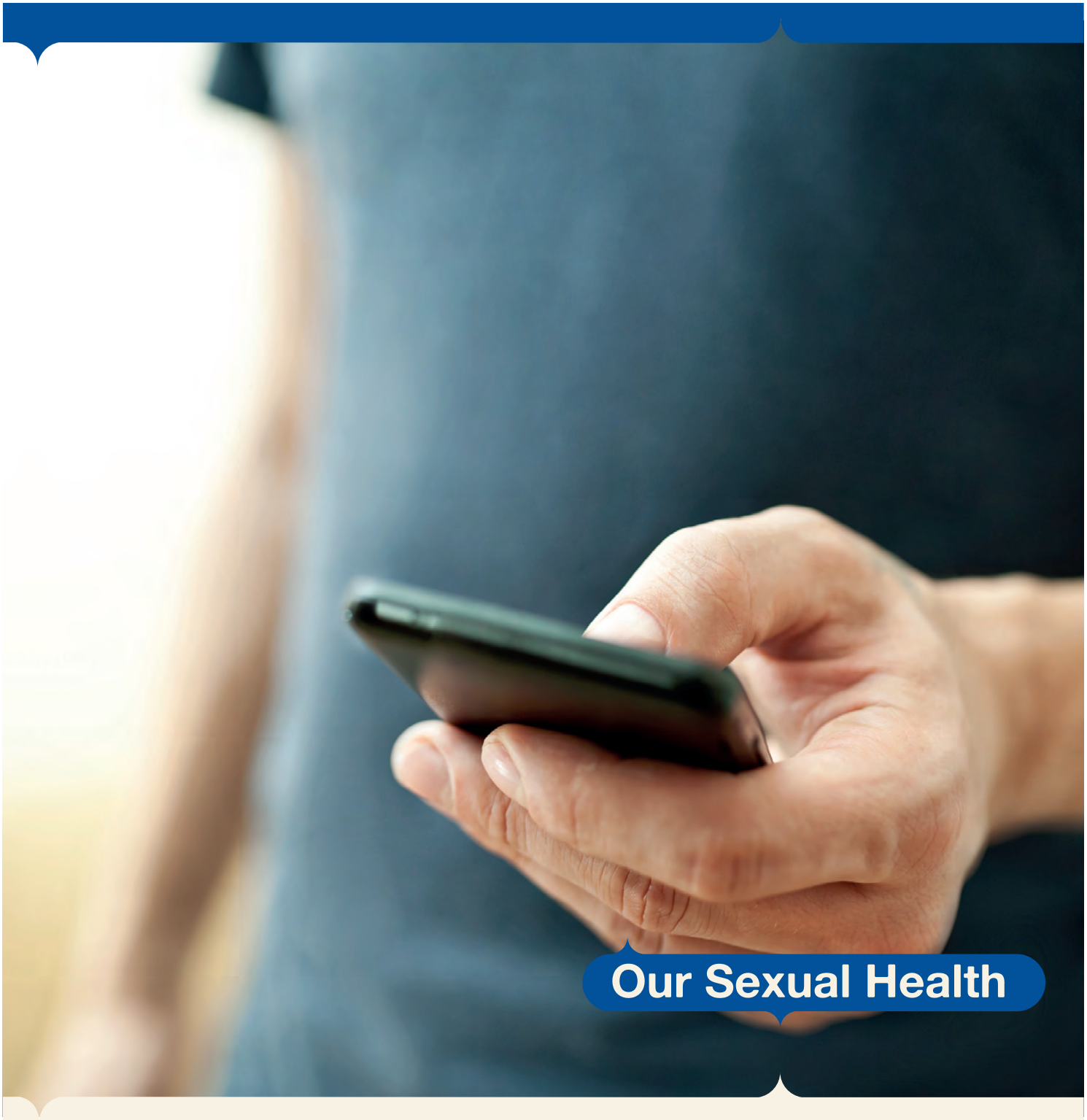


All-Ireland findings from the 2010 European MSM Internet Survey (EMIS)

Man2Man: Report Four

Daniel McCartney
Mick Quinlan (GMHS HSE)
Susan Donlon (GHN)

June 2014

GMHS
Féidhmeannacht na Seirbhíse Sláinte
Health Service Executive
GAY HEALTH NETWORK
the rainbow project

Our Sexual Health

‘Our Sexual Health’ is the final of four thematic reports in the ‘Man2Man’ series. These reports aggregate data generated in the 2010 European MSM Internet Survey (EMIS), and represent the largest ever research sample of men who have sex with men (MSM) across the 32 counties of Ireland. Each report contains information relevant to those working to improve the sexual health and well-being of MSM and presents evidence relevant to policy and programme design for gay and bisexual men in both Northern Ireland (NI) and the Republic of Ireland (RoI).

The EMIS data was significant to the development of the first National HIV Prevention and Sexual Health Programme for MSM in Ireland, a joint initiative by the Gay Health Network and Health Service Executive (HSE). Launched on December 1st 2011, information and materials from this ongoing campaign are available at www.man2man.ie.

Thank you!

All-Ireland findings from the 2010 European MSM Internet Survey (EMIS)

Man2Man Report Four:	Our Sexual Health	
Published by:	Gay Men’s Health Service HSE, Gay Health Network, and the Rainbow Project (June 2014)	
Data Analysis:	Daniel McCartney	
Report Design:	Maurice Farrell	www.Creationpod.ie
Funding:	GMHS HSE and GHN	
For Further Information:	www.gmhs.ie www.ghn.ie www.rainbow-project.org	e: gmhsadmin@hse.ie e: info@ghn.ie e: director@rainbow-project.org
EMIS and Other Country Reports:		www.emis-project.eu

GMHS, GHN and the Rainbow Project would like to acknowledge all of you who completed the questionnaire; the HIV, sexual health and LGBT groups and organisations, social venues and websites who promoted the survey in Ireland and the scientists who organised and conducted EMIS between 2009 and 2011: Axel J. Schmidt (Project co-ordination); Ulrich Marcus (Project initiation and supervision); Peter Weatherburn (Promotion co-ordination); Ford Hickson and David Reid (Technical implementation); Harm J. Hospers (Questionnaire drafting).

The EMIS survey

The European MSM Internet Survey (EMIS) was a joint project of academic, governmental, and non-governmental partners from 33 countries in Europe (EU and neighbouring countries) to simultaneously run an online questionnaire in 25 different languages. This pan-European survey collected information on the knowledge, attitudes, needs and behaviours of men who have sex with men (MSM), including those who identify as gay or bisexual, in relation to HIV, sexual health, and well-being. The EMIS questionnaire was available online between June 4 and August 31, 2010. Following the slogan "Be part of something huge!" more than 180,000 MSM living in 35 European countries completed the survey, making EMIS the largest international study ever conducted on MSM. The full European report was launched in May 2013 and is available at www.emis-project.eu.

The lead agency in Ireland, the Gay Men's Health Service, Health Service Executive (GMHS HSE), collaborated with the Gay Health Network (GHN) and the Rainbow Project NI to produce additional analysis and reporting for the all-Ireland dataset. In total, there were 2,610 valid respondents from all of Ireland: 2,194 from RoI and 416 from NI. Man2Man Reports are available at www.ghn.ie and www.emis-project.eu.

Access to sexual health

This final report focuses on access to sexual health information and services, and barriers that prevent gay men and other MSM from accessing the support and services they need.

This report includes all 2,610 respondents as described in the first Man2Man report 'Our Community'.
All results are disaggregated by country of residence (NI and RoI). Further analysis was conducted against other demographic variables presented in the first report, including age, area of residence, education level, and sexual identity*.

Country of residence	# of respondents	%
Northern Ireland (NI)	416	15.9
Republic of Ireland (RoI)	2194	84.1
Total	2610	100

This report should be read in conjunction with the other 'Man2Man' reports. Of the 2,610 respondents, 92.4% identified as gay or bisexual, 73.5% were attracted only to other men, 25.2% were aged 24 or younger, rising to 44.5% for those aged 29 and younger. 5.5% were living with HIV (9% of those men who had ever tested).

1. Access to information about HIV and other STIs

This section reports on respondents' knowledge about HIV and other sexually transmitted infections (STIs), as well as their sources of information about HIV and other STIs.

A total of thirteen questions addressed knowledge related to HIV testing, treatment and transmission, as well as other STIs. They were formulated not only to assess but also to educate, as all knowledge statements were true, and respondents were told this beforehand. For each statement, respondents were asked: ***'Did you know this already?'*** and could choose one of the following answers: I already knew this; I wasn't sure about this; I didn't know this already; I don't understand this; and I do not believe this.

The following tables highlight those who responded 'I already know this' as these were considered to have had correct pre-existing knowledge. The analysis includes only respondents who answered all thirteen questions.

Knowledge about HIV testing and treatment

Five questions assessed knowledge about HIV in general, including testing and treatment for HIV. The following respondents stated that they already knew the following statements were true.

Knowledge about HIV testing and treatment (n=2544, missing 66)	**% Overall**	**% by country**	
		NI (n=410)	**RoI** (n=2134)
There is a medical test that can show whether or not you have HIV	98.6	99.0	98.5
AIDS is caused by a virus called HIV	97.6	97.1	97.7
There is currently no cure for HIV infection	93.7	92.0	94.0
HIV infection can be controlled with medicines so that its impact on health is much less	92.2	93.4	92.0
If someone becomes infected with HIV it may take several weeks before it can be detected in a test	83.1	80.5	83.6

While over 90% of respondents knew that four of the five statements were true, only 83% knew that there is a 'window period' before an HIV infection can be detected by most tests.

Five questions assessed knowledge about HIV transmission. The following respondents stated that they already knew the following statements were true.

Knowledge about HIV transmission (n=2544, missing 66)	**% Overall**	**% by country**	
		NI (n=410)	**RoI** (n=2134)
You can pick up HIV through your rectum while being 'passive' in unprotected anal sex (being fucked) with an infected partner	96.6	96.1	96.7
You cannot be confident about whether someone has HIV or not from their appearance	95.3	96.6	95.1
You can pick up HIV through your penis while being 'active' in unprotected anal or vaginal sex (fucking) with an infected partner	84.2	87.4	83.6
HIV cannot be passed during kissing, including deep kissing, because saliva does not transmit HIV	75.2	74.8	75.3
Effective treatment of HIV infection reduces the risk of HIV being transmitted	49.8	50.7	49.7

Three of the five statements were known as true by less than 90% of respondents, with some uncertainty related to the possibility of transmission as the 'active' or 'insertive' partner as well as the transmission risk related to saliva. There was a much lower level of knowledge about the effect treatment has on transmission risk, with less than half of respondents reporting that they already knew that effective treatment reduces the risk of HIV being transmitted.

Knowledge about HIV and other STIs

The survey assessed general knowledge about STIs with three questions.
The following respondents stated that they already knew the following statements were true.

Knowledge about HIV and other STIs (n=2544, missing 66)	**% Overall**	**% by country**	
		NI (n=410)	**RoI** (n=2134)
Even without ejaculation, oral sex (sucking and being sucked) carries a risk of infection with syphilis or gonorrhoea	80.9	80.5	80.9
Most sexually transmitted infections can be passed on more easily than HIV	62.1	60.0	62.5
When HIV infected and uninfected men have sex together, the chances of HIV being passed on are greater if either partner has another sexually transmitted infection	54.6	50.7	55.4

All three statements related to STIs were known as true by less than 90% of respondents. In particular,only 55% of respondents knew that and STI infection can increase the risk of HIV transmission. Overall, respondents were more knowledgeable about HIV testing than other topics; and knowledge of HIV transmission was greater than that of STIs. Almost one-quarter (23.4%) of respondents stated that they knew all statements were true. Knowing all statements were true was most common among older men (30 years or older), those living in more urban areas (population of 500,000 or more), men who identified as gay, those who have ever had an HIV test, and those with a higher level of education.

Where information is accessed

A series of questions were asked about the sources of sexual health information respondents had accessed. Respondents were asked when was the last time they saw or heard any information specifically for MSM; saw information in a magazine or newspaper; looked for information on the internet; or called a telephone helpline for information.

The following table highlights respondents who accessed information within the 12 months prior to the survey. The analysis included only respondents who answered all four questions.

Accessed information about HIV and other STIs in the past 12 months (n==2563, missing 47)	**% Overall**	**% by country**	
		NI (n=410)	**RoI** (n=2153)
Saw or heard any information about HIV or STIs specifically for men who have sex with men	85.2	86.1	84.9
Saw any information about HIV or STIs in a magazine or newspaper	78.0	74.5	78.6
Actively looked for information about HIV or STIs on the internet	63.1	57.9	64.1
Called a telephone helpline for information about HIV or STIs	3.5	3.9	3.4
Effective treatment of HIV infection reduces the risk of HIV being transmitted	49.8	50.7	49.7

While it is impossible to know the quality of the information received, or whether this information was actively accessed, this does highlight how respondents received information related to sexual health. The internet is a significant source of information about sexual health, with one in five (20.0%) actively seeking this information online within the past four weeks, and over three in five (63.1%) in the 12 month period prior to the survey.

Overview

Gay men and other MSM need to be able to easily access reliable sexual health information. This information helps to inform the content of future awareness and prevention interventions. The low levels of knowledge about how HIV treatment can lower the risk of HIV transmission and the effect that STIs can have on HIV transmission risk, highlights these as possible topics for intervention. There is also a need to utilize specific prevention messages that focus on STIs other than HIV. For maximum impact, awareness interventions should continue to be placed both online and within print media.

2. Access to HIV testing

Participants were asked a series of questions about testing for HIV, with almost two-fifths of respondents indicating that they had never been tested (38.0%). Overall, 5.5% indicated they had tested positive for HIV (9% of those who had ever tested). (See Man2Man Report One)

HIV testing history (n=2599, missing 11)	**% Overall**	**% by country**	
		NI (n=415)	**RoI** (n=2184)
Never tested	38.0	43.9	36.9
Last tested negative	56.5	53.3	57.1
Tested positive	5.5	2.9	6.0

Of respondents who reported that their last HIV test was negative, almost two-thirds (65.0%) had received this test result within the 12 months prior to the survey (ROI: 65.2%; NI: 63.8%). These men were asked where they had their last HIV test, and questions about their experience, including how satisfied they were with the confidentiality and the counseling received (if received), and whether they were treated with respect.

Location of last HIV test

Men who had tested for HIV within the last 12 months were asked: '***Where did you go for your last HIV test?'*** and were given a series of locations to choose from.

Location of last HIV test (n=777, missing 2)	**% Overall**	**% by country**	
		NI (n=111)	**RoI** (n=666)
GUM clinic	48.9	58.6	47.3
Practice-based physician (GP)	25.6	18.0	26.9
Community testing service (not in hospital or clinic)	19.7	17.1	20.1
Hospital or clinic (in-patient)	1.4	0.0	1.7
Other	4.4	6.3	4.1

The main testing sites in both the Republic of Ireland and Northern Ireland were in hospital out-patient clinics, more commonly known as genitourinary medicine (GUM) clinics, with almost half (48.9%) reporting this as the location of their last HIV test. This was followed by practice-based physicians (GPs or family practice) (25.6%) and community testing services (19.7%). Across Ireland, both GUM and HIV-testing clinics are free public health services. While GP services are free in Northern Ireland, these are fee-based in the Republic of Ireland.

Quality of last HIV test

Questions about confidentiality, respectful treatment and the counselling received were used to assess the performance of all types of testing sites.

Respondents were asked: ***'The last time you tested for HIV, how satisfied were you with: the way the testing service kept your confidentiality; the respect you were treated with; and the counselling you received.'*** and could choose from the following: Very satisfied; Satisfied; Dissatisfied; Very dissatisfied; I don't remember / I did not think about it. The following table highlights respondents who reported being 'satisfied' or 'very satisfied'. The analysis includes only men who answered all three questions.

Satisfaction with last HIV test (n=772, missing 7)	**% Overall**	**% by country**	
		NI (n=109)	**RoI** (n=663)
Satisfied with the way the testing service kept your confidentiality	92.5	94.5	92.2
Satisfied with the respect you were treated with	92.6	89.9	93.0
Satisfied with the counselling you received	45.7	27.5	48.7

Overall, satisfaction with confidentiality and respect received was very high for most respondents (92.5% and 92.6% respectively). Satisfaction with the counselling received was lower, and two in five respondents (40.4%) reported that they did not receive counselling during their last HIV test (NI: 60.6%; ROI: 37.1%).

Perceived access to HIV testing

Access to HIV testing was assessed by asking about respondents' confidence in being able to get an HIV test. Respondents who had not yet been tested for HIV were asked: ***'How confident are you that you could get a test for HIV if you wanted one'*** and could select: Very confident; Quite confident; A little confident; Not at all confident; I don't know.

Confidence in getting an HIV test among those never tested for HIV (n=981, missing 6)	**% Overall**	**% by country**	
		NI (n=181)	**RoI** (n=800)
Very confident	53.3	49.2	52.9
Quite confident	22.7	21.5	23.0
A little confident	11.6	13.8	11.1
Not at all confident	7.4	6.1	7.8
I don't know	5.3	9.4	6.0

Respondents were considered confident about their ability to get tested for HIV if they answered 'Quite confident' or 'Very confident'. Overall, 76.0% of respondents who had not previously tested for HIV were confident of their ability to get tested if desired. Confidence was higher among men in the Republic of Ireland (75.9%) than in Northern Ireland (70.7%).

Those who were less confident of their ability to get tested were more likely to be younger men (under 25 years), men living in more rural areas (populations of less than 100,000), men who identified as bisexual or other non-gay identity, men reporting a low level of 'outness', and men with a lower level of education.

Overview

The differences regarding access to HIV testing in rural and urban settings, and the lower testing rates among young MSM, require innovative approaches to address these differences. With the low levels of counselling reported, there is a possibility that risk reduction counselling in the context of HIV testing is currently underutilised. This might also reflect the limited resources at the clinic level and the availability of counselling personnel.

This information about the prevalence of specific sexual practices helps sexual health service providers better address the needs of gay and bisexual men and other MSM. In particular, the data highlights the importance of screening for throat, penile, and ano-rectal STIs among all sexually active MSM. While fisting is less common, health providers should be aware of the potential risks and colorectal complications, and be able to provide information about safer fisting.

3. Access to Post-Exposure Prophylaxis (PEP)

Post-exposure prophylaxis (PEP) to prevent HIV infection after sexual exposure was available in some parts of Ireland when this survey took place. PEP is available on a case-by-case basis at the discretion of a physician following a risk assessment, and is available free of charge. PEP is only available at some STI/GUM clinics and A&E departments[1].

The survey asked if men had ever been treated with PEP, and of all men, 2.0% reported having ever been treated with PEP (n=51) [NI: 1.2%; ROI: 2.1%]. The survey did not ask where PEP was received or prescribed, so respondents may have been treated with PEP outside of Ireland.

PEP-related knowledge

Three statements assessed knowledge about post-exposure prophylaxis (PEP) by asking respondents whether or not they knew the statements were true. This table highlights men who responded 'I already know this' and were considered to have had correct pre-existing knowledge. The analysis included only respondents who answered all three questions.

Knowledge about PEP (n=2577, missing 33)	**% Overall**	**% by country**	
		NI (n=413)	**RoI** (n=2164)
Post-exposure prophylaxis (PEP) attempts to stop HIV infection taking place after a person is exposed to the virus	43.8	48.7	42.8
PEP should be started as soon as possible after exposure, preferably within hours	42.3	46.2	41.5
PEP is a one month course of anti-HIV drugs	27.1	32.0	26.2

Overall, there was a low level of knowledge for all three statements related to PEP, with less than half of respondents reporting pre-existing knowledge. There was very low knowledge that PEP consists of a one-month course of antiretroviral therapy. In Real Lives 2 (2005/2006) only a quarter (25%) of the 1,160 respondents knew about PEP[2].

Perceived access to PEP

Access to PEP was assessed by asking about confidence in being able to get PEP if needed. Respondents who had not tested positive for HIV were asked: ***'How confident are you that you could get PEP if you thought you needed it?'*** and could select: Very confident; Quite confident; A little confident; Not at all confident; I don't know.

Confidence in getting PEP (n=2441, missing 26)	**% Overall**	**% by country**	
		NI (n=400)	**RoI** (n=2041)
Very confident	16.9	21.3	16.1
Quite confident	18.4	18.8	18.3
A little confident	14.5	10.3	15.4
Not at all confident	17.3	16.0	17.6
I don't know	32.8	33.8	32.6

Perceived access to PEP was defined as being 'quite' or 'very' confident of being able to obtain PEP if needed. Overall, just over one-third (35.3%) were confident of being able to obtain PEP with those in Northern Ireland (40.0%) being more confident than respondents from the Republic of Ireland (34.4%).

Overview

The low level of knowledge about PEP and perceived access to PEP among respondents suggests that PEP is underutilised as a prevention intervention among MSM in Ireland. Gay men and other MSM who are exposed to HIV, regardless of the reason for exposure, should be informed about all potential interventions. In Man2Man Report Three, a high level of condom failure was reported with more than one in five men (21.9%) who used condoms for insertive anal intercourse reported that a condom they were using tore or slipped off during intercourse in the previous year.

Gay men and other MSM should be able to access the best available information related to sexual health, including any debate concerning the benefits, costs and effectiveness of PEP. This is also true of pre-exposure prophylaxis (PrEP), which was not examined in this study.

[1] *A list is available at http://www.man2man.ie/services.html*
[2] *page 39: http://www.gayhealthnetwork.ie/assets/files/pdfs/reports/Real_Lives_2_2009.pdf*

4. Access to STI testing

Gay men and other MSM have disproportionately high rates of infection with STIs other than HIV, including anal or genital warts, syphilis, gonorrhoea, and chlamydia. STIs (in particular syphilis and rectal STIs) are known to increase the risk of HIV transmission. Because STIs are often asymptomatic, effective detection requires regular screening, even in the absence of signs or symptoms. As discussed in Man2Man Report Three, the frequency of specific sexual practices among sexually active MSM highlights the importance of screening for throat, penile, and ano-rectal STIs.

STI testing

Survey participants were asked a series of questions about testing for STIs other than HIV. All were asked: ***'Have you ever had a test for sexually transmitted infections (STIs) other than HIV?'*** and could choose from the following responses: Yes; No; I don't know. Over half of respondents (59.2%) indicated that they had been tested for other STIs. Respondents from the Republic of Ireland (60.3%) were more likely to report being tested for other STIs than respondents from Northern Ireland (53.3%).

STI testing history (n=2545, missing 65)	**% Overall**	**% by country**	
		NI (n=407)	**RoI** (n=2138)
Never tested	40.8	46.7	39.7
Tested in previous 12 months	37.4	33.9	38.1
Tested over 1 year previously	22.2	19.4	22.8

Respondents were considered confident about their ability to get tested for STIs if they gave the answer 'Quite confident' or 'Very confident'. 90.7% were confident of their ability to get tested if needed (NI: 91.7%; ROI: 90.5%).

Overall 9.3% of respondents were less confident of their ability to get tested. This was more commonly reported by men under the age of 30 years, men who have never had an HIV test, men living in more rural areas (populations of less than 100,000), men who identified as bisexual or other non-gay identity, men reporting a low level of 'outness', and men with a lower level of education.

Quality of STI testing

Men who reported testing for STIs other than HIV in the 12 months preceding the survey were asked a series of questions to determine which diagnostic procedures were accessed, including provision of a blood and urine sample, and examination of penis and anus. The following analysis includes only those who answered all six questions.

Confidence in getting a STI test (n=2583, missing 27)	**% Overall**	**% by country**	
		NI (n=412)	**RoI** (n=2171)
Very confident	72.9	74.0	72.7
Quite confident	17.8	17.7	17.8
A little confident	5.6	4.9	5.8
Not at all confident	1.7	1.5	1.8
I don't know	1.9	1.9	1.9

Respondents were considered confident about their ability to get tested for STIs if they gave the answer 'Quite confident' or 'Very confident'. 90.7% were confident of their ability to get tested if needed (NI: 91.7%; ROI: 90.5%).

Overall 9.3% of respondents were less confident of their ability to get tested. This was more commonly reported by men under the age of 30 years, men who have never had an HIV test, men living in more rural areas (populations of less than 100,000), men who identified as bisexual or other non-gay identity, men reporting a low level of 'outness', and men with a lower level of education.

Quality of STI testing

Men who reported testing for STIs other than HIV in the 12 months preceding the survey were asked a series of questions to determine which diagnostic procedures were accessed, including provision of a blood and urine sample, and examination of penis and anus. The following analysis includes only those who answered all six questions.

Tests for STIs in the last 12 months (n=918, missing 35)	**% Overall**	**% by country**	
		NI (n=136)	**RoI** (n=782)
Blood sample provided	93.1	89.0	93.9
Urine sample provided	83.4	92.6	81.8
Penis examined	83.2	79.4	83.9
Swab inserted into penis	77.6	78.7	77.4
Anus examined	70.8	69.1	71.1
Swab inserted into anus	67.2	66.9	67.3

Testing blood for antibodies to diagnose syphilis and viral hepatitis was very common, with 93.1% reporting they had provided a blood sample as part of an STI test in the last 12 months. However,

with many clinics in Ireland integrating STI services within HIV services, it is not possible to confirm that these tests were utilised to screen for these STIs.

Physical examinations of the penis or anus as part of STI testing varied with 83.2% reporting penile inspection and 70.8% reporting anal inspection. Given the high frequency of physical examinations, certain STIs such as anal or genital warts or herpes are more likely to be diagnosed among MSM. Overall, 84.5% reported a penile or anal examination; and a total of 68.2% reported both a penile and anal examination.

Diagnostic tests to detect urethral STIs were reported by 83.4% who reported providing a urine sample, and 77.6% who provided a urethral swab. A urine test was more frequently reported than a urethral swab. Overall, 91.1% of respondents reported a diagnostic test to detect urethral STIs by providing a urine sample and/or a urethral swab.

Anal swabbing was the least frequently reported of all diagnostic approaches. Overall, it was reported by 67.2% of respondents. This relatively lower level of rectal diagnostic tests is of particular concern, as a higher level would allow for substantially higher detection of rectal gonorrhoea or chlamydia infections among MSM who access STI testing services.

Frequency of STI diagnoses

The survey asked about recently diagnosed STIs common among MSM: anal/genital warts, anal/genital herpes, gonorrhoea, chlamydia, and syphilis. Bacterial STIs such as syphilis, gonorrhoea or chlamydia can be acquired repeatedly, but anal/genital warts (associated with the human papilloma virus (HPV)) and anal/genital herpes (associated with herpes simplex viruses (HSV)) may to become chronic, with recurring symptomatic episodes.

Therefore, the survey asked for any new diagnosis of syphilis, gonorrhoea, or chlamydia during the past 12 months, and for any first diagnosis of anal/genital warts or anal/genital herpes in the past 12 months. The following includes only those who had tested in the previous 12 months and who answered all six questions.

Diagnosis for STIs in the last 12 months (n=924, missing 29)	**% Overall**	**% by country**	
		NI (n=132)	**RoI** (n=792)
Syphilis	4.7	2.3	5.1
Gonorrhoea	6.1	3.8	6.4
Chlamydia	7.7	7.6	7.7
Anal or genital warts	5.7	3.8	6.1
Anal or genital herpes	0.8	0.0	0.9

Overall, 21.3% of respondents reported newly-diagnosed STIs other than HIV in the preceding 12 months, which is similar to the annual reports from the GMHS STI Checkpoint for MSM[3]. The most common newly-diagnosed STIs were chlamydia (7.7%); followed by gonorrhoea (6.1%); anal/genital warts (5.7%); and syphilis (4.7%).

The distribution of men who reported newly-diagnosed STIs in previous 12 months was similar to that of all who tested, aged 20-39 years, living in more urban areas (populations of 500,000 or more), identified as gay, had higher level of education, and had previously had an HIV test.

Overview

With relatively low STI testing rates, there is a critical need to strengthen sexual health programmes to meet the health needs of gay men and other MSM. This includes ensuring appropriate STI screening for young men and non-gay identified men, as they might not receive the same level of screening (throat and anal swabs) if information is omitted during sexual history taking. A particular cause of concern is the lower levels of rectal diagnostic tests being reported among MSM. Increased screening requires greater accessibility to confidential, non-judgemental, stigma-free services.

[3] *http://hse.ie/eng/services/list/5/sexhealth/gmhs/research/gmhsannualreports.html*

5. Access to viral hepatitis services

Gay men and other MSM have disproportionally high rates of infection with viral hepatitis. Viral hepatitis is an infection of the liver most commonly caused by hepatitis A, hepatitis B, and hepatitis C viruses. While all three types of hepatitis can cause similar symptoms, the viruses are transmitted in different ways: hepatitis A is usually transmitted by ingesting faecal matter; hepatitis B via body fluids; and hepatitis C through contact with blood. The best way to prevent infection of both hepatitis A and B is through vaccination. The survey did not ask any questions related to hepatitis A.

Hepatitis B

Universal infant immunisation was introduced in the Republic of Ireland in 2008, although vaccination has been available free at STI/GUM clinics for a number of years, and from a family doctor (since 2012) for groups at increased risk of infection, including MSM.

All respondents were asked ***'Have you been vaccinated against hepatitis B?'***, and could select the following: No, I am naturally immune to hepatitis B (because I had it in the past); No, and I don't know if I'm immune; Yes, and I completed the course of 3 shots of vaccine; Yes, but I did not complete the course of 3 shots of vaccine; Yes, but I did not respond to the vaccinations; I don't know.

Hepatitis B Vaccine (n=2601, missing 9)	**% Overall**	**% by country**	
		NI (n=415)	**RoI** (n=2186)
No, I am naturally immune to hepatitis B (because I had it in the past)	4.2	4.3	4.1
No, and I don't know if I'm immune	28.4	28.4	28.4
Yes, and I completed the course of 3 shots of vaccine	39.3	38.3	39.5
Yes, but I did not complete the course of 3 shots of vaccine	8.0	9.9	7.7
Yes, but I did not respond to the vaccinations	2.0	0.7	2.2
I don't know	18.1	18.3	18.1

To assess hepatitis B vaccination needs among MSM, natural immunity and completion of the course of three shots were taken to indicate that there was no need of vaccination. Overall, 43.5% of respondents were not in need of vaccination. Thus, more than half (56.5%) of respondents were at risk of hepatitis B infection.

While not possible to determine those who 'don't know', it can be concluded that at least 46.9% of MSM in Ireland are in need of hepatitis B vaccination. Men at risk of hepatitis B infection were more commonly younger men (under the age of 30 years), men born in Ireland, men living outside urban areas (populations less than 500,000), men with lower level of education, men who identified as bisexual or other non-gay identity, men with low level of 'outness', and men who had never tested for HIV.

Hepatitis C

Hepatitis C is primarily spread through blood-to-blood contact rather than sexual contact, with people who inject drugs with non-sterile injecting equipment at greatest risk of infection. However, instances of sexual transmission are increasingly being reported among MSM, in particular MSM living with HIV.

All respondents were asked if they had ever been diagnosed with hepatitis C. In total, 20 respondents (0.8%) reported being diagnosed with hepatitis C, with 5 being diagnosed in the previous 12 months. Of these men, 6 had a history of injecting drug use and 7 were living with HIV. Half (10) were non-injecting, HIV negative men. These men were asked about their current hepatitis C status. In total, 9 men were infected with HCV at the time of the survey, and 5 self-reported clearance without treatment.

With a small sample size of those ever diagnosed with hepatitis C, it is difficult to make any specific conclusions, however, it is important to note that half of the men ever diagnosed with hepatitis C had no history of injecting drugs and had not tested positive for HIV. Perhaps engagement in practices (fisting, sharing sex toys, snorting drugs) that increase the risk of the spread of hepatitis C are likely to explain transmission among non-injecting MSM.

Overview

Responses about hepatitis B vaccination suggest that there are extensive unmet needs for vaccination among MSM in Ireland. Scaled up vaccination programmes for hepatitis A and B could provide an entry point for MSM to access other sexual health services. This should also be considered in the debate about provision of HPV vaccinations to gay men and other MSM. While there is a low prevalence of hepatitis C among MSM in Ireland, there is a need to continue or to increase testing for hepatitis C, especially among men living with HIV, and to ensure access to treatment for hepatitis C. Prevention programmes should also address the routes of infection for hepatitis C.

6. Barriers to sexual health

Although laws exist in Ireland to protect people from violence and discrimination due to sexual orientation and gender identity, stigma and homophobia remain widespread. The survey asked questions related to three forms of stigma: HIV-related stigma, experience of homophobic abuse, and internalised homonegativity. This section focuses on the ways they affect access to services.

HIV-related stigma

HIV-related stigma is known to be a major barrier to accessing HIV prevention, testing, treatment and care services. HIV-related stigma and discrimination experienced by men living with HIV in Ireland was discussed in Man2Man Report Two. The survey asked questions related to HIV-stigma only to men living with HIV.

Homophobic abuse

Abuse towards men who are attracted to men was assessed by asking all respondents the following three questions: ***'When was the last time you: were stared at or intimidated; had verbal insults directed at you; were punched, hit, kicked or beaten; because someone knew or presumed you are attracted to men?'***. The following table includes only those who reported experiencing homophobic abuse in the 12 months prior to the survey and who answered all three questions.

Experience of homophobic abuse in the past 12 months (n=2588, missing 22)	**% Overall**	**% by country**	
		NI (n=412)	**RoI** (n=2176)
Stared at or intimidated because someone knew or presumed you are attracted to men	41.9	47.2	40.9
Verbal insults directed at you because someone knew or presumed you are attracted to men	33.6	38.9	32.6
Punched, hit, kicked, or beaten because someone knew or presumed you are attracted to men	4.3	5.4	4.1

Over two-fifths (41.9%) reported having been stared at or intimidated in the previous 12 months. Almost half (47.2%) of respondents from Northern Ireland reported this compared to two-fifths (40.9%) from the Republic of Ireland. Approximately one-third (33.6%) of respondents had been verbally insulted in the past 12 months, again higher in Northern Ireland (38.9%) than in the Republic of Ireland (32.6%). Overall, 4.3% of men reported being physically abused because of their sexuality in the past 12 months, with 5.4% in Northern Ireland and 4.1% in the Republic of Ireland. In the Real Lives 2 report, 7.1% of the 1,160 respondents were physically attacked and 28.3% were verbally abused within the last 12 months. Its worth noting that the low likelihood of reporting these incidents to the police[4].

Overall, 47.5% reported at least one form of homophobic abuse in the past 12 months. This was more commonly reported by men living in Northern Ireland, younger men (under the age of 30 years), men who were currently students, men with lower levels of education, and gay-identified men.

Internalised homonegativity

Self-stigma or internalised homophobia (also referred to as internalised homonegativity) is the direction of negative social attitudes towards the self and is a major source of stress for many MSM. Respondents were given a series of statements and asked to respond using a five-point Likert scale from 'Strongly disagree' to 'Strongly agree'. The following table highlights those who were in agreement with each statement, and includes only those who answered all five questions.

Agreement with statements (n=2546, missing 64)	**% Overall**	**% by country**	
		NI (n=411)	**RoI** (n=411)
I feel comfortable being a homosexual man	69.9	65.9	70.6
I feel comfortable in gay bars	66.0	68.4	65.6
I feel comfortable being seen in public with an obviously gay person	63.5	62.0	63.8
I feel comfortable discussing homosexuality in a public situation	62.7	58.4	63.6
Even if I could change my sexual orientation, I wouldn't	59.1	56.5	59.6

[4] *page 33: http://www.gayhealthnetwork.ie/assets/files/pdfs/reports/Real_Lives_2_2009.pdf*

Overall, 7.7% responded negatively to all five statements. These men were more commonly living in Northern Ireland, born in Ireland, living in more rural areas (populations less than 100,000), younger men (under the age of 25 years), identified as bisexual or other non-gay identity, men who reported low level of 'outness', men not in a steady relationship with a man, and men who have never received an HIV test result. As respondents who had never had an HIV test were more likely to respond negatively to all five statements, this could suggest that this might also discourage them from testing for HIV. Similarly, those who had never tested for an STI other than HIV were more likely to respond negatively.

Overview

Homophobic abuse was a common experience among respondents, but the findings suggested an association between experiencing abuse and violence and age and education levels. This provides an important focus for targeting prevention strategies against homophobic violence and abuse.

The level of internalised homonegativity or self-stigma reported by men was similar to the findings of the Vital Statistics survey[5] in 2000 which found nearly one in 10 (12%) respondents whished they weren't gay. Overall, internalised homonegativity appears to be connected with never testing for both HIV and STIs. Those responding negatively also tended to be younger and from more rural areas, highlighting a need for specific strategies to reach these subsets of MSM.

7. Outreach to increase access

Survey respondents were asked a series of nine questions related to places they have visited in their country of residence. The following table includes only those who responded to all nine questions and highlights those who visited within the last four weeks prior to the survey.

Places visited in country of residence in the past 4 weeks (n=2438, missing 172)	**% Overall**	**% by country**	
		NI (n=364)	**RoI** (n=2044)
Website for gay and bisexual men (including dating, information and porn sites)	96.9	95.1	97.2
Gay café, bar or pub	50.0	44.9	51.0
Gay disco or nightclub	42.5	38.1	43.4
Gay community centre, organisation or social group	17.6	18.6	17.5
Cruising location where men meet for sex (street, roadside service area, park, beach, baths, lavatory)	14.0	15.9	13.6
Gay sauna	11.0	11.5	11.0
Backroom of a bar, gay sex club, public gay sex party	7.2	5.8	7.4
Gay sex party in a private home	5.1	5.6	5.1
Porn cinema	2.5	0.3	2.9

Overall, 17.6% of respondents had visited a gay community centre, organisation or social group in the preceding four weeks. Commercial gay social venues (gay café, bar, pub, disco or nightclub) were visited more frequently, with more than half (52.4%) reporting they visited in the precedingfour weeks. One-quarter (25.0%) of respondent had visited a sex venue in the previous four weeks. The most likely venues were cruising locations and gay saunas. Because the survey was conducted online, it is not surprising that almost all (97.2%) reported visiting gay websites in the preceding four weeks.

Overview

This information about the places and venues most frequently visited helps to identify opportunities to reach gay men and other MSM with targeted interventions. While the potential of the internet remains high, physical venues continue to provide further opportunities for reaching MSM with targeted promotion and outreach activities.

[5] *page 33: http://www.gayhealthnetwork.ie/assets/files/pdfs/reports/Real_Lives_2_2009.pdf*

Summary

'Our Sexual Health' is the final of four thematic reports in the 'Man2Man' series, which aggregated data generated from the 2010 European MSM Internet Survey (EMIS). This final report provided an in-depth overview of access to sexual health information and services among MSM in Ireland, as well as barriers that prevent gay men and other MSM from accessing the support and services they need.

This report is a vital call for greater consideration of the critical issues to increase access, and highlights some key strategies to improve the sexual health and well-being of gay, bisexual, and other MSM in Ireland. In particular, targeted strategies are required to increase access among MSM aged under 30 years, those with lower levels of education, men living outside larger urban areas, men who do not identify as gay or bisexual men, and those who have never tested for HIV.

Information and outreach

Gay men and other MSM must be able to access the best available information related to sexual health. The report highlights the need for targeted promotion of specific information to address uncertainties about HIV and STI transmission risks, information on how STIs can increase the risk of HIV transmission, information on the effect HIV treatment has on lowering the risk of transmission, and information on PEP and access to PEP. There is also a need to utilise specific prevention messages that focus on STIs other than HIV.

The internet is an important source of information about sexual health, while social venues and other locations frequented by MSM offer further opportunities for reaching with targeted promotion and outreach activities. For maximum impact, awareness interventions should continue to be placed both online and within print media.

HIV-related services

Innovative and targeted approaches to address the differences in levels of confidence in accessing HIV testing is required and with low levels of counselling reported, the potential for risk-reduction counselling as a prevention intervention within the context of HIV testing should be utilised.

PEP remains an underutilised prevention intervention among MSM in Ireland, with low levels of both awareness of and perceived access to PEP. Regardless of the reason for exposure, MSM exposed to HIV should be informed about all potential interventions.

STI-related services

With relatively low STI testing rates, the report highlights a critical need to strengthen sexual health programmes for MSM in Ireland to ensure appropriate STI screening for young men and non-gay identified men, as these men are unlikely to receive the same level of screening if information is omitted during sexual history taking. This requires greater accessibility to confidential, non-judgemental, stigma-free services.

This report also highlights a requirement to scale up targeted hepatitis B vaccination programmes, which can also be an important entry point for MSM to access other sexual health services. While the report indicates a low prevalence of hepatitis C among MSM in Ireland, there is a need to increase testing for hepatitis C, especially among men living with HIV and to ensure access to treatment for hepatitis C.

Overcoming barriers

The report also indicates that other factors can impact on accessing HIV and STI screening. Internalised homonegativity among MSM appears to influence not testing for both HIV and STIs. To address this, the report highlights a need for specific strategies to reach particular subsets of MSM and for initiatives to build positive self-awareness as well as to support and promote self-acceptance of, and comfort with, an individual's gay identity. In addition to this, high levels of homophobic abuse were reported among specific subsets of MSM highlighting an important focus for targeted prevention strategies against homophobic violence and abuse.

Conclusion

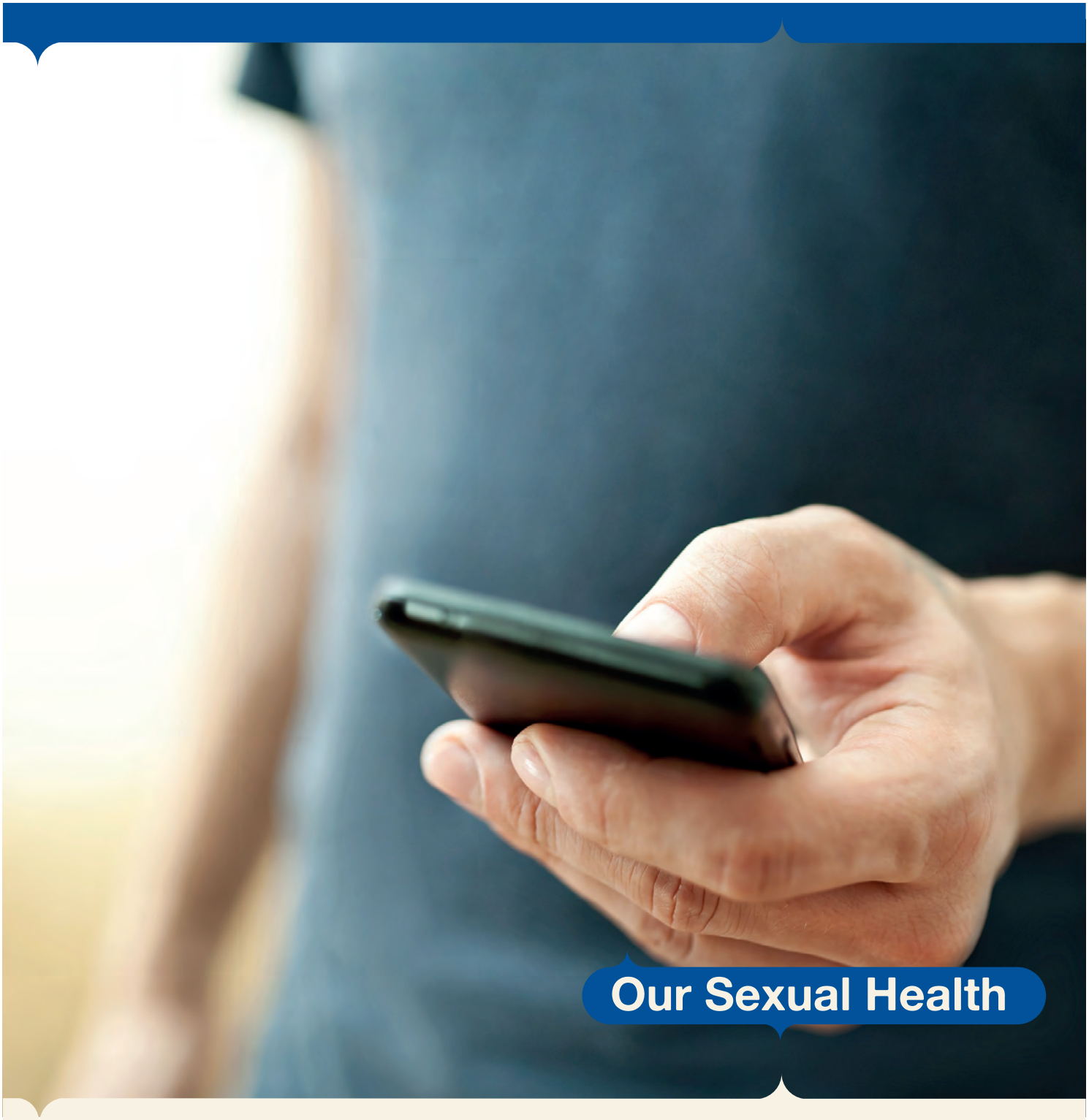
There is an urgent need to strengthen sexual health programmes to meet the specific health needs of gay men and other MSM in Ireland. This requires greater accessibility to confidential, non-judgemental, stigma-free services; and specific strategies to reach particular subsets of MSM. Addressing issues of homophobia, HIV-related stigma and self-esteem continue to be an important aspect of any programme, and requires the involvement of not only LGBT and HIV-related organisations, but other organisations and state institutions. There is a need for initiatives to build positive self-awareness as well as to support and promote self-acceptance of, and comfort with, an individual's gay identity. In addition to this, the high levels of homophobic abuse reported among specific subsets of MSM highlights an important focus for targeted prevention strategies against homophobic violence and abuse.

EMIS Partners:

EMIS was funded by a grant of the European Commission under the EU Health Programme 2008-2013.

Further funding was received from CEEISCat (Centre d'Estudis Epidemiològics sobre les ITS/HIV/SIDA de Catalunya, Spain); Department of Health for England; Maastricht University (The Netherlands); Regione del Veneto (Italy); and Robert Koch Institute (Germany).

Scientific co-ordination: Robert Koch Institute (Germany), Administrative co-ordination: GIZ -Gesellschaft für Internationale Zusammenarbeit (Germany), Technical Implemenation: Sigma Research, London School of Hygiene & Tropical Medicine (UK), Questionnaire drafting: University College, Maastricht (The Netherlands)"



Our Sexual Health

All-Ireland findings from the 2010 European MSM Internet Survey (EMIS)

Man2Man.ie

GMHS

Féidhmeannacht na Seirbhíse Sláinte
Health Service Executive

rainbow project