Promoting the Health and Rights of Gay Men Worldwide

A Handbook for All Health Professionals

CONTENT

Foreword

Having access to the highest attainable standard of health is a fundamental human right for all people. Yet, the health needs of gay men, bisexual men, and other men who have sex with men, including transgender men who have sex with men, are often neglected in sexual health programs and in healthcare services.

Many gay and bisexual men and other men who have sex with men, including transgender men who have sex with men (hereafter referred to as gay men in this publication) often encounter silence, denial, exclusion, violence, and criminalization from their families, communities, and countries. They are victims of widespread and ongoing human rights abuses that are often sanctioned and carried out by governments, communities, and families. Sixty-nine countries criminalize consensual same-sex sexual behavior between consenting adults and some countries even permit the use of the death penalty for those convicted of engaging in same-sex acts.

Gay men face additional health challenges when compared to the general population because of factors related to the social determinants of health. These determinants are social, political, economic, and healthcare-related and can amplify existing health inequities, including mental health challenges. Negative attitudes about same-sex relations can, and do, harm gay men's health. Internalized homophobia often compounds and interacts with other areas of a gay man's life where they experience discrimination. Depending on the country or context in which they live, stigma and discriminatory consequences of racism, economic inequities, and belonging to a sexual minority can interact to cause adverse health outcomes.

As such, healthcare providers and public health professionals should make a genuine effort to understand the history of oppression and discrimination faced by gay men and the disparities and challenges that occur as a result. The benefits of addressing gay men's health concerns and reducing disparities include improved mental and physical well-being of gay communities, reduced healthcare costs, reduced burdens on healthcare facilities, increased average longevity, and a healthier and happier life for gay men, their loved ones, and the communities in which they live.

Irrespective of gender identity or sexual orientation, men engaging in sex with other men can experience social exclusion, sexual otherness, marginalization, stigma, discrimination, and violence. Similarly, there can also be powerful common experiences of support, affinity, solidarity, and community. It is important to note that, for many gay men, the exclusion they experience from their families and from traditional institutions can motivate them to seek out and create separate communities centered on their gay identity. Joining self-selected and supportive communities can provide many benefits for gay men's mental health and physical well-being. Despite the many levels of challenges that gay men experience, many survive and even thrive. This has led researchers to highlight the need for studies on the resilience of gay men rather than just focusing on their problems.

There is a clear need for new approaches that can alleviate the damaging impacts of homophobia and other social determinants of health on the well-being of gay men. We need approaches that address homophobic stigma, such as school-based interventions to affirm sexual orientation, social marketing campaigns to promote acceptance of gay men by their families, and community-based interventions to promote cohesion and connectedness. All of these efforts can help combat anti-gay stigma and lead to better health for gay men.

Healthcare providers play a central role in promoting the health and well-being of all patients, including gay men. Health education and medical training around the world inadequately addresses the physical, mental, and sexual health needs – and the disproportionate HIV burden – faced by gay men. The paucity of adequate information on the health needs of gay men can be addressed by systematically including a robust baseline of information in health and medical school curricula and by developing resources to facilitate that process, including through the use of this curriculum.

MPact, in partnership with the Center for Public Health and Human Rights (CPHHR) at Johns Hopkins University, has developed this handbook as a robust technical guide to build cultural and clinical competency among healthcare providers serving gay communities. This handbook leverages the strengths of existing tools while drawing from published and emerging research and clinical guidance on the health of gay men. With a strong focus on sex positivity and an affirmation of the value of intimacy, this handbook departs from viewing gay men's health in a disease framework. In such a framework, negative health outcomes are viewed as consequences of socially unacceptable behavior. This curriculum, instead, centers on a sex-positive, harm reduction framework, focusing on health as a basic human right with sexual health as only one component of health more broadly. Organized across distinct modules, the handbook is designed to increase healthcare providers' knowledge, attitudes, and skills on a wide range of clinically relevant topics.

In close partnership with local LGBTI organizations and CPHHR, the handbook was pilot tested by MPact's Omar Banos and Angel Fabian in 2020 with more than 60 healthcare providers from Botswana, Kenya, Tanzania, and Zimbabwe.

We hope you find this handbook useful in your work.

Sincerely,
Mohan D. Sundararaj, MBBS, MPH
Director of Public Health Programs
MPact Global Action for Gay Men's Health and Rights

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Acknowledgements

Lead Authors
Mohan D. Sundararaj, MPact Global Action for Gay Men's Health and Rights
Saurav Jung Thapa, Consultant
Ryan Zahn, Emory University
Krystal Mason, Johns Hopkins University

Contributors
George Ayala, Alameda County Department of Public Health
Omar Banos, MPact Global Action for Gay Men's Health and Rights
Stefan Baral, Johns Hopkins University
Adam Bourne, La Trobe University
Angel Fabian, MPact Global Action for Gay Men's Health and Rights
Tushar Malik, Aidsfonds
Mark Pakianathan, Guy's and St Thomas' NHS Foundation Trust

Design and Layout
Andrey Tran, Bangkok

Copyediting
Saurav Jung Thapa, Consultant

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Module 1

Understanding Gay Men's Health Needs

- 1.Introduction
- 2.Key concepts and terminology
- 3.Myths and harmful stereotypes about gay men
- 4.Common sexual practices of gay men and their health implications
- 5.Normalizing anal sex between men
- 6.Understanding transgender men
  - *6.1.Transition*
  - *6.2.Transgender bodies and sexual practices*
  - *6.3.Physical transition*
  - *6.4.Sexual and reproductive health among transgender men*
- 7.Sexual concurrency and situational same-sex behavior
- 8.Relationships among gay men and legal recognition
- 9.Long-term relationships and sexual health
- 10.The importance of discussing sexual health with gay clients
- 11.Mental health issues
- 12.Sexual violence
- 13.Healthcare provider roles and responsibilities
- 14.Key points from the module
- 15.Quiz

1 Introduction

Gay men, bisexual men, and other men who have sex with men, including transgender men who have sex with men (hereafter referred to as gay men)[1] live in all societies and countries. Gay men are members of different races, ethnicities, religions, cultures, and socioeconomic classes. By eliminating health disparities and improving gay men's access to healthcare, every society will stand to benefit. Efforts to improve societal health outcomes in any country will necessarily need to include gay men.

Sexuality describes the ways in which people express their sexual desires and feelings. Understanding sexuality helps healthcare providers understand if and how important sexual expression is in a client's life, which sexual partners they choose, the sexual acts they engage in, and the level of satisfaction and pleasure they experience. Sexual behavior between same-sex partners is a normal expression of human sexuality. Like all humans, gay men express their sexuality through a range of both sexual and non-sexual ways that may involve love, intimacy, romance, dating, relationships, marriage, family, children, and participation in a community.

Homophobia is one of the main drivers of poor health outcomes among gay men around the world.[2] Many gay men avoid seeking necessary primary or sexual healthcare and lack basic HIV and STI prevention knowledge due to homophobia or due to unwelcoming healthcare settings where they experience discomfort discussing their sexuality.[3]

In nearly every country where reliable evidence is available, gay and bisexual men and other men who have sex with men have shouldered a disproportionate burden of HIV and sexually transmitted infections (STI) when compared to the general population.[4] Around the world, gay men are 26 times more likely to acquire HIV when compared to the general population.[5]

Bearing a disproportionate burden of HIV and of STIs are examples of the many health challenges faced by gay men. A large body of evidence indicates that they present with a host of other unique health needs, require targeted services to meet those needs, and face significant barriers when accessing healthcare services.[6] These barriers occur at multiple levels and result from widespread stigma and social discrimination.[7]

This module covers the following issues related to gay and bisexual men:

- Basic concepts and terminology
- Common sexual practices
- Unique health needs and challenges
- Harmful and untrue myths
- Healthcare provider roles and responsibilities
- Principles for effective clinical practice for providers

This module also provides information on same-sex sexuality to help healthcare providers understand the holistic health needs of their clients. By gaining such an understanding, providers will be better able to provide appropriate and timely healthcare services and referrals to gay men. Finally, the module discusses the need for healthcare providers to serve their gay clients in a non-judgmental, compassionate, and respectful manner in order to ensure optimal health outcomes.

2 Key concepts and terminology

A broad spectrum of homosexual and homosocial acts, identities, and communities form a continuum of sexual and gender self-expression among men in every part of the world. Men engage in sexual and/or romantic relations with other men regardless of their sexual orientation or gender identity. Men who engage in such relationships exclusively or predominantly with other men may identify as gay. Those who do so with one or more genders may identify as bisexual or pansexual. Yet others may identify as heterosexual, straight, or as something else.

Sex between men can occur in a large variety of settings and contexts, it can be motivated by a variety of reasons, it may depend on opportunity and convenience, and it can occur regardless of the sexual orientation and gender identity of the participants.

Healthcare providers should be aware of, acknowledge, and respect local terms used by men across diverse cultures and societies (e.g. gay, bisexual) through which men identify and affiliate in relation to their gender identity, sexuality, and sexual practice. It is also important to recognize the importance and distinct needs of interlinked identities and populations, including men who are: transgender, living with HIV, sex workers, use drugs, and/or are young.

Researchers have attempted to measure the prevalence of sex between men in the general population for a long time. A study in the U.S. indicated that while at least 3.8% of Americans surveyed explicitly identified as lesbian, gay, bisexual, or transgender, more than twice as many (8.2%) self-reported that they had engaged in same-sex sexual acts at some point in their lives.[8] This variation signals the presence of both overt and covert sexual identities in men, and suggests that such behaviors may be sustained, temporary, or circumstantial.

A meta-analysis on lifetime prevalence of sex between men found similar estimated results based on a range of studies in Asia, Eastern Europe, and Latin America, while other studies have confirmed the widespread occurrence of sex between men in Africa.[9] These data provide compelling evidence about the frequent occurrence of same-sex sexual relations between men around the world, including in countries that vehemently deny the existence of gay men, and which may criminalize such activity.

Additionally, it is likely that the number of men admitting to having sex with other men may be considerably underestimated. Many men are unlikely to admit to engaging in sexual acts with other men to researchers, epidemiologists, or government officials out of fear of stigma or discrimination, including self-stigma. This is especially true in countries where same-sex sexual acts are stigmatized, socially taboo, or criminalized. As of mid 2021, 69 countries criminalized same-sex sexual acts, sometimes with harsh prison sentences, and up to nine countries may provide for the death penalty. This explains why many gay men choose to remain closeted in the healthcare system, making it challenging to identify and meet their unique health needs.

It is important to distinguish between sexual behavior or acts, sexual orientation, and sexual identity as distinct concepts in healthcare settings. When talking to clients who may be gay, bisexual, or transgender men, providers should be familiar with the following terminology and apply them accurately in the clinical context:

- Sex typically refers to the designation of a person as either male or female on the basis of their biological characteristics - including their chromosomes, genitals, hormones and neurobiology. Sex is typically determined at the time of a person's birth ('assigned sex'). Whilst sex is often thought of as being restricted to either male or female, some people may in fact not be exclusively male or female, or may have a combination of

both male and female characteristics. These people are typically described as being intersex, and research estimates indicate that approximately 2% of the population may have some sort of intersex variation.

- Gender refers to the way in which a person understands, identifies, or expresses their masculine or feminine characteristics within a particular sociocultural context. A person's gender is not always exclusively male or female and may or may not correspond to their sex. Furthermore, gender identity and expression may not always be fixed, and can be fluid and change over the course of a person's lifetime.

While sex and gender are separate and distinct concepts, many people do not understand the differences between the two. As a result, both terms are sometimes used interchangeably and inaccurately in medical, legal and community settings.

- **Transgender** ('trans') is an umbrella term for people whose gender identity and expression do not conform to norms and expectations traditionally associated with their sex assigned at birth. Transgender people may, or may not, choose to alter their bodies hormonally and/or surgically.
- **Transgender men, transmasculine people, or transmen**, are all terms used to refer to people who were assigned female at birth and have a male gender identity and/or masculine gender expression. Some of these people may also refer to themselves as **FTM (female to male)** or **AFAB (assigned female at birth)**.
- **Transgender women, transfeminine people, or transwomen**, are all terms used to refer to people who were assigned male at birth and have a female gender identity and/or feminine gender expression. Some of these people may also refer to themselves as **MTF (male to female)** or **AMAB (assigned male at birth)**.
- **Transition** refers to the process that an individual goes through to align their external presentation with their own sense of self. This may include telling other people about their identity **(coming out)**, changing the way they dress, changing their name or the details recorded in documentation **(legal transition)**, or taking hormones or undergoing surgeries **(physical/medical transition)**.
- **Cisgender** is a term used to refer to people who are not transgender.
- **Same-sex sexual behavior (or homosexuality)**: Sexual acts between people of the same sex or gender.
- **Sexual orientation**: An enduring pattern of emotional, romantic, and/or sexual attraction to men, women, and/or other genders. Sexual orientation often ranges along a continuum[10] and often may not be absolute.
- **Sexual identity:** The label people use to describe themselves in relationship to their sexuality. While many men who engage in sex with other men identify as gay or bisexual, some relate to other culturally unique identities or identify as straight or heterosexual.[11]
- **Gender**: A social construct reinforced by attitudes, feelings, behaviors, and clothing or appearance that is associated with a person's sex assigned at birth. While usually aligned, gender and sex are not the same thing.
- **Gender identity**: An individual's sense of their gender, which may or may not align with their sex.
- **Gender expression**: The manner in which an individual communicates gender within a culture through appearance, clothing, speech, hobbies, or other means. An individual's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect their gender identity.[12]

3 Myths and harmful stereotypes about gay men

Myths and stereotypes about gay men are widespread, often unfounded, and can be harmful. Many of these myths marginalize gay men and prevent their full participation in and contributions to society. Healthcare providers should familiarize themselves with common myths and stereotypes about gay men and examine their own attitudes and misperceptions in light of scientific evidence and facts.

1. **Myth**: "Sex between men does not exist in my country or community."
   Fact: Sex between men occurs and has occurred in all cultures, societies, and places. Ignoring or criminalizing same-sex sexual acts does not mean the people who engage in them do not exist.[13]
2. **Myth:** "Being gay is a choice and gay men can be turned straight."
   Fact: Scientists agree that sexual orientation is not a choice, but rather the result of a complex interaction of biological and environmental factors.[14] Same-sex attraction is a normal expression of human sexuality and any attempts to change or "cure" someone's sexual orientation through so-called "conversion therapy" is likely to both fail and to cause harm. This purported therapy is not a valid mental health treatment. Rather, it is a harmful, unethical, and discredited practice that exploits internalized homophobia and shame in those who are subjected to it.[15] So-called "conversion therapy" can result in mental illness, homelessness, and suicide, and it is especially harmful to adolescents and young adults. Victims are eight times more likely than the average person to attempt suicide and six times likelier to report high levels of depression.[16] So-called "conversion therapies" have been denounced by the World Health Organization (WHO) and other scientific bodies.[17] Several jurisdictions across the world have banned this harmful practice. In cases where gay men express the desire to change sexual orientation, the most effective and appropriate therapeutic response that results in maximum mental health benefit is affirmative therapy that helps them develop skills to cope with coming out and accept their sexual orientation.[18] Providers should give support, acceptance, and validation of same-sex sexual orientation to help gay clients.
3. **Myth:** "Homosexuality is a mental disorder."
   Fact: Homosexuality is normal and it is not a mental disorder. The American Psychiatric Association removed homosexuality as an illness from the second edition of its Diagnostic and Statistical Manual (DSM) in 1973. In 2013, the American Psychiatric Association (APA) declared that it "...does not believe that same-sex orientation should or needs to be changed... nor, from a mental health perspective does sexual orientation need to be changed."[19]
4. **Myth:** "There are no transgender people, or trans men where I work/in my country."
   Fact: Trans men exist in all cultures, societies, and geographic locations, and there are historical references to transgender people all over the world stretching far back into human history. Criminalization laws, poor data collection, and other factors may render trans men invisible, but it does not mean that they do not exist.
5. **Myth:** "All transgender people are mentally ill."
   Fact: Some - but not all - trans people experience gender dysphoria, which is a state of emotional distress caused by the mismatch between the sex assigned to them at birth and their gender identity. This is a temporary, treatable condition. And while it is true that many transgender people experience other mental illnesses during their life, research has shown that this largely arises from the distress experienced from being gender variant in societies that stigmatize and discriminate against people for not adhering to rigid gender norms.
6. **Myth:** "You can tell a person is transgender just by looking them."
   Fact: Transgender people come in all shapes and sizes and it is a myth to think that they can be 'spotted.' Transgender people have bodies just like cisgender people, and may present their gender in very traditional ways.
7. **Myth:** "Transmen do not have sex with cisgender men."
   Fact: Transgender people broadly, and transgender men more specifically, have a range of sexual orientations and identities, just as cisgender people do. Some transmen identify as gay or bisexual, while other transmen who may not identify as gay or bisexual may also engage in sex with cisgender men.

4 Common sexual practices of gay men and their health implications

Gay men engage in a wide range of sexual practices. These include, but are not limited to, kissing, masturbation, oral sex, anal sex, rimming, fingering, fisting, threesomes, group sex, watersports, role playing, and the use of sex toys. All these sexual practices are valid, pleasurable and normal. Some are more common than others. For instance, a study found that 99% of gay men have oral sex, more than two-thirds have engaged in group sex, two-thirds have used insertive sex toys, and 15% have engaged in fisting.[20]

The sexual act perhaps most commonly associated with gay men in the popular imagination is penetrative anal sex. This is defined as a sexual act that involves the insertion of the penis (or clitoris in the case of transgender men) into the anus. When a person engages in penetrative anal sex with another person, they can take one of two roles: that of the insertive partner (top), or that of the receptive partner (bottom). Some people may exclusively prefer only one of these roles. Others may engage to varying degrees in both roles (versatile). Penetrative anal sex can be a highly pleasurable activity for both partners.

Condomless penetrative anal sex may carry additional health implications depending on the sexual partner. There are important anatomical and physiological considerations needed to understand sexual health in the context of penetrative anal sex. The structure and biology of the anus and rectum can render penetrative anal sex a high-risk event for HIV and STI transmission. Bodily fluids can be transmitted easily during anal sex for the following reasons:[21]

- There is no natural lubrication in the anus (unlike in the vagina). Without lubrication, the anus and rectum may be susceptible to damage more easily.
- The anus has limited elasticity.
- The colon and rectum have only a single layer of epithelial cells which reduce protection against viruses if there is extensive breakdown.
- Fecal matter containing bacteria may be present.
- There are many inflammatory cells (with CD4 receptors) under the surface in the rectum. Since HIV targets these cells, this makes HIV transmission easier.

The table below provides additional information on the health implications of sexual practices among gay men. This information can help providers conduct non-judgmental sexual history-taking and fully understand what treatment options are available to them.

Sexual Acts	Health Implications
Kissing	Kissing is the mutual touching of lips and tongues and it likely involves the exchange of saliva. It is a universal and safe sexual practice.
Penetrative anal or vaginal (front hole) sex	Inserting one's penis (or clitoris) into the partner's anus or front hole (vagina). Penetrative intercourse is a common sexual practice among gay men. There is no HIV transmission risk associated with condomless anal sex among serodiscordant partners if the HIV-negative partner is on pre-exposure prophylaxis (PrEP) or if the HIV-positive partner is on antiretroviral therapy (ART) and has an undetectable viral load. There is also little or no transmission risk when condoms are used correctly and consistently along with a condom-compatible lubricant.

Sexual rubbing	Rubbing bodies or body parts together using similar movements as penetrative sex but without actual penetration. It is a universal and safe sexual practice.
Mutual Masturbation	Mutual masturbation is a universal and safe sexual practice.
Fellatio or Oral Sex	Inserting one's penis or clitoris into a partner's mouth. This is a very common sexual activity. It is a universal and relatively safe sexual practice, although some STIs can be transmitted through oral sex.
Rimming	Stimulating the anus with the tongue. This is a common sexual practice among gay men. However, parasites and some STIs such as hepatitis A can be transmitted even by invisible fecal matter entering the performing partner's mouth.
Fingering	Stimulating the anus or vagina (front hole) by rubbing or penetrating using one's finger. This is a safe sexual practice.
Fisting	Stimulating the anus by penetrating it with a fist for increased pleasure. This is a safe sexual practice if done properly.
Sex toys	Using toys to stimulate the penis, anus, vagina (front hole), or other body parts and erogenous zones. Many men enjoy using toys for sexual stimulation. Using sanitized sex toys by oneself poses no risk for STI or HIV transmission.
Group sex	Group sex is sex with more than one partner in the same session. The individual acts involved pose the same risk for HIV and other STIs as they do one-on-one sex acts. Thus, the number of people involved alone does not, by itself, increase the risk of STI transmission.
Watersport	Sexual acts that involve urine. There is no risk of HIV transmission through urine.
BDSM	Bondage and discipline, dominance and submission, sadism and masochism (BDSM) include elements of sexual role-playing, fantasy, dominance, and power exchange. These activities are generally safe sexual practices.

Table 1.1
Health implications of sexual practices among gay men

5 Normalizing anal sex between men

In many societies, only penile-vaginal sexual intercourse is perceived as normal or acceptable. Other kinds of sexual activity, including anal sex between men, or simply any kind of sex between men, is regarded as deviant and abnormal. Sex between men, in all the forms described in the prior section, is normal. It can also be pleasurable and healthy when undertaken with necessary precautions.

Anal sex is a common sexual practice in both gay couples and heterosexual couples across different age groups, countries, and sexual orientations. Studies have reported more that about 20 percent of heterosexual people in the Americas, Sub-Saharan Africa, and elsewhere engage in anal intercourse.[22] In fact, there is evidence that the absolute number of heterosexual women who engage in condomless anal intercourse is greater than the number of gay men engaging in this practice.[23]

Given the widespread prevalance of anal sex, healthcare providers should ask all clients about their sexual practices when taking a sexual history. They should not assume that only gay men engage in anal intercourse, or that all gay men do so.

6 Understanding transgender men

Transgender men, transmasculine identified people, or transmen, are all terms used to refer to people who were assigned female at birth and have a male gender identity and/or masculine gender expression. Such individuals may use a variety of other words to describe themselves, including FTM (female to male); AFAB (assigned female at birth); a man of transgender experience; or simply just male. In addition, there are a number of other culturally unique identities, such as the brotherboys of Aboriginal Australia.

Transgender men exist in all countries and cultures. Estimates in studies of the prevalence of transgender people in the general population have ranged from a lower bound of 1 in 2,000 (or about 0.05% of the population) up to 1.2% of the population.[24] [25] However these figures are likely to underestimate the true prevalence as they are based on counting those who disclose their transgender status or can be identified within health systems due to their access to medical treatment. There are many reasons why transgender people do not either disclose their gender identity or access medical treatment.

Transmen who have sex with men refers to all transgender men/masculine identified people who engage in sexual and/or romantic relations with other cisgender men. Trans men who have sex with men is an inclusive term focused on behaviors and experience, rather than identity. This means that trans men who have sex with men can include:

- Gay and bisexual identifying transmen;
- Other transmen who have sex with men but do not identify as gay or bisexual, including transmen who engage in sex work, heterosexually-identified transmen who may engage in situational sex with other men (e.g in prisons, boarding schools, military barracks), and transmen in relationships with women.

Despite these differences, trans men can have many similar experiences as gay men, both in terms of experiencing social exclusion, stigma, discrimination, and/or violence, and in terms of health needs and in interactions with the healthcare system and healthcare professionals.

Trans men should not, however, be conflated or confused with trans women - people who were assigned male at birth and have a female gender identity. Although both trans men and trans women may share common experiences relating to social exclusion, stigma and discrimination, there are significant differences between their personal identities, physical bodies, health needs, and HIV and STI risk.

- *Transition*

For many trans men it is critically important to their sense of self, and their mental and emotional wellbeing, to take steps to remove the disparity between their male gender identity and their female sex assignment at birth. This process is commonly referred to as transition, and can involve social, physical, and legal changes.

Social transition generally refers to the actions that a trans man may take to change the way that they identify and express their gender outwardly - to family, friends, colleagues, and/or other community members. Social transition can include actions such as:

- Adopting a masculine gender presentation in grooming, dress, or other behaviors;
- Telling other people about their gender identity;
- Using or asking other people to use a different (masculine) name for them;
- Using or asking other people to use male pronouns when referring to them.

For many trans men, social transition is a critical step in their life, and for some, it may be the only transition they will undergo. It is however important to recognize that some trans men do not take these public steps due to the real or perceived risk of experiencing discrimination, rejection, harassment, and/or violence.

Physical transition, sometimes referred to as medical transition, describes the actions a trans man may take to masculinize their physical body. Physical transition broadly can consist of hormone treatment, surgery, and/or exercise or diet regimes designed to create changes in the body.

Legal transition refers to the process of changing one's name and/or sex as recorded on legal documents such as birth certificate, passport, drivers license, and other identity documents. Not all countries around the world allow for changes to legal documentation, and the process for changing documentation can differ between jurisdictions. Nevertheless, having documentation that accurately reflects a person's lived identity can be vital to affirming a person's sense of self, protecting their privacy, and reducing their risk of experiencing discrimination, harassment, or violence.

- *Transgender bodies and sexual practices*

There is no such thing as a 'typical' trans man's body. Trans men present with a wide diversity of anatomical configurations and bodies, depending on their genetics and the specific physical transition steps they may or may not have taken. The bodies of trans men may vary in these ways:

- Breast tissue may be absent or present. If the latter, they may vary in size depending on when hormones were started, the level of a person's development during puberty, whether a person has been binding their chest, and whether surgery has been undertaken. The type of surgery undertaken (reduction v. removal) and a person's healing process can influence the overall shape and aesthetic of a trans man's chest.

- Depending on a person's genetics, and their use of and/or response to hormone replacement, secondary sexual characteristics such as voice pitch, facial and body hair, overall fat distribution, and muscular development can vary widely.

- A trans man may, or may not, retain their uterus and/or ovaries depending on whether they have undergone the relevant surgery. When these organs are retained, their functionality (including menstruation and possibility of pregnancy) can vary.

- External genitalia can vary widely. A transman may retain 'typical' looking and functioning female external genitalia, they may have a clitoris that is enlarged to varying degrees (through hormones and/or surgery), they may have a surgically constructed penis, they may retain their vagina, they may have testicular implants, and urination may be via the penis or via a urethra which remains in situ.

Trans men may engage in a wide spectrum of sexual activities and may use their bodies in many different ways:

- Some trans men experience significant discomfort with the existence of their breasts and/or with the composition of their external genitalia and, as a result, they may not engage in any physical or sexual contact with others. Such individuals may remain entirely celibate, may only engage in very specific sexual activities and practices, may choose to focus only on their sexual partner, and/or may never remove some or all of their own clothes during sexual acts.

- Other trans men will have varying degrees of comfort with their physical body and may have a range of preferences related to sex, for example:

    - They may engage in anal and/or vaginal sex as the receptive partner;
    - They may give and receive oral sex;
    - They may engage in anal sex as the insertive partner, using fingers, hands, sex toys, prosthesis, and/or their surgically reconstructed penis.

Some trans men also engage in sex and have romantic relationships with cisgender or transgender women, while others may exclusively engage in sex with men. Trans men's relationships may be monogamous, non-monogamous, or polyamorous. Contrary to some assumptions, trans men can also engage in sex work with both cisgender men and women.

Trans men may use a wide variety of words to describe their bodies and their sexual practices. For example:

- Even when breasts are still present, and especially when they are not, trans men may speak about their chest or pecs.

- There may be a wide variety of terms used to refer to genitals - cock, penis, dick, and other phallus-related words may be used to refer to the clitoris. 'Front hole,' 'bonus hole,' and/or other colloquial terms may be used to refer to the vagina. Words such as 'junk' or 'equipment' may be used to refer to the genitals overall. Trans men may also refer to their sex toys and/or prosthetics as their penis, cock, or dick.

- Sexual activity may also be described in a variety of ways - receptive vaginal sex may be described as bonus or front hole sex and terms commonly associated with fellatio may be used to describe cunnilingus.

This high degree of diversity amongst trans men's bodies, sexual practices, and associated language brings with it varying needs and risks. As such, it would be unwise for healthcare providers to make unsupported assumptions.

- *Physical Transition*

  It is important to note at the very outset that not all trans men will physically transition their bodies and that not all physical transitions are the same. There is no 'right' or 'wrong' way for a person to transition, and a person not choosing to physically transition their bodies is no less a man than someone who does so. Nevertheless, for those who do wish to physically transition, being able to change their bodies can be an essential step to resolving the incongruence they experience between their gender identity and the sex they were assigned at birth.

  To this end, the following information is designed to provide a high-level overview of the hormonal and surgical approaches typically involved in physical transition. Health professionals are encouraged to consult the resources listed at the end of this section for more information.

- *Hormones*

  One common component of physical transition can be the taking of hormones, usually testosterone. The goal of hormone therapy is to achieve testosterone levels equivalent to the usual hormone range for cisgender males, thereby bringing about the development of a range of secondary sex characteristics usually associated with males. Typical changes as a result of testosterone treatment will vary from individual to individual and are described in the table below.

Average timeline	Effects
1-3 months	Increased sex drive Vaginal dryness Clitoral growth (typically 1-3 centimeters) Oilier skin with possible acne Increased growth, coarseness, and thickness of body hair Increased muscle mass and upper body strength Redistribution of fat to a more masculine pattern (usually more at the waist and less around the hips)
1-6 months	Menstruation ceases
3-6 months	Voice begins to crack/drop (can take up to a year to finish changing)
1 year +	Gradual growth of facial hair (usually take 1-4 years to reach full growth) Possible male-pattern baldness

Table 1.2
Typical effects from testosterone therapy over time

Testosterone can be administered in a variety of ways, including:

ROA	Examples	Benefits	Side effects/Risks
Oral	Andriol	Less fluctuation in testosterone levels	May cause liver damage if used for a long time Masculinization changes take longer to occur
Injection	Sustanon, Primoteston, Reandron	Masculinization changes take place more rapidly More affordable option	Greater fluctuations in testosterone levels Risks of injection complications
Transdermal application	Patches (such as Androderm), creams, gels (such as Androgel)	Less fluctuation in testosterone levels	Masculinization changes take longer to happen Much more expensive than injectable options

Table 1.3: Overview of types of testosterone treatments

Once testosterone treatment is commenced, it is usually continued for life in order to maintain the level of masculinization achieved and to continue to support emotional stability and psychological wellbeing. For transgender men under the age of 18, and in particular for those who have not yet reached puberty, it is typical to give puberty blockers rather than testosterone. Medications such as Leuprolide, Lupron Depot, Suprellin or Histrelin prevent puberty from occurring, thus avoiding the distress of developing secondary female sex characteristics.

It is important to note that not all trans men will access testosterone under the care of a healthcare provider. This can be for a variety of reasons, including cost, real or feared stigma and discrimination, and/or unavailability or lack of access to care. Some trans men successfully self-administer testosterone, but this carries a number of risks such as:

- Legal problems if accessing hormones through the black market;
- Adverse effects on liver and kidney function, red blood cell count, or insulin levels that may go undetected;
- Hormone levels that are too high (leading to possible complications) or too low (leading to inadequate masculinization);
- Complications or infections arising from poor intramuscular injecting techniques and/or sharing of injecting equipment.

Some trans men may also seek to alter their hormones through 'natural' means such as:

- Eating a diet centered on foods thought to boost testosterone production;
- Undertaking exercise, primarily weightlifting, to boost the body's natural testosterone production and to sculpt the body into a more masculine shape.

- *Surgery*

Some trans men choose to undertake surgical interventions to modify their body so that it aligns with their gender identity. There is no single sex-change surgery, but rather a variety of surgeries (outlined in Table 1.4 below) that people may choose to undergo alone or as a combination. In some instances, trans men may choose only surgical interventions and forgo hormonal treatment.

Medical Terms	Description	Common Ussage Terms
Reduction mammoplasty	Removal of some breast tissue in order to make the breasts smaller.	Top surgery; chest surgery
Bilateral mastectomy (techniques including double incision and periareolar incision)	Removal of breast tissue, excess skin, and (if needed) surgical alterations to the nipple and areola in order to form a male chest.	
Hysterectomy	Removal of the uterus. This may be done via large incision or keyhole surgery. Often accompanied by an oophorectomy.	
Oophorectomy	Removal of the fallopian tubes and ovaries. This may be done via large incision or keyhole surgery. Often accompanied by a hysterectomy.	
Metoidioplasty	Refers to a range of techniques to make the hormonally enlarged clitoris larger, so that it approximates a very small penis. May include cutting of the suspensory ligament (clitoral release) and grafting of additional tissue. Sometimes accompanied by scrotoplasty, vaginectomy, and/or urethroplasty.	Lower surgery; bottom surgery
Phalloplasty	Creation of a penis using tissue grafted elsewhere from the body (including the abdomen, torso, and forearm). Usually accompanied by scrotoplasty and vaginectomy, may also include urethroplasty.	
Urethroplasty	Lengthening the urethra (usually using tissue grafted from inside the mouth) in order for it to exist through a newly created penis.	
Scrotoplasty	Creation of a scrotum, usually by using existing skin from the labia. Silicone implants are typically added.	
Colpectomy, vaginectomy	Removal of the vagina.	
Liposuction	Removal of fat - often from the hips, thighs, or buttocks - in order to create a more typically male body shape.	
Implants	Inserting material such as silicone into the calf, jaw, chest, and other parts of the body in order to make these appear more muscular.	

Table 1.4: Overview of surgeries for the physical transition process

◆ *Sexual and reproductive health among transgender men*

Although there is limited research data on transgender men who have sex with men and HIV prevalence, the existing studies make for alarming reading. Gay and bisexual trans men report substantially more high-risk sexual behaviors than any other demographic group:

- One small study found that over 40% of this sample reported having condomless vaginal sex with cisgender men of unknown HIV status within the past year (Reisner, 2010)
- Another larger study of transgender men found that over half reported having condomless vaginal sex with a cisgender male partner, and over a quarter reported having condomless receptive anal sex with a cisgender male partner (Clements-Nolle, 2001)
- Yet another study found that 64% of transgender male participants had engaged in receptive vaginal intercourse without a condom and 59% had experiences of forced sex or rape (Clements et al., 1999).

Negotiating safer sex can be especially challenging for many trans men, in particular due to the vulnerability often associated with disclosing one's transgender status, and the resulting power differential that may exist with sexual partners. Many trans men may have limited experience or knowledge regarding safer sex practices when first becoming sexually active with other men, and a lack of engagement with healthcare providers can exacerbate this problem. Trans men can also be victims of sexual assault and rape perpetrated by intimate partners, sex work clients, and strangers. In fact, many trans men can be at specific risk for this type of violence precisely because they are trans men. In some parts of the world, "corrective rape" is seen as an appropriate response to "fix" a person who is transgender.

Additionally, trans men have a range of unique gynaecological health considerations. Some research has suggested that testosterone therapy increases the risks of endometrial hyperplasia and subsequent endometrial carcinoma, as well as potentially increases the risk of ovarian cancer for transmen who do not undergo hysterectomy or oophorectomy. Trans men who retain their uterus, ovaries, and/or cervix continue to be at least at the same risk profile as females for gynaecological cancer and require ongoing surveillance. This can present challenges with many trans men being reluctant to, or experiencing distress, about the required check-ups.

For trans men who retain their uterus and ovaries, are not on testosterone treatment, and who have receptive vaginal sex without condoms, pregnancy - both intentional or unintentional - is also a possibility. Pregnancy can create unique challenges for trans men, particularly in relation to being able to access appropriate and welcoming services.

Sexual concurrency and situational same-sex behavior

Sexual concurrency refers to having more than one sexual partner over the same period of time. Sexual concurrency is widely reported among gay men and heterosexual men.[26] [27]

A study exploring sexual concurrency in Malawi, Namibia, and Botswana found that nearly 54 percent of men who have sex with men had male and female sexual partners in the previous six months. Approximately 34 percent of these men were married to women. Many of the gay men reported being married to female partners because of heteronormative societal expectations and family pressure.[28]

Sexual concurrency by itself does not pose health risks but can pose health risks based on the nature of each sexual practice.[29] [30] Healthcare providers should carefully assess the health implications of such concurrent partnerships by engaging their gay clients in an open, sex-positive, and non-judgmental discussion.

Many men who generally do not have sex with other men may do so when they live or work in certain environments such as military barracks, boarding schools, mines, prisons, and other places where men may be congregated in close quarters for extended periods of time. Although sexual encounters between men in these places may be situational and opportunistic, they highlight the need for health information and access to safer sex supplies such as condoms and lubricants to be made easily accessible in such locations.[31] [32]

8 Relationships among gay men and legal recognition

Emotional and romantic relationships between men can take different forms and can evolve over time. Some gay men choose a long-term monogamous relationship with a primary partner whereas others may be in open relationships with one or more primary partners and have additional sexual partners. Some may choose to not have a primary partner and others may choose to abstain from sex altogether.

When providers discuss sexual and romantic relationships with gay clients, they should keep these tips in mind:

- Maintain an open and non-judgmental attitude;
- Do not assume that the client is either monogamous or in an open relationship;
- Do not assume that the client is emotionally involved with any or all of their sexual partners;
- Ask clients how they describe their partners and use their terminology;[33]
- The term “partner” is usually an acceptable way to start a conversation about sexual or romantic partners.

Gay men in long-term relationships are now able to get married or enter other legally recognized partnerships in dozens of countries in six continents. Since the Netherlands became the first country to introduce marriage equality in 2001, 28 other countries have followed suit as of 2021.[34] Some other countries afford lesser recognition - such as civil unions or domestic partnerships - to gay men in long-term relationships. Same-sex couples living in countries with marriage equality have reported better health outcomes.[35] They may also enjoy tax, financial, social, and legal benefits. Legal recognition can improve health outcomes of same-sex couples by, among other things, removing legal jeopardy when seeking care.

Nevertheless, a majority of countries around the world do not provide any legal recognition to gay couples in committed long-term relationships. In fact, more countries – at least 69 in 2021 - criminalize consensual same-sex sexual relationships between gay men[36] than afford legal recognition to gay couples. Some countries may even punish same-sex relationships harshly with the death penalty.[37] Laws that criminalize same-sex sexual relationships contribute to stigma, discrimination, and poorer health outcomes, including disproportionate rates of HIV transmission, among gay men by dissuading them from seeking treatment. Such harmful laws also dissuade providers from offering appropriate care and treatment to their gay clients.[38]

9 Long-term relationships and sexual health

As with some heterosexual relationships, some gay couples may not be monogamous or the HIV status of one or more partners may not be known. HIV and STI infections have been recorded in individuals in stable long-term relationships, suggesting the need for a mediatory role for healthcare providers to encourage their clients to talk about their sexual practices openly and honestly with their partners. In some cases, couples may need to enter into negotiations to come to an agreement about what is acceptable with regards to sex outside the relationship. In addition to mediating and encouraging more open communication, providers should address relationships and sexual health of their clients in a respectful, compassionate, and non-judgmental manner.

Providers should encourage gay clients to get regularly tested for HIV and STIs. If positive, clients should be referred to specialists and linked to care and treatment. It is crucial not to stigmatize a client or their partner who is living with HIV or has a STI.

Some long-term relationships between men are monogamous relationships with known and concordant HIV status, limiting the need for condoms or for PrEP. Condom use in established same-sex couples is generally low.

Clients in long-term relationships may also benefit from referrals to couples counseling, community support groups, and sexual health education events. Couples-based counseling and testing approaches for male couples may be an effective strategy to promote open conversations about sexual health needs and practices. It can help facilitate negotiations without coercion. Some key issues that could come up during couples counseling and negotiations over sexual needs and practices are: [39] [40] [41]

1. Disclosure of HIV status to a partner or partners;
2. Decision to get tested together for HIV and/or STIs;
3. Disclosure of a STI infection to a partner or partners;
4. Desire for and openness to relationships outside of a primary partnership;
5. Discussion of the nature of open relationships and understanding associated health risks;
6. Prioritizing the health goals of all partners.

10 The importance of discussing sexual health with gay clients

It is essential that healthcare providers proactively discuss sexual health with their gay clients as they often have poorer physical and mental health outcomes and are disproportionately impacted by high rates of HIV and STI transmission. HIV, for instance, was first identified among gay men in the early 1980's. The initially high number of gay men diagnosed with HIV shaped early attitudes and societal responses to the epidemic, generating stigma as gay men were associated with the virus.[42] The stigma persists to this day despite the fact that the majority of new HIV infections today are transmitted during sex between heterosexual people.

Gay men are more likely to be living with HIV when compared to other adults in the general population. Evidence suggests that this is true in populations across the income spectrum and in a variety of countries.[43] [44] [45] For instance, in the U.S., gay men account for the vast majority of new HIV transmissions each year and comprise the majority of people already living with HIV.[46]

Many biological, social, structural, and behavioral factors put gay men at increased risk of

HIV. Some of the other reasons why they account for a disproportionate share of people living with HIV, or acquiring HIV each year, include:[47]

- Large and overlapping social and sexual networks;
- High probability of transmission per act, especially during condomless receptive anal intercourse;
- High levels of undiagnosed or untreated STI infections;
- Poor adherence to ART medications, especially in low-income settings.

Gay men are also vulnerable to, and disproportionately affected by, STIs such as syphilis, gonorrhea, chlamydia, hepatitis, herpes, and human papillomavirus (HPV).[48] When infectious, many STIs can increase the risk of HIV infection. STIs like syphilis and herpes that cause ulcers or lesions on the genitals or rectum can allow HIV to enter the bloodstream more easily. Gay men who concurrently have HIV and gonorrhea - and are not on treatment - often have higher concentrations of HIV in their semen. This makes it more likely that they will transmit HIV through a sexual act.[49]

Social discrimination and persistent homophobia partly account for the higher rates of HIV and STI transmission among gay men. Gay men may delay or avoid seeking healthcare and HIV-related information, and services as a result of perceived homophobia in the healthcare system and in society.[50] They are also less likely to disclose information regarding their health or sexuality in healthcare settings if they are afraid of harassment, judgment, or rejection.[51] Providers should make gay patients feel welcome, safe, and affirmed when receiving care so that HIV and STIs can be diagnosed and treated in a timely manner.

Gay men disproportionately face sexual health challenges because of behavioral factors and because of factors related to the social determinants of health. These determinants are social, political, economic, and healthcare-related and can amplify existing health inequities, including mental health problems. Negative attitudes about same-sex relations can harm gay men's health. One meta-analysis study describes how stigma, prejudice, and discrimination against gay men creates hostile and stressful social environments which can cause mental health challenges. Such challenges are caused through these processes: [52]

1. Gay men concretely experience discrimination because of their sexual orientation;
2. The stress of expecting such events to occur in the future creates anxiety;
3. As a result, gay men may seek to conceal their sexual orientation and may constantly fear discovery and the resulting discrimination;
4. The constant negative social messages and condemnation of gay people may cause them to hate themselves, i.e. cause internalized homophobia.

Internalized homophobia often compounds and interacts with other areas of a gay man's life where they experience discrimination. Depending on the country or context in which they live, stigma and the discriminatory consequences of racism, economic inequities, and belonging to a sexual minority can interact to cause adverse health outcomes. Despite the many challenges that gay men experience, many survive and even thrive. This has led researchers to highlight the need for studies on the resilience of gay men rather than just focusing on problems.[53] [54]

There is a clear need for new approaches to address the sexual health of gay men. These approaches should emphasize the damaging effects of homophobia and other social determinants of health on the well-being of gay men. There are emerging community-based approaches to HIV prevention that address homophobic stigma such as affirming school-based interventions, social marketing campaigns to promote acceptance of gay men by their families, and interventions to promote community connectedness. All of these efforts can combat anti-gay stigma and lead to better health outcomes for gay men.[55]

11 Mental health issues

Being gay or bisexual is normal and is not a mental health illness or a pathology. Gay men do not have a predisposition to mental health illnesses solely on account of their sexual orientation or behaviors. However, they can experience higher than average levels of mental health challenges as a result of external factors such as rejection, isolation, marginalization, hate-motivated violence, and bullying simply because of who they are or whom they love.[56 57 58 59] These challenges include increased risk for anxiety, depression, suicide ideation, and HIV and STI transmission, the common basis of which is homophobia.[60 61]

Gay and bisexual men experience sustained mental stress as a result of encountering stigma and discrimination in their daily lives. The minority stress theory posits that they are thus likely to experience higher incidences of negative mental health outcomes.[62] Minority stress is experienced by gay men through rejection and isolation, the expectation of rejection or isolation, or internalized homophobia.[63]

Like any other person, some gay and bisexual men may attempt to cope with minority stress by using drugs and alcohol.[64] Gay men belonging to racial and ethnic minorities or to lower socioeconomic strata may face additional challenges and additional mental stress. Providers should be sensitive to these facts when meeting with their gay clients, especially clients who belong to several overlapping minority and marginalized groups.

While gender dysphoria/gender identity disorder are both classified as mental health issues, it does not mean that being a transgender man is in itself a mental illness. Rather, both classifications speak to the profound emotional and psychological distress that individuals can experience as a result of the incongruence between their own identity and their physical bodies, and/or between their own identity and social and legal recognition. As discussed in greater detail in a later module of this curriculum, the role of the healthcare professional is not to "cure" a person of being transgender, but to help them navigate and resolve the resulting distress, if any exists.

However, existing research has consistently shown that transgender people experience significantly higher rates of mental illness than people in the general population, including an increased risk of depression, anxiety, and self-harm or suicidality. Some studies have found that one in two transgender people have attempted suicide. Once again, stigma and discrimination have been identified as the underlying drivers for these poorer mental health outcomes that endanger the lives and well-being of transgender people. Personal rejection and ostracism, experiences of discrimination, criminalization, the denial of legal rights, and disenfranchisement by societal institutions can all have serious and long-lasting psychological consequences, both due to the high levels of constant stress they create, and due to the reduction in support and services that individuals usually rely on during period of stress. Some transgender people may also internalize these negative views and experiences, resulting in poor self-esteem or self-hatred that can further compromise their mental (and physical) health. Trans men can often be doubly affected, due to experiencing stigma and discrimination on account of both their gender identity and their sexual orientation.

12 Sexual violence

Men can be victims of sexual assault and rape despite prevailing cultural stigma and myths that try to hide this fact. The perpetrators of sexual assault and/or rape of men can be other men, women, family members, friends, acquaintances, intimate partners, fellow prisoners, or strangers.

Gay and bisexual men are at higher risk of sexual violence and their risk levels are similar to that of heterosexual women. Some studies estimate that between 14–20% of gay and bisexual adult men experience sexual assault.[65] While gay men are more likely to be victims of sexual assault, men of all sexual orientations, including heterosexual men, can be victims.[66]

Being a victim of sexual assault and rape can have damaging consequences such as post-traumatic stress disorder, psychological distress, sexual dysfunction, heightened sexual risk behavior, self-harming behaviors, and heavy alcohol or drug use. Lifelong negative effects can lead to a downward spiral of self-harm and self-medication.[67]

Healthcare providers should note that seeking support after a sexual assault is fraught for men due to societal gender norms, homophobia, and/or a dismissive reception by law enforcement officials. Gay men are likelier to seek informal support from friends who are accepting of their sexual orientation, rather than formal support services.[68]

Some gay men may not recognize that they are experiencing sexual violence when it is committed by their male partner because of societal norms that portray only women as victims of violence from male partners. Providers should adopt sexual violence prevention messaging to increase understanding among gay men of sexual violence in intimate relationships.[69] They should also be prepared and willing to provide support and referrals to gay victims of sexual assault and rape.

13 Healthcare provider roles and responsibilities

According to the WHO, a primary objective of healthcare systems is to provide high quality health services to *all* people when and where they need them. Primary care is often the first point of contact with the healthcare system for many gay men.[70] Homophobic stigma and discrimination in the healthcare setting can make it particularly difficult for gay men to access vital care and support. As such, healthcare providers have an ethical responsibility to provide equitable care for gay men regardless of their personal, moral, or religious preferences or biases.

Providers who object to providing care to gay men because of their own anti-gay prejudice can harm their client's health, which contradicts their professional obligation to provide care without discrimination.[71] Like the majority of people, gay men rely on their providers to understand their needs and deliver appropriate care in a sensitive, responsive, and non-judgmental manner.

A healthcare provider who delivers non-judgmental and supportive care can play an outsize role in improving the health outcomes of their gay clients. Affirmation from providers may help gay men overcome the harms caused by stigma and discrimination in other parts of their life, such as at home, at school, or at the workplace. Gay men must trust their provider in order to divulge sensitive information, and a provider with an affirming attitude can help their clients' open up and thus improve their health outcomes. By overcoming personal prejudices to deliver quality healthcare, providers can successfully address barriers to care-seeking and encourage care-seeking behavior among gay clients.

14 Key points from the module

- Gay, bisexual, transgender, and other men who have sex with men live in all societies and countries. They hail from all races, ethnicities, religions, and socioeconomic classes.
- Men can have sex with each other regardless of their sexual orientation or gender identity.
- Myths and harmful stereotypes about gay men fuel stigma and discrimination which leads to poorer physical and mental health outcomes.
- Being gay or bisexual is normal and is not a mental illness or pathology.
- Gay men experience higher than average levels of mental health challenges due to discrimination, stigma, rejection, violence, and bullying fueled by homophobia.
- Sexual identity, attraction, behavior, gender, gender identity, and gender expression are fluid concepts that do not always align and may evolve or change over time.
- Gay men may engage in a wide range of sexual practices such as kissing, anal sex, rimming, masturbation, oral sex, group sex, threesomes, and so on.
- Not all gay men have sex exclusively with men. Some also have sex with cisgender women and transgender people.
- Many men who generally do not have sex with other men may do so when they live or work in certain environments where predominantly other men are present.
- Like heterosexual people, many gay men have sexually concurrent partnerships with more than one individual.
- Gay men are much more likely to acquire, or to be living with, HIV and STIs compared to other adult men in nearly every country where data is available.
- Providers should encourage gay clients to get regularly tested for HIV and STIs. If positive, clients should be immediately linked to specialized care and treatment.
- Gay men are at higher risk of sexual assault and rape than other men and victims have a harder time seeking support due to societal norms and homophobia.
- Providers should be prepared and willing to provide necessary care and referrals to male victims of sexual violence.
- Providers should serve their gay clients in a non-judgmental, compassionate, and respectful manner in order to ensure optimal health outcomes. Providers must not let their anti-gay prejudices interfere with their professional obligation to provide care.
- Taking the sexual history of all clients in a non-judgmental manner will help providers identify health problems and provide optimal care for gay clients.
- The benefits of addressing gay men's health concerns and reducing disparities include reductions in disease transmission, improved mental and physical well-being of gay clients, reduced healthcare costs, and reduced burdens on healthcare facilities.

13 Quiz

1. All men who have sex with men are gay.
1.1 True *1.2 False*

2. _____ refers to the label that people use to describe themselves in terms of whom they are romantically or sexually attracted towards.

3. Which of these is not true concerning gay, bisexual, transgender, and other men who have sex with men?
3.1 Gay men exist in all cultures, societies, and geographic locations.
3.2 Same-sex attraction is likely the result of the complex interaction of biological factors and environmental factors.
3.3 HIV targets gay men because of their sexual orientation.
3.4 Not all gay men have anal sex.

4. Conversion therapy is a scientifically proven method to effectively and safely change the sexual orientation of gay men.
4.1 True *4.2 False*

5. Which of these factors put gay men at higher risk of HIV transmission than other men?
5.1. Stigma and discrimination
5.2. Criminalization of same-sex sexual acts
5.3. Lack of adequate natural lubrication and limited elasticity of the anus
5.4. Insensitive or prejudiced healthcare providers
5.5. All of the above

6. Healthcare providers have no obligation to serve gay clients if it conflicts with their personal beliefs
6.1 True *6.2 False*

7. Which of these outcomes are associated with the provision of high-quality and non-judgmental healthcare services to gay men
7.1 Improved physical and mental well-being *7.4 Reduced HIV and STI transmission*
7.2.Reduced healthcare costs *7.5 All of the above*
7.3.Increased longevity

8. Transgender men who have sex with men face disproportionately higher rates of mental health issues due to transphobia, stigma, and discrimination.
8.1 True *8.2 False*

9. Which of these STIs produces painless sores, flu-like symptoms, and damage to major body systems if left untreated? Select all answers that are correct.
9.1 Chlamydia *9.4.Herpes*
9.2. Human papillomavirus (HPV) *9.5.Hepatitis B*
9.3. Syphilis

10. Healthcare providers can determine the sexual orientation of their gay clients based solely on their appearance and speech.
10.1 True *10.2 False*

11. All transgender men ultimately seek to transition physically, legally, and socially to be their true selves
11.1 True *11.2 False*

12. Men cannot be the victims of rape or sexual assault.
12.1 True *12.2 False*

[1]In the interest of rhetorical economy, men who have sex with men, regardless of their sexual or gender identity, may be referred to as "gay men" or as "gay and bisexual men" throughout this curriculum. Unless otherwise specified, "gay men" refers to all men who have sex with men, including transgender men who have sex with men.

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2

Module 2

Barriers to health

1 Introduction

Gay, bisexual, and other men who have sex with men, including transgender men who have sex with men (hereby referred to as gay men) often experience discrimination from their families, from educational institutions, while obtaining housing, at their places of work, and when accessing healthcare. In many countries they are persecuted by governments that use laws and policies which criminalize consensual same-sex relations. The rise of conservative and populist movements and leaders from India to Brazil to Poland has further put the rights and health of many minorities, including gay men, in peril. These challenges have been compounded by declining global HIV funding, which often supports human rights and health programs benefiting gay men, and by the COVID-19 pandemic which has affected the health and economic well-being of many gay men and their families.

Healthcare providers should take the initiative to equip themselves with information and resources about the social and legal contexts in which gay men navigate their healthcare needs. Doing so will allow them to create a safe and welcoming clinical environment for their gay clients. This module will increase provider understanding of a range of barriers faced by gay men in accessing healthcare and explain how the lack of appropriate or adequate healthcare can adversely impact gay men's health outcomes.

2 Facilitators, barriers, and critical enablers for healthcare access

There are many ways to understand social discrimination against gay men. In this module, we will refer to a Conceptual Framework (see figure below) developed by MPact.[1] The framework demonstrates the strong relationships between structural-level, community and interpersonal-level, and individual-level factors that influence how gay men access healthcare services, including sexual health and HIV services. We will first discuss higher-level structural barriers and facilitators to accessing healthcare services before moving to community and interpersonal-level factors, and finally to the factors at the individual-level.

- *Structural-level factors*

The structural factors that affect access to healthcare may include social, economic, organizational, political, and legal components. Structural factors can enhance or limit access to, and utilization of, healthcare services. They can also create or exacerbate social inequities[2]. Higher-order structural factors play a significant role in determining access to healthcare by gay men.[3,4] These are outlined in the table below.

Figure 2.1 Conceptual Framework of Facilitators, Barriers, and Critical Enablers for Service Access Among men who have sex with men

	Structural	Community/Interpersonal	Individual	
Facilitators	*Safe spaces* *Comprehensive, tailored health & mental health*	*Stable relationships* *Family support* *Community engagement*	*Financial resources* *Sustainable work* *Education*	Sexual Health
Barriers	*Criminalization* *Sexual prejudice* *Discrimination* *Cultural norms* *Poverty* *Insensitive/uninformed*	*Extortion* *Blackmail* *Ridicule* *Eviction* *Job termination* *Violence*	*Fear* *Poor self-worth* *Depression* *Suicide* *Anxiety* *Substance abuse* *Delay/avoidance of services* *Treatment interuption*	Sensitive Access
Critical enablers	*Political will* *Laws, policies and practices*	*Mobilization* *Organization capacity* *Provider sensitization* *Education & training* *Social connectivity*	*Linkage to care and comprehensive services*	

Homophobia	A significant barrier that prevents gay men from accessing healthcare in many settings.[5] It can make healthcare services inappropriate or inaccessible. It can also impede or undermine the healthcare response to sexual health needs and for HIV in gay men, potentially putting their lives at risk.
Social norms	Cultural norms around the world generally align with heteronormative attitudes and this can serve to amplify the effects of homophobia in social and healthcare settings. For instance, the pressure felt by gay men to acquiesce to traditional social norms may lead them to hide the sexual behaviors that they enjoy in order to maintain their social standing.[6] This can have a negative impact on mental and physical health as it limits the ability of gay men to seek and receive appropriate healthcare. Transgender men face additional levels of social stigma and discrimination (described later in this module).
Provider stigma and insensitivity	Healthcare providers who are unfamiliar with the key health issues of concern to gay men may demonstrate stigma and insensitivity with gay clients.[7] Other providers may be homophobic or transphobic and may deliberately stigmatize gay clients (or treat them poorly). Many gay men may not use the healthcare system to avoid poor treatment, harming their health.
Poverty	Poverty is a major barrier to accessing healthcare services for many gay men. Those who are poor may not have the financial and logistical resources and/or social connections to access the services they need. Gay men often feel the need to hide their sexual orientation from employers, landlords, teachers, and family members in order to preserve their livelihoods or for their security.[8] Being openly gay or being outed can lead to being fired and/or kicked out of home, putting gay men in financial jeopardy and at risk of poverty which can harm their access to healthcare.
Criminalization	Criminalizing same-sex behavior and gender non-conformity harms the health of gay men and transgender people, including by fueling the HIV epidemic. Criminalization laws dissuade gay men from seeking healthcare services and prevent providers from dispensing care.[9] Criminalization increases social discrimination and stigma. Additionally, it promotes a climate of impunity in which gay men may be subjected to blackmail, extortion, and violence with no accountability or consequences for the perpetrators. Those who fear discussing their sexual behaviors with providers because of criminalization may be unable to access essential healthcare including sexual health, mental health, and HIV services.

Table 2.1 Structural Barriers

Despite the existence of the structural barriers discussed above, there are other factors that may moderate them and promote the health and well-being of gay men. A few such facilitators are described in the following table.

Safe space	Spaces where gay men can meet and safely engage with peers. The availability of such spaces can promote gay men's sense of well-being and increase their knowledge of and access to healthcare.
Mental health services	Access to appropriate mental health services may help gay men deal with fear, self-loathing, and other mental health issues.
Comprehensive healthcare service	Healthcare services that comprehensively address the needs of gay men, including sexual health, physical health, and mental health, can greatly enhance the overall health outcomes of this population.

Table 2.2 Structural Facilitators

- *Community and interpersonal-level factors*

Gay men often face widespread social exclusion from families, friends, cultural institutions, legal institutions and processes (such as civil marriage), and religious institutions. Some of these institutions actively seek to harm or ostracize gay men. As such, many gay men feel inhibited in their ability or willingness to disclose their sexual orientation or their engagement in same-sex sexual behaviors. This reluctance can be a barrier to accessing and receiving appropriate and timely healthcare.

In a study published by MPact, gay men identified a variety of community and interpersonal barriers to healthcare. These included experiences of:[10]

- *Ridicule*
- *Violence*
- *Extortion*
- *Blackmail*
- *Eviction*
- *Job termination*

These barriers shape the ways in which gay men approach and interact with the healthcare system and the decisions they make about their health and sexual choices. Additionally, the damage caused by these barriers may prevent the formation of – or harm – intimate relationships, cause low self-esteem, cause anxiety, and lead to depression.

In the MPact study referenced above, several mitigating factors were identified that may be used to overcome the interpersonal and community-level barriers. These mitigating factors generally involve creating a supportive social network that can help gay men navigate their lives:[11]

- Community engagement
- Family support
- Stable intimate relationships

Individual-level factors

Individual-level factors can compound the harm caused by the higher-level structural and community and interpersonal-level factors that were discussed earlier. Higher-level factors limit access to education, employment, and a sustainable income. They force gay men to live in environments where they encounter constant stigma and discrimination. Individual-level factors in turn may lead gay men to live in a state of fear and experience negative mental health outcomes. Some barriers at the individual level include:

- Fear of being recognized as gay
- Fear of being involuntarily outed
- Low self-esteem
- Anxiety
- Depression
- Suicidality

Individual-level facilitators that can help overcome the barriers to health discussed above include access to financial resources, access to higher education, and sustainable employment. Higher education can prepare gay men to work in well-paying jobs and have more employment options. Fulfilling and sustainable employment, which may be contingent on educational achievement or formal certification, can then provide gay men with a sense of worth and the ability to advocate for themselves.[12] This can help them overcome the various barriers that limit their access to healthcare and harm their health.

3 Stigma, discrimination, homophobia, and transphobia

Stigma and discrimination underlie many of the barriers to healthcare faced by gay men. They are the underlying causes of many health disparities between gay men and other men. Stigma and discrimination against gay men has been well documented in a wide variety of countries and contexts.

Stigma

Stigma is an attitude that is deeply discrediting and which reduces the object of stigma from a whole individual to a tainted, discounted one[13]. It is an attribute that unfairly and baselessly shames an individual or a group of people. People may express stigma openly/externally or keep it unsaid/internal (see Table 3.3 below). At the individual level, there are three primary manifestations of stigma[14]:

- Enacted stigma: The external expression of stigma through actions, including a wide variety of actions such as those shown in Table 3.3 under "Signs of External Stigma." These experiences are common among gay men across societies and countries. In one study of men in the U.S., gay men reported the highest levels of enacted stigma. 25% of gay men reported experiencing hate-motivated violence because of their sexual orientation, 28% reported anti-gay property crimes, 21% reported having had an object thrown at them, and 63% percent reported being subjected to verbal abuse[15]. Enacted stigma also occurs in healthcare settings, such as when gay men are denied healthcare or are seated in a separate waiting area.

- Felt stigma: This describes the internal expectation among gay men that they will experience stigma because of knowledge that they are stigmatized and because of prior experiences of overt stigma. Felt stigma can affect the lives of those towards which stigma is directed even if stigma is not always openly demonstrated[16]. It often leads gay men to modify their behavior by attempting to "act straight" or hiding their sexual behaviors in order to avoid enacted stigma. This can significantly affect the lives of gay men by forcing them to act unnaturally and by creating stress.

- Internalized stigma: This involves accepting stigma as part of one's own value system. Internalized stigma encompasses the negative feelings that one has about oneself because of being gay or because of same-sex sexual attraction. Gay men's self-esteem may suffer due to internalized stigma and internalized homophobia. They may consequently experience shame, anxiety, depression, suicidality, or other negative health outcomes.[17] [18]

Table 2.3
Signs of Stigma [19]

Signs of External Stigma	Signs of Internal Stigma
• Avoidance of gay men • Rejection of gay men • Negative moral judgment • Stigma by association • Gossip • Unwillingness to invest in gay men's health, well-being, or advancement • Discrimination • Human rights abuses • Hate-motivated violence • Housing discrimination • Employment discrimination	• Avoiding services or opportunities for gay men • Low self-esteem • Social withdrawal and avoidance • Overcompensation or overachievement • Remaining closeted • Not seeking necessary or appropriate healthcare • Experiencing mental health issues such as anxiety, depression, and/or suicidality

Discrimination

One harmful manifestation of stigma is discrimination. Though stigma does not always lead to discrimination, negative attitudes associated with stigma can cause discrimination.

Discrimination can be defined as behaviors or actions towards others that lead to inequality, inequity, or unfairness. It is based on the belonging, or perceived belonging, of an individual to a particular group.[20]

Gay men are the victims of discrimination on a daily basis across the world in a wide variety of contexts. Discrimination marginalizes and harms gay men and puts them at elevated risk for a wide variety of negative health outcomes.

Homophobia and transphobia

Homophobia is the irrational hatred, fear, and intolerance of gay men or of same-sex behavior. Transphobia is similar to homophobia and targets transgender people, including transgender men. Homophobia and transphobia are often the result of ignorance and prejudice. Homophobia and transphobia fuel myths, harmful stereotypes, stigma, and discrimination that can lead to violence against gay men.[21] Gay men who are gender non-conforming are more likely than other gay men to experience homophobia and transphobia.

Homophobia is a significant barrier to providing effective healthcare services, including sexual health, mental health, and HIV services to gay men. As it is, gay men are disproportionately affected by mental health problems and they are more likely to be living with HIV/more likely to acquire HIV in every part of the world.[22] In many parts of the world, gay men find it hard to access HIV prevention and treatment services and fewer than half of gay men in developing countries have knowledge about HIV. [23] [24]

4 Unique barriers for transgender men who have sex with men

Transgender men who have sex with men experience a number of unique barriers to good health - both at the individual, interpersonal, and structural levels. Stigma and discrimination are often the underlying drivers, with the effects of stigma - negative, stereotypical views that devalue a person - felt in many different ways. Pervasive stigma can result in:

- Community stigma leading to rejection from family, social isolation, homelessness, discrimination and violence;
- Institutional stigma reflected in laws that criminalize trans men, education and economic disenfranchisement, and a lack of knowledge and/or willingness to provides healthcare and other services, and;
- Self-stigma whereby trans men internalize the stigma they experience, resulting in feelings of shame, fear or self-loathing. This can further negatively impact their physical and mental health, and their willingness to access healthcare and participate in their communities.

Where stigma exists, direct and indirect discrimination follows, and research has clearly demonstrated that these can be social determinants of poorer physical and mental health outcomes for the individual. This can arise as a result of the direct impact of violence or sexual assault, greater risk taking (including the risks associated with survival sex work), drug use, self-harm and suicide; the detrimental health impacts of poor education, unemployment, poverty and homelessness; the denial of access to health and welfare services and support, and/or the reluctance to access such services in the first place for fear of experiencing stigma and discrimination.

These problems are very often exacerbated by a lack of social support, relationship loss and/or instability, and family rejection arising from the negative impacts of stigma at the community/interpersonal level, thus leaving a trans person socially isolated and vulnerable. These experiences of negative reactions from others can in turn lead to trans men being reluctant to disclose to, trust, or engage with healthcare professionals, potentially further jeopardizing their heath and/or leading to delayed diagnosis and treatment.

Stigma can also lead to a number of systemic, structural barriers to good health for trans men who have sex with men. For example, the marginalization of trans men and their experiences can manifest in a lack of investment in trans men-focused medical and other research, and the lack of training for healthcare providers on the needs of trans men.

Even when healthcare professionals do not hold stigmatizing or discriminatory views, they may still have low levels of knowledge about trans men and their healthcare needs, either through a lack of training, or the absence of relevant research. As a consequence, many trans men can find themselves educating the very people from whom they are seeking healthcare. This can result in frustration and the feeling that there is nothing to be gained from accessing professional healthcare, causing some trans men people to disengage from services or not seek assistance when needed. At other times, this lack of knowledge among healthcare professionals can have more direct and dangerous effects on trans men, for instance, if inaccurate information and advice or inappropriate healthcare is provided.

Negative experiences with healthcare providers can contribute to high levels of mistrust and suspicion among many trans men. The negative interactions may arise due to stigma, discrimination, poor levels of knowledge among providers, or the experience of healthcare professionals as ‘gatekeepers’ who have power to help or hinder transgender people from accessing the medical services they require (especially to physically transition). This

can contribute to high levels of mistrust and suspicion for many trans men. This mistrust can create barriers for many trans men to access and engage with healthcare providers.

Affordability is another key concern for many trans men, with healthcare in general, and trans-specific medical care in particular. Healthcare services are often financially out of reach for many trans men. Trans men may be excluded from approved target populations, especially in sexual health and HIV prevention programs, in many countries that are rely on foreign donors to support these services. Even in high-income countries, the lack of coverage for trans-specific healthcare by most insurance policies and public health systems (where they exist) may make healthcare access challenging or non-existent. Furthermore, in many places, gender-affirming surgical procedures are not widely available, often because there are few surgeons that have appropriate training and due to the prohibitive costs.

5 Stigma, discrimination, and racism within gay communities

Stigma within the gay community can be based on a variety of factors such as:

1. Race or ethnicity - Belonging to a minority racial or ethnic group[25 26 27]
2. Immigration status or accent - Hailing from another country
3. Geography - Hailing from a rural area or a poorer region
4. HIV status - Being HIV positive
5. Religion - Belonging to a minority religion
6. Socioeconomic status - Having fewer resources or living in poverty
7. Sex work - Engaging in survival sex or voluntary sex work
8. Promiscuity - Being perceived as having multiple sexual partners
9. Gender Expression - Expressing gender in non-stereotypical ways [28]

Gay men are not a monolith and hail from every conceivable social, economic, racial, ethnic, and religious background. As a group, gay men face stigma, prejudice, and discrimination in societies the world over. However, gay men who have other intersecting minority identities can face additional stigma and discrimination. They can experience this not just from broader society, but also from within the majority (racial, economic, or religious) gay community. For instance, people of color in the U.S. and in the West have reported high levels of racism from white gay men in the form of sexual exclusion, negative sexual attitudes, and fetishization. Racism within gay communities can often masquerade as a "personal preference."[29]

6 HIV-related stigma and discrimination

An HIV diagnosis can lead to significant stigma and discrimination regardless of sexual orientation or behavior. Among gay men living with HIV, the stigma of their sexual orientation or behaviors combined with the stigma of their HIV positive status can create severe mental distress. HIV positive gay men who belong to a racial, religious, or other minority group can face yet more stigma.

In a study in Vietnam, nearly all participants living with HIV experienced some form of stigma and discrimination.[30] Another study, also in Vietnam, showed high amounts of stigmatizing beliefs towards HIV positive people, even among adolescents.[31] Additionally, stigmatizing attitudes toward people living with HIV can be prevalent among healthcare providers. [32 33] In a study among healthcare providers and people living with HIV in Grenada and in Trinidad and Tobago, providers demonstrated both passive neglect of HIV patients and also active refusal to provide care.[34] These behaviors were particularly evident when a client was perceived to be gay or bisexual. The causes of HIV stigma can include:

- Lack of knowledge or ignorance about HIV
- Exaggerated fears of HIV transmission
- Misperceptions about HIV transmission routes
- Negative media representations of people living with HIV
- Association of HIV transmission with illegal or immoral behavior

The stigma and discrimination associated with HIV may be experienced in a variety of ways such as the loss of family and community support, the loss or denial of housing, and the loss of employment and income.[37] The layers of stigma associated both with being gay and of living with HIV can make it difficult for HIV positive gay men to access timely and appropriate treatment and care services. This can reduce their quality of life.[38]

The figure below shows the links between the causes of HIV-related stigma and the effects it may have on the lives of gay men living with HIV.

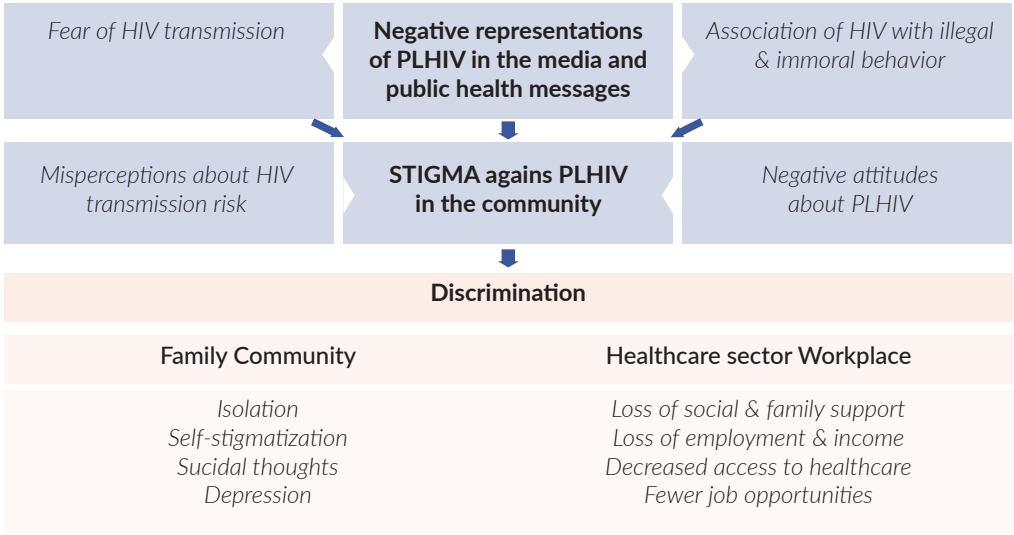

Figure 2.3 Diagram of stigma and discrimination against People Living with HIV (PLHIV) in Ho Chi Minh City, Vietnam: Causes, Effects, Relationships [39 40]

Link between discrimination and gay men's health outcomes

Social discrimination, including state-sanctioned discrimination, harms the health of gay men in many ways.

- *Criminalization and impact on sexual health and HIV services*

Many countries have laws and policies that harm gay men or interfere with their ability to access healthcare. These laws and policies can range from outright criminalization of same-sex sexual relations to the arrest of healthcare providers serving gay clients. It can also include laws and policies that deny gay men the equal right to marry, work, receive an education, or express affection. At the end of 2020, 69 countries criminalized same-sex acts between consenting adults and up to nine countries allowed for the death penalty for same-sex acts.[41]

Discriminatory laws and policies lead to gay men being rendered invisible, and thus underserved, in international development, human rights, healthcare, and health surveillance programs. Even when discriminatory and harmful laws are not necessarily enforced, their presence may create a chilling social and legal environment for gay men. Such laws can also be used to justify harassment, abuse, torture, and violence.

A study in Senegal on the arrests of gay men showed that the negative publicity surrounding the arrests increased public scrutiny of, and stigma towards, gay men. The increased scrutiny heightened fear and forced gay men to live in the closet or in hiding. This in turn led to a decrease in the uptake and provision of healthcare and HIV services, thus harming gay men's health.[42] Situations such as these are not unique to Senegal.

Criminalization of same-sex acts can undermine prevention, care, and treatment services for gay men who are disproportionately affected by the HIV epidemic.[43] In general, countries that criminalize same-sex behavior have a higher prevalence of HIV as compared to those that do not. The HIV rates among gay men is much higher in African and Caribbean countries that criminalize same-sex behavior compared to neighboring countries that do not criminalize.[44]

The aforementioned study in Senegal showed that laws against same-sex behavior limited the ability of healthcare providers to provide HIV-related services including education, supplying condoms and lubricants, and providing treatment of STIs for gay men. Countries that criminalize same-sex behavior devote fewer resources to HIV services for gay men, fail to monitor or track HIV in this population, and even divert donor funds intended for gay men.[45]

In Guyana, for instance, HIV programs for gay men are often limited to small-scale behavioral interventions since criminalization makes it difficult for government health agencies to address HIV in this population.[46] Even in instances where non-governmental organizations do attempt to provide HIV services for gay men, they risk being hounded by governments. In Uganda and Nigeria, healthcare workers face the threat of punishment if they do not report people who disclose same-sex behavior to the authorities.[47] [48]

While decriminalization of same-sex sexual acts is a necessary step in promoting an enabling environment in which gay men can access appropriate healthcare, including mental health services, it is not sufficient in and of itself. Even in countries where same-sex acts are legal or protected, stigma and discrimination continue to harm the health of gay men.

- *Impact of homophobia and transphobia on sexual health*

Studies have shown that gay men who experience high levels of homophobic or transphobic stigma and discrimination have lower self-esteem and engage in higher-risk sexual behaviors. Such behaviors can potentially result in greater rates of mental health issues, sexual health

problems, and transmission for HIV and STIs. For instance, in China, higher levels of self-stigma and poorer mental health were associated with higher rates of unprotected anal intercourse among gay men.[49]

Studies from around the world have also shown that violence by intimate partners against gay men, and by clients against male sex workers, is associated with higher rates of unprotected anal intercourse and higher HIV and STI rates among gay men.[50] Many gay men may be afraid or unwilling to report violence and abuse by partners and clients because of homophobia or transphobia among law enforcement officials and social disapproval.

- *Mental health challenges*

Being gay or bisexual or transgender, or being a man who has sex with other men, is perfectly normal and is not a mental health illness or a pathology. However, gay men can experience higher than average levels of mental health challenges as a result of external factors such as rejection, isolation, marginalization, hate-motivated violence, and bullying simply because of who they are or whom they love.[51 52 53]

The mental health challenges gay men encounter because of stigma and discrimination include increased risk for anxiety, depression, suicide ideation, and transmission of HIV and other STIs.[54 55] Gay men experience sustained stress as a result of encountering stigma and discrimination in their daily lives. The minority stress theory posits that they are thus likely to experience higher incidences of negative mental health outcomes.[56]

Minority stress is experienced by gay men through rejection and isolation, the expectation of rejection or isolation, or internalized homophobia. These experiences cause high blood pressure, elevated anxiety, and make it more likely that gay men may undertake higher risk sexual practices. Many gay men attempt to cope with minority stress by using drugs and alcohol and they are more likely to contemplate or attempt suicide.[57 58]

- *Homophobia and transphobia in the healthcare system*

Appropriate and safe healthcare services for gay men are usually not easily available or accessible. This forces many gay men to seek healthcare in settings where providers may not be appropriately trained or sensitized to serve gay clients.

Homophobia and transphobia in healthcare settings can have a harmful effect on the health outcomes of gay men. In many countries, anti-gay laws, anti-transgender laws, and societal homophobia and transphobia serve to replicate stigma and discrimination in healthcare settings. Due to this, gay men are often systematically excluded from healthcare services in many countries. As a result, their well-being and overall health outcomes can be harmed. For instance, a study in Uganda found that gay men subjected to homophobic abuse were five times more likely to be living with HIV compared to other gay men.[60]

Many providers may lack specialized knowledge on the unique healthcare needs of gay men and may express disapproval and prejudice, whether intentionally or unintentionally. A study in Jamaica and the Bahamas found that most healthcare providers had not received training on the health needs of gay men and many expressed negative judgments about gay men.[61] Additionally, misinformed and misguided policies in healthcare systems can result in poorer quality services and poorer health outcomes for gay men.

In healthcare settings where gay men are worried about facing stigma, evidence shows that they are less likely to provide a complete or accurate sexual history. They are also less likely to openly discuss their sexuality.[62] They may also avoid the health system altogether.

8 Roles and responsibilities of healthcare providers

Healthcare providers play a central role in reducing stigma and discrimination against gay men seeking medical care. Given the disproportionate health burdens that gay men already shoulder, providers have a responsibility to serve gay clients without stigma or discrimination. Providers should do everything in their power to reduce stress, anxiety, and trauma for gay clients - who may already be experiencing these negative emotions in their interactions with their families, neighbors, friends, work colleagues, and others. They can do so by proactively educating themselves about the social and legal realities in which gay men live and learning the barriers to healthcare that gay men face.

Providers should foster a welcoming atmosphere for gay clients in healthcare settings. As providers are often widely respected outside medical settings, their actions can do much to encourage communities and families to also treat gay men respectfully and fairly, thus reducing the harmful effects of societal stigma, discrimination, homophobia, and transphobia.

9 Key points from the module

- Gay men's engagement with healthcare systems are shaped by various barriers and facilitators ranging from higher-order structural factors, mid-level community and interpersonal factors, to lower-level individual factors.
- This combination of barriers at multiple levels can prevent gay men from accessing essential healthcare services in a timely manner. As a result, gay men's ability to achieve optimal health outcomes can be compromised.
- Stigma, discrimination, homophobia, and transphobia underlie many of the barriers that gay men face when engaging with healthcare systems.
- Different kinds of stigma – enacted, felt, and internalized – result in gay men not being open with their healthcare providers about their sexual behaviors. Some gay men may avoid the healthcare system altogether.
- Laws criminalizing same-sex acts and gender non-conformity along with laws and policies that deny equal rights such as marriage equality to gay men can adversely affect their health outcomes.
- Racism and discrimination against minorities within gay communities' harms minority gay men by imposing additional stress and by further reducing their access to healthcare.
- Gay men living with HIV face the dual stigma of being gay and of their HIV positive status. If they belong to a minority racial or religious group or are of a lower socioeconomic status, they face even more stigma.
- Homophobia and transphobia in healthcare settings can harm the health outcomes of gay men.
- Gay-identified trans men in particular, experience a number of unique barriers to good health - both at the individual, interpersonal, and structural levels.
- Healthcare providers have a responsibility to serve gay clients without stigma or discrimination. They should foster a welcoming atmosphere for gay clients and do everything in their power to reduce stress, anxiety, and trauma for gay clients.
- Providers should educate themselves about the healthcare barriers gay men face.

10 Quiz

1. Criminalization of same-sex acts is an appropriate public health strategy as it reduces the chances for gay men to engage in same-sex behavior.
1.1 True *1.2 False*

2. Avoiding treatment and care is one of many negative health behaviors that gay men present with in the face of social stigma and discrimination.
2.1 True *2.2. False*

3. In which of the following circumstances are gay men least likely to discuss their sexuality with their healthcare provider?
3.1 When it is legal in the country to engage in same-sex behavior and social protections exist for the gay community.
3.2 When all frontline staff within a clinic have undergone sensitivity training to deal with gay clients.
3.3 When a provider tells their gay client that it is morally wrong to engage in anal sex.
3.4 When healthcare settings openly welcome gay men.

4. Government laws and policies can be in contradiction with ethical and non-judgmental delivery of healthcare.
4.1 True *4.2 False*

5. Which of these behaviors targeted at gay men may place them at higher risk for mental health challenges and HIV transmission?
5.1 Blackmail
5.2 Eviction from home
5.3 Violence
5.4 All of the above

6. _____ is an attribute that shames an individual or group of individuals in the eyes of others.

7. Which of the following are not examples of stigma against gay men?
7.1 Avoidance of other gay men
7.2 Employment discrimination
7.3 Gossip
7.4 Non-judgmental delivery of care

8. Which of the following are not signs of internalized stigma?
8.1 Low self-esteem
8.2 High-risk behavior
8.3 Hepatitis B
8.4 Suicidality

9. Gay men should be encouraged to enter marriages with cisgender heterosexual women to promote their own health.
9.1 True *9.2 False*

10. Which of the following actions can a healthcare provider take to improve the health of gay clients?
10.1 Proactively seek education and knowledge about gay men's health needs
10.2 Pass knowledge about gay men's health needs to other coworkers
10.3 Reach out to families and communities to advocate on behalf of gay men
10.4 Speak to local authorities and provide support for gay men
10.5 All of the above, when it is safe to do so

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Module 3

Creating a friendlier environment

1 Introduction

Healthcare environments should be intentionally designed to be welcoming and respectful of gay, bisexual, and other men who have sex with men, including transgender men who have sex with men (hereby referred to as gay men). When gay men feel welcome and safe, it creates an enabling environment for them to build trusting relationships with providers. This can alleviate concerns of stigma or discrimination and can lead to better quality care and improved health outcomes. Providers can take proactive steps to improve the health of gay men by examining their practices and policies, undertaking sensitivity training, and establishing a welcoming and accessible clinical environment.

This module begins with a discussion of why gay men might avoid seeking healthcare or avoid disclosing their sexual orientation and behaviors. It addresses the importance of culturally competent care before discussing the Ottawa Charter and strategies to create a more welcoming and hospitable environment for gay clients.

2 Anticipating concerns about stigma and discrimination

Reducing stigma and discrimination are essential to creating a healthcare environment that is safe for gay clients. Stigma and discrimination interfere with gay men's ability to access healthcare services or may cause gay men to avoid seeking healthcare altogether.

Many gay men mistrust healthcare systems due to the homophobia of healthcare providers. Research has documented the prevalence of anti-gay discrimination in healthcare settings and the negative attitudes of many providers towards gay clients. [1 2 3]

Since homophobia among healthcare providers can be widespread, many gay men expect that they will experience stigma and discrimination when seeking medical care. Providers who anticipate this expectation will be better prepared to assuage their gay clients' concerns.[4] By examining and acknowledging their possible prejudices, providers will become better prepared to change their attitudes and to work to dismantle barriers to care for gay men.

3 Culturally competent care for gay men

All healthcare providers should seek or should be required to take training in providing culturally competent care for gay men and other minority groups. Such training can be an important step to overcoming the barriers to healthcare that harm gay men.

Culturally competent care is defined as healthcare that is sensitive to and knowledgeable about the health beliefs, behaviors, epidemiology, disease risks, treatments, and treatment outcomes of specific client populations.[5 6] Culturally competent care for gay men requires that providers:[7]

- Be aware of their values and beliefs on gender and sexuality and how these might affect how they care for gay clients;
- Be knowledgeable about the specific healthcare needs of gay men;
- Stay current on appropriate prevention and treatment options for health issues commonly faced by gay men, including transgender men;
- Adapt clinical practice skills to match the needs of gay men.

Culturally competent healthcare emphasizes the value of cross-cultural communication. This may be especially important for gay men who often have difficulty, or even fear, disclosing their sexual behaviors or preferred gender identities to their healthcare providers. Non-disclosure may lead to lack of access to appropriate healthcare services, poor client healthcare management, inaccurate clinical decisions, and poor health outcomes. Gay men need to feel comfortable discussing their sexual history with their providers. A provider's communication style is an important factor in a client's willingness to disclose their sexual orientation or gender identity.

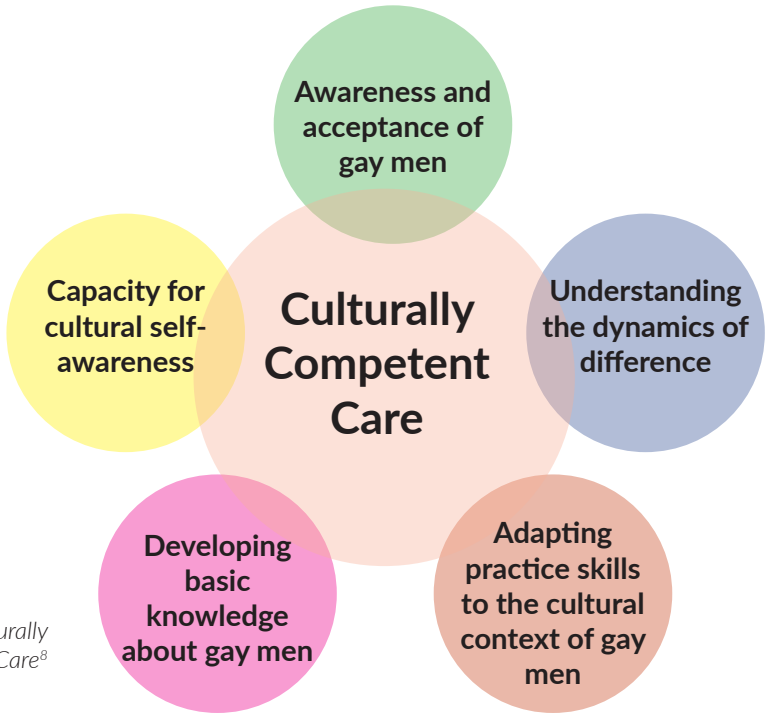

Figure 3.1 Culturally Competent Care[8]

4 The Ottawa Charter

The World Health Organization (WHO) organized the first International Conference on Health Promotion in Ottawa, Canada in 1986. This conference launched a series of coordinated actions between international organizations, governments, and local communities to achieve the goal of "Health for All" by 2000 and beyond through better health promotion.

The Ottawa Charter set standards for building appropriate services for healthcare service delivery using a comprehensive, multi-strategy approach. According to the WHO and the Ottawa Charter, health promotion actions involve:

1. Building healthy policies
2. Creating supportive environments
3. Strengthening community actions
4. Developing personal skills
5. Reorienting healthcare services

The health promotion emblem below signifies this approach to health as outlined in the Ottawa Charter.

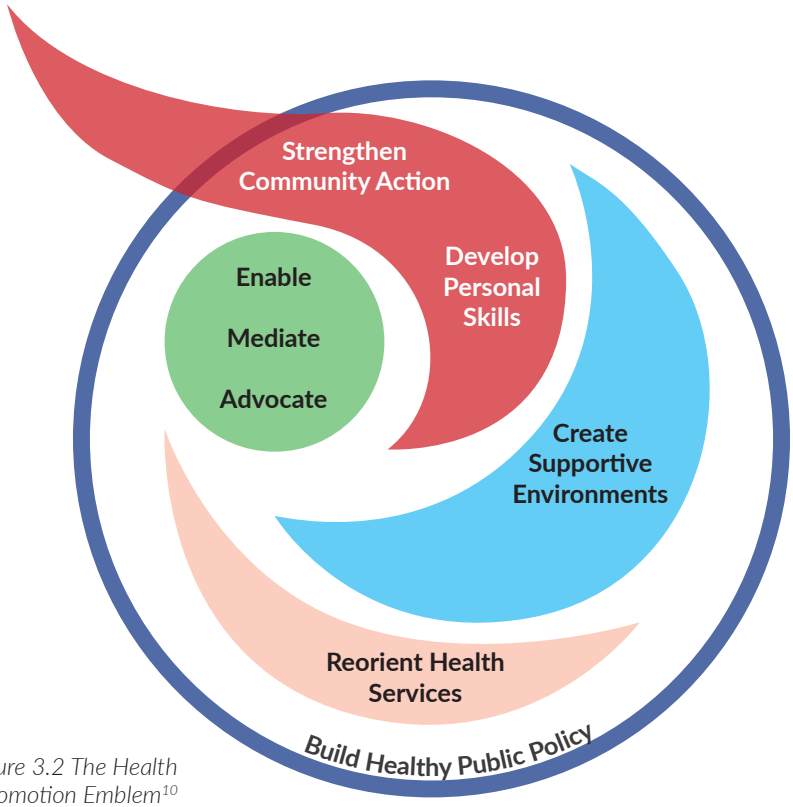

Figure 3.2 The Health Promotion Emblem[10]

The five actions of health promotion, as outlined in the Ottawa Charter, touch upon the vital health needs of gay men and other marginalized populations across the globe. Laws and policies that criminalize or otherwise harm gay men must be struck down. Laws and policies that give equal rights and protections to gay men should be instituted. Healthcare providers should collaborate with local gay communities to build supportive environments where gay clients can receive high quality care.

5 Reorienting healthcare services for gay men

Healthcare services can be reoriented or reimagined in many ways to make them more welcoming and friendlier for gay men. In order to do so, it is advisable to seek out the advice and input of members of the local gay community and to involve gay clients. Such actions can demonstrate that the local gay community's views are valued and there is genuine commitment on the part of healthcare providers to improve care. Doing so can also develop a sense of ownership by members of the gay community in their local healthcare service options.

This section will explore key areas that should be modified to overcome barriers to healthcare for gay men using a series of standards.[11]

- *Client rights*

  Comprehensive policies prohibiting discrimination in the delivery of healthcare services should be established to ensure protection of the rights of gay clients. All staff should be required to agree to these policies under their terms of employment. These policies should be posted in visible physical locations and be available as brochures or pamphlets for clients. Gay clients report that they often look for subtle cues such as these to determine whether they may be accepted and treated equitably when seeking healthcare.[12]

  Procedures should be put in place for clients to file complaints if they experience discrimination or are denied healthcare services. A staff member should be designated to ensure compliance with anti-discrimination policies by all staff. The complaint procedures should be available in writing and easily accessible to clients. All employees should be given written notice that discrimination based on sexual orientation, sexual behaviors, or gender identity will not be tolerated and will be subject to formal disciplinary action.

- *Clinical staff*

  The presence of gay or other LGBTI staff members at clinics can be a source of comfort for gay clients. One way of ensuring that a clinical environment is friendly for gay men is to support and encourage the visibility of staff that may be LGBTI. Such staff may be actively recruited as part of diversity initiatives, too. Policies should be put in place to explicitly promote diversity and prohibit harassment of staff based on sexual orientation or gender identity. In addition, organizational policies should extend benefits such as health insurance, life insurance, disability insurance, and family benefits to all employees, including gay men. All staff should receive training on issues related to sexual and gender diversity.

- *Clinic reception*

  As the first point of contact with clients, staff at the reception area of healthcare facilities must be comfortable with and welcoming of gay clients. They should be familiar with providers who have experience with issues affecting gay men and they should be able to provide appropriate referrals if needed. Healthcare facilities should invest in developing the skills of receptionists and other client-facing staff.

  A few key elements of a welcoming reception staff include:

  - Being good and friendly;
  - Creating unique client identifiers to ensure correct but confidential identification of clients and their information;
  - Clarifying how identifying information may be used with client permission, for instance:
    - Information needed: Where do you live?
    - Explanation: So we may contact you if needed. (might be sensitive when clients reside with family or friends to whom they may not be out)
  - Being able to assure clients of confidentiality.

  In places where gay men face stigma and criminalization, healthcare facilities and front office staff should take precautions to avoid drawing undue attention to gay clients. For instance, in mainstream facility-based clinics, labels such as ‘key populations department’ or ‘screening form for men who have sex with men’ should be avoided if such labels could serve to identify and further stigmatize the very communities the clinics intend to serve. Providers should find neutral and discreet ways of labeling facilities and paperwork that are meant for gay clients.

- *Service planning and delivery*

  Clinical services should be designed to be culturally competent in dealing with gay clients. Four critical elements help create competent, respectful service:

  1. *Staff training on gay men and LGBTI culture:* All staff should receive mandatory training on issues affecting LGBTI people. This can ensure that the services they provide are culturally competent and relevant to clients. Training programs on diversity, harassment, and anti-discrimination should utilize appropriate informational resources on gay men. After the training, participants should implement what they have learned. It may also be helpful to invite the facilitators, participants, or members of the local LGBTI community to the training to interact with staff.

  2. *Identify staff with special skills or an understanding and acceptance of LGBTI issues:* It is important to identify staff members who understand health issues that are common among gay men and LGBTI people. Identifying and cultivating individuals who are especially interested in these issues and, if appropriate, recruiting them to form a staff working group can help increase overall staff sensitivity and knowledge.

  3. *Identify resources and referrals:* It is important to have a list of resources to share with clients who have specific sexual orientation, sexual behavior, and gender identity-related health concerns or questions. Providers can approach local gay and LGBTI organizations and ask for their assistance in compiling resources. Local organizations can be sought out at gay bars or online. Providers should also collect information on gay-friendly clinical providers and facilities so that gay clients can be referred, if needed.

  4. *Develop a relationship with the local community:* Developing relationships with the LGBTI community in a provider's neighborhood or city can make healthcare services more approachable for gay men. Providers can increase their visibility and establish a positive reputation by seeking out local gay groups and inviting them to meetings to discuss how to better serve the needs of gay clients. As providers work with these groups to create a friendlier environment for gay men, they will have opportunities to change attitudes and become increasingly comfortable dealing with sexual health issues of gay men.

- *Community relations*

  Ensuring that a healthcare facility is seen by the gay community to be a welcoming space is very important. As discussed earlier, this can be done by identifying appropriate local gay and LGBTI resources to share with gay clients and by sharing information on gay-friendly providers in the neighborhood or a particular city where the client lives.

  Advertising and promotional materials should clearly indicate a healthcare facility or provider's non-discrimination policies. Such materials should accurately reflect the level and quality of services available to gay men. If appropriate, community programs run by the organization should include gay men from the community. Another way to ensure a good relationship with the community is to have board members or advisers who hail from the local gay community.

- *Ensuring trans-inclusivity*

  It is important to ensure that the physical environment in which healthcare services are to be provided is welcoming and appropriate to all gay men, including gay-identified transgender men. To do so, a clear commitment has to be made to provide inclusive and sensitive services. The building blocks for competent service delivery – in the form of appropriate policy and training – need to be established. Indeed, when considering whether to avail of a healthcare service at all, or whether or how much information to disclose

about themselves, many trans men will look for signs and clues of trans acceptance in the physical environment around them. To this end, there are a number of ways that health services can help make it clear that trans men are welcome, such as:

- Including images or words about trans men in advertising and health education materials;
- The presence of trans men-specific posters, stickers, brochures, or other information and resources;
- Non-gender segregated restrooms, with single occupancy unisex restrooms being ideal.

In some contexts, it may also be beneficial for services and healthcare professionals to proactively reach out to trans men by advertising in LGBTI and transgender media or gathering venues, and/or by showing visible and vocal support for LGBTI and transgender events and advocacy causes (when safe for healthcare providers to do so).

Specific consideration should also be given to the steps that can be taken by providers to minimize the intense physical and psychological discomfort that can arise for trans men in some healthcare situations. This applies particularly to procedures that involve disrobing, and/or to procedures related to gynecological health. To make such experiences as minimally traumatic as possible, providers should be conscious of the potential for discomfort, be responsive to client preferences, ensure maximum privacy, and complete procedures competently and quickly.

6 Non-judgmental and client-centered communication

In addition to instituting inclusive policies and creating a welcoming reception experience for gay clients, healthcare providers also play a major role in creating a welcoming clinical environment for gay men.[13]To do so, providers must educate themselves on key health issues affecting gay men. While not all providers will or can become experts, they should have basic familiarity with the health needs of gay men.[14]

Regardless of their level of knowledge, healthcare providers can begin to create a welcoming environment by taking a non-judgmental sexual and social history of all clients.[15] They should not make assumptions about sexual orientation or gender identity based on appearance or behavior and they should ask open-ended questions. Homophobia or perceived homophobia in the healthcare setting may hinder disclosure of sexual behaviors or prevent gay clients from providing a full sexual history. By communicating in a non-judgmental manner and listening carefully to the client, providers are more likely to get accurate information and be able to render appropriate diagnosis, advice, and treatment.

A few additional tips to consider when communicating with gay clients are:[16]

- Being aware of verbal and body language and being non-judgmental.
- Using gender-neutral language when inquiring about sexual partners and not making assumptions about gender identity, heterosexuality, family, and sexual relationships. For example, do not ask, “Are you married?” or “Do you have a boyfriend/girlfriend?” Rather ask, “Are you in a relationship?” and “What is the term you use for your partner?”[17]
- Mirror the language that the client uses when discussing sexual behavior and identity.
- When unsure what terminology to use, ask the client what they prefer.
- If the client is in a primary relationship, offer (but do not insist) to include their partner in medical discussions and decision-making.

- Examine personal beliefs about same-gender partnerships. Ask if any of your personal biases get in the way of delivering effective and appropriate healthcare and if you have an assumption that all clients are heterosexual. Undertake modifications needed to change these unhelpful biases.

It may take time for providers to feel comfortable discussing sexual health and behaviors with their gay clients. It is not necessary to have all of the answers right away. A study in the U.S. showed that healthcare providers who were perceived as good providers were those who listened and learned from their clients rather than presenting as being already knowledgeable about gay men's health issues.

Intake forms

One of the first thing gay clients do when visiting a healthcare facility is to complete intake forms. As this is one of the first encounters that clients have in a healthcare setting, it is an opportunity for providers to make their gay clients feel welcome and at ease. A few points providers should consider are:[18]

- Use inclusive language in all forms and remove any wording that assumes heterosexuality. This can be done by:
  - Using gender-neutral terms such as partner or spouse instead of husband or wife
  - Replacing "marital status" with "relationship status"
  - Include options such as "partnered" in addition to "married"
  - Consider adding "multiple partners" as an option
  - Inquire about the gender of the spouse or partner(s)
  - Provide an option for same-gender parents in questions about families
  - Provide an option for self-identification in categories including gender identity, sexual orientation, and relationship status
  - Provide an option to give additional written explanation in all categories

- To emphasize the importance of confidentiality, include information about who will see the information, how it will be used, whether it will be included in the medical record, and where it will be stored;

- Allow the client to decline to answer any question for any reason;

- Offer information on the organization's commitment to non-discrimination, confidentiality, and culturally sensitive care.

8 Key points from the module

- Gay men may avoid the healthcare system because of stigma, discrimination, and homophobia from healthcare providers and an unwelcoming clinical environment.
- In many places, laws and policies criminalizing same-sex behaviors or discriminating against gay men pose additional barriers to healthcare.
- An important step to overcoming the barriers healthcare is to train providers in culturally competent care for gay men.
- The Ottawa Charter sets standards for building good services for marginalized clients using a comprehensive, multi-strategy approach.
- There are many areas of healthcare services, including client rights, clinic staff and reception, service planning and development, confidentiality, communication, and community relations that may be reoriented and reimagined to ensure a welcoming, respectful, and friendly environment for gay clients.
- Healthcare facilities should be made trans inclusive, for example by ensuring that restrooms are not segregated by gender or are unisex.
- Healthcare providers should assure gay clients of confidentiality and communicate in a non-judgmental manner in order to get accurate information and render an accurate diagnosis, provide appropriate advice, and provide effective treatment.
- Intake forms should not assume heterosexuality and should use inclusive language.

Quiz

1. _____ are barriers to effective healthcare for gay and trans men.

2. Lack of trust in healthcare professionals limits the dialogue between the client and the healthcare provider, making it difficult to provide appropriate care.
2.1 True *2.2 False*

3. The following is an example of an appropriate question for a gay men-friendly medical intake form:
Current Relationship Status:
- Single
- Married
- Divorced
- Separated
- Widowed

3.1 True *3.2 False*

4. Where it is safe to do so, which of these is a visual cue to show that a clinic is LGBTI or gay-friendly?
4.1 Posters or signs showing same-sex couples
4.2 Presence of LGBTI magazines in the clinic reception area
4.3 Posting a non-discrimination policy that includes LGBTI people
4.4 Presence of visibly gay or other LGBTI staff
4.5 All of the above

5. Only clinical staff like physicians and nurses need to be familiar with the issues facing gay men. Non-clinical staff such as receptionists do not need to be given sensitivity training as they do not provide direct healthcare for gay men.
5.1 True *5.2 False*

6. In order to take the first step towards the provision of culturally competent care, it is most important for a healthcare provider to:
6.1 Be an expert on all aspects of gay men's health
6.2 Hire only gay staff
6.3 Be aware of how their own values and beliefs on gender and sexuality might affect their provision of healthcare for clients
6.4 Be 100 percent confident when speaking about gay men's health issues

7. _____ sets standards for building good healthcare services for clients using a comprehensive, multi-strategy approach, which includes (1) building healthcare policy, (2) creating supportive environments, (3) strengthening community action, (4) developing personal skills, and (5) reorienting healthcare services.

8. It is difficult for a healthcare provider who is prejudiced against same-gender relations to provide appropriate care to gay men.
8.1 True *8.2 False*

9. Assurance of _____ is critical for sexual healthcare, but especially for those gay men who are not open about their sexual behavior.

10. It is important for healthcare facilities and providers to develop relationships with local LGBTI organizations and to be able to share a community resources list with gay clients.
10.1 True *10.2 False*

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Module 4

Taking a Sexual History

1 Introduction

Taking a complete and accurate sexual history is critical to providing healthcare that is timely and appropriate. Better health outcomes for gay men can be facilitated by comprehensive and sensitively conducted health assessments. While health promotion occurs largely at the individual level, it can certainly be facilitated by providers who are able to effectively assess the health concerns faced by their clients.

This module discusses the steps for taking a comprehensive sexual history of gay and bisexual men, and other men who have sex with men, including transgender men who have sex with men (hereby referred to as gay men). It stresses the importance of confidentiality when taking a sexual history, presents the barriers to sexual history taking, and suggests strategies for providers on overcoming barriers. The module also discusses key communication issues when taking the sexual history of gay clients. It provides specific questions to ask clients during the course of the sexual history interview while remaining gender sensitive. Finally, it explores motivational interviewing before ending with a brief section on charting of sexual history.

2 Confidentiality

Healthcare providers have a responsibility to keep information about all their clients confidential. Ensuring the confidentiality of clients is a cornerstone of sexual healthcare for gay men, especially in places where same-sex behavior and nonconforming gender identities are stigmatized or criminalized. Providers should put in place policies to explicitly require patient confidentiality and the policies should be prominently displayed in healthcare facilities and handed out to clients. Information on sexual behavior and on gender identity that is obtained during history taking should be considered sensitive and treated accordingly.

Client confidentiality policies and practices may conflict with anti-gay or anti-transgender laws in some jurisdictions. For example, in some countries, such laws mandate that healthcare providers turn in people suspected of same-sex sexual behavior to law enforcement. In such cases, healthcare providers should act with sensitivity and discretion and do their best to protect the health and human rights of gay clients. Breaches of confidentiality in such instances can lead to serious harm to individual clients. It may also undermine the trust of other gay men in the healthcare system and lead them to avoid providers or not disclose their sexual behaviors, thus harming their health.

A recent area of healthcare innovation - which accelerated during the COVID-19 pandemic - is the reliance on telehealth. Telehealth makes it easier for clients to access care when their mobility is restricted in some contexts. However, providers should keep in mind that many clients may not have a private space at home where they can have confidential conversations. As such, providers should ask gay clients at the outset of a telehealth conversation whether they are in a private space and if they are comfortable having sensitive conversations. If the client is unable to have a private conversation, they should be offered the option of scheduling an in-person visit with adequate pandemic safety precautions.

Providers working from home should take precautions to ensure the integrity of sensitive patient data. They can do so, for instance, by using lockboxes for their documents or protecting work laptops and phones with strong passwords that are regularly changed

3 Barriers to sexual history taking

It is likely that a healthcare provider who interacts with several clients in a day will have one or more clients who are gay.[1] Many providers will never realize or recognize this fact due to incomplete or inaccurate sexual history taking and due to biases and assumptions that are false. Many gay men and are often reluctant to disclose their sexual history or gender identity to a provider due to the fear of being ridiculed or even rejected. Some of the key barriers to taking an accurate sexual history are discussed below.

- *Provider barriers*
  - Homophobia
  - Transphobia
  - Lack of experience with gay or trans issues or discomfort with asking questions
  - Discomfort or inability to respond to problems faced by gay men
  - Refusal to accept consensual same-sex sexual acts between adult men as normal
  - Making false assumptions regarding same-sex sexual acts and gender identities
  - Lack of knowledge on how to help gay clients feel comfortable
  - Lack of time
  - Lack of training and knowledge

- *Client barriers*
  - Embarrassment or shame
  - Fear of ridicule, rejection, or denial of care
  - Fear of outing
  - Lack of confidentiality or privacy
  - Perception of stigma from a healthcare provider
  - Lack of awareness of sexual health issues
  - Differences between the clients and the provider based on race, ethnicity, national origin, appearance, sexual orientation, culture, social class, language, or other categories

4 Overcoming barriers to sexual history taking

Providers can overcome most of the barriers discussed above by planning ahead and learning more about the healthcare needs and issues faced by gay clients. They can learn how to take a comprehensive sexual history of clients with sensitivity. Most providers already possess the skills necessary to discuss sexuality and sexual health with clients. With preparation and practice, providers can grow to become comfortable discussing sexuality with gay clients.

Here are a few tips on how providers can become better at taking the sexual history of gay clients:

- Institute a policy of taking the sexual history of all clients
- Ensure that sexual history taking includes explicit questions about sexual acts
- Develop a policy on when to initiate a sexual risk assessment
- Determine how sexual risk assessment will be integrated into the care plan for a client
- Formulate specific questions to ask
- Develop a plan for how to respond to information that might surface
- Train other staff on how to perform a sexual risk assessment

Many healthcare providers might feel that their clients will be surprised or uncomfortable fielding questions about their sexual practices and sexual health. However, most clients will welcome such questions. Providers should alert clients that they will be asking routine questions about sexual health and sexual practices.[2] Providers should also take the following steps prior to taking the sexual history of a client:[3]

- Let clients know they can speak freely without fear of judgment
- Assure clients that they take confidentiality very seriously.
- Explain the importance of taking a comprehensive and accurate sexual history.
- Tell clients that they should be honest during the interview as the questions will help the provider give optimal care, even though the questions may be very personal.
- Never assume the sexual orientation or gender identity of clients.
- Use gender-neutral language when talking about sexual or emotional partners.
- Use the same language as the client when talking about sexual behaviors and identity.
- Underscore that the interview is part of routine care.

These additional tips can help providers communicate more effectively with their clients:[4]

- Avoid making assumptions based on race, ethnicity, national origin, gender, age, marital status, disability, or other characteristics. For example, a man married to a woman may not be sexually monogamous with his spouse and may have sex with men.
- Be nonjudgmental, direct, and specific with questions about sexual behavior. This is a good way to normalize different kinds of sexual behaviors and put clients at ease.
- Cultivate self-awareness about their own biases and prejudices and how these affect their work. They should then put aside negative and baseless judgments and focus on providing quality care without stigmatizing and discriminating against gay clients.
- Be aware of non-verbal communication cues to avoid coming across as judgmental or uncomfortable.
- Ask open-ended questions that require more than a 'yes' or 'no' answer. Such questions will help initiate a dialogue and facilitate a more complete sexual history taking. Here are some examples of statements to introduce the sexual history and assure clients of confidentiality: [5]

    - Everything we discuss is strictly confidential and will stay between you and me.
    - As I do with all of my clients, in order to provide you with the best possible care, I am going to ask you several straightforward questions related to your current and past sexual activity.
    - I will also ask questions about drug and alcohol use.
    - I take a sexual and alcohol/drug use history with all of my clients as part of their health assessment. This is important in order to provide optimal care. I know that these subjects are very personal. I will not divulge this information to anyone.

5 Asking about same-sex sexual behavior

Healthcare providers should ask all clients, including transgender men, about potential sexual behavior in a sensitive and non-judgmental manner. In doing so, they can make the client comfortable knowing that all clients are asked the same questions. It can also increase the comfort of the provider.

Providers can benefit from the tips below on asking about same-sex sexual behavior in male clients.

- *Ask about same-sex sexual behavior in all clients*
  Providers should ask all male clients, including transgender men, about same-sex or different-sex behavior regardless of the client's age, sexual orientation, gender expression or identity, or marital status. Providers should never make assumptions about sexual orientation and gender identity based on the appearance or presentation of clients. Gender identity or expression is not indicative of sexual behavior.

- *Ask about same-sex sexual behavior in men married to women*
  All male clients, including men is married to cisgender women, should be asked whether they engage in same-sex sexual acts.

- *Ask about same-sex sexual behavior across all age groups*
  Men in all age groups can identify as gay or have sex with other men. Providers should not assume that only younger men will engage in same-sex sexual acts.

- *Ask about steady male partners of self-identified gay men*
  Providers should ask self-identified gay clients about any long-term male partners they may have. This is important not only for referral and partner testing services, but also for assessing a client's network of social support.

  Ask about sexual behavior or relationships with all genders in self-identified gay men
  Self-identified gay men may have partners of different genders. Many gay men may be married to women due to social and family pressure. Other gay men may have children with their wives in order to fulfill societal expectations. Asking about all partners is important so the provider can refer clients and their partners to appropriate healthcare services.

6 Ensuring gender sensitivity during history-taking

Verbal or written questions about gender and sexual identity at a health clinic can significantly impact - in both positive and negative ways - a trans man's experience of the service they receive. Failure to nonjudgmentally affirm trans men's gender and sexual identities can result in a lost opportunity to engage that person in effective prevention services and health treatment.

There are simple steps that can be taken to show, through the choice of language and formal documentation, that trans men are welcome and respected, including:

- Avoiding gendered language both when addressing/speaking about patients, and on forms. For e.g.:
  - Instead of asking "How may I help you, sir?" simply ask, "How may I help you?"
  - Use "they" instead of "she" or "he," for instance, "they are here for their 3 o'clock appointment."
  - Never, however, refer to a person as "it."

- Asking all patients which pronouns they prefer to be addressed by, and using these consistently and accurately
- Asking all patients (including on forms) if they have a preferred name, and using that consistently and accurately
- Respecting a person's self-identification, rather than relying on 'official' legal documents, given that the latter can often be extremely difficult to change.

When it comes to asking for detailed information regarding a person's sex, gender, or sexual orientation, it is beneficial to first consider whether that information is necessary. Both bodies and sexual behaviors can frequently not conform to rigid categories and thus this information may be of limited benefit to revealing anything about a person's physiology or behavior. If a decision is made to ask questions about a person's sex, gender, or sexual orientation, it is recommended that forms contain a number of options that can accommodate anyone and also communicate a service's inclusiveness.

Trans men have a diversity of bodies and sexual practices. The key to supporting good sexual health therefore is to make no assumptions, build rapport, and develop a good understanding of an individual's behaviors in order to provide appropriate care and services. As a first principle underlying the provision of all sexual and reproductive health services to trans men, it is important to mirror the terms that the individual uses to refer to their body and genitalia. Doing so helps to establish rapport, awareness, and trust between the healthcare workers and the trans client. This will then assist with taking a thorough and accurate sexual history in order to understand behavior and risk.

Sexual Health History Framework

Explain and normalize

I am going to ask you a few questions about your sexual history. I ask these of all my clients because they are important for your overall health. Everything you tell me is confidential. Do you have any question before we start ?

Ask them to describe

- Their most recent sexual experience.
- Their concerns about their sexual health and safety

Clarify

- Refrain from asking why as a clarifying question. Instead ask who, what, how, when, and/or where to clarify.
- Remember that trans people have many term to describe their anatomy, and their sexual behavior.

Determine follow-up necessary

- Education
- Condoms & Lube
- STI/HIV screening
- Partner Testing & Counselling
- Reproductive Health

Key issues and approaches to taking a sexual history

This section explores key topics and questions for healthcare providers to ask when taking a sexual history of gay and bisexual clients. It also provides examples of how to frame sexual history taking questions to elicit accurate and essential information that can help providers give optimal care.[7]

- *Assessing the partner situation*

Ask open-ended questions to initiate a free-flowing conversation. A good way to start is by stating:

-Tell me about your recent sexual partners.

If this question does not elicit clear and specific information, providers can probe further for information such as the gender of sexual partners, the number of sexual partners, and the nature of the relationships with these partners (steady or casual partners), for instance by asking questions such as:

-Do you have sex with men, women, both, or neither?
-How many sexual partners do you have?
-How many sexual partners have you had in the past six months?
-Does your primary partner have other sexual partners?

- *Assessing sexual practices*

Healthcare providers need to identify the types of sexual contact in which a client has engaged in so that health risks can be accurately evaluated. Providers should ask clients whether they have engaged in anal (insertive and/or receptive), oral (insertive and/or receptive), and vaginal (insertive and/or receptive) sexual acts. They should also ask about oral-vaginal, oral-anal sexual contact (rimming), or digital-anal sexual contact (fingering or fisting), as these may also pose unique health risks. For instance, enteric parasitic infections or hepatitis can be transmitted through rimming and rectal fissures may occur due to fisting.

When asking questions about sexual practices, providers should avoid using labels (such as gay, homosexual, or straight) because many men do not identify as gay even if they engage in sexual acts with other men. If a provider is uncomfortable using colloquial terms (such as top, bottom, rimming, or fisting), they can use descriptive terms instead.

Some questions that can be used to obtain information on sexual practices include:

-Do you have oral sex?
-If yes, do you put your penis (or clitoris) in your partners' mouth?
-Do partners put their penises (or clitorises) in your mouth?
-Do you have vaginal (or front hole) sex?
-Do you have anal sex?
-If yes, do you put your penis (or clitoris) in your partners' anus or vagina (or front hole)?
-Have you been a top?
-Have you been a bottom?

- *Assessing venues for meeting sexual partners*

Healthcare providers should ask their clients whether they meet sexual partners at bars, clubs, online apps (Grindr, Hornet, etc.), parties, bathhouses, and/or in other venues. They should also ask about recent travel and sex abroad. These questions are for epidemiological purposes, such as to gain awareness about potential antibiotic resistance or about STIs prevalent in the countries where a client has traveled and had sex. Some men may engage in sex with other men or engage in different kinds of sexual practices only when traveling.

Providers should also ask about the exchange of sex for money, drugs, food, shelter, or anything else.

Some questions to use to obtain information on venues for meeting sexual partners include:

-Where and how do you meet your sexual partners?
-Have you had sex abroad recently?
-Does your sexual behavior change when you travel outside of your locality or country?
-Have you exchanged sex for money, drugs, food, shelter, or anything else?

- *Assessing condom use*

If appropriate to the individual and their reported behavior, providers should ask clients about the frequency, consistency, and methods in which they use condoms or other barrier methods and the circumstances surrounding their use. Some clients may never use condoms or may use them differently with casual partners than with regular partners. They may use condoms only for certain types of sexual acts, such as anal or vaginal intercourse but not for oral sex. Other clients may be on PrEP regimens and may not find it necessary or important to use condoms altogether. It is best to ask an open-ended question since clients may provide more information this way. Providers should also ask clients about the methods in which they use condoms, for instance with adequate and appropriate lubrication for anal or vaginal sex.

An open-ended way to ask for information about condom use is as follows:

-Tell me about your experience with condom use.

- *Assessing HIV status, PrEP adherence, and STI status*

Healthcare providers should ask clients about their HIV status and the HIV status of their partners. They should also ask if clients have any STIs or are aware of active STIs in their sexual partners.

Some questions to use to obtain information on HIV and STI status in clients and in their partners include:

-Have you ever been tested for HIV?
-If yes, when were you last tested for HIV and what was the result?
-If no, what are the reasons you have not been tested for HIV?
-Do you have any concerns that prevent you from getting tested for HIV?
-Have you been tested for STIs?
-If yes, when were you last tested for STIs?
-What STIs were you tested for and what were the results?
-If you have not been tested for STIs, what are the reasons you have not been tested?
-Do you have any concerns that prevent you from getting tested for STIs?
-If HIV positive, do you have access to antiviral medication?

- *Assessing drug and alcohol use*

Gay men, like many other people, may use drugs and alcohol for a wide variety of reasons. Gay men may use drugs and alcohol as a mechanism to cope with minority stress arising from stigma and discrimination.[8 9] Gay youth and adults often use 'club drugs' like ecstasy, ketamine, or methamphetamine which are linked to sexual behaviors that can potentially increase the chances of acquiring HIV and STIs. Some gay people who feel isolated or lonely use drugs to feel connected to others.[10] Gay men experience depression and anxiety at higher rates than other men and use alcohol and drugs at disproportionately higher rates as a coping mechanism.[11]

In the context of sexual history taking, healthcare providers should ask about alcohol and drug use in a nonjudgmental manner. Providers should not assume that gay men who use drugs necessarily engage in high-risk sexual behavior.

Some questions to use to obtain information on drug and alcohol use in clients include:
-Tell me about your alcohol use.
-How many drinks do you consume in a week?
-What has been your experience with illicit drugs?
-What types of drugs do you take?
-How do you take them?
-How often do you take them and with who?
-Are you comfortable with your level of drug use?

- *Ending the interview*

By the end of the sexual history interview, the client may have questions or concerns that they were not ready to discuss earlier. Providers should give the client the time and opportunity to voice these concerns.

Examples of prompts to use to ask if clients have questions are:
-What other things about your sexual health would you like to discuss today?
-What other things about your sexual practices would you like to discuss today?

8 Motivational interviewing

A provider will have a clear sense of their client's healthcare needs once the sexual history taking has been completed. Based on this information, a provider can counsel the client on how best to promote and protect their health.

A provider can effectively counsel their client using motivational interviewing. This is a person-centered counseling method that focuses on exploring and resolving ambivalence about change and working to create motivation within the client to facilitate this change. Motivational interviewing is an established, evidence-based practice to help individuals change behavior. It does not impose change, but rather supports change in a manner that is congruent with a client's values and priorities.

Motivational interviewing uses collaborative, goal-oriented communication and generally requires the provider to adhere to these guiding principles:[12]

- Express empathy through reflective listening: By demonstrating to the client they are able to see the world as the client sees it, the provider creates an environment in which clients can openly and honestly share their experiences.
- Develop discrepancy: Discrepancy occurs when the client perceives a mismatch between where they are and where they would like to be. Developing discrepancy involves assisting the client to see that their current behaviors place them in conflict with their values or goals. This makes it likely that the client will feel motivated to change.
- Adjust to client resistance: The client can put up resistance when their views conflict with the provider's views on an issue or a solution. Resistance may also manifest when the client feels that their autonomy is being infringed upon. When resistance occurs, providers should not argue or confront the client, but instead de-escalate the situation.

- Support self-efficacy and optimism: Self-efficacy is the belief in one's ability to reach goals. In motivational interviewing, providers help clients believe that change is possible by focusing on prior successes and highlighting the client's existing skills and strengths.

Motivational interviewing has proven to be effective at initiating change in many fields, for instance in medication adherence in adults being treated for chronic diseases.[13] Among gay men, motivational interviewing has been shown to be acceptable and feasible to deliver in a variety of settings. It is largely equivalent to other treatments for reducing behaviors such as drug use and condomless penetrative sex, at least in the short-term.[14]

However, the effectiveness of motivational interviewing as an intervention has shown limited success in reducing the risk of acquiring a new STI or HIV. As such, other interventions should be used in conjunction with motivational interviewing to craft programs to reduce HIV and STI transmission rates and improve the sexual health of gay men.

9 Ensuring the confidentiality of sexual history records

Individual healthcare office practices on protecting client sexual history records vary greatly. Each system has benefits and limitations. Some systems keep client information in one centralized record. While this is convenient for providers, it may undermine the confidentiality of clients. Other systems have a designated place to store confidential records. This is better for confidentiality but may lead to providers overlooking important information due to the need to review two charts. Other systems use codes for test results and diagnostic information. This may create problems if the system is too complex.

It should be made clear to clients that reporting sexual behavior and gender identity on forms and records is optional. Clients should be provided with written notices about when this information may be shared or disclosed, whether it will be shared as aggregate or individual information, and whether personal identifiers may be disclosed. Clients should also be informed of how and by whom such information may be used. All consultations with providers should be kept confidential with appropriate privacy safeguards.

Some questions to use to determine which records keeping system to use include:

- -Do client history forms include questions on sexual history?
- -If not, how will this information be documented if a sexual history is done? How will updated versions be documented?
- -Do client history forms provide for self-identification in categories such as gender identity, sexual orientation, marital status, and family status?
- -Do client history forms provide the option for additional written explanations?

It is important to remember that clients must be able to access their records easily regardless of the records keeping system that is used by a provider. Clients must also easily be able to understand the information that has been recorded.

Key points from the module

- Assuring gay clients of the confidentiality of their sexual history and medical records will make them comfortable.
- When gay clients are comfortable, providers will be able to obtain an accurate sexual history and effectively assess the risks their clients face. This will allow them to provide clients with diagnosis, care, and treatment that is accurate and effective.
- Barriers to taking an accurate sexual history range from homophobia and transphobia in providers, or lack of provider knowledge to fear and embarrassment in clients.
- Providers can overcome most barriers to sexual history by planning ahead and becoming educated on how to take sexual history with sensitivity.
- Providers should ask about same-sex sexual behavior in all clients regardless of a client's race, age, sexual orientation, gender identity, or marital status.
- Providers should not make assumptions or be judgmental when taking a sexual history.
- Sexual history questions should be direct, specific, and gender neutral.
- Providers can become comfortable in taking sexual history over time and with practice.
- Motivational interviewing is an evidence-based counseling method that helps clients change behaviors that harm their health and helps them adopt healthier behaviors.
- It is crucial that providers take precautions to protect the confidentiality of the sexual history data obtained from gay clients by using protocols that are established in advance.

10 Quiz

1.Gay and bisexual men are less likely than other men to receive adequate assessment, treatment, and prevention services for health problems.
1.1.True *1.2.False*

2._____ is an established, evidence-based, person-centered counseling method that focuses on changing client behaviors that harm their health.

3.Which of these is a barrier to the taking of an accurate sexual history?
3.1.Making false assumptions regarding the sexual behavior and risk level of clients
3.2.Discomfort discussing sexuality and sexual practices
3.3.Homophobia or stigma towards gay men
3.4.Lack of time
3.5.All of the above

4.Providers can overcome most barriers to taking an accurate sexual history by planning ahead and educating themselves on their clients and on how to take their sexual history.
4.1.True *4.2.False*

5.Providers should assume that men who look masculine do not have sex with other men.
5.1.True *5.2.False*

6._____ is the cornerstone of all physician-client relationships, but is crucial when assessing the health of gay clients, especially those who have not come out or who are not open about their same-sex sexual behaviors.

7.It is important to ask all clients about sexual partner meeting venues, including bars, online, circuit parties, bathhouses, public venues, and about sex during travel.
7.1.True *7.2.False*

8.With which of the following group of male clients should providers ask about same-sex sexual behaviors?
8.1.Young cisgender men
8.2.Men married to cisgender women
8.3.Self-identified gay men
8.4.Gender non-conforming or transgender men
8.5.All clients

9.The best client record keeping system is a centralized system which protects client confidentiality.
9.1.True 9.2.False

10. Questions during sexual history taking should be limited to the topic of sexual behavior.
10.1.True *10.2.False*

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5

Module 5

Promoting Mental Health

- 1.Introduction
- 2.Factors linked to poorer mental health outcomes among gay men
  - *2.1.Homophobia and transphobia*
  - *2.2.Criminalization and lack of legal recognition*
  - *2.3.Family rejection*
  - *2.4.Childhood sexual abuse*
  - *2.5.Bullying in schools*
  - *2.6.The harmful practice of so-called "conversion therapy"*
  - *2.7.Violence and trauma*
  - *2.8.Aging*
  - *2.9.Discrimination in healthcare settings*
  - *2.10.Religious discrimination*
  - *2.11.Social isolation during the COVID-19 pandemic*
- 3.Common mental health concerns of gay men
  - *3.1.Anxiety*
  - *3.2.Depression*
  - *3.3.Suicidality*
  - *3.4.Post-traumatic stress disorder*
  - *3.5.Body dysmorphic and eating disorders*
  - *3.6.HIV-related stress*
  - *3.7.Substance-related and addictive disorders*
  - *3.8.Sexual problems arising due to poor mental health*
- 4.Tools to address the mental health needs of gay men
  - *4.1.Normalizing homosexuality*
  - *4.2.Anxiety and depression screening*
  - *4.3.Suicide risk assessment and prevention*
  - *4.4.Trauma-informed care*
  - *4.5.Countering so-called "conversion therapy"*
  - *4.6.Body dysmorphic and eating disorders*
  - *4.7.HIV-related stress disorder*
  - *4.8.Sexual problems due to poor mental health*
  - *4.9.Addictive disorders*
  - *4.10.Mental health screening*
  - *4.11.Motivational interviewing*
  - *4.12.Counseling*
  - *4.13.Mind-body medicine*
  - *4.14.Psychopharmacology*
- 5.COVID-19 global pandemic: Isolation, fear, and anxiety
- 6.The importance of relationships and community building
- 7.Guidelines for mental health professionals
- 8.Key points from the module
- 9.Quiz

1 Introduction

Gay and bisexual men, including transgender men who have sex with men, do not have a predisposition to mental health illnesses solely on account of their sexual orientation, gender identity, gender expression, or sexual behaviors. According to the World Health Organization (WHO), the American Psychiatric Association, and professional mental health organizations around the world, being gay or transgender is a natural phenomenon and is not a mental health illness or a pathology. However, the LGBTI community can experience higher than average levels of mental health stress and challenges as a result of external factors such as rejection, isolation, marginalization, hate-motivated violence, and bullying.[1 2 3 4] The minority stress theory posits that such stressors are likely to result in higher incidences of negative mental health outcomes. LGBTI people, including gay men, may experience this through rejection and isolation, the expectation of rejection or isolation, or internalized homophobia.[5 6 7 8]

Critical Thinking Questions

Case Study 1: Since 2016, homophobic and transphobic rhetoric has been steadily rising in Country A. This has included inflammatory anti-LGBTI statements by senior government officials and religious leaders, the use of a draconian anti-pornography law to arrest and imprison gay men, the public caning by religious authorities of men convicted of engaging in same-sex sexual acts, police raids on businesses catering to LGBTI customers, and the passage of several local ordinances that harm LGBTI people. A survey conducted in 2019 found that a vast majority of Country A's inhabitants find gay men repulsive and would not like them as a neighbor or a friend. Country A has a growing HIV epidemic which is concentrated in a few key populations, including among gay and bisexual men.

Critical thinking questions:

1. What impact do you think homophobic statements by senior government officials and religious leaders might have on the mental health of gay men in Country A?
2. How many factors can you identify from the case example that have the potential to adversely impact the mental health of gay and bisexual men in Country A?
3. If you worked as a health professional in Country A, how might you serve the mental health needs of gay and bisexual men in your clinical practice?
4. How is the repressive environment in Country A likely to impact the shape of the HIV epidemic among gay and bisexual men? How is this linked to mental health outcomes?

2 Factors Linked To Poorer Mental Health Outcomes Among Gay Men

- *Homophobia and transphobia*

Homophobia and transphobia against gay, bisexual and transgender men who have sex with men is well documented around the world, regardless of the cultural, social, political, economic, or legal environments they live in. Longstanding, persistent, and lifelong social stigma and discrimination has been described as the main factor contributing to poorer mental health outcomes in gay and bisexual men across diverse settings.[10 11 12 13] Stigma and discrimination can take the form of day-to-day personal hardships like harassment, ridicule, rejection, and violence. They can also be manifested through structural factors such as punitive and exclusionary laws, discriminatory social and economic policies, or violations of human rights by states or societies. As a result, many gay men experience mental health challenges of varying kinds and degrees at some point in their lives.

- *Criminalization and lack of legal recognition*

  Sixty-nine countries criminalize same-sex sexual behavior between consenting adults (as of July 2020).[14] Penalties can include fines, restrictions on LGBTI civil society organizing, and stiff prison sentences. Up to 9 countries may even impose the death penalty.[15] These discriminatory and/or punitive laws are prevalent in countries in Sub-Saharan Africa, the Caribbean, the Middle East and North Africa, parts of Eastern Europe and Eurasia, and parts of Asia.[16] In addition to violating human rights and dignity, criminalization laws make gay men vulnerable to poor mental health outcomes by forcing them to live in fear. Such laws prevent gay men from accessing life-saving mental health and other healthcare and reduce their access to education, housing, and employment. They can further discourage governments, healthcare providers, and nonprofits from engaging with gay men.

- *Family rejection*

  Nearly all children and adolescents rely on their families for food, shelter, physical safety, and emotional support. This is also true for gay children and adolescents. As such, facing family rejection after coming out, or after being unwillingly outed as gay or bisexual, can have devastating consequences for physical safety and emotional stability. One study found that having a non-accepting family was the top concern for LGBTI youth, just ahead of school and bullying problems, and the fear of being outed. This finding stood in sharp contrast to non- LGBTI youth for whom the top three concerns were rather more prosaic - grades, college, and career.[17] The risks for suicide, substance use, and depression are higher for gay youth who experience family rejection when compared to peers who report no or low levels of family rejection.[18]

Coming Out

Coming out refers to a period when an individual becomes aware of their sexual orientation and recognizes that they are sexually attracted to members of the same gender or have non-heterosexual sexual attractions.[19] Coming out is a complex emotional and psychological process that may take months, years, or even decades. The process often involves a period of confusion that ends in the formation of a sexual identity with which the individual is comfortable.[20] During this time, some experience personal crises related to their sense of self, especially if they feel their sexual orientation conflicts with their own, societal, or family expectations of them. Feelings of shame, guilt, and fear may be overwhelming, and risk for depression and suicidality may be heightened.[21]

Deciding how and when to come out should ultimately be the decision of your client. As their healthcare provider, you can make it safe for them to come out to you and then assist them in assessing the risks and benefits of coming out to others.[22] Coming out is correlated with less stress and improved self-esteem. However, it may be inappropriate or even dangerous to come out in settings where it can result in expulsion from home, violence, severe mental distress, further marginalization, or even criminal prosecution.

Healthcare providers must remain sensitive to the safety concerns of their young gay clients in the context of coming out and must strictly uphold confidentiality.[23] Regardless of their personal prejudices and religious beliefs, healthcare providers have the duty to provide competent services, including providing the necessary referrals or resources. This includes creating a supportive clinical environment, asking non-judgmental questions, and overcoming discomfort and providing appropriate and timely care and referrals.[24] While all healthcare provider may not be experts on sexuality, gender identity, or coming out, it is essential that you familiarize yourself with a few key resources to assist gay clients who are considering coming out. Here are a couple of resources that may be useful:

1. Coming out to your doctor. Human Rights Campaign. https://www.hrc.org/resources/coming-out-to-your-doctor
2. Do ask, do tell: Talking to your healthcare provider about being LGBT. National LGBT Health Education Center. https://www.lgbthealtheducation.org/wp-content/uploads/COM13-067_LGBTHAWbrochure_v4.pdf

- *Childhood sexual abuse*

  Approximately one in six men has experienced traumatic or abusive sexual experiences in childhood.[25] Gay men are more likely to have had these experiences than their heterosexual peers.[26] [27] This is because they are more likely to be targeted due to low self-esteem and more susceptible to be manipulated or coerced. However, childhood sexual abuse does not lead to homosexuality. Gay children may feel confused about their sexual orientation but abuse in and of itself does not lead to same-sex sexual orientation.

  Early sexual initiation (before age 16) is linked to risk factors such as higher rates of alcohol use, sexual risk-taking, delinquency, and violence. Sexual debut may vary by gender and sexuality, or by subjective experience, such as forced versus consensual sex. Forced sexual initiation, which is child sex abuse, of gay and bisexual youth before age 16 can lead to poorer quality of life, poorer mental health outcomes, and greater risk behaviors throughout the lifetime of a person. It can also cause psychological distress, substance use, and increase the likelihood of acquiring HIV.[28]

- *Bullying*

  Eight out of 10 LGBTI youth report being bullied at school. As a result, many gay children and adolescents fear schools which are frequently the site of bullying. This can cause depression, missing classes, and lower scholastic achievement.[29] These factors can contribute to unfavorable employment prospects and lower lifetime earnings.[30] As a result of bullying, gay youth can report higher than average rates of mental health issues such as anxiety, isolation, depression, suicide, alcohol and drug use, and homelessness.[31] Suicide may be the leading cause of death among LGBTI youth who may be three times likelier than heterosexual peers to attempt it.[32] Nevertheless, most gay and bisexual adolescents demonstrate great resilience and go on to lead healthy and well-adjusted lives despite the challenges they faces.[33]

- *So-called "conversion therapy"*

  So-called "conversion therapy", sometimes known as reparative therapy, is a harmful and discredited intervention that seeks to change an individual's sexual orientation. They are used to try and "cure" the sexual orientation and behaviors of gay and bisexual men. This purported "therapy" is not a valid mental health treatment. It seeks to exploit internalized homophobia in those who are subjected to it.[34] So-called "conversion therapy" can cause irreparable trauma and harm to individuals including insomnia, depression, homelessness, and suicide. It is especially dangerous for adolescents and young adults. Victims are eight times more likely than the average person to attempt suicide and six times likelier to report high levels of depression.[35]

  Mental health and medical professionals consider same-sex attraction a normal variation of human sexuality. Research has shown that gay men do not have any objective psychological dysfunction.[36] Leading health institutions have endorsed this position:

  - The WHO removed homosexuality as a psychiatric disorder from its International Classification of Diseases in 1992.[37] In 2016, the WHO stated that recognition of diversity in sexual behavior and expression contributes to better health of people.[38]
  - The American Psychiatric Association declassified homosexuality as a mental disorder in the Diagnostic and Statistical Manual (DSM) in 1973[39] and rejected so-called "conversion therapy" in 1998.[40]
  - The Chinese Society of Psychiatry removed homosexuality from its list of mental disorders in 2001. It also developed standards of care for LGBT people.[41]
  - In August 2013, the Lebanese Psychological Association and the Lebanese Psychiatric Society issued a statement declaring that homosexuality is not a disease and does not need to be treated. In 2015, Lebanon's health ministry included information about LGBT issues in the national mental health strategic plan.[42]

- In September 2018, India's Supreme Court decriminalized same-sex sexual acts between adults. The verdict declared that "...homosexuality is a completely natural condition, part of a range of human sexuality."[43]

- *Violence and trauma*

  Physical violence, emotional abuse, and sexual abuse - including rape - of gay and bisexual men remains an overlooked area within clinical science research and practice around the world.[44] Rape, sexual assault, sexual coercion, and domestic violence between male same-sex partners can occur at home, at work, in schools, on the streets, and elsewhere. Gay men who are out and visible may be at higher risk of being subjected to sexual harassment and rape.[45] Rates of domestic violence in same-sex relationships are similar to rates toward heterosexual women[46] and approximately 40 percent of gay men report having experienced domestic violence. Gay men are more likely to experience criminal victimization – domestic assault, physical assault and sexual assault – as they are also less likely to seek legal support.

  Gay men who have suffered violence or abuse can present with mental health problems such as debilitating anxiety or post-traumatic stress disorder. They may not report these crimes because of shame, fear, guilt, indifference, the possibility of additional trauma, or the possibility of prosecution. Support and resources for men who experience sexual violence is often scarce. Many healthcare providers who do provide services geared for men often lack appropriate training or sensitivity. Providers should familiarize themselves with organizations and providers that provide services for male victims of sexual violence.

- *Aging*

  Aging can be a stressful process. However, it can be particularly fraught for gay and bisexual men. A study of people aged 50 to 95 showed that older gay and bisexual men are less likely to be partnered or married, more likely to live alone, and more likely to have fewer children than their heterosexual peers.[47] Compounding these challenges is the fact that many subcultures within the gay community place great value on youth, physical beauty, fitness, and virility, resulting in both explicit and implicit ageism. One study reported that 44 percent of older gay men "feel disconnected from or even unwelcomed by younger generations of LGBTI people."[48] Aging gay or bisexual men may have limited access to social and financial support and can be at higher risk of social isolation. Isolation in older adults has been linked to poor mental and physical health outcomes, cognitive impairment, chronic disease, and premature death.[49] For instance, the previously mentioned study found higher rates of disability and mental health problems in older gay men than in their heterosexual peers. 29 percent of gay male and 36 percent of bisexual male older adults exhibited symptoms of depression as well as elevated anxiety. The results for suicide were alarming, with 37 percent of gay men and 39 percent of bisexual older men having seriously considered suicide and many reporting that this was directly related to their sexual orientation.

- *Discrimination in healthcare settings*

  Non-verbal gestures and disparaging remarks aimed at gay men have been widely reported in healthcare systems.[50] In many countries, the fear of judgment and shaming has discouraged gay men from seeking essential healthcare.[51] Gay men can also suffer when they are rendered invisible by healthcare providers and systems that view care through a heteronormative lens.[52] When gay men do not seek care for mental health issues because of their fear of stigma and discrimination, they are likely to remain ill or see their conditions worsen. Further, gay men who do not feel safe with or do not trust their healthcare providers are less likely to discuss their mental health issues openly, are more likely to provide incomplete or inaccurate histories, and are less likely to seek essential follow-up mental health care.[53] Gay and bisexual men can be doubly stigmatized by

healthcare providers for having a mental health illness, being a racial or ethnic minority, being a religious minority, being an immigrant, belonging to a lower socioeconomic class, being differently abled, being HIV positive, or being overweight.[54] Gay men facing dual or multiple levels of stigma experience even poorer mental health outcomes.

- *Religious trauma*

A majority of the world's population participates in organized religion.[55] As such, most gay men belong to a religious tradition when growing up and many continue practicing during adulthood. Studies have shown that most religions do not affirm homosexuality. Religious settings that are not supportive of gay men can be hostile environments. Affiliation with anti-gay religions has been linked to significantly higher levels of internalized homophobia which can cancel out the positive mental health benefits that organized religion may otherwise provide.[56] Homophobic bigots can also cite religion as an excuse to discriminate against gay people. Such cases of trauma have been widely documented and can cause gay men to feel socially ostracized and inferior. As a result, their mental health and well-being can be undermined.[57] Healthcare providers have the responsibility to treat gay men equitably and without allowing their personal religious choices to interfere with their professional responsibilities.

- *Social isolation during the COVID-19 pandemic*

Gay and bisexual men - who are already likely to be more socially isolated and susceptible to mental health challenges - are suffering disproportionately from the prolonged isolation caused by the COVID-19 global pandemic. Anxiety and fear about restrictions on mobility and socializing is likely to be particularly acute for gay men who live alone and rely on closely knit networks of friends for support. It can be further compounded by the fear of the unknown, such as not knowing when restrictions will be lifted and by fears of job loss. Pandemics pose a unique danger to gay men as they make it impossible for people to congregate and receive support.[58]

3 Common mental health concerns for gay men

This section will give healthcare providers a broad overview of the mental health issues commonly experienced or reported by gay and bisexual men.

- *Anxiety*

Owing to life-long experiences of stigma, harassment, discrimination, and violence, gay men are twice as likely to experience anxiety when compared to their heterosexual peers.[59] [60] [61] Experience of anxiety is linked to depression, elevated suicide risk, and other mental health illnesses.[62] Evidence shows that gay men are at increased risk for debilitating anxiety disorders, likely because they often need to conceal their sexual behaviors or identities to varying degrees because of fear, shame, or guilt. Bisexual men were twice as likely as heterosexual men to experience an anxiety disorder during their lifetime. Studies show that gay men often have lower self-esteem than heterosexual men and may experience additional social anxiety.[63] While anxiety is a normal human emotion that is closely related to fear,[64] it can be a disorder when it becomes excessive, is difficult to control, and affects day-to-day functioning. Symptoms of anxiety disorders may include sweating, heart palpitations, nausea, dizziness, and chills.

- *Depression*

  Depression is another common mental health issue that is related to anxiety and often afflicts gay and bisexual men. While it is normal for people to have mood swings, depression is far more than simply a low mood. It is a prolonged mood disorder that may drastically affect daily life and the ability to function normally. Some symptoms of depression may include feeling sad, hopeless, worthless, guilty, or bad about oneself; being unable to enjoy activities that would normally be pleasurable; feeling apathetic; feeling tired and having low energy; feeling lonely; having difficulty concentrating; experiencing disrupted sleep; and experiencing a drastic change in eating habits. Depression may sometimes include suicide ideation.

- *Suicidality*

  In general, men are about twice as likely to commit suicide as women.[65] Studies have shown that gay and bisexual men may commit suicide at a rate up to eight times higher than their heterosexual peers.[66] Suicide risk can be very high for gay adolescents and youth[67] who experience family rejection and are deprived of access to caring adults and safety at school. The strongest risk factor for suicide is a history of previous attempts. Additionally, gay men who face dual or multiple stigmas because of their racial minority identity or socioeconomic disadvantages can face even more elevated suicide risk. For instance, a recent study in Brazil found that young gay Brazilians who were poor and experienced stigma because of their sexual orientation were four times more likely to attempt suicide than heterosexual counterparts.[68]

- *Post-traumatic stress disorder*

  Gay men who are violently attacked, emotionally abused, sexually abused, or raped often present with mental health problems such as debilitating anxiety and/or post-traumatic stress disorder (PTSD). PTSD may be undiagnosed but it can have adverse impacts in the social and professional lives of victims. Many gay men are unwilling to report an attack or abuse because of the shame, guilt, fear of ridicule, indifference, the possibility of additional trauma, or the fear of criminal prosecution.

- *Body dysmorphic and eating disorders*

  The connection between physical health and body image is fundamental. How we feel about our bodies affects how we treat our bodies, particularly with regard to how much and what we choose to eat. Studies have found a relationship between body image dissatisfaction and dietary lifestyle, overeating, excessive exercising, and the development of eating disorders.[69] [70] Gay and bisexual men are significantly more likely to develop eating disorders. One study found that over 40 percent of men with eating disorders were gay.[71] Gay men have higher rates of dissatisfaction with their body shape and appearance than heterosexual men.[72] [73] They diet more frequently and have greater fear than heterosexual men of being overweight. Many gay subcultures are heavily focused on physical appearance and fitness.[74] Gay men who view themselves as overweight or inadequate may be at increased risk of developing debilitating eating disorders.[75]

- *HIV-related stress disorder*

  Biomedical advances have led to HIV being treated as a chronic but manageable permanent condition. But in many parts of the world, gay men living with HIV experience stigma, discrimination, and rejection when they disclose their HIV status. These experiences can cause stress, aggravate depression, increase isolation, and harm self-esteem. In some countries, laws that criminalize HIV transmission can worsen the stress. To avoid negative mental health outcomes and risks to safety and freedom, some HIV-positive gay men may not disclose their status to sexual partners, thus putting the latter at risk.[76] Gay men living with HIV may experience incidents that may cause them physical harm or mental stress.[77] Life-threatening illnesses such as HIV are recognized in the DSM as stressors that can lead

to a post-traumatic stress response.[78] The harassment, violence, and abuse that gay men encounter on a daily basis are risk factors for post-traumatic stress disorder. However, rather than causing shame, humiliation, or guilt, this response is primarily associated with fear and helplessness[79] [80] and may lead gay men with HIV to avoid seeking treatment or counseling.

Several events associated with HIV can cause severe stress. These include the trauma associated with receiving a diagnosis; beginning treatment, distress caused by the prospect of life-long treatment, inability to access treatment, fear of disclosing HIV status, side effects from treatment, and facing discrimination because of HIV positive status. Gay men with HIV encounter dual stigma from being a sexual minority and from their HIV status. They may encounter multiple stigmas if they belong to a marginalized group such as a racial minority or are an immigrant. The resultant accumulation of stigma and discrimination can cause severe mental distress.

- *Substance-related and addictive disorders*

  Studies have shown that gay men are much more likely to use substances such as drugs, alcohol, and tobacco than other men although there is a major distinction between recreational use and problematic use. One study found that LGB youth are 190% more likely to use these substances than the general population. Gay and bisexual men have also been shown to be particularly likely to use 'club' drugs such as cocaine, MDMA, methamphetamine (meth) and ketamine. 'Club' drugs are used to lower inhibitions and meth, in particular, is linked to high risk sex in gay and bisexual men and is a major factor in the transmission of HIV and STIs.[81] Substance use may be a way to cope with homophobic stressors such as bullying, violence, family rejection, and discrimination.[82]

- *Sexual problems arising due to poor mental health*

  Gay and bisexual men can experience sexual problems that afflict men in general or that may be unique to sexual minority men.[83] Sexual problems can include issues related to desire, drive, excitement, arousal, erectile dysfunction, difficulty in ejaculation, pain, and compulsivity.[84] Additional sexual problems in gay men are related to issues around anal sex or to mental problems caused by HIV diagnosis or STIs. Though not always the case, these problems may arise or persist for longer when combined with existing mental health issues such as anxiety or depression. Sexual dysfunction, in turn, can adversely impact overall psychological well-being and lead to cause stress in intimate relationships.

4 Tools for addressing the mental health needs of gay men

Healthcare providers can help address mental health problems for gay men by ensuring that they are treated with respect and dignity. Providers have a professional and ethical responsibility to avoid stigmatizing and discriminating against gay patients. They should also call out such behavior from other providers and staff. Additionally, as medical experts whose opinions are widely respected, providers have a unique responsibility to counsel family members to be more accepting of their gay children and relatives. This section will help providers increase their knowledge of and sensitivity to mental health problems among gay men. In general, trained mental healthcare professionals are best placed to assess and treat mental health concerns presented by gay men. Providers not adequately trained should not attempt to diagnose or treat mental health problems. This section is not designed to make clinical diagnoses. Providers should strive to become familiar with the key factors that affect the mental health of gay men and the most common issues they

face. Providers should also seek to do no harm to patients and should be able to make referrals to specialists if they are unable to provide care.

- *Normalizing homosexuality*

  First and foremost, providers who are presented with patients that are gay or bisexual should unconditionally affirm the validity of same-sex sexual orientations, attractions, and behaviors. For example, tell your client "there is nothing wrong with being gay" or "it is normal to be attracted to a person of the same gender." Next, providers should make available evidence-based information on the normality of same-sex orientations, attractions, and behaviors to clients and their family members. They should emphasize that these are not mental illnesses and do not require treatment. Providers should strive to be cognizant of factors that may contribute to stress and anxiety in the lives of gay men and be prepared to provide appropriate advice and referrals.

- *Anxiety and depression screening*

  A gay client presenting to a provider with symptoms of anxiety and depression should be referred to a competent and gay-friendly mental healthcare provider. To be able to do this, healthcare providers should familiarize themselves with tools to assess common mental health problems faced by gay men so they can recognize them and act accordingly.

  - Generalized Anxiety Disorder 7-item Scale (GAD-7) – Initial screening tool for generalized anxiety disorder. Available at: *https://www.hiv.uw.edu/page/mental-health-screening/gad-7*
  - The Hospital Anxiety and Depression Scale – A self-assessment scale for screening purposes that can be used in medical settings, primary healthcare settings, and community settings. Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC183845/pdf/1477-7525-1-29.pdf*
  - Hamilton Anxiety Rating Scale (HAM-A) – A scale used in clinical and research settings that measures mental agitation, psychological distress, and physical complaints related to anxiety. Available at: *https://dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-ANXIETY.pdf*

- *Suicide risk assessment and prevention*

  Healthcare providers should keep in mind that suicide is one of the leading causes of death among gay people of all ages. Young gay people are particularly vulnerable.[85] When treating gay clients, providers should be aware that distressed patients often visit their doctors in the lead up to a successful suicide. Thus, being able to conduct a basic psychological assessment should be a standard practice as it allows for timely interventions.[86] Providers should familiarize themselves with gay-sensitive resources on suicide. They should have a list of gay-friendly professionals who can handle suicide-related mental health concerns and should share this list with clients who might need it. If the risk of suicide is imminent, providers should immediately contact emergency services to report it. Here are some useful resources to screen for suicide and to make referrals:

  - The Columbia Protocol for families, friends, and neighbors (C-SSRS) – Can be used to assess suicide risk and determine whether someone needs help by asking three to six questions. Available at: https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-families-friends-and-neighbors/
  - Suicide Assessment Five-step Evaluation and Triage (SAFE-T) for clinicians – Based on APA practice guidelines, this tool provides a five-step evaluation and triage plan to conduct a suicide assessment. Available at: https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

- Preventing Suicide: The Warning Signs of Suicide, The Trevor Project – A useful list of warning signs about suicide ideation in others or self. Available at: https://www.thetrevorproject.org/resources/preventing-suicide/warning-signs-of-suicide/
- Suicide Screening Questions – A simple one-pager with questions to screen for suicide and a list of emergency resources: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf
- List of Suicide Risk Reduction Interventions, SAMHSA's National Registry of Evidence-based Programs and Practices. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918883/table/T1/?report=objectonly

◆ *Trauma-informed care*

Healthcare providers should familiarize themselves with organizations that provide services for gay men who have been subjected to sexual, physical, and emotional violence. This is crucial as support and resources for men who experience sexual violence is often scarce. Providers should also adopt the principles of trauma-informed care which focuses on providing support services that are accessible and appropriate for those who have undergone trauma. By trying to understand what has traumatized a person – rather than treating their behaviors as a pathology – trauma-informed care forestalls the possibility of re-traumatizing or triggering people.[87] The following can be useful to providers who seek to administer trauma-informed care:

- PTSD Assessment Instruments – Interview and self-report instruments that can help measure the severity and effects of PTSD. Available at: https://www.apa.org/ptsd-guideline/assessment/
- Management of PTSD and acute stress reaction, 2017 – Evidence-based recommendations to improve outcome for patients with PTSD and help with their clinical management. Available at: https://www.healthquality.va.gov/guidelines/MH/ptsd/

◆ *Countering so-called "conversion therapy"*

In situations where a family member has difficulty accepting an individual's sexual orientation or gender identity, healthcare providers should provide scientific data about the normality of same-sex attractions. They should help them understand and accept a gay individual without feeling guilt, shame, hatred, or prejudice. In some cases, family members may try to force gay relatives into the discredited practice of so-called "conversion therapy." This is an ineffective, unethical, and dangerous practice. The WHO has labeled it a "severe threat to the health and human rights" of those who are subjected to it. So-called "conversion therapy" violates human rights that are protected by universal and regional treaties and conventions and the WHO has stated that these practices should be "subject to adequate sanctions and penalties."[88] The American Psychiatric Association (APA) denounced this practice in 1998. In 2013, the APA declared that it "...does not believe that same-sex orientation should...be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated... nor, from a mental health perspective does sexual orientation need to be changed."[89] If gay men express the desire to change sexual orientation, the most effective and appropriate therapeutic response is affirmative therapy which can help clients develop skills to cope with coming out and accept their sexual orientation or desires.[90] Therapists should provide support, acceptance, and validation of same-sex sexual orientation.

◆ *Body dysmorphic and eating disorders*

Here is a list of useful resources for healthcare providers who encounter gay men with body image or eating disorders:

- Eating Disorders Screening Tool, National Eating Disorders Association (NEDA) –

A short screening for those aged 13 and over that can help determine if someone needs professional help. Available at: https://www.nationaleatingdisorders.org/screening-tool

- SCOFF questionnaire – A tool to help primary care providers assess if a patient has an eating disorder. Available at: https://pcptoolkit.beaconhealthoptions.com/wp-content/uploads/2016/02/SCOFF-Questions.pdf
- Addressing eating disorders, body dissatisfaction, and obesity among sexual and gender minority youth, National LGBT Health Education Center – An informative guide on how primary and behavioral healthcare providers and others can screen for and address eating disorders and body image issues in sexual and gender minority youth. Available at: https://www.lgbthealtheducation.org/wp-content/uploads/2018/04/EatingDisordersBodyImageBrief.pdf

- *HIV-related stress disorder*

The tools listed above to measure and address anxiety, depression, and PTSD should be used when providers are working with gay men living with HIV. Additionally, providers should expand traditional stress management interventions to deal with co-morbid conditions such as PTSD, mood disorders, anxiety disorders, and substance use as these can disrupt adherence to ART – which is critical for effective management of HIV.[91] By making ART adherence more likely, providers can improve the overall mental health, physical health, and quality of life of HIV positive gay men. Adherence training should also be integrated into stress management interventions.

- *Sexual problems due to poor mental health*

Healthcare providers should refer gay men encountering sexual problems to appropriate psychological or specialized medical services as necessary. If psychological distress is the cause of the sexual problem, then addressing the underlying causes of the distress will likely solve the sexual problem.

- *Addictive disorders*

Once a substance use or addictive disorder is diagnosed, providers have to evaluate and choose from a range of options as there is no cure per se. Treatments can be contingent on the substance used and any related mental health or other health considerations. Some of the options available to providers are behavior therapy, recommending a self-help or support group, withdrawal therapy or detoxification, chemical dependence treatment programs, or emergency hospitalization to treat overdoses.[92]

- *Mental health screening*

A mental health screening includes a series of observations to get a full picture of a patient's thinking, cognition, and emotions with the goal of identifying issues that may merit further investigation, intervention, or a referral for additional care. The following tools can be utilized by mental health providers to conduct a mental health screening:

- Mental Status Examination Screening for Mental Disorders Template, University of Nevada – Focused questions to reveal pathological findings related to a patient's appearance, thinking, emotion, and cognition at a point in time. Combined with other it can help make a provided make a psychiatric diagnosis.
- Kessler 6 and Kessler 10 scales – Measurement scales that help distinguish between cases of serious mental illness and non-cases. Available at: https://www.hcp.med.harvard.edu/ncs/k6_scales.php
- The Mental Status Examination – A tool that evaluates a comprehensive range of mental indicators in a patient to determine their mental status and identify problems. Available at: http://www.mhit.org/assets/mse.pdf

- *Counseling*

  As discussed above, gay men can experience isolation, anxiety, depression, suicidal ideation, sexual health problems arising from mental distress, psychological trauma, eating disorders, HIV-related stress and other problems. Healthcare providers who encounter gay men experiencing one or more of these issues should refer them to a qualified clinical mental health counselor. A clinical mental health counselor is a trained professional who operates from a holistic wellness approach that seeks to elevate the well-being of patients. Counselors may utilize a variety of approaches, theories, and guidance to help their patients:

  - The top 10 basic counseling skills – Useful guidance for counselors on how to be more effective without focusing on any particular counseling methodology. Available at: http://www.people.vcu.edu/~krhall/resources/cnslskills.pdf
  - AIPC's Counselor Skill Series – Guidance on verbal and non-verbal communications skills that can help counselors assist their patients. Available at: https://www.counsellingconnection.com/wp-content/uploads/2009/10/report-1-verbal-and-non-verbal-communication-skills.pdf
  - Counseling and mental healthcare of transgender adults and loved ones. Guidance for providers who may have trans men as clients. Available at: https://lgbtqpn.ca/wp-content/uploads/woocommerce_uploads/2014/08/Guidelines-mentalhealth.pdf

- *Mind-body medicine*

  Mind-body and complementary medicine are emerging fields in healthcare. A mind-body approach looks at healthcare holistically and from an overall well-being perspective. It recognizes that mental illness and health are intrinsically linked and that many medical disorders are exacerbated by lifestyle, stress, and psychological factors. Mind-body medicine emphasizes behavioral changes to improve mental health. It empowers primary healthcare providers to deliver simple behavioral interventions to improve patient health.[93] Providers can offer the following mind-body health tips and resources to help gay patients cope with and overcome their mental health problems:

  - Exercise regularly to treat depression and anxiety: https://pubmed.ncbi.nlm.nih.gov/21495519/
  - Get adequate sleep: https://pubmed.ncbi.nlm.nih.gov/30832951/
  - Eat nutritious meals: https://pubmed.ncbi.nlm.nih.gov/28707609/
  - Engage in pleasurable and relaxing hobbies
  - Keep in touch with loved ones through digital means if meeting up is not possible
  - Practice yoga: https://pubmed.ncbi.nlm.nih.gov/28437149/
  - Practice meditation: https://pubmed.ncbi.nlm.nih.gov/25783612/

- *Psychopharmacology*

  While clinical mental health counseling and behavioral interventions can be highly beneficial for the mental health and well-being of gay patients, they may not always be adequate. In many cases, the introduction of drugs as part of a treatment plan can have a highly beneficial impact on patient well-being. Using behavioral counseling and drugs together might also achieve optimal results. Healthcare providers should always refer patients to an appropriately qualified mental healthcare professional to prescribe drugs to treat mental health issues. Both the use of drugs and behavioral counseling should be part of a holistic intervention to improve a gay patient's health and well-being. Psychiatrists and psycho-pharmacologists can prescribe drugs as part of a treatment plan to resolve mental health problems faced by patients that cannot not be resolved other means. It must be emphasized that drugs used to treat mental health issues should only be prescribed by those specially trained to understand their uses, effects, and side effects. Untrained practitioners and others should be careful not to prescribe drugs as they can cause serious

harm or have unexpected side effects. The following resource provides useful information on the five primary kinds of drugs used to treat mental health issues – antidepressants, anti-anxiety medicines, stimulants, antipsychotics, and mood stabilizers:

- Mental Health Medications, National Institute of Mental Health: https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml

COVID-19 global pandemic: Isolation, fear, and anxiety

A deadly new infectious disease originated in Wuhan, China in December 2019 and caused a global pandemic. By the end of April 2021, about 161 million people had been infected and over about 3.2 million people had been killed around the world by the disease known as COVID-19.[94]

COVID-19 is caused by a novel coronavirus that is highly infectious and easily transmitted. It causes respiratory problems and is particularly deadly for older people and those with underlying medical conditions such as diabetes, cardiovascular disease, and cancer.[95]

The WHO and many governments mandated social distancing to slow down the spread of COVID-19. This involved avoiding physical contact with people and keeping a distance of at least six feet from others when outside home.[96] Billions of people worldwide went into government-enforced or voluntary isolation for months owing to the pandemic. For many, this involved living alone or having limited contact with a small number of people for an extended period of time. Public health authorities warned that this isolation would generate fear, anxiety, helplessness, boredom, and an obsession with following every new development related to the pandemic.

Isolation, sometimes for even a few days, has been shown to cause mental health problems such as anxiety and depression and long-term isolation can increase the risk of premature death.[97] [98] Social isolation can also be twice as harmful as obesity and it can also set off two triggers for mental illness - the decaying of emotional attachments with loved ones and the persistent fear for one's own life.[99] Loneliness can also lead to an increased use of alcohol and tobacco, reduced time spent exercising, and increased risk of cardiovascular disease.[100] Many gay and bisexual men were confronted with a variety of mental health challenges as a result of prolonged isolation due to the COVID-19 pandemic. For many, these challenges were compounded by the loss of jobs and difficulty in obtaining food, medicines, and essential supplies.

The anticipatory fear and increase in mental illnesses brought about by the COVID-19 pandemic can be addressed by increasing access to medication and to therapists,[101] even if these have to be accessed through telemedicine or other creative ways.

6 The importance of relationships and community building

Gay and bisexual men experience social stressors and structural inequities from a young age. These can include stigma, discrimination, harassment, violence, and harmful or exclusionary laws. Nevertheless, most gay men demonstrate incredible resilience and overcome challenges and go on to live healthy and well-adjusted lives.[102] Social support from family, friends, and partners is an important facilitator of this well-being. Despite the pernicious stereotype that gay and bisexual men are unable to maintain stable relationships, studies show that they do maintain long-lasting relationships as a primary source of support and affection even in socially unsupportive or openly hostile environments.[103 104 105]

Beyond healthy and stable relationships, studies of gay and lesbian adults suggest that finding a community and developing a support system are fundamental elements in protecting against the risks and dangers posed by homophobia. Gay social, cultural, and political groups play a particularly critical role as they provide resources, information, and support and are able to conduct outreach to vulnerable individuals.

7 Guidelines for mental health professionals

These guidelines which are modified and adapted from the American Psychological Association[106] can be useful for professionals providing mental healthcare or referrals to gay clients:

1. Providers understand that gay and bisexual orientations are not mental illnesses and that same-sex attractions, feelings, and behavior are normal.
2. Providers strive to be knowledgeable about and respect the importance of gay and bisexual relationships.
3. Providers strive to understand the effects of stigma and its manifestations in the lives of gay and bisexual men.
4. Providers understand that efforts to change sexual orientation are unethical, unsafe, and ineffective.
5. Providers strive to recognize the challenges related to multiple and often conflicting norms, values, and beliefs faced by gay members of racial and ethnic minority groups.
6. Providers strive to recognize intersectional identities which include but limited to age, ability, and socioeconomic status differences among gay and bisexual men.
7. Providers strive to understand the disproportionate and deadly impact of HIV on the lives of gay and bisexual men and their communities.
8. Providers should be able to make appropriate referrals when needed.
9. Providers strive to distinguish issues of sexual orientation from those of gender identity.
10. Providers recognize that the families of gay people may include people who are not legally or biologically related.
11. Providers strive to understand the ways in which a gay person's sexual orientation may have an impact on their relationship with their family of origin.
12. Providers strive to understand the unique workplace challenges that exist for gay men.

Healthcare providers should be able to give their patients tools and resources from the LGBTI community. This should include directing clients to resources produced by local community-based organizations and groups and supplying a list of mental health providers who are sensitive to the needs of gay men.[107] Providers should always seek to be informed, affirming, and supportive in order to provide effective mental health treatment to gay clients. While affirming providers can help clients cope with their mental health challenges, biased or hostile providers can harm clients due to their negative attitudes which may be manifested through body language or the presentation of unsuitable care options.[108]

8 Key points from the module

- Same-sex attractions, behaviors, or orientations are normal. They are not mental disorders.
- Experiences of homophobia, stigma, discrimination, and violence subject gay and bisexual men to higher risk of developing mental disorders.
- Gay and bisexual men experience elevated stress while coming out and during certain life stages such as during adolescence and when aging.
- So-called "conversion therapy" is not a valid, safe, or effective response to a gay adolescent or adult who comes out.
- Affirmation of same-sex behavior and identities and providing counseling can minimize the effects of stigma. This can improve the well-being of gay and bisexual men.
- Healthcare providers should strive to be knowledgeable about mental health issues affecting gay and bisexual men and be prepared to make appropriate referrals.
- Gay men are more likely than other men to experience anxiety, depression, suicidal ideation, and eating disorders.
- Healthcare providers should provide mental health and other healthcare to the best of their professional ability to gay men even if they have personal biases or reservations.
- Healthcare providers should be open to using and adapting a range of evidence-based practices to help gay clients.
- Support from community-based organizations or support groups can be protective against social isolation and the dangerous effects of homophobia.

Quiz

1. Homosexuality is classified as a mental illness in the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.
1.1. True *1.2. False*

2. Most studies have shown that so-called "conversion therapy" that attempts to "cure" an individual of their same-sex sexual attraction is effective.
2.1. True *2.2. False*

3. Examples of stigma and discrimination toward gay and bisexual men by healthcare providers include:
3.1. Refusing to provide care;
3.2. Refusing to touch a gay client;
3.3. Using abusive language;
3.4. Blaming the gay client for their health problems;
3.5. All of the above.

4. _____ refers to a period when a gay man becomes conscious of his sexual orientation and the fact that he is sexually and/or emotionally attracted to other men.

5. Affirming an individual's same-sex sexual orientation and reflecting a positive view of same-sex identities and relationships are strategies to address the negative influences of stigma and discrimination on gay clients.
5.1. True *5.2. False*

6. Experiences of stigma and social discrimination put gay and bisexual men at higher risk of developing mental disorders such as anxiety or depression.
6.1. True *6.2. False*

7. It is not possible for a man to be raped.
7.1.True *7.2. False*

8. Which of these is NOT a consequence of the criminalization of same-sex sexual relations or identities?
8.1. Decreased access to health services, housing, and/or employment opportunities for gay and bisexual men;
8.2. Increased likelihood of disclosure of same-sex behavior by gay and bisexual men;
8.3. Deterrence of health workers from providing essential medical services to gay and bisexual men;
8.4. Higher rates of stigma and discrimination toward gay and bisexual men.

9. Younger gay men usually exhibit higher rates of depression, anxiety, and suicidality than other men in their age cohort.
9.1. True *9.2. False*

10. Social support from partners, family, or the community improves the mental health outcomes of gay and bisexual men.
10.1. True *10.2. False*

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Module 6

Supporting Gay Men Who Use Drugs and Alcohol

1 Introduction

Gay, bisexual, and other men who have sex with men, including transgender men who have sex with men (hereby referred to as gay men) are more likely to use alcohol and non-prescription drugs that are considered illegal or recreational than other adults.[1] The higher rates of drug and alcohol use in gay men are often a mechanism to cope with homophobia, discrimination, and violence that they experience because of their sexual orientation.[2]

Drug and alcohol use, problematic use, and/or dependence are driven by different factors in different parts of the world and the interventions by healthcare providers need to be tailored accordingly. This module will provide an overview of drugs and alcohol use in gay men. It will discuss the contexts in which drug and alcohol use occurs, including in sexual settings.

The module will also increase healthcare providers' comfort in discussing drug and alcohol use with gay clients in clinical settings. However, this module does not provide clinical training on implementing harm reduction interventions like needle exchange programs nor does it provide medical training on diagnosing or treating drug and alcohol dependence. Clients needing such interventions should be referred to specialized medical professionals who can provide appropriate care.

2 Discussing drugs and alcohol with gay men in clinical settings

An unknown number of people around the world use drugs and alcohol. People of all ages, socioeconomic classes, sexual orientations, gender identities, races, and nationalities use drugs and alcohol for various reasons. Many individuals, including gay men, use drugs and alcohol regularly or occasionally without any disruption or negative impact on their health or their social and professional lives.

Some gay men report benefits such as increased ability to cope with problems and enhancement of pleasure from their use of drugs or alcohol.[3] There is no innate link between drug and alcohol use (especially when use is moderate) and health problems in gay men.

It is also important to recognize that for many other people, drug and alcohol use might be problematic. For some such usage can pose challenges each time they use it. For others, problems may arise only under specific circumstances. For instance, drug and alcohol use may be problematic only when using a particular drug or a specific type of alcohol or only when using excessive amounts. In these cases, individuals may report that their drug and alcohol use interfere, at all times or under specific circumstances, with their personal health and/or with their job, relationships, and family relations.[4]

Candid discussions about the use of drugs and alcohol between healthcare providers and their gay clients in clinical settings can be challenging. The use and possession of drugs is socially stigmatized and criminalized in nearly every country,[5] making it hard for clients and their providers to openly and honestly discuss drug use. Discussions about drug use can present with barriers in nearly every context and in any population.

For gay and bisexual men who use drugs, the added stigma of their sexuality can make it even more challenging to honestly talk about drug and alcohol use with providers.

3 Drugs and alcohol usage among gay men

Research of drug and alcohol use among any population is difficult for many reasons. Some of these reasons are methodological due to challenges in comparing data across studies or in different regional contexts. Additionally, most studies on drug use do not collect data on LGBTI people and, even if they do so, do not disaggregate the data by sexual orientation or gender identity.[6]

The prevalence of drug use among gay and bisexual men also varies greatly across different parts of the world[7] and cannot be generalized or extrapolated based on a study based on trends in a single country or a single geographic region. Gay men are also more likely to use certain drugs more frequently compared to other populations. For instance, a national study in Australia found that gay and bisexual men used meth almost four times as much as heterosexual men.[8]

Healthcare providers should keep in mind that patterns of drug and alcohol use can vary greatly across different parts of the world, across communities within the same country, and even across the lifetime of an individual. These factors make it challenging to study and to accurately understand drug and alcohol use patterns among gay men. As it is, gay men are often hidden, or otherwise difficult for providers to reach due to societal stigma, homophobia, criminalization and/or violence. The stigma associated with drug can compound the stigma related to same-sex attraction and prevent gay men from openly discussing drug use with their providers or with researchers.

As mentioned before, studies have suggested higher rates of drug and alcohol use among marginalized populations such as gay men. While more research is needed to understand why gay men disproportionately use drugs and alcohol, some of the currently known reasons are:

- The use of drugs and alcohol may be common or acceptable in social venues where gay men socialize or seek sexual partners.
- Drugs can intensify perceptions of intimacy and facilitate a sense of sexual adventure.[9]
- Drugs and alcohol help gay men overcome social inhibitions and increase their confidence when seeking sexual partners.[10]
- Drugs and alcohol can increase pleasure during sexual experiences, enable sex for extended periods of time, and lower sexual inhibitions.[11 12 13]
- Drugs and alcohol can help gay men cope with anxiety, depression, isolation, and loneliness that result from stigma, homophobia, and social marginalization.
- For gay men living with HIV, drugs and alcohol may help them cope with their diagnosis and escape the fear of rejection.[14]

4 Known patterns of drug use among gay men

Healthcare providers should be aware that drug use among gay and bisexual men can vary depending on where they live, their socioeconomic class, their access to drugs, and individual circumstances. Based on the data that is currently available, inferences can be made about the patterns of drug use among gay men. Weekly or monthly drug use appears to be more common among gay men than daily use. This suggests that a majority of gay men are not drug-dependent. Rather, they may use drugs in specific settings, such as when they experience stress, at social events, or when having sex.[15]

The use of drugs such as crystal methamphetamine (meth) and other drugs during sex, or sexualized drug use, is colloquially called 'party and play' or 'chemsex' and is increasingly prevalent among gay men in many parts of the world, especially in Asia and in North America.[16] Meth is highly addictive and potent. A single dose can create euphoria and hyperactivity for hours. The psychological effects of long-term meth use include aggression, hallucinations, depression, and suicidality. Meth causes long-term harm including neural damage, cognitive impairment, cardiovascular damage, dental disease, and stroke. The drug is also associated with risky sexual behavior.[17]

A study of gay men in Germany found that over a quarter of them had used meth in the preceding year. Of those who had used meth, almost 90 percent had used it in sexualized settings and half reported injecting it.[18]

The prevalence of injection drug use, especially heroin, has historically been low among gay men. Rates of non-injection drug use have generally been higher. However, higher levels of injection drug use are being reported in some settings in more recent studies.[19] [20]

A practice called "slamming," in which psychostimulant drugs (such as meth) are injected during sex, has increased in popularity among gay men in the last decade. A recent study in France found poorer mental health outcomes in gay men who engaged in this practice. It suggested that healthcare providers proactively take harm reduction measures to address drug dependency and sexual health in this population.[21]

Another drug that gay men increasingly use in sexualized contexts is Gamm-hydroxybutyrate, or GHB, which is a sexual-enhancer often used in sex parties. GHB can cause serious harm, including death, especially when mixed with alcohol or with drugs such as ketamine, cocaine, and mephedrone.[22] A study in Australia found that one in five gay men had used the drug and almost 15 percent of users had overdosed on it.[23] Those who used more frequently were likelier to overdose. The gay men likelier to use GHB more frequently had larger numbers of sexual partners, more gay friends who used drugs, were likelier to engage in condomless anal sex, and were more likely to be HIV positive. Healthcare providers with gay clients who use GHB frequently should consider harm reduction interventions.[24]

Not all drugs that gay men commonly use are as harmful as crystal meth or GHB. For instance, poppers or amyl nitrate inhalants are a very popular drug used by many gay men. Poppers relax muscles in the throat and anus (sphincter muscles) and facilitates more comfortable and pleasurable anal sex. The effects of poppers last for a brief time and are generally not associated with serious or longer-term harm. While extended use of poppers may cause headaches or irritate skin if there is contact, poppers are relatively lower risk compared to a drug like meth.

The patterns of drug use may not be uniform or consistent across communities of gay men even in the same country. For instance, gay men from ethnic or racial minorities in the United States and Australia, younger gay men, and gay men who live in urban areas have reported higher rates of drug use compared to the overall gay male population.[25] [26] [27] [28]

Gay men sometimes may use more than a single kind of drug during the same session or within a given time frame. This is known as poly drug use. Poly drug use may pose additional or unknown health risks due to the synergies between drugs and the side effects. For healthcare providers, poly drug use has implications for taking a comprehensive drug use history in a clinical encounter and for delivering accurate, effective, and timely healthcare.[29] [30]

Healthcare providers with gay clients who use drugs should provide harm reduction interventions that account for the cultural and social contexts of sexualized drug use.[31] Harm reduction strategies can take a variety of forms and will be discussed in greater detail later in this module.

How to Inject Safely

Drug users who inject should take precautions to ensure their own safety and the safety of those around them. Unsafe injection practices can be a serious threat to health. Needles and syringes should be discarded after every use. Sharing either needles or syringes can transmit diseases such as HIV, hepatitis C, or hepatitis B.[32]

These tips - adapted from a resource created by the National Harm Reduction Coalition - can help people who inject drugs do so safely:[33]

1. *Learn how to prepare and safely inject drugs in order to avoid dangerous mistakes and to not have to rely on others.*
2. *Learn about parts of the body where it is safer to inject. The arms are the safest part of the body, followed by the hands, feet, groin, and legs in that order.*
3. *Always inject into a vein and never into an artery.*
4. *Avoid injecting repeatedly in favorite spots to prevent leaky veins and infection.*
5. *Clean skin prior to injection to reduce risk of blood poisoning and other infections.*
6. *Tie tourniquet in such a way that it can be easily removed if necessary.*
7. *Insert the needle into a vein with the needle tip facing up and at a 15-35-degree angle.*
8. *When mainlining cocaine, be extra careful to do so in a vein as they can become numb. This can prevent trauma to the veins and the surrounding tissues and prevent bleeding.*
9. *Keep in mind that mainlining (injecting cocaine, meth, or heroin intravenously) can be risky as it creates an opening between the bloodstream and the outside world.*

5 The link between drug use and HIV and STI transmission

Links between non-injection drug use and HIV are not fully understood and are complex. Many gay clients and their healthcare providers may be concerned about possible links. While some studies have shown a connection between the use of some kinds of drugs and higher incidences of HIV, there is limited evidence to suggest a direct causal relation. The strength of the correlation may further vary depending on variables such as the kind of drug used, the frequency of use, and the amount used.

Injecting drug use in particular may be linked to higher risk of HIV transmission. This is especially true when injection equipment is shared and condomless penetrative sex occurs between a serodiscordant couple (in which one person is HIV positive and viremic). In the United States, injection drug users represent an estimated 12% of new HIV cases each year.[34]

Many gay people and providers are concerned about whether the increasing use of pre-exposure prophylaxis, or PrEP, by gay men is causing a spike in STI cases. Others worry that gay men may not adhere to their PrEP regimen when using drugs. PrEP is a major scientific breakthrough in HIV prevention science. It involves the use of antiretroviral medication taken orally every day by HIV-negative people to prevent the transmission of HIV (it will also be discussed in much greater detail in the next module on HIV and STI prevention and sexual health promotion).

The use of PrEP among gay men has been linked to a rapid rise in syphilis and other STI cases among gay men in the U.K. Many gay men who use PrEP have stopped using condoms. While PrEP protects against HIV, it does nothing to stop the transmission of STIs. Additionally, the growing number of gay men who engage in chemsex and do not use condoms (both because of the lowered inhibition from the drugs and because they are on

PrEP) has further fueled the rise of syphilis and STIs among gay men.[35]
The fear that gay men engaging in chemsex may not adhere to their PrEP regimen has not been borne out by evidence. On the contrary, a recent study indicated that gay and bisexual men engaging in chemsex are, in fact, specifically getting on PrEP in increasing numbers to actively reduce the possibility of HIV transmission.[36] PrEP use is often higher among drug users, which might suggest a higher level of risk awareness and/or good signposting by healthcare providers. Nevertheless, another study has found that gay men who use meth in sexualized contexts are more likely to be HIV positive.[37] As such, providers should offer PrEP, if available, to their gay clients who engage in chemsex, use other drugs, or engage in sexual behaviors that put them at higher risk of HIV transmission..

6 Drugs commonly used by gay men and their effects

The table below describes the nicknames or regional variations and the effects of drugs that are most commonly used by gay and bisexual men around the world.[38] [39] [40] Not all drugs are problematic at all times, and gay men are likelier to find some drugs - such as crystal meth - more problematic than others. The frequency of use and the amount of a drug (or drugs) used may also be relevant to whether they cause problems.

Drug name	Street name/ Regional Variation	Effect
Alcohol		*-Induces a state of relaxation and happiness -Inhibitions can be lowered -Continuous consumption can lead to blurred vision, coordination problems, and aggressive behavior -Long-term and heavy use may harm vital organs and may increase the risk of cardiovascular disease, alcoholic liver disease, and cancer*
Amphetamine	*Speed, Uppers, Sulphate, Whizz*	*-Immediate effects include high energy, confidence, feeling invincible, impulsiveness -Continuous use may lead to anxiety, depression, confusion, insomnia, psychosis, suicidal ideation -Long term use can lead to loss of motor control or memory*
Canabis	*Marijuana, Mary Jane, Dope, Pot, Spliff, Hash(ish),Weed, Puff, Grass, Herb, Draw, Wacky backy, Ganja, Hemp*	*-Induces a state of relaxation and happiness -Heightens physical sensitivity -Can enhance sexual pleasure and satisfaction -Can increase appetite*

Cocaine	*Coke, Charlie, C, Snow, Blow, A toot, Bolivian/ Peruvian/Colombian marching powder*	*-Feelings of extreme happiness, confidence, and sexual arousal -This is usually followed by agitation, anxiety, paranoia, and decreased appetite -Rare side and dosage-dependent effects include cardiac arrest or seizures, respiratory problems, insomnia, blurred vision, and vomiting*
Crack Cocaine	*Rock, Base*	
Crystal meth-amphetamine	*Crystal, Tina, Meth, Ice, Crank*	*-Related to amphetamines (see above) but stronger -Triggers intense sexual arousal -Facilitates sexual longevity with the effect being much more pronounced than with regular amphetamines -Can trigger psychosis, anxiety, and depression[41]*
Ecstasy	*E, MDMA, X, XTC*	*-Feelings of extreme wellbeing and happiness -Large doses may lead to an increase in core body temperature, confusion, irrational behavior, palpitations, shaking, dehydration, collapse, and convulsions*
GHB/GBL	*Gina, G, Liquid ecstasy*	*-Sense of euphoria and feelings of sexual arousal -Even an extra milliliter of GBL over a moderate dose can result in an overdose -An overdose can cause unconsciousness, coma, or death by respiratory depression*
Heroin	*Smack, Skag, Junk, Horse*	*-Produces initial pleasurable sensation, warmth, dry mouth, heaviness in arms and legs, possibly nausea, vomiting, and severe itching -Large doses may lead to nausea, vomiting, respiratory paralysis, heart attack, stroke, anaphylactic shock, coma, psychiatric complications, or death*
Mephedrone	*Meow Meow, White Magic, Drone, M-CAT*	*-Produces euphoria, improves mental function, mildly stimulates sexual desire, reduces aggression, suppressed appetite -Withdrawal can cause nasal congestion, tiredness, insomnia, and reduced concentration*
Poppers	*Amyl, Butyl, Isobutyl nitrate, Aromas, Liquid incense*	*-Makes anal sexual intercourse, especially for those bottoming or being penetrated, highly pleasurable -Overuse may cause headaches, skin rashes, sinus pains, and burns if the liquid comes into contact with the skin around the nose while inhaling*

Table 7.1 List of commonly used drugs and their effects

Discussing drug and alcohol use with gay clients in clinical settings

Discussing drug and alcohol use is a difficult topic for both healthcare providers and their gay and bisexual clients. It is therefore crucial that providers be sensitive to their own anxieties and those of their gay clients when discussing drug and alcohol use.

When meeting with a gay client who uses drugs and/or alcohol, providers should acknowledge at the outset that such usage can be an important aspect of the client's life. The motivations for using drugs and alcohol can be multifaceted. Simply lecturing clients about the harms associated with such use is unlikely to facilitate behavior change. Instead, it may indeed trigger disengagement from healthcare services and end up causing more harm than good.

Healthcare providers should use appropriate language when asking questions about drug and alcohol use. They should do the following:

-Build rapport and confidence with the client.

-Use a nonjudgmental and non-confrontational approach.

-Remind clients that any information they share will be kept confidential.

-If client information has to be shared externally, providers should reveal to the client with whom it will be shared and under what circumstances. This also applies to information that the provider documents. Clients have a right to know if what they disclose will be documented and how that information will be used.

There are other techniques that can be helpful for providers when discussing drug and alcohol use with gay clients. These techniques involve using language that is sensitive and can draw out the information that is needed from clients. Below are some examples of phrases and language that can be used and the purpose they will serve:[42]

- Normalize the conversation: *"Many people find it difficult to talk about sex, alcohol, and drugs."*
- Be transparent on why you are asking questions and how it will help the client: *"I need to ask you some very specific questions about your drug and alcohol use in order to better understand your health needs and provide the best possible care."*
- Ask permission: *"Would it be alright if I asked you some questions about your drug and alcohol use?"*
- Provide an option to not answer questions: *"If you are not comfortable answering any of these questions, you do not have to answer them."*
- Offer response choices: *"How often do you mix drugs together? Never, Sometimes, Always, or Almost Always?"*
- Avoid asking for judgments or opinions: *"How often do you drink in a week?"* or *"how many drinks do you drink in one setting?"* is much better than asking *"Do you get drunk?"* or *"Do you drink often?"*
- Ask specific questions: *"Have you ever used marijuana?"* or *"Have you ever used cocaine?"* is better than *"Have you ever used drugs recreationally?"*

8 Drug and alcohol use screening tools

Screening tools can help healthcare providers support their gay and bisexual clients who use drugs and alcohol. While it is ultimately a gay client's decision whether to stop or modify their drug and alcohol use, providers can help them make an informed decision.

The guidance below can help providers support gay clients who use drugs and alcohol. It is not a substitute for clinical guidance. It is also not a substitute for delivering harm reduction interventions such as needle-exchange programs or for diagnosing problematic use and/or dependence.

To support gay clients who use drug and alcohol and who wish to modify or reduce their dependence, providers can do the following:

- Identify what the client's goals are in relationship to drug use and/or alcohol use.
- Ask the client what they enjoy and value about using drugs and/or alcohol.
- Ask the client how they might experience pleasure or satisfaction without the use of drugs and/or alcohol.
- Engage the client in an open discussion about whether or not current use aligns with where the client wants to be.
- Use motivational interviewing techniques to help the client articulate their personal goals.
- Come to a clear understanding of where clients' stand with their goals in relationship to their current drug and alcohol use.

Regardless of the outcome of such discussions, healthcare providers should provide accurate information to clients, including on the risks of death from overdosing. They should also flag any relevant local information to help prioritize personal safety and security, for instance clients should be aware if applicable laws provide for their arrest, a prison sentence, or their firing from a job if they use drugs.

Providers can effectively screen for drug and alcohol use in a health history taking session by asking questions on diet, exercise, habits, and sleep patterns. For more in-depth screenings, they can use the tools below. In conducting screenings using these tools, providers should be aware of the role that gay men's sexual orientation and the resulting social stigma and discrimination may play in creating and exacerbating drug and alcohol dependence.

- The World Health Organization's (WHO) Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) is an eight-item screening tool that is available in several languages and is designed for use with adults and adolescents. It can help healthcare providers detect and manage substance use in primary care and general care settings: https://www.who.int/management-of-substance-use/assist/
- The WHO Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool that is available in several languages and is designed for use with adults and adolescents. It can help healthcare providers identify hazardous alcohol consumption in clients: https://www.who.int/substance_abuse/activities/sbi/en/index.html
- The U.S. National Institute of Drug Abuse's (NIDA) drug use screening tool is a 1-7 question screening tool. It is designed for use by clinicians for use with adult clients: https://www.drugabuse.gov/sites/default/files/pdf/screening_qr.pdf
- The Fagerstrom Test for Nicotine Dependence is a 6-item test used to assess the intensity of addiction to cigarettes and nicotine dependence in adults. Providers can recommend or plan treatment depending on the severity of the nicotine dependence: https://www.smokefree.hk/en/content/web.do?page=FagerstromTestofNicotineDependence

9 Signs of problematic drug or alcohol use

The screening tools described in the preceding section are generally useful for providers who seek to identify and support gay and bisexual clients who use drugs and alcohol. However, these tools may not always help providers distinguish between occasional or recreational use and dependence or abuse. While clients are best positioned to determine if they have a drug or alcohol abuse or dependence problem, some general signs of abuse may include:

- Severe withdrawal symptoms
- Loss of control or the inability to stop use, despite the desire to do so
- Failed attempts to quit using the drug or quit drinking alcohol
- Continued use despite negative consequences on personal lives and professional careers
- A reported inability to have or enjoy sex without the use of drugs

Sometimes, clients may recognize a problem with drug or alcohol dependence or problematic use and an inability to quit. A useful technique for facilitating a client-centered conversation about the readiness to change. This can be done by asking questions about the client's perception of the importance of the issue and their confidence in making any kind of change. Treatment options exist along a continuum and include detoxification, treatment of comorbid conditions, maintenance of treatment, and prevention of relapse. For clients who request professional or medical assistance, healthcare providers should refer them to an appropriate drug counselor or organization for specialty evaluation and treatment.

10 Gay men who do not report problematic drug and alcohol use

As with other populations, many gay and bisexual men use drugs and/or alcohol but may not report any problems such as problematic use or dependence. For clients who do not report problems, providers should share information on drug and alcohol use and risks from credible sources. They should do so in an honest and nonjudgmental manner.

If a client's drug or alcohol use generally occurs within the context of sex, then engaging in a conversation about sexual health and harm reduction strategies will be useful.

If a gay client does not report any problems with drug or alcohol use or dependence but shows signs of problems or dependence, providers should sensitively and respectfully probe further. By asking questions about broader lifestyle and professional life issues, providers can gain the trust of their client and get a better sense of what, if any, risks they face and what harm reduction strategies may be warranted.

In order to provide the highest possible quality of care to gay men who use drugs and alcohol, providers should take the initiative to be informed about drugs commonly used and drinking patterns of gay men. Providers should also understand the possible reasons for why some men might choose to use drugs and alcohol and how they can address health needs arising from usage. In doing so, healthcare providers must be compassionate and maintain confidentiality while adopting harm reduction approaches that are aligned with public health best practices.

11 Strategies to reduce or better manage drug and alcohol use

This section contains advice for healthcare providers on how to reduce drug and alcohol use in their gay and bisexual clients. It also includes harm reduction approaches to alcohol and drugs that promote strategies such as safer use, managed use, abstinence, non-judgmental assistance, and addressing conditions of use. Harm reduction interventions are designed to serve people who use drugs and alcohol with sensitivity to individual and community realities and needs.[43]

The distinction between drug and alcohol use, abuse, and dependence is sometimes vague. Usage and tolerance can also vary greatly between individuals. Healthcare providers must also take into consideration whether or not clients are reporting that their drug and alcohol use is problematic. Finally, providers should keep in mind that drug and alcohol crises are driven by different factors in different parts of the world and the solutions and interventions need to be tailored so they are appropriate to the problem.

If a client reports problematic drug or alcohol use, for instance that drug use is preventing them from achieving their goals, providers should nonjudgmentally and respectfully offer support through client-directed goal setting. They also can collaboratively identify harm reduction strategies that work for the client and refer the client for additional help if necessary. Referrals are usually appropriate when the healthcare provider is not qualified or comfortable dealing with issues concerning drug use in a sensitive manner or when the client requests a referral to a specialist.

Here are some tips that providers can give to their clients who wish to manage or reduce their alcohol use:[44]

- Keep a drink diary to track your overall pattern of drinking.
- Recognize situations in which you drink excessively.
- Tell friends and family that you are cutting down on drinking. It is easier to stick to decisions when others know what they are and you feel accountable.
- Choose a similar drink to your usual one, but one that is weaker. For example, choose a single whiskey serving instead of a double serving.
- Replace some alcoholic drinks with a non-alcoholic drink (a spacer rather than a chaser).
- Start drinking later in the day/evening and drink more slowly with smaller sips.
- Try not to finish your drink before others finish theirs.
- Make your first drink a non-alcoholic one, particularly if you are thirsty.
- Have at least two alcohol-free days a week.
- Avoid “rounds” when drinking in pubs/clubs.
- Decide on a limit for any drinking occasion. For example, three drinks. Be realistic.
- Keep a supply of non-alcoholic drinks at home.
- Identify other ways of relaxing such as exercising.
- Avoid or minimize social contact with heavy drinkers.

Here are some tips that providers can provide to their clients who wish to manage or reduce their drug use:

Safer injecting practices[45]	Providers should find out about programs providing sterile injection equipment and share this information with gay clients who use injecting drugs. Using sterile equipment can reduce the risk of acquiring or transmitting infections. Such programs reduce HIV and HCV transmission by an estimated 50% and are a crucial component of comprehensive community-based health programs. Used syringes and injection equipment should also be disposed of properly. Additional guidance on safer injecting practices is provided in a box earlier in this module.
Marijuana/ cannabis:	Heavy use of marijuana can harm health by causing bronchitis, temporary psychosis, or memory problems.[46] Providers should inform clients about how to responsibly use marijuana and about activities to avoid while impaired, such as driving, biking, or taking care of young children.[47]
Crystal Meth[48]	Providers should advise their clients on precautions to take when smoking crystal meth, which is a powerful drug. These include not smoking alone, going slow, avoid mixing meth with other drugs, staying hydrated, eating before smoking, and having lubricants and condoms on hand for sex. Clients should be told to be careful not to mix meth with Viagra or GHB as it can cause strokes and heart attacks. Mixing meth with drugs like cocaine or MDMA can also cause strokes. Finally, clients should be advised to use their own mouthpiece to reduce hepatitis C transmission risk.
Cocaine/coke	Providers should advise their clients about the risks posed by heavy cocaine use. This is especially important for gay men living with HIV as cocaine use can speed up HIV transmission by impairing cell function, promote the reproduction of the HIV virus, and increase susceptibility to hepatitis C.[49] Providers should advise clients who use cocaine to start with small doses, use slowly, use a straw to snort instead of paper bills, use a sterile syringe if injecting, and check the drug to ensure it does not include fentanyl, a powerful synthetic opioid that is highly potent and addictive.[50]
Other drugs	Besides the more common kinds of drugs used by gay men which have been covered, there are drugs such as MDMA/ecstasy and GHB (which were discussed earlier on in this module) that gay men use more commonly than other drugs. Providers should give advice to gay clients who use drugs using a harm reduction approach that is evidence-based and seeks to improve the health of clients and their communities. Advice should cover topics as varied as safe drug use, injecting drugs safety, drug checking, overdose prevention, overdose reversal, and psychosocial support.[51]

The COVID-19 pandemic poses additional risks for drug users such as shortages and limitations on movement and socialization. The information hub on harm reduction resources created by the International Network of People Who Use Drugs (INPUD) is a valuable resource for providers and their drug using clients who seek information on protecting and enhancing health while using drugs.[52] Additionally, providers should be informed about more recent medical developments like preexposure prophylaxis (PrEP) and be able to prescribe this to their gay clients who are HIV negative and may benefit from it.

12

Key points from the module

- Gay, bisexual, and other men who have sex with men are more likely to use drugs and alcohol when compared to other adults in the general population.
- The higher rates of drug and alcohol use among gay men can be a reaction to stigma, discrimination, or violence experienced due to their sexual orientation.
- Many gay men use drugs and alcohol recreationally in sexual or social contexts and do not experience any problems or dependence.
- Drugs and alcohol use may be a coping mechanism for many gay men.
- Drug and alcohol use can lead to the loss of sexual inhibition and make higher risk sexual encounters more likely.
- The use of drugs such as crystal meth and GHB is increasingly common among gay men. These drugs can cause serious harm if overused or if used along with other substances.
- Drug and alcohol use and/or dependence are driven by different factors in different parts of the world and interventions by providers must be tailored accordingly.
- Providers should be sensitive to their own anxieties and those of their gay clients when discussing drug and alcohol use.
- A variety of screening tools can be used to evaluate and address problematic drug and alcohol use and dependence in gay clients.
- Providers should exercise compassion and confidentiality when treating gay clients with drug and alcohol dependence or problematic use.
- Providers should learn about and use harm-reduction best practices when treating gay clients with drug and alcohol dependence or problematic use.

13 Quiz

1. Higher rates of drug and alcohol use among gay men can be a reaction to which of the following?
1.1.Stigma
1.2.Homophobia
1.3.Discrimination
1.4.Violence
1.5.All of the above

2. Like other adults, many gay men use drugs and alcohol for recreation or pleasure.
2.1.True
2.2.False

3. Drugs and alcohol can provide psychological enhancement of sexual experiences.
3.1.True
3.2.False

4. The most common pattern of drug use among gay men appears to be:
4.1.Daily
4.2.Weekly/monthly
4.3.Annually
4.4.Every two years

5. Younger gay men tend to report higher levels of drug and alcohol use.
5.1.True
5.2.False

6. The most common form of drug use seen among gay men is injection drug use with heroin.
6.1.True
6.2.False

7. Drug and alcohol use can lead to higher-risk sexual behaviors through the loss of sexual inhibition.
7.1True
7.2.False

8. _____ are inhalants that can make anal intercourse and other sexual behaviors highly pleasurable.

9. Which of the following statements is most accurate when discussing alcohol use in the clinical setting:
9.1.Do you get drunk?
9.2.How often do you get wasted?
9.3.Do you drink often?
9.4.How often do you drink in a week?

10. Development of tolerance to a given drug can be a sign of problematic drug use.
10.1.True
10.2.False

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7

Module 7

Healthcare Needs of Adolescent and Young Gay Men and Boys

- 1.Introduction
- 2.Global health and HIV trends among gay adolescents and young men
- 3.Understanding the sexuality and sexual expression of gay adolescents and young men
- 4.Myths about comprehensive sexuality education
- 5.Legal obstacles
- 6.Affirmative healthcare for gay adolescents and young men
  - 6.1.Counseling and communication
  - 6.2.Confidentiality
  - 6.3.Coming out
  - 6.4.Mental health and so-called "conversion therapy"
  - 6.5.Bullying and stigmatization
  - 6.6.Forced sex versus consensual sex in childhood and adolescence
  - 6.7.Consent and relationships
- 7.Key points from the module
- 8.Quiz

1 Introduction

Many healthcare providers lack adequate knowledge, resources, or capacity to effectively address the unique health needs of adolescent and young gay men, bisexual men, transgender men, and other men who have sex with men (hereafter referred to collectively as gay men). In addition to provider knowledge gaps, there may be other barriers to meeting the needs of this sub-population, such as laws on the age of consent to access sexual and reproductive health services, assumptions about young men's sexuality and sexual orientation, and laws criminalizing consensual same-sex sexual activity. Such laws and social biases can lead to or abet harassment, discrimination, bullying, hate-motivated violence, and ostracism by family or peers. These can, in turn, increase risk-taking behavior among adolescent and young gay men and harm their physical and mental health.

Most lesbian, gay, bisexual, transgender, and intersex (LGBTI) youth are resilient and emerge from adolescence as healthy adults. Nevertheless, homophobia and heterosexism can contribute to long-lasting health disparities in mental health between LGBTI and other youth. LGBTI youth have higher rates of depression, suicidal ideation, substance use, HIV transmission, and STIs than other young people.[1]

Gay adolescents and young men are a critical target for healthcare and HIV services outreach. Some of them may not be able to access such services due to a combination of socioeconomic, legal, and personal factors, all of which will be explored in this module. This module will also provide guidance on how affirmative healthcare and HIV services can be provided for gay adolescents and young men, with a focus on effectively addressing their unique needs and challenges.

2 Global health and HIV trends among gay adolescents and youth

Adolescents and youth under the age of 25 account for a significant global share of those living with HIV and acquiring HIV each year. Here are some highlights about the burden of HIV in this population segment:

- Over 30% of new HIV transmissions around the world occur among those below 25 years of age.[2]
- Adolescents and young people represent a growing share of people living with HIV worldwide. In 2018 alone, over half a million young people between the ages of 10 to 24 acquired HIV, of whom 190,000 were adolescents between the ages of 10 and 19.[3]
- Globally, young gay men carry a higher HIV burden and face increased risk of HIV transmission compared to the larger at-risk population of adolescents and youth.[4]

The large number of cases of HIV transmission among gay and other youth and adolescents can be attributed to gaps in targeted interventions and social attitudes that prevent comprehensive sexuality education being provided to young people. Among young key populations, especially gay men, there is a paucity of information and awareness about HIV prevention. Combined with stressors such as social stigma and discrimination and resulting mental health challenges, the paucity of awareness or access to HIV services can lead young people to engage in sexual behaviors that might promote HIV transmission.

Healthcare providers should use HIV prevention packages that are tailored and layered and that account for unique adolescent needs. Such packages should include biomedical,

behavioral, and structural components in order to effectively provide HIV services to gay and other adolescents and youth. The interventions should be designed with the input of youth and adolescents.[5]

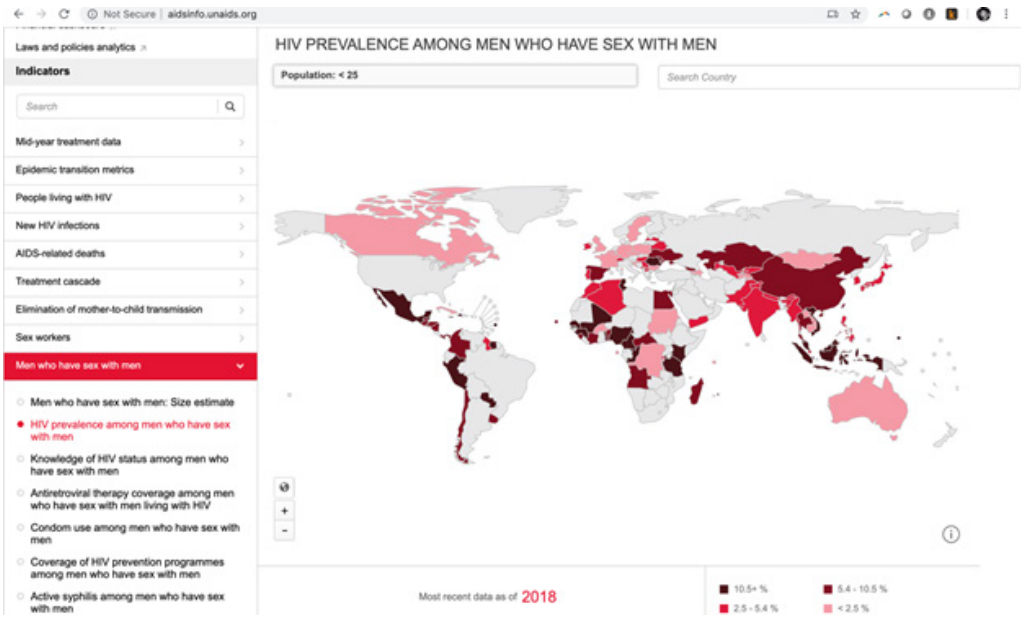

Figure 1: HIV prevalence among men who have sex with men aged <25 years, UNAIDS 2018

Understanding the sexuality and sexual expression of gay adolescents and young men

Children develop and mature sexually as well as physically, emotionally, and socially as they grow up. Sexual development is thus integrated with other forms of development. Even young children have sexual feelings and may engage in sexual behavior such as touching their sex organs or using slang/colloquial words to refer to sexual acts and sexual organs.[6]

Normal sexual development happens gradually and the timeline and speed of the process varies for each person. Just because an adolescent's development is slower or faster than others does not necessarily mean that something is wrong. Adolescents have different characteristics, temperaments, and experiences. Their families and social environments have different values and practices that may affect the speed of their sexual development. Practices and educational interventions that seek to foster sexual development among gay adolescents should be age and individual-appropriate, in the same manner that educational, physical, emotional, and social interventions are tailored.

Pre-pubescent and pubescent adolescents become increasingly aware of their own sexual feelings that accompany puberty. With changes underway in their bodies, adolescents get more curious and aware of how their physical features are changing. This may result in curiosity about the bodies of their peers or of adults. Alongside sexual development and exploration, adolescents may also begin to explore emotional and romantic relationships. It is common for adolescents of all genders and sexual orientations to have crushes on their peers or on adults.

As they grow up, adolescents and young gay men may start engaging in experimental sexual activity by themselves or with other adolescents or adults, irrespective of their gender. Some of these activities may involve:

- Masturbation by themselves
- Masturbation with others
- Exploration of bodies and erogenous zones by themselves or with others
- Thigh sex by rubbing genitalia between another person's thighs
- Using objects or fingers to play with the genitalia and/or orifices of self or others
- Rubbing of genitalia together
- Getting their penis, anus, perineum, scrotum, or other orifices pleasured orally or performing oral sex on others
- Penetrating another person's anus or vagina with genitalia, or getting penetrated

How young and adolescent gay men experiment with sexual activity might become a source of anxiety or of empowerment. This may depend on a young gay man's individual experiences and on how these acts are perceived by adults and peers in their sociocultural environments. Anxiety resulting from negative experiences or negative social feedback can have a significant impact on the sexual and mental health on young gay men.

Adults such as parents, teachers, policymakers, and healthcare providers often overlook the sexuality or sexual expression and activities of young people. This may happen deliberately or out of ignorance. Some adults may believe that adolescents are too young to understand matters related to sex. Other adults let their personal moral preferences guide their outlook, leading them to condemn youth who engage in sexual activity.

Social pressures to conform, misinformation, and the unwillingness of trusted adults such as healthcare providers, parents, and teachers to address sexuality may prevent gay adolescents and young people from accessing the information they need.

Sexuality in this context refers to the sum total of an individual's sexual inclinations (who they are sexually attracted to), sexual activity, as well as the extent to which they wish to express themselves sexually in social settings. Every individual's sexuality is unique and is influenced by the following factors:

- Biology and hormones
- Life experiences, both positive and negative
- Social and cultural norms, values, and attitudes regarding sexuality
- Laws and policies that can impact sexual expression and behavior

The manner in which young and adolescent gay men express their sexuality is a complex outcome of their biology, personal life experiences, sociocultural factors, and legal environments. It is also influenced by their access to information about sex and sexuality, and an individual's capacity to introspect and understand their own bodies and emotions. Given the social pressures that youth and adolescents already face from family, peers, educational institutions, and society in general, coming to terms with sexuality and emotions can be a challenge for many gay adolescents.

4 Myths about comprehensive sexuality education

In the absence of comprehensive sexuality education (CSE), adolescents get information about sex and sexuality from the media, peers, hearsay, and the internet. The information they access may be biased, misleading, or scientifically incomplete or inaccurate. This can prompt confusion and distress, especially among adolescents coming to terms with their non-heterosexual sexual orientations and gender identities. The distress can be more acute for adolescents and youth in cultures and environments that are strongly heteronormative or have punitive laws based on sexual orientation, gender identity, or gender expression.

Myths about adolescent sexuality impede the ability of healthcare providers and educators to provide evidence-based, relevant, and effective CSE to gay adolescents and young adults. Some of the prevailing myths around adolescent sexuality in or outside educational settings are as follows:[7]

- Introducing sex and sexuality education in the curriculum will encourage promiscuity.
- It is not the role of schools to teach about reproductive health and sexuality.
- Adolescents are too young to understand the topics relating to sex, sexuality, and gender (even in the most progressive environments this argument can be used as justification to avoid imparting information about same-sex sexual activity and gender identity).
- Making contraceptives accessible will promote premarital sex.
- Maintaining conservative cultural values centered on abstinence and discouraging sexual activity is the most effective way to guide adolescents on issues of morality.

5 Legal obstacles

The right to access comprehensive sexuality education is grounded in fundamental human rights principles and is a means to empower young people to protect their health, well-being, and dignity.[8] However, discussing sex and sexuality topics with adolescents might have legal consequences and/or might require parental consent in some jurisdictions. These legal obstacles may make it more difficult to reach gay adolescents and provide them with the support they need during times of rapid change, such as puberty.

Some jurisdictions impose a partial or complete ban on providing CSE to adolescents. Other jurisdictions might have laws mandating parental consent before a minor can undergo an HIV or STI test. Such laws make it challenging to serve gay youth and adolescent clients through existing frameworks of community health centers.

One of the most fundamental challenges of working with a rights-based perspective is finding the balance between protecting young people and affirming their right to participate in decisions that affect them, while enabling them to take responsibility for exercising their own rights.[9] Since each young person develops at their own pace, there is no universal age at which certain sexual rights and protections gain importance. Therefore, striking the balance between protection and autonomy should be based on the evolving capacities of each individual young person.

6 Affirmative healthcare for gay adolescents and young men

Gay and bisexual adolescents and young men face a variety of barriers to accessing healthcare that is effective and tailored to their needs. Adolescent and young gay men should be able to access information and services to protect their sexual, physical, and mental health without prejudice, stigmatization, and fear. Healthcare providers should provide affirming care in a safe environment. Affirming care for gay adolescents and young men should:

- Treat them with respect and dignity
- Recognize the unique challenges and background of each patient
- Be evidence-based
- Ensure confidentiality
- Promote healthy attitudes towards sex and pleasure
- Be nonjudgmental and informative

Some key issues that healthcare providers should consider to provide affirming care to their adolescent and young patients who are gay are discussed below.

Counseling and communication

Many gay adolescents or young men visiting a healthcare provider may feel shy, embarrassed, anxious, uncertain, or even intimidated. To assuage these fears, it is important that providers earn the trust of their gay adolescent and young clients by adhering to the following guidance:[10]

Respect

- Do not use judgmental words or body language
- Do not talk down, scold, shout, or get angry
- Do not be critical of physical appearance, concerns expressed, or behaviors

Empathy
- Be reassuring when responding to concerns or questions
- Explain you want to help
- Provide time for questions
- Empathize with the client's situation and concerns
- Provide reassurance that the client's feelings and experiences are normal

Open and effective communication
- Be genuinely open to questions or requests for information
- Be transparent and admit when you do not know the answer to a question
- Use words and language that are age appropriate
- Use educational materials like flip charts or pictures to explain complicated information

These skills are useful for all interactions
- Use helpful non-verbal communication
- Actively listen and empathize
- Ask open-ended questions
- Help set goals and identify next steps in care

Confidentiality

Healthcare providers have a responsibility to keep information about the sexual orientation and gender identity of gay and bisexual clients confidential. Ensuring the confidentiality of gay clients is a cornerstone of sexual healthcare for gay men, especially in places where same-sex behavior is stigmatized or criminalized. Providers should put in place policies to explicitly require patient confidentiality and the policies should be prominently displayed in healthcare facilities and handed out to clients. Information on sexual behavior that is obtained during sexual history taking should be considered sensitive and treated accordingly.

Privacy and confidentiality are of the utmost importance for gay adolescents and young men when availing of healthcare. This is because of the social, emotional, and safety challenges and risks associated with being involuntarily outed. The fear of being outed is one of the most critical factors that prevent gay adolescents and young men from accessing essential medical care. Family rejection after being outed can have devastating consequences for the physical safety, economic security, and emotional stability of young people. In countries where consensual same-sex relations are criminalized, young gay men who are outed may face prison sentences or even the death penalty. A lot of young gay men withhold information or provide incomplete sexual histories in healthcare settings due to the fear of being outed or of being judged unfavorably.

Healthcare providers should keep an open mind about how youth and adolescents express their sexuality. They should be non-judgmental and non-stigmatizing in discussing risks associated with different types or frequencies of sexual activity, the types of sexual partners, or the locations where sexual activity occurs.

Providers should receive training on data collection and reporting, including on the rights of minors. It should be made clear to clients that reporting sexual behavior and gender identity on forms and records is optional. Clients should be provided with written notices on instances when this information may be shared or disclosed, whether it will be shared as aggregate or individual information, and whether personal identifiers may be disclosed. Clients should also be informed of how and by whom such information may be used.

Client confidentiality policies and practices may conflict with anti-gay laws in some jurisdictions. For example, in some countries, anti-gay laws have led to legal mandates for healthcare providers requiring them to turn in people suspected of same-sex sexual behavior to law enforcement. In such cases, providers should act with sensitivity and discretion and do their best to protect the health and human rights of gay clients. Breaches of confidentiality in such instances can lead to serious harm to individual gay clients.

A recent area of healthcare innovation - which accelerated during the COVID-19 pandemic - is the reliance on telehealth. Telehealth makes it easier for clients to access care when their mobility is restricted. However, providers should keep in mind that many clients may not have a private space at home where they can have confidential conversations. As such, providers should ask gay clients at the outset of a telehealth conversation whether they are in a private space and comfortable having sensitive conversations or whether they prefer to schedule an in-person visit with adequate safety precautions. Additionally, providers working from home should also take precautions to ensure the integrity of sensitive patient data, for instance by using lockboxes for their documents or protecting work laptops and phones with passwords.

The increase in digital convening spaces such as social media (Facebook or Twitter) and dating apps (Grindr or Hornet) where people can anonymously seek health information has led to a need to rethink healthcare outreach. While online platforms provide some anonymity, the veracity of the information available is not always reliable and can even be harmful. Rapid innovation in digital technologies is creating novel ways of delivering services and information to adolescents and young people,[11] but the safety of many of these platforms can be questionable. Ensuring data security and the confidentiality of young patients online should be a concern for providers.

Some online portals and campaigns utilize innovative social and behavior change messaging to promote testing and provide information about HIV and STIs to gay adolescents and young men. Healthcare providers should explore ways to disseminate accurate information online where their young patients can ask questions and seek in-person follow-up care, if needed. A best practice to develop such outreach initiatives is to meaningfully engage gay adolescents and youth in each step of program design and implementation[12] so as to increase the relevance and efficacy of the intervention.

Coming Out

Coming out, or coming out of the closet, is an emotional and psychological process in which an individual recognizes, accepts, and discloses their non-heterosexual sexual orientation or gender identity to another individual or a group. Often a personal journey rather than a one-off event, the process of coming out for a gay or bisexual man may span months, years, or even decades.

Many gay adolescents are coming out at younger ages than was the norm a few decades ago. A gay adolescent might come out to a trusted individual such as a friend, a family member, or a teacher, or to groups such as their classmates, their extended family, or on social media. Some choose not to come out at all. Based on whether a gay adolescent gets a positive or negative reception when they come out, they may wish to come out to more people, or they may refrain from coming out to anyone else. Deciding how and when to come out is ultimately the decision of an individual who should decide when and how to come out, whom to confide in, and to assess the risks and benefits of coming out.

Coming out is correlated with less stress and improved self-esteem. However, it may be inappropriate or even dangerous to come out in settings where disclosing a non-

heterosexual orientation can result in criminal prosecution, expulsion from home, violence, unmanageable mental distress, or in further marginalization. Coming out can be a challenging ordeal for gay adolescents and young adults because of the lack of social acceptance.

Increasing social acceptance of openly gay adolescents and young men will take time, effort, and advocacy. Given this reality, healthcare providers have a responsibility to provide a confidential, safe, and non-judgmental environment for gay youth and adolescents to obtain the sexual, physical, and mental healthcare they need. Providers should speak about the diversity of sexual orientations and gender identities in a positive and validating manner to create a safe space where gay youth can be honest about their sexuality and ask questions.

- *Mental health and so-called "conversion therapy"*

Many gay and bisexual adolescents and young men might feel anxious and depressed due to stigma and bullying on the basis of their sexual orientation. Depending on their socio-cultural environment, many of them might also feel isolated. Isolation and depression might lead to self-loathing, self-harm, self-injury, and suicidal thoughts, which are often compounded by the fear of coming out or being outed, peer pressure, pressure to conform to social norms on masculinity, and fear of rejection by family. Such pressures have also been associated with an increased prevalence of high-risk behaviors.[13]

Compounding all of these stressors is so-called "conversion therapy" that gay youth may sometimes be forced to undergo. Also known as reparative therapy, so-called "conversion therapy" is a harmful and discredited intervention that seeks to change an individual's sexual orientation. They are used to try and "cure" the sexual orientation and behaviors of gay and bisexual men. This purported therapy is not a valid health intervention. Rather, it is a harmful, unethical, and discredited practice that exploits internalized homophobia and shame in those who are subjected to it.

There are no rigorous scientific studies that demonstrate the efficacy of efforts to change sexual orientation. However, there are many testimonies about the severe harm to mental and physical health that such so-called "therapy" can cause. Victims of this dangerous practice can suffer from insomnia, depression, homelessness, and even suicide, and it is especially dangerous for gay adolescents and young adults. Those subjected to so-called "conversion therapy" are eight times more likely than the average person to attempt suicide and six times likelier to report high levels of depression. In many cases, gay adolescents are forced into this harmful intervention and deprived of their liberty and in some cases kept in isolation for many months.

Gay adolescents or young men who have been traumatized by this purported "therapy" should receive affirmation that their sexual orientation and behaviors are normal and acceptable. They should also be referred to appropriate mental and legal resources to ensure their well-being and to enable them to hold the perpetrators accountable, if they wish. Creating an affirming safe space and reiterating the self-worth and dignity of gay adolescents is key to building the trust that can help a victim talk about their experiences and seek help.

In instances where gay adolescents or youth express the desire to change sexual orientation, the most effective and appropriate therapeutic response for maximum mental health benefit is affirmative therapy. Affirmative therapy can help clients develop skills to cope with coming out and accept their sexual orientation or desires. Therapists should

provide support, acceptance, and validation of same-sex sexual orientation to help clients overcome external stigma and internalized homophobia and self-loathing.

So-called "conversion therapy" has been condemned and rejected by mainstream organizations for decades and several jurisdictions across the world have banned this harmful practice. The World Health Organization (WHO) has criticized it as being unscientific, harmful, and contributing to stigma,[14] and also removed same-sex sexual activity from the International Statistical Classification of Diseases (ICD) in 1990. According to the Pan American Health Organization, services that purport to "cure" people with non-heterosexual sexual orientation lack medical justification and represent a serious threat to the health and well-being of victims.[15]

The mental health module in this curriculum has additional, useful information about so-called "conversion therapy" and related dangers to the mental health of gay youth.

- *Bullying and stigmatization*

Many gay and bisexual adolescents and young men fear schools, which are frequently the site of bullying. Bullying puts youth at increased risk for depression, suicidal ideation, misuse of drugs and alcohol, risky sexual behavior, and can adversely affect their academic performance as well.[16] For gay adolescents, that risk is even higher. A UNESCO review found that the proportion of LGBTI youth who experienced violence and bullying in schools ranged from a low of 16% in Nepal to as much as 85% in the United States. The same review found that LGBTI students were three to five times more likely to be subjected to violence than their non-LGBTI peers.[17] Bullying can occur at school, at social events with peers, online (cyber-bullying), as well as within family settings.

In another report, 36% of young LGBTI people reported having been cyberbullied at some point in their lifetimes and 17% had experienced this in the month prior to the survey. These numbers were significantly higher than the numbers reported by their heterosexual peers (20% and 7% respectively).[18]

Healthcare providers can give the following messages to gay adolescents and young men who are being bullied or are at risk of being bullied:[19]

- No one ever deserves to be bullied
- You have the right to ask for help to stop the behavior
- Your opinion about what to do to is important
- You don't have to suffer alone through a bullying experience - talk to a trusted adult, a friend, or a teacher

There are many reasons why gay adolescents or young men may not wish to report bullying. The reasons include a fear of retribution, low self-esteem, or feeling that their concerns will not be taken seriously.[20] These fears can be compounded by the risk of being outed. One study found that school and bullying problems and the fear of being outed were the second and third most important concerns for LGBTI youth (after having a non-accepting family). This finding stood in sharp contrast to non-LGBTI youth for whom the top three concerns were rather more prosaic - grades, college, and career.[21]

Depending on the frequency and severity of bullying, a healthcare provider's interventions can range from affirmation and empathy, to referrals to counselors or mental health professionals, to asking for immediate outside help. If a gay adolescent or youth shows signs of physical abuse due to bullying, it is crucial that the provider give appropriate medical care and also discuss whether reporting the abuse to a parent, another trusted adult, or the authorities might be safe and appropriate for the young person. If a family member is responsible for the bullying and abuse, the provider should evaluate the options of getting child services/social services and the authorities involved in a manner that does not put the gay adolescent in danger.

- *Forced sex versus consensual sex in childhood and adolescence*

Sex is a foundational part of human development but sexual initiation among gay and bisexual youth has generally been understudied.[22] Existing studies indicate that patterns of sexual initiation among men before the age of 16 vary widely around the world. For example, from one-half to three-quarters of adolescent males in seven countries have had sexual intercourse by this age. But one-third or fewer have done so in countries such as Ghana, Zimbabwe, the Philippines, and Thailand.[23] In the United States, approximately 34% of males have sex by age 16.[24 25 26]

Among adolescents in general, early sexual initiation before the age 15 or 16 has been linked to risk factors [27 28] such as higher rates of alcohol use,[29 30] sexual risk-taking,[31 32] delinquency,[33] and violence.[34] As a result, what is known about sexual initiation tends to emanate from a literature whose premise is that sex during adolescence is in itself a risk factor. However, this fails to account for how sexual debut may vary by gender, sexuality, or by subjective experiences such as forced versus consensual sex.

When forced sexual initiation is compared to voluntary sexual initiation among gay and bisexual youth before age 16, those who were forced into sex report a poorer quality of life and greater risk behaviors. [35 36 37 38 39] Also, when examining three categories of sexual initiation among gay and bisexual men - forced, consensual, and no sexual initiation before age 16 - the forced sex group had the highest levels of psychological distress, substance use, and likelihood of acquiring HIV. Notably, no differences in rates of depression and suicidal ideation were found between the men who reported consensual or no sex before age 16. These findings suggest that among gay youth, forced sexual initiation results in poorer health outcomes than either consensual or no sexual initiation before age 16. Forced sex before age 16,[40] or childhood sexual abuse, has negative outcomes including psychological distress, substance use, and higher risk for HIV transmission.

The distinction between forced and non-forced sexual initiation, or experiences, has implications for healthcare providers. First, when taking a sexual history, the subjective experience of gay adolescents and young men should be taken seriously. If he describes having had consensual sex at an early age, the provider should not assume it was abuse. If the patient describes the experience as having been forced, the provider should use language used by the young patient rather than labeling it as childhood sexual abuse. The provider should be sensitive to the possibility that this is the first time the patient has revealed this experience and follow the lead of the patient, listen non-judgmentally, and be prepared to offer referrals and advice.

Where required to report child sexual abuse to designated authorities, such as when seeing an adolescent, providers should inform the patient and possibly their non-offending caregivers about the obligation to report the abuse and the limits of confidentiality prior to interviewing them.

- *Consent and relationships*

  Navigating consent in sexual acts and relationships is an important issue that needs to be addressed with sensitivity and thoughtfulness. Gay adolescents and young men might often feel uncertain or not knowledgeable about sexual activity. This may lead to them to rely on an older sexual partner to make decisions on when and how to have sex. This can include what activities the younger partner is going to perform or have performed on them, intensity or aggression of these activities, or other activities that could potentially be physically or mentally painful or harmful. Negative sexual interactions at a young age can also skew a person's view of safe and pleasurable sex or even place them in serious jeopardy.

  At times, a gay adolescent or young man might feel obliged to engage in sexual activity because their partner gives them a gift, buys them a meal, or otherwise compensates them. At other times, young gay men may simply not have the confidence to refuse sexual or physical contact initiated by a partner.

  Healthcare providers can impart the following advice to gay adolescents and young men when having a conversation about consent, sexual dynamics, and relationships:

  - You can decide whether or not you are comfortable with being touched or sexual activity
  - Learn how to have safe and pleasurable sex – ask me any questions you have
  - You can revoke consent and stop a sexual activity if you do not feel comfortable
  - It is okay to be assertive to end a sexual encounter that causes discomfort or pain
  - Being given money or gifts does not mean you must perform sexual favors

  Finally, healthcare providers should create a safe environment for gay adolescents and young men to be able to freely describe the dynamics of their sexual relationships. This will provide an opportunity to note potential signs of abuse. Providers should also arrange necessary referrals and follow-up in cases of abuse, violations of consent, or other harmful situations.

Key points from the module

- Gay and bisexual adolescents and young men have unique health needs and face barriers to accessing healthcare that is effective and tailored. Healthcare providers should strive to identify and meet the needs of this subpopulation.
- Gay and other LGBTI youth have higher rates of depression, suicidal ideation, substance use, HIV transmission, and STIs than other young people.
- About a third of new HIV transmissions around the world occur among those below 25 years and young gay men carry a disproportionate HIV burden.
- Providers should use HIV prevention packages that are tailored and layered and include appropriate biomedical, behavioral, and structural components.
- Children develop and mature sexually, physically, emotionally, and socially as they grow up. Adolescents may begin to explore sexual, emotional, and romantic relationships.
- Adults, including schools and healthcare providers, often overlook the sexuality or sexual activities of young people. In the absence of comprehensive sexuality education, adolescents may get inaccurate information about sex and sexuality.
- Given the social pressures that gay youth face from family, peers, educational institutions, and society, coming to terms with their sexuality can be challenging.
- Providers should provide gay youth with affirming care in a safe environment. They should treat gay youth with respect, recognize their unique needs and backgrounds, and provide care that is evidence-based, confidential, and nonjudgmental.
- Confidentiality is of the utmost importance for gay youth when accessing healthcare because of the social, emotional, and safety risks from being involuntarily outed.
- So-called “conversion therapy” is a harmful, unethical, and discredited intervention that seeks to change the sexual orientation of gay youth.
- Many gay and bisexual adolescents are bullied, putting them at increased risk for depression, substance use, risky sexual behavior, and poor academic performance. Providers with clients who are bullied should give appropriate care and discuss whether reporting the abuse might be warranted.
- Gay youth should be told that they can revoke consent and stop a sexual activity at any time if they feel uncomfortable or unsafe.

8 Quiz

1. Gay and bisexual men are best served by healthcare that is tailored to their unique needs.
1.1.True *1.2.False*

2. Children and adolescents do not engage in sex until the age of 18.
2.1.True *2.2.False*

3. About a _____ of new HIV transmissions each year in world occur in youth below the age of 25.

4. Which of these is the best way to impart accurate information about sexuality, safe sex, and sexual health to gay adolescents and youth?
4.1.Movies and TV shows *4.2.Peer information and knowledge sharing*
4.3.Comprehensive sexuality education *4.4.Hearsay and social gossip*

5. So-called "Conversion therapy", also known as reparative therapy, is a useful and effective intervention with which to treat gay youth.
5.1.True *5.2.False*

6. Providers should give evidence-based, nonjudgmental, and confidential treatment to young gay patients to assure their physical and mental well-being.
6.1.True *6.2.False*

7. _____ is the cornerstone of all physician-client relationships, but is crucial when assessing the health of young gay clients, especially those who have not come out.

8. _____ is a personal, emotional, and psychological process in which an individual recognizes, accepts, and discloses their non-heterosexual sexual orientation or gender identity.

9. Gay and LGBTI youth are more likely to be bullied than other youth.
9.1.True *9.2.False*

10. Sexual consent cannot be revoked once it is given and a sexual act is underway.
10.1.True *10.2.False*

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Module 8

Sexual Health Promotion

1 Introduction

This module presents evidence-based biomedical and behavioral interventions to prevent HIV and STIs among gay and bisexual men. It discusses the importance of community empowerment and combination HIV prevention and describes the key World Health Organization recommendations for HIV and STI prevention among gay men. In addition to becoming familiar with these recommendations, healthcare providers must get comfortable talking about sex with their gay and bisexual clients even if they hold opposing moral or religious beliefs. Providers must remain open-minded and use non-judgmental approaches when assisting gay and bisexual men achieve optimal sexual health and reduce their risk for HIV and STI transmission. Rolling out evidence-based HIV and STI preventions also requires providers to recognize that gay men deserve pleasurable and safe sexual experiences free of coercion, stigma, discrimination, and violence.[1]

Critical Thinking Questions

Case Study: A Lancet study published in 2018[2] found that gay and bisexual men who are on PrEP are more likely to have condomless sex. Condomless anal sex - especially receptive intercourse - is considered the most common method of HIV transmission.[3] While PrEP provides a very high degree of protection against HIV transmission when taken everyday, it does not stop transmission of other STIs such as syphilis, gonorrhea, and chlamydia. In Australia, where PrEP was recently introduced and has become easily accessible for gay men, the proportion of gay men who are not on PrEP and who engage in condomless sex has remained flat over the last few years.[4]

Critical thinking questions:

1. Why may some HIV-negative gay men who regularly engage in condomless sex decide not to get on PrEP?
2. What factors could affect the decision to forego condoms during sex?
3. What role does sexual pleasure and/or age, substance use, and access to condoms have in the decision by gay men to use or not use condoms during sex?

2 Community empowerment

Gay and bisexual men are disproportionately affected by HIV in every country in the world as a result of legal and social barriers that stymie HIV responses and exacerbate their vulnerabilities.[5] Despite this, gay men are not merely victims. They have a record of effectively and swiftly responding to the HIV epidemic by mobilizing, by empowering themselves, and by bringing a sense of urgency when advocating for HIV responses tailored to the needs of key populations. In doing so, they have become an integral and crucial part of the global HIV response since the beginning of the epidemic four decades ago.

Additionally, gay communities[6] have relentlessly, and with increased success, challenged societal and internalized homophobia. The community empowerment and engagement of the global gay community has been demonstrably effective at linking gay men with HIV and STI services. As such, community empowerment is a proven approach that should be integrated by healthcare providers and clinicians into all aspects of HIV and STI programming.[7]

Community empowerment begins with individual empowerment. Gay men need to feel a sense of social belonging and feel they have control and agency over their lives. If that happens, they are able to participate in a community that actively advocates for its own well-being and human rights. Gay men's health and well-being can best be assured by ensuring they have choice and control over their lives, enabling them to be part of

integrated communities that provide social support and affirm their identities, and by ensuring they have access to essential resources such as employment, education, housing, healthcare, food, and security.[8]

HIV and STI prevention initiatives designed to address the unique needs and challenges of key populations, including gay and bisexual men, should actively seek to empower communities, engage with them, strengthen community systems and mobilization, foster community leadership, and operate within a human rights framework. Healthcare providers and clinicians have a responsibility to involve gay men in prevention programming and clinical interventions that seek to benefit them.

3 Combination HIV prevention

Comprehensive HIV prevention approaches that are tailored to gay men's needs and sustained over time are necessary to effectively reduce HIV and STI incidence among gay and bisexual men.[9] Combination approaches involve integrating biomedical, behavioral, community, and structural approaches. One example is delivering behavioral interventions such as risk reduction counseling with biomedical interventions such as PrEP while also addressing structural barriers to healthcare access. Such an approach can address obstacles to care and thus make it more likely that gay men have the knowledge and the ability to prevent HIV and STI transmission. The table below outlines contemporary approaches to HIV prevention among gay and bisexual men.

Contemporary approaches to HIV prevention among gay and bisexual men

Sexual Acts	
	• Daily Pre-Exposure Prophylaxis (PrEP) • Event-driven PrEP (ED-PrEP) • HIV and STI Testing • HIV and STI Treatment incl. U=U • Post-Exposure Prophylaxis
Behavioral	
Individual	• Mental health counseling • Risk reduction counseling • Substance use counseling
Couple and partners	• Couples counseling
Family	• Family counseling
Group	• Communication skills building • Disseminating information on the proper use of condoms and lubricants • Support groups

Institutional	• Sensitization of service providers • Workplace sensitization training
Networks	• Peer education • Diffusion of innovation • Network-based strategies
Community	
	• Community mobilization • Mass media and social marketing
Structural	
	• Anti-discrimination laws and policies • Repeal of criminalization and other punitive laws and policies • Increased and widespread availability of condoms and lubricants

The most effective HIV and STI prevention strategies should combine biomedical, behavioral, community, and structural interventions. Focusing prevention strategies only on one type of factor, whether it be a structural-level factor or an individual-level factor, cannot sufficiently address HIV incidence at the population level. It is also unlikely to lead to significant long-term reduction in HIV transmission rates. With biomedical approaches such as PrEP, for example, there are inequities in access to basic healthcare. Gay men cannot benefit from biomedical interventions if their access to these interventions is reduced because of cost, stigma, discrimination, or criminalization. Factors such as being a racial minority or belonging to a lower socioeconomic strata can pose additional obstacles to accessing life saving interventions such as PrEP.

4 Normative guidance for HIV and STI prevention

Normative guidance on HIV and STI prevention and treatment for gay and bisexual men define a set of evidence-based interventions and establish standards for the design and implementation of those interventions. Such guidance is targeted at national health bureaucracies, program implementers, service providers, and community-based organizations. Normative guidance is typically issued by entities such as the World Health Organization (WHO) and other United Nations agencies. Governments often adopt standards laid out in global normative guidance into their national guidelines.

When national HIV programs and service providers adopt and use global normative guidance, gay men are less likely to experience stigma, discrimination, and structural barriers that can impede their access to healthcare. They are also more likely to be able to fully enjoy their human rights. Normative guidance can therefore help achieve optimal epidemic control by informing more effective, rights-based HIV and STI services.[10] As a result, normative guidance developed using iterative processes and in consultation with a variety of stakeholders at the national, regional, and global levels, including representatives of key populations, has a greater likelihood of being adopted and implemented.[11]

It is crucial that healthcare providers familiarize themselves with current normative guidance on HIV and STI services. The WHO's consolidated guidelines on HIV prevention, treatment, and care for key populations[12] is the most salient example of available normative guidance for key populations. These guidelines raise awareness about critical issues facing gay men, improve access and uptake of essential HIV services, and provide comprehensive standards for a minimum package of services of evidence-grounded interventions to achieve optimal epidemic control.[13]

Some of the key takeaways from normative guidance on HIV and STI that are particularly applicable or beneficial for gay men are as follows:

- Emphasize healthcare services that are inclusive of gay men
- Emphasize the importance of consent and confidentiality
- Recommend that HIV testing and counseling be linked to care and treatment
- Advocate for both individual-level and community-level behavioral interventions
- Advocate for making PrEP accessible, including event-driven PrEP (ED-PrEP)
- Emphasize the need for equitable access to antiretroviral therapy, including the management of opportunistic infections, comorbidities, and treatment failure
- Do not recommend adult male circumcision
- Recommend internet-based information dissemination, social marketing strategies, and sex venue-based outreach strategies to promote sexual well-being and HIV services
- Recommend psychosocial interventions for those who have substance use issues
- Recommend syringe programs and opioid substitution therapy for injecting drug users
- Recommend syndromic management and treatment for those with STIs
- Recommend regular testing for syphilis, gonorrhea, and chlamydia

Below is a list of currently available normative guidance on HIV and STI prevention and treatment among gay and bisexual men including a short description and a link for easy access.

Key Normative Guidance	Description	Producing Entity	Publication Date	Link
Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations	Provides a comprehensive package of evidence-based HIV-related recommendations for all key populations. The recommended interventions include clinical advice and a discussion of critical enablers for successful programming.	WHO	July 2014 July 2014 July 2016 September 2017	-Guidelines -Policy Brief -Guidelines 2016 update -Policy Brief 2016 update
Brief sexuality-related communication: Recommendations for a public health approach	Recommendations for health policymakers and professionals on the use of counseling skills to address sexual health concerns in a primary healthcare setting.	WHO	May 2015	-Brief
Sexually transmitted diseases treatment Guidelines, 2015	Guidelines for the treatment of people who have STIs or are at risk of acquiring them. Includes recommendations and counseling advice on STIs for physicians and other healthcare providers.	CDC	June 2015	-Guideline
Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV	Recommendations for national HIV program managers and others on starting ART for people living with HIV. Recommendations are targeted for adults, pregnant women, adolescents, children, and infants.	WHO	September 2015	-Guideline

Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV: Recommendations for a public health approach, Second edition	Recommendations on providing ART to all people living with HIV with no limitations, delivering HIV services closer to people's homes, expediting test reporting, and integrating HIV treatment with TB and other medical services.	WHO	June 2016 November 2015	-Guideline -Policy Brief
Key considerations for differentiated antiretroviral therapy delivery for specific populations: children, adolescents, pregnant and breastfeeding women and key populations	Guidelines to adapt HIV services to address the unique needs of different groups of people living with HIV while reducing burdens on healthcare systems. Guidance on meeting the needs of key populations including those who are marginalized, stigmatized, and criminalized.	WHO, CDC, PEPFAR, USAID, IAS	July 2017	-Guideline
Preexposure prophylaxis for the prevention of HIV in the United States - 2017 update: A clinical practice guideline	Comprehensive information for the use of PrEP to reduce risk of HIV transmission in adults. PrEP is presented as one prevention option for those at high risk.	CDC	March 2018	-Guideline
What's the 2+1+1? Event-driven oral pre-exposure prophylaxis to prevent HIV for men who have sex with men: Update to WHO's recommendation on oral PrEP	Summarizes the current evidence on the safety and efficacy of event-driven PrEP (ED-PrEP) and discusses how gay men can switch from daily dosing to ED-PrEP and vice-versa.	WHO	July 2019	-Guideline

5 Pre-exposure prophylaxis

Pre-exposure prophylaxis, or PrEP, is a major scientific breakthrough in HIV prevention science and involves the use of antiretroviral medication taken orally by HIV-negative people to prevent the transmission of HIV. It is taken as a daily pill, or around sexual events (event-driven, or ED-PrEP), for instance a double dose of two pills 2-24 hours in advance of sex and a third and fourth pill 24 and 48 hours after a sexual event.

PrEP uses a combination of antiretroviral drugs to prevent HIV transmission (see infographic below for more information). Some gay men think of PrEP as a way to protect themselves against HIV. Others view it as an enabling tool to explore and enjoy sex without condoms. These are both valid perspectives. PrEP is, and can be, of great benefit to gay and bisexual men all over the world. It should be available on demand and without judgement at minimal or no cost to the user. There is still persistent stigma and moral judgment attached to using PrEP and enjoying condomless sex. This stigma must be overcome through sex-positive re-framing and by prioritizing principles of bodily autonomy and self-determination.

PrEP is most effective when healthcare providers prescribe it in a manner that engages, prioritizes, and empowers the gay community. It is an integral part of a comprehensive package of HIV prevention and sexual health services. Comprehensive sexual health for gay men is an assessment of well-being which focuses on the holistic physical and emotional state of the person. It goes beyond the mere prevention or treatment of a

given disease. With regard to HIV, comprehensive sexual health views HIV as more than a pathogen. It considers a panoply of factors affecting gay men's health, including structural barriers. The World Health Organization defines sexual health as:[14]

> *"...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*

PrEP is an intervention that gay men can use to further actualize their sexuality and themselves by dramatically reducing their chances of acquiring HIV. It is a powerful tool for self-care and self-empowerment. Gay men have the right to PrEP, as they have the right to pleasure, intimacy, and comprehensive sexual health. The infographic below provides more information on PrEP for gay and bisexual men.

PrEP Basics

- *Drug information*

  The drug most commonly used for PrEP is composed of 300mg of tenofovir disoproxil fumarate with 200 mg emtricitabine. It was originally developed as an antiretroviral therapy for people living with HIV and is still used as a medication for treatment. Until 2019, it was the only drug that had been formally approved for use as oral PrEP in many countries. In October 2019, the U.S. Food and Drug Administration (FDA) approved a second drug for use as a HIV prophylaxis containing a newer form of tenofovir. This new PrEP drug has 25 mg tenofovir alafenamide with 200 mg emtricitabine.

- *Who should take PrEP?*

  PrEP has been shown to provide substantial and reliable protection against HIV transmission among gay and bisexual men who may be exposed to the HIV virus. This includes those who are sexually active, those who engage in sex work, those who do not have access to condoms, those who opt to enjoy sex without condoms, and those who have sex with multiple and unknown partners. Although HIV undetectability assures zero transmission (Undetectable=Untransmissible or U=U), PrEP is an additional, powerful tool for gay and bisexual men in sero-discordant partnerships.

- *Effectiveness and dosing*

  The recommended dosage for oral PrEP is to take a single tablet every day at approximately the same time. Injectable PrEP administered once every eight weeks has been proven to be safe and effective based on data from clinical trials (although it has not been approved for use yet). When taken daily, oral PrEP is extremely effective in preventing HIV transmission through anal sex among gay men. Based on the findings of the iPrEx Study, for gay men and transgender women who consistently took PrEP seven days every week, PrEP was 99% effective at preventing HIV transmission. For those who took PrEP less frequently, its effectiveness was less but still significant. PrEP effectiveness for those taking four pills a week was estimated at 96%. For those taking just two pills a week, protection against HIV transmission was estimated at 76%.

- *Event driven PrEP*

  Recent HIV prevention guidelines also recommend the use of event-driven or on-demand PrEP for gay men who are unable to adhere to a daily PrEP regimen. Event-Driven PrEP or ED-PrEP involves taking PrEP tablets on a 2+1+1 schedule - two tablets taken 2-24 hours before sex and one tablet each taken 24 and 48 hours after sex. Event driven PrEP was demonstrated to be highly effective for gay and bisexual men who have infrequent sex (less than five times a month on average).

- *Getting on PrEP and side effects*
  PrEP is a safe and well-tolerated drug with minimal to no side-effects. However, gay men who wish to get on PrEP should first seek a medical evaluation by a trained healthcare provider. Among others, this will include being tested for HIV and renal impairment. PrEP is only recommended for those who are HIV negative and do not have significant renal impairment. A small proportion of people report side effects such as nausea, vomiting, loss of appetite, headache, and fatigue in the initial days of taking the medication, but these generally subside.

- *PrEP, HIV, and STIs*
  PrEP does not prevent or impede the transmission of sexually transmitted infections (STIs) other than HIV. Other STIs include syphilis, gonorrhea, herpes, hepatitis, or chlamydia. It is recommended that individuals taking PrEP combine it with other methods to prevent STIs. It is also recommended that people who take PrEP and are sexually active be tested for HIV and STIs every three months.

- *Availability and accessibility*
  PrEP availability and accessibility vary a great deal depending on the country, proximity to health facilities, financial ability, knowledge about HIV and PrEP, and other factors. In some countries, PrEP is readily available at low or no cost to most people who demand it. In other countries, PrEP is not approved and therefore not available. Most countries fall somewhere in between. For current information on the availability of PrEP in your country, you can check https://www.prepwatch.org/.

6 Treatment as prevention and U=U

Treatment as prevention (TasP) is often used interchangeably with the U=U concept, which stands for undetectable equals untransmittable. The U.S. National Institutes of Health defines U=U as:[15]

"U=U means that people living with HIV who achieve and maintain an undetectable viral load—the amount of HIV in the blood—by taking and adhering to antiretroviral therapy (ART) as prescribed cannot sexually transmit the virus to others."

U=U is about ensuring treatment access for gay men living with HIV so they can live healthy and sexually fulfilled lives.[16] For gay and bisexual men living with HIV, ART reduces the viral load and makes it nearly impossible for HIV transmission to occur sexually.[17]

The HPTN 052 study showed that early initiation of ART reduced sexual transmission of HIV among serodiscordant heterosexual couples by up to 96%.[18] Among gay men, the San Francisco Men's Health Study found a link between ART and decreased incidence of HIV within gay serodiscordant couples. This was true even though not all of the men in the study adhered to their treatment regimen.[19] Other than the San Francisco study, however, there is limited evidence that TasP provides the same prevention benefits to gay men as it does to the serodiscordant heterosexual couples.[20] A HIV negative partner in a serodiscordant relationship also has the option of getting on a daily PrEP regimen to eliminate the likelihood of HIV transmission. One of the drawbacks of TasP is that - unlike PrEP which can become effective after one week of beginning the course of drugs - it can take a few months to become an effective prevention tool.[21]

Scaling up TasP for use by gay men around the world will be challenging for these reasons:

- The high cost of ART
- Lack of knowledge of their HIV status among many gay men
- Adverse events
- Drug toxicity
- Increased drug resistance

Furthermore, homophobia and HIV stigma can impede access to HIV treatment by gay men living with HIV. Many gay men report that ART is difficult to access or not accessible at all.[22] As such, TasP is a promising intervention for gay men if they are able to access HIV services with fewer hindrances.

Some of the conditions needed for TasP to be an effective HIV prevention tool are:[23]

- Increased advocacy for TasP as part of a combination prevention package for gay men
- Capacity-building and mobilization of gay activists and community-based organizations
- Improved linkages to care and treatment for gay men
- Sensitivity training for healthcare workers

7 Condoms and lubricants

Condoms and lubricants can be highly effective at preventing HIV and STI transmission through sex among gay when when they are used consistently and correctly.

Male condoms are sheaths of latex/rubber or other materials that gay men can use during anal or oral sexual intercourse. Condoms create a physical barrier between the genitals and sexual fluids of the partners engaging in sexual intercourse. When used correctly, condoms can be more than 90% effective at preventing the transmission of HIV and STIs such as gonorrhoea and Hepatitis B. However, many gay men do not use condoms correctly or consistently, increasing the potential of exposure to HIV and other STIs. Healthcare providers can provide the following tips to gay clients for the correct use of condoms:

- Purchase condoms that are pre-lubricated.
- Check the packaging to ensure condoms are not expired or damaged.
- Do not use sharp devices when opening packaging to prevent damage to the condom.
- Put on the condom the right way up on a hard penis with the lubricated side outside.
- Pinch the tip of the condom to create space for semen and unroll the condom to the base of the penis.
- Use lubricant as needed and reapply it frequently.
- Do not remove condom before ejaculating or during sexual intercourse. If the condom slips off or disintegrates, stop sexual intercourse and put on a new condom.
- When finished with sex or after ejaculating, hold the condom at the base of the penis and remove the condom before the penis becomes flaccid.
- Use a new condom for each new act of intercourse.

Healthcare providers should provide information to their gay clients about the use of condom-compatible lubricants during anal sex. Water-based or silicone-based condoms are generally compatible with condoms. Oil-based lubricants are not recommended for

anal sex as they degrade condoms and increase the likelihood of breakage. Lubricants are essential for anal sex as the rectum, unlike the vagina, does not produce its own lubrication.

In some places, gay men may experience difficulty in accessing condom-compatible lubricants. Providers should be prepared to provide their clients with advice on what condoms and lubricants are appropriate for anal sex and where to access them safely. Saliva is not recommended as a lubricant as it dries quickly and increases the risk of damage to the delicate rectal mucosal lining. If water or silicone-based lubricants are not readily available, unflavored low-fat yogurt or fresh raw egg whites can be used as substitutes. However, oils, vaseline, moisturizing lotions, and margarine should not be recommended as lubricants.

8 Risk reduction issues

There are several ways to reduce the likelihood of HIV and STI transmission among gay men including by promoting correct and consistent condom use, getting HIV negative men on PrEP, and getting men living with HIV on antiretrovirals to make Treatment as Prevention (TasP) possible. However, correct and consistent condom use is not always possible for gay clients for a variety of reasons. PrEP may be out of reach for many due to accessibility, financial, and privacy issues. TasP may not work if gay men cannot get tested or get on treatment.

As such, other viable methods of harm reduction should be evaluated by healthcare providers who have gay clients. Providers should inform clients engaging in each of the practices below of their possible risks. This allows clients to make thoughtful decisions about their health and to work with their provider to take steps to stay healthy.

- *Condomless anal sex*

Many people do not use condoms when they have anal sex. One study found that 90% of gay and bisexual men have reported having condomless anal sex and about six in 10 have had sex with a person they did not know.[26]

Condoms are highly effective at interrupting HIV and STI transmission during anal sex. Receptive anal sex is the most effective method of HIV transmission and the risk is even greater with practices that can occur around anal sex, such as douching, having multiple sexual partners in quick succession, role versatility, and substance use.[27] Research shows that even occasional condom use can substantially reduce the risk of acquiring HIV or another STI. The reasons for not using condoms can be varied. They include discomfort, inconvenience, reduced sensation, inability to get a hard on, latex allergies, and not being able to afford or access condoms. While polyurethane condoms are an alternative for people allergic to latex, many gay men (with or without latex allergies) still forego condoms during sex.

Providers should use a risk reduction model that involves using small and manageable steps to reduce risk of HIV transmission. As consistent condom use may not be a realistic goal for all gay men, providers can explore a client's reasons, methods, and practices for using or not using condoms or other methods of risk reduction. They can then work to gradually alter behaviors to reduce harm.

- *Sexual practices*

As discussed in Module II on Sexuality and Health, gay men engage in a wide range of sexual practices. These include, but are not limited to, kissing, masturbation, penetrative

anal sex, rimming, fingering, fisting, threesomes, group sex, watersports, role playing, and using sex toys.

All these sexual practices are valid and normal. Some are more common than others. For instance, a study found that 99% of gay men have oral sex, more than two-thirds have engaged in group sex, two-thirds have used insertive sex toys, and 15% have engaged in fisting.[28] Some sexual acts are correlated with higher risk of HIV and STI transmission. Participating in group sex, anonymous sex, or using enemas was correlated with higher levels of HIV and other STI transmission in one study. Providers should advise their gay clients to pursue sexual practices such as fisting with adequate precautions - such as using adequate and appropriate lubricants and latex gloves - as it can also result in colorectal perforation or other harms.

Oral sex acts such as giving or receiving a blowjob or rimming with a partner living with HIV, poses no risk of transmitting HIV.[29] This makes oral sex a no-risk option for gay men. [30] HIV and STI transmission risk may increase, however, if one or more sexual partners have an STI or have cuts or sores in the mouth.[31]

- *Injection drug use*

Like all people who share needles and equipment to inject drugs, gay men who do so are at elevated risk of acquiring HIV and Hepatitis C.[32] Additionally, gay men using drugs may also be more likely to engage in higher risk sexual practices, thus further increasing their risk of acquiring HIV and other STIs.[33]

People who inject drugs are 28 times more likely to be living with HIV than the general population. In addition to the likelihood of HIV transmission from sharing needles and other equipment, factors such as criminalization of drug use, aggressive law enforcement, stigmatization, discrimination, and violence drive drugs users underground. This makes it hard for people who use drugs to access harm reduction and health/HIV services, thus making them vulnerable to HIV transmission For gay men who are drug users, the additional risk factors associated with their sexual practices put them at exponentially higher risk of HIV transmission compared to the general population.[34]

9 Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) is a biomedical HIV prevention intervention in which a gay or bisexual man who is HIV-negative takes antiretroviral drugs following a potential exposure to HIV. PEP involves getting on a course of ART drugs immediately following exposure – usually within 72 hours – and continuing to take the drugs daily for 28 days. While PEP does not reduce the risk of HIV transmission to zero, it has been demonstrated to be highly effective at reducing the possibility.

PEP has been used to reduce transmission from several exposure routes including sexual exposures such as condomless sex or sexual assault and potential exposure during injection drug use. Clients who are receiving PEP should:[35]

- Receive HIV prevention counseling to reduce risk of future exposure
- Be monitored every day to ensure medication adherence
- Be monitored for liver function and creatinine levels
- Be tested for HIV and other STIs including hepatitis B and C

PEP can be difficult to access or unavailable in many parts of the world, including parts of the Caribbean, Africa, Latin America, and the Middle East. Many gay men may also not know its benefits. Additional awareness-raising, funding, and programming is necessary for PEP to be widely available as a valuable tool to reduce HIV transmission among gay communities.

10 HIV testing and prevention counseling

HIV testing and counseling (HTC) refers to a public health intervention whereby a gay or bisexual individual, a couple, or a family gets tested for HIV and receives counseling on HIV prevention, treatment, care, and support.[36] There are several ways in which the approach may vary, but the core components generally consist of:

- Pre-test counseling that outlines the testing process
- A behavioral risk assessment and sexual history taking
- Informed consent of the participant
- Administration of the HIV test
- Post-test counseling which depends on the results of the test

HTC is a key entry point to HIV and STI testing, care, treatment, and support for people living with HIV. Early detection enables timely linkage to care and support services. Such services can improve quality of life, prolong the life of an individual living with HIV, and prevent the spread of HIV through TasP, risk reduction, and behavior change. Healthcare providers should strive to offer HTC in an accessible and affordable manner. HTC can be delivered in different modalities ranging from individual level, group-based, community-based, and structural interventions.[37] It can be delivered in physical facilities, in mobile clinics, or through door-to-door visits by providers.

Many communities lack providers who have cultural competency in working with gay men. Outreach and HTC by peer educators and community-based facilities can often be more effective.[38] Providers should also use non-clinical language during the screening visit and when conducting sexual history taking to ensure that language and literacy are not barriers that might prevent gay men from accessing HCT.[39]

HIV stigma, societal homophobia, and hostile policies create environments in which gay men and are unable to safely access services. Many gay men believe that health services are primarily geared toward heterosexual people. Providers should address this by affirming their clients sexual orientations and identities and creating a welcoming and supportive clinical environment. Healthcare providers should also be given sensitivity training, health infrastructure should be made LGBTI-friendly, and healthcare facility policies should be updated to be inclusive of gay men. These broad health system-level interventions can improve access to and uptake of HTC by gay men.

Couples-based HCT

One important modality of delivering HTC to gay men is through couples-based HIV testing and counseling (CHTC). While CHTC has primarily been tested in heterosexual couples, the CDC has also endorsed it as a safe and acceptable modality for gay couples.[40] CHTC differs from standard HTC in that a couple receives pre- and post- test counseling – including the results of HIV tests – at the same time and in the same location. It is a

way to interrupt HIV transmission in serodiscordant couples, help seronegative couples negotiate plans to remain negative, and link seropositive couples to care. It also facilitates communication and partner support. The advantages of testing couples together include:[41]

- Provide a safe environment for couples to discuss risks and concerns
- Partners hear information together, enhancing the likelihood of a shared understanding
- The counselor can ease tension and diffuse blame
- Counseling messages are based on the test results of both individuals
- An individual who receives a positive test result is not burdened with the need to disclose the result to their partner or persuade their partner to be tested
- Counseling facilitates the communication and cooperation required for risk reduction
- Treatment and care decisions can be made together
- Couples can engage in joint decision-making for the future

CHTC is a voluntary and confidential intervention that respects the right of each client to make decisions with which they are most comfortable. Each client must consent to the counselor sharing HIV test results with their partner or they will revert to individual HTC. Once consent is given, CHTC will assist couples to establish goals that fit their particular situation.

Single-session HCT

Single-session HCT (SHCT) is a more recent innovation which has been made possible by the advent of rapid HIV tests. SHCT is replacing or has replaced standard two-step HCT in many countries. Rapid testing is a one-step process, meaning it takes place in a single session.

The first step of standard HCT is a risk assessment. If the client decides to get tested, the provider collects blood and sends it for testing. The client then returns 1-2 weeks later for the results. With SHCT, the provider verifies the client's desire to test, obtains informed consent, and collects a sample for the test, which takes 20 minutes or less. SHCT provides two primary enhancements to standard HCT. It allows the provider to focus on the most recent risk incident, explore it in detail, and help the client understand the motivation for their risk behavior. This creates motivation to change sexual behaviors in the future. SHCT also focuses on helping the client make a realistic plan with incremental steps rather than grand long-term goals.

SHCT has been well-received by clients and by providers. In a survey of 1,048 clients who accepted rapid testing in California, 95% said they would prefer a rapid test the next time they tested and 99.5% said they would recommend rapid testing to a friend.[42] Providers generally feel positively about SHCT as it increases client perceptions of HIV risk and allows them to build better rapport.

Clients can be more anxious with SHCT and giving clients a preliminary positive result can be a concern. Providers should validate the client's feelings of anxiety, reassuring them that anxiety is a normal part of testing for HIV and waiting for the results. They should discuss what the client thinks might be the root of the anxiety, specifically the most recent risk incident, and how they might modify their sexual behaviors in the future. Providers should discuss both the possibility that the test results will be negative and the possibility that the test will be positive. As all HIV-positive antibody tests in SHCT must be confirmed, a reactive result on a rapid test should be delivered to clients as a preliminary result that is subject to laboratory verification.

11 Motivating behavior change

Sexual behaviors among gay and bisexual men that lead to HIV transmission are deeply ingrained and often highly pleasurable. This makes it difficult to motivate a change in such behaviors. However, facilitating behavior change is a central tenet of HIV prevention counseling. Clients must have access to the right information in order to change high risk behaviors that make them vulnerable to acquiring HIV. But knowledge by itself is insufficient to produce lasting behavior change.[43] Healthcare providers need be able to motivate a gay client to change their behavior and improve their health outcomes.

Below are some guidelines that healthcare providers should follow to enhance the effectiveness of their communications with clients. By establishing solid and trusting relationships with their clients, providers can help them feel comfortable and help motivate them to change their behaviors:[44]

- Accept clients and do not judge them when they express or describe their sexual orientations or sexual behaviors. An affirming attitude towards clients when they share information that is difficult can have enormous therapeutic benefits.
- Choose language carefully to avoid hurting patients, even unintentionally. Be especially careful to avoid words and actions that convey disgust, horror, pity, or anger.
- It is okay to feel discomfort and to admit lack of knowledge and ask for more information
- Ask the clients how they identify. Make a conscious effort to set aside assumptions about a client's sexuality, sexual behavior, or sexual orientation, and gender identity

Brief sexuality-related communication

Brief sexuality-related communication (BSC) describes how a healthcare provider can use counseling skills during an encounter with a gay client to address psychological difficulties relating to sexuality and sexual wellbeing.[45] These skills can be used during a typical primary care visit or a specialized medical visit. BSC aims to support clients in exercising their sexuality with autonomy, satisfaction, and safety.[46] The key components of BSC include:[47]

- Setting up the relationship with a client
- Posing questions to learn about client's sexual health
- Conducting a basic evaluation of the medical, sexual, and social history of the client and interpreting the findings to identify sexual concerns or difficulties
- Relating to the client's personal goal of sexual health and wellbeing and the client's needs
- Planned follow-up or referral when needed.

Through BSC, a client is supported in exploring and understanding issues relating to their sexuality and sexual health. BSC is offered in a non-judgmental and non-stigmatizing manner and can be age- and sex-appropriate for all gay clients. The conversation is individualized to the client's specific needs so that each client's needs are met to the best of the provider's ability. To begin using BSC, providers use a client-centered approach to ask questions and learn about a gay client's satisfaction with their sexual life, their relationship with others, difficulties with using condoms, and issues with being able to express their sexuality. Using a client-focused approach can help providers influence behavior change in their clients.

12

Key points from the module

- There is no one-size-fits-all formula to prevent the transmission of HIV and STIs in gay and bisexual men. A combination approach using biomedical, behavioral, community-level, and structural approaches can be most effective at reducing the prevalence and incidence of HIV and STIs.
- Healthcare providers should integrate community empowerment approaches into all aspects of HIV and STI clinical care and programming. Community empowerment has been demonstrated to be effective at linking gay men to HIV and STI prevention and other services and to improving their overall sexual, physical, and mental health.
- Providers should adopt and adapt normative guidance on HIV and STIs from the World Health Organization and others to ensure that gay men are able to access prevention and other services without the barriers posed by stigma, discrimination, and violence.
- Pre-exposure prophylaxis (PrEP) is a valuable HIV prevention biomedical intervention for HIV negative gay men that should be prescribed by providers on demand, at minimal cost, and without judgment.
- Treatment as prevention (TasP) is a valuable HIV biomedical intervention that treats HIV, improves health, and prolongs the life of gay men who are living with HIV while simultaneously eliminating the possibility of them transmitting HIV to other gay men.
- Condoms and lubricants are effective tools to reduce HIV and STI transmission among gay men when used correctly and consistently during penetrative anal sex.
- Providers should consider a variety of risk reduction alternatives to recommend to gay men who may not be able to consistently access or use condoms or get on PrEP.
- Gay men engage in a wide variety of sexual practices which are all valid. Some are more common than others and some are higher risk than others. Providers should understand this diversity and tailor their risk reduction advice to gay clients accordingly.
- Post-exposure prophylaxis (PEP) is a valuable HIV prevention biomedical intervention for HIV negative gay men who might be exposed to HIV. It involves getting on ART drugs within 72 hours of possible exposure and taking the drugs daily for 28 days.
- HIV testing and counseling (HTC) is a critical component of any HIV program and serves as an entry point to care, treatment, and support for gay men living with HIV. It also serves as a valuable tool to raise awareness among HIV negative gay men about the risks associated with various sexual practices and the precautions they can take.
- Couples-based HCT and single-session HCT are both valid and useful methods of providing HCT to gay men.
- Motivating behavior change in gay clients is a central tenet of HTC. Providers should advise gay men to take small, realistic, and incremental steps that result in behavior change which reduces the risk of HIV and STI transmission.
- It is crucial that providers establish solid and trusting relationships with gay clients to ensure optimal health outcomes. This includes accepting and affirming a client's sexual orientation and sexual behaviors, using affirming language and avoiding judgmental or condemnatory language, being comfortable admitting to a lack of knowledge and asking for more information, and not making assumptions.

13 Quiz

1. _____ on HIV and STI prevention and treatment for gay and bisexual men define a set of evidence-based interventions and establish standards for the design and implementation of those interventions.

2. Which of the following is the recommended approach to addressing HIV prevalence and incidence among gay men?
2.1.Biomedical approach
2.2.Behavioral approach
2.3.Structural approach
2.4.Combination approach

3. Pre-exposure prophylaxis (PrEP) has been shown to be effective at eliminating the risk of HIV acquisition in gay men.
3.1. True *3.2. False*

4. Setting small incremental goals is preferable over setting one large long-term goal to bring about in lasting behavior change.
4.1. True *4.2. False*

5. It is not essential to include people living with HIV in an HIV-prevention program.
5.1.True *5.2.False*

6. Which of the following is the most effective method for HIV risk reduction?
6.1.Ask for your partner's HIV status
6.2.Put a condom on right before ejaculation
6.3.Pre-Exposure Prophylaxis (PrEP)
6.4.Reduce the number of sexual partners

7. Male circumcision has been shown to be effective at reducing the risk of HIV acquisition for gay men and other MSM.
7.1True *7.2.False*

8. The HPTN 052 study showed that early initiation of ART reduced sexual transmission of HIV among serodiscordant heterosexual couples by up to 96%.
8.1True *8.2.False*

9. One benefit of couples HIV testing and counseling is that it provides a safe environment for couples to discuss sexual health concerns.
9.1.True *9.2.False*

10. Gay men do not have difficulties accessing condoms and lubricants in many parts of the world.
10.1.True *10.2.False*

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Module 9

Clinical Care for HIV and Other STIs

1 Introduction

Gay and bisexual men around the world are often rendered invisible by healthcare systems or are denied healthcare tailored to their unique needs. The HIV epidemic has spurred healthcare providers to gather useful epidemiological data and data on the health indicators of gay men, although significant gaps remain. The data indicate that gay men are significantly more likely to be living with HIV than other men.[1]

Sexually transmitted infections (STIs) pose a serious health hazard for gay men. In addition to posing health risks in and by themselves, STIs increase susceptibility to HIV transmission.[2] Many STIs can be difficult to detect, diagnose, and treat, especially in resource-limited settings. Since early 2020, the COVID-19 global pandemic has further increased the health risks posed by STIs and the ability of gay communities to access the sexual healthcare they need. Owing to the redeployment of sexual health clinic staff, including disease intervention specialists (DIS), from STI contact tracing to the COVID-19 response, there have been significant adverse impacts on STI screening, diagnoses, and treatment.[3]

Providing counseling, testing regularly, and providing prompt treatment to gay clients are essential to limit the health hazards posed by HIV and STIs. While specific guidelines differ by country, this module provides healthcare providers with broad recommendations for HIV and STI counseling, testing, and treatment of gay and bisexual clients.

This module also covers the benefits of early HIV treatment, considerations for initiating antiretroviral therapy (ART), the concept of treatment as prevention or TasP (which was discussed in greater detail in the preceding module), and HIV co-infection with tuberculosis and hepatitis.

The final section of this module provides an overview of a variety of sexual health issues affecting gay men such as mental health challenges, rape and sexual violence, prostrate and anal cancer, anal warts, hemorrhoids, and the importance of anal exams.

Critical Thinking Questions

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is the world's largest funding mechanism to halt the spread of HIV around the world. Between its launch in 2003 and 2021, PEPFAR achieved remarkable results such as supporting ART treatment for over 17 million people and training hundreds of thousands of healthcare workers to deliver HIV care and services.[4] Millions of lives have been saved or extended because of PEPFAR funding and programming.

A significant portion of PEPFAR funding - as much as $250 million in just one single year - has gone to so-called abstinence programs which advocate refraining from sexual contact before heterosexual marriages. Abstinence is promoted as a HIV prevention strategy through sex education classes, on the radio, and even on billboards. For instance, the office of the wife of the long-time dictator of Uganda put up giant billboards in the country promoting abstinence.

A report published in 2016 found that abstinence had failed as strategy in Africa and in the United States. Promoting abstinence did not decrease high-risk sexual behaviors. It did not change young people's choices about sex. It did not change the number of sexual partners that young people had. Finally, it did not increase the age of first sexual intercourse.

Critical thinking questions:

1. *Why have abstinence programs been continued in many countries despite evidence showing that they do not work?*
2. *Where do gay men fit in programming priorities for abstinence interventions in countries such as Uganda?*
3. *What HIV interventions are demonstrably more likely to succeed than abstinence programs?*

2 Sexual history taking

As discussed in greater detail in an earlier module, healthcare providers should take a sexual history of all male clients in a clinical setting regardless of their stated sexual orientation or preferences. Obtaining a full sexual history should be a routine part of healthcare. It will enable providers to effectively assess the range of health risks their clients face and to give advice that can promote better health outcomes.[5]

Confidentiality is of paramount importance when taking a sexual history of gay clients. Owing to the stigma, discrimination, violence, and criminalization that they face in many parts of the world, gay men's freedom, safety, or lives could be endangered if their non-heterosexual behaviors or identities are revealed outside a clinical setting. Protecting the privacy of gay clients by maintaining the confidentiality of clinical discussions is especially crucial for gay adolescents who fear being outed and could suffer grievously should that happen.[6]

Taking a complete sexual history of gay clients should begin with creating a welcoming and supportive clinical environment. Clients can derive enormous therapeutic benefits if they have healthcare providers who are positive, supportive, and affirming.[7] Providers have the duty to overcome their discomfort and ask non-judgmental questions regardless of their personal prejudices or religious beliefs. They should take a complete sexual history without assumptions or judgment.

Providers who express doubt, fear, disgust, horror, pity, or anger will not be able to establish trust with their patients and the quality of clinical care and advice will thus be poorer. It is okay for a provider to admit to a lack of knowledge and ask their clients for more information or to seek help from their colleagues and supervisors.[8]

If language or literacy issues pose barriers to a full sexual history taking, providers should use simple and non-clinical language.[9] They should avoid slang and euphemisms and ask direct and open-ended questions, focus on sexual behaviors and not identities, and maintain transparency on why they are asking the questions.[10]

3 Conducting a physical exam and testing for HIV and STIs

After taking an initial sexual history of gay and bisexual male clients as a routine part of healthcare, providers should conduct a thorough physical exam. In addition to all the elements of a routine physical, gay and bisexual clients should also get additional exams such as genital testing, anal screening, and extragenital testing.

Gay men require these additional tests as they have far higher rates of HIV and STI transmission compared to the general population in every region of the world where data is available. In just the United States, for example, gay men account for almost two-thirds of annual HIV diagnoses, three-fourths of syphilis cases, are more likely to acquire antibiotic-resistant gonorrhea, and are 17 times more likely to be diagnosed with anal cancer than other men.[11] Additionally, as mentioned earlier, the presence of an STI is associated with increased risk of HIV transmission. There are several biological reasons for this:

- Having a sore or break in the skin may allow the HIV virus to more easily enter the body[12]
- STIs cause localized inflammation, facilitating HIV transmission into mucosal cells
- STIs cause generalized inflammation within the body, increasing the rate of HIV replication and progression to AIDS in clients who are infected with HIV

Providers should routinely screen gay men for HIV and STIs as the prevalence rates among this population is disproportionately high. By screening regularly as part of routine care, healthcare providers have the opportunity to make a significant impact on global STI and HIV prevention efforts.

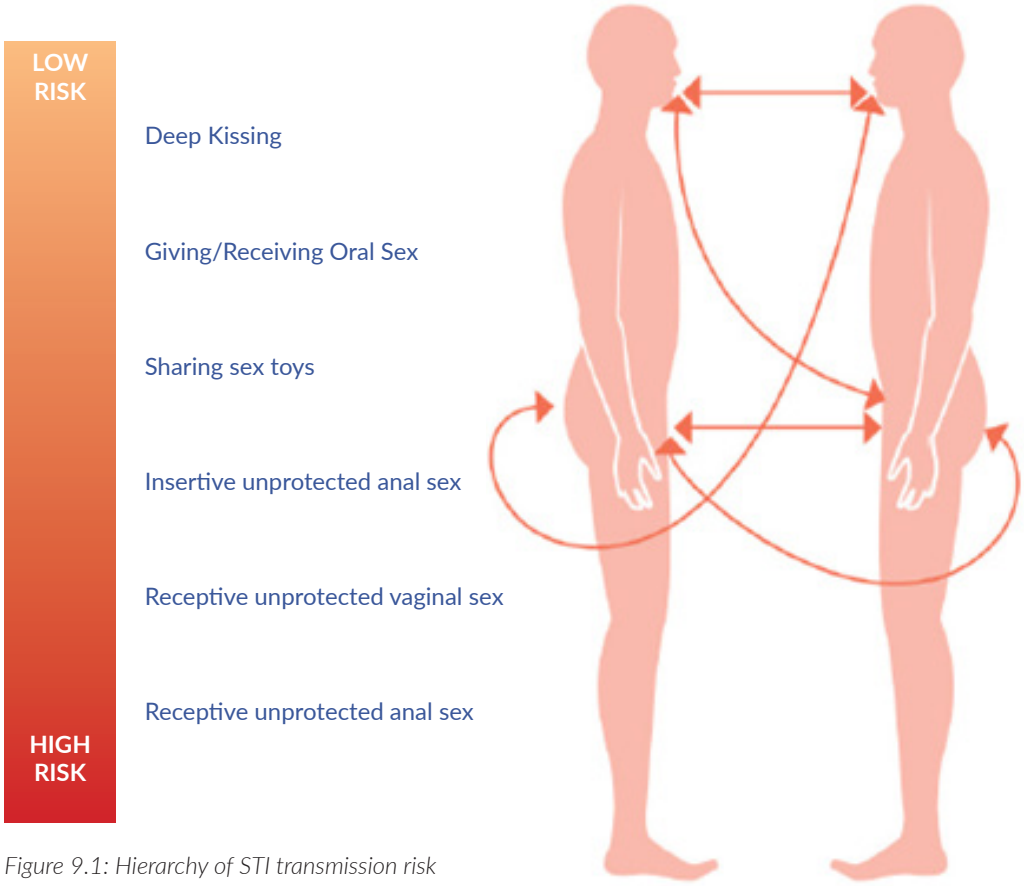

Figure 9.1: Hierarchy of STI transmission risk

Extragenital screening of gay men for gonorrhea and chlamydia is also important. A study has shown that regular blood and urine testing cannot detect these STIs in a significant portion of gay men. For instance, urine-only chlamydia and gonorrhea tests miss up to 88% of rectal infections in gay men as there are no concurrent urethral infections. Rectal gonorrhea infections can also be asymptomatic up to 85% of the time.[14] Thus, conducting extragenital screening by using rectal swabs, pharyngeal swabs, and other means is more likely to detect STIs among gay men and allow providers to clients to treatment and care. In addition to extragenital testing for all sexually active gay men, trans men who have sex with men should also regularly be given vaginal exams. Regular testing benefits gay men, their sexual partners, and the public at large.

The U.S. Centers for Disease Control and Prevention (CDC) recommends that all sexually active gay men should be tested for rectal and pharyngeal infections at least once a year.[15] Without timely detection and treatment, STIs that are left untreated can lead to antimicrobial resistance.[16]

4 HIV, STI, and sexual health counseling

About 40 million people worldwide are living with HIV and key populations - which include gay and bisexual men - account for as much as 99% of new infections in some parts of the world. Gay men are 26 times more likely to have HIV than someone in the general population.[17]

HIV, or the human immunodeficiency virus, is a retrovirus that attacks essential cells in the human immune system, including T cells (specifically CD4+ T cells), macrophages, and dendritic cells. Over time, HIV destroys CD4+ T cells, depriving the body of cell-mediated immunity. The body becomes progressively more susceptible to opportunistic infections, leading to the development of acquired immune deficiency syndrome (AIDS). During the initial acute infection phase of HIV, the viral load is high and CD4+ cell count decreases as HIV attacks these cells. The symptoms during this phase are often flu-like and include fever, swollen glands, sore throat, rashes, muscle and joint aches, fatigue, and headaches.[18] The viral load is particularly high during the acute infection phase. As such, individuals with HIV are more likely to transmit the virus during this time through sexual intercourse.[19]

The immune system then kicks into full gear and begins to fight the HIV virus. The viral load gradually decreases and CD4+ cell count increases, but not to the levels present before HIV transmission. The infected person enters the clinical latency phase, when the virus is still replicating but at lower rates than during acute infection.[20] Many people are asymptomatic during this phase and it may take years to develop full-blown AIDS. Progression to AIDS occurs when the immune system weakens to a level where the CD4+ cell counts drop to less than 200 cells per cubic millimeter. When this happens, chest infections, skin rashes, mouth sores, diarrheal illnesses, and some types of cancer can occur.[21]

Sexual intercourse is the most common mode of HIV transmission. Bodily fluids such as blood, semen, pre-cum, and rectal fluids of infected individuals can transmit HIV. It is not transmitted through saliva or sweat. Some modes of HIV transmission include:[22]

1. Unprotected anal or vaginal intercourse with a partner living with HIV but not on antiretroviral treatment
2. Sharing unsterilized needles, syringes, or other equipment when injecting drugs
3. From mother to baby during pregnancy, birth, or breastfeeding
4. Blood transfusions and blood donations
5. Organ or tissue transplants

Sexual health counseling is a key entry point to care, treatment, and support for gay and bisexual men infected with STIs and/or living with HIV. Sexual health counseling interventions play a crucial role in reducing HIV and STI transmission and in addressing sexual compulsivity in gay men. Additionally, counseling can reduce loneliness and improve mental health outcomes.[23]

Sexual health counseling includes testing and linkage to treatment and care. By getting tested, HIV and/or STIs can be detected earlier. Linkage to care can help gay men prolong and improve the quality of their lives. Treatment can also prevent the spread of HIV and STIs through risk reduction and behavior change interventions. Being on HIV treatment and ensuring an undetectable viral load will also make it impossible for sexual transmission of HIV to occur.

5 HIV treatment

Sexual health counseling can facilitate HIV testing for gay men and link them to treatment if they are positive. Antiretroviral therapy, or ART, is the core biomedical component for the management of HIV. ART has significantly reduced morbidity and mortality from HIV since its introduction in the 1990's. The biological effects of ART are similar in all people, regardless of their sexual orientation and gender identity. Therefore, ART recommendations for gay men are the same as for other key populations and for the general population.

HIV can only be detected by tests 2 – 12 weeks after infection. Seroconversion needs to occur before it can be detected. This is the point at which HIV antibodies are detectable in sera. Rapid tests are used to draw blood from a vein or finger prick to test for the presence of HIV antibodies. An enzyme immunoassay (EIA) or enzyme-linked immunoassay (ELISA) is used to look for the antibodies. Before seroconversion, an individual will continue to test negative for HIV even though the virus is present in their body. Confirmatory testing is usually done with a Western blot. Gay men should be tested for HIV at least annually and more frequently for those with higher risk of exposure (such as serodiscordant couples, sex workers, and those who have condomless anal sex with multiple partners of unknown HIV status).

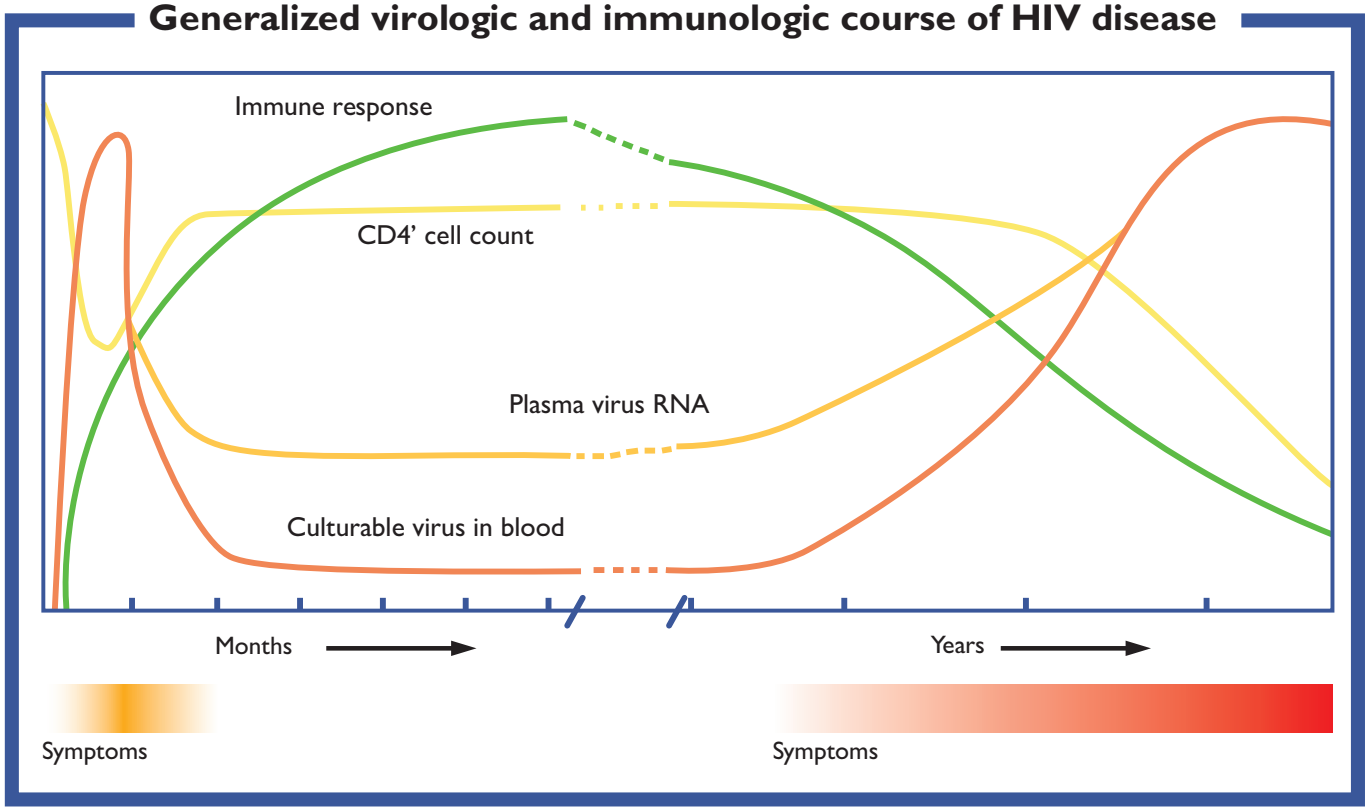

Figure 9.2: Schematic of the natural course of HIV[24]

WHO recommends the following core steps for treating gay adults and adolescents with HIV:[25]

- All clients should have access to CD4+ cell-count testing to optimize pre-ART care and ART management.
- Routine viral monitoring and treatment evaluation should be carried out at six months, one year, and then every year thereafter after beginning ART.

- *First-line therapy:* Two nucleoside reverse transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse transcriptase inhibitor (NNRTI) or an integrase inhibitor (INSTI).
  Note: Tenofovir disoproxil fumarate/TDF + lamivudine/3TC or emtricitabine/FTC + efavirenz (EFV) as a fixed-dose combination is recommended as the preferred option to initiate ART.
- *Second-line therapy:* Should be initiated only if first-line therapy has failed. A ritonavir-boosted protease inhibitor (PI) plus two NRTIs, one of which should be AZT or TDF, based on what was used in first-line therapy.
  Note: AZT plus 3TC if TDF plus 3TC (or FTC) treatment has failed. TDF plus 3TC (or FTC) if AZT or d4T plus 3TC regimen has failed.

Initiating a gay adult or adolescent with HIV on ART should follow the same WHO guidelines that apply to all adults or adolescents with HIV. In general, current WHO guidance recommends starting all children, adolescents, and adults living with HIV on ART regardless of CD4+ cell count or the clinical stage of the disease.[26]

The WHO recommends prioritizing ART initiation in clients living with HIV in the following instances:[27]

- Adults with a CD4+ cell count of 350 cells/mm3 or less
- Adults with severe or advanced HIV clinical disease
- Adolescents (10-19 years old) with a CD4+ cell count of 350 cells/mm3 or less
- Adolescents with severe or advanced HIV clinical disease
- Children 5-9 years old with a CD4+ cell count of 350 cells/mm3 or less
- Children 5-9 years old with severe or advanced HIV clinical disease
- Children less than five years old with a CD4+ cell count of 750 cells/mm3 or less
- Children less than five years old with severe or advanced HIV clinical disease
- All children less than two years old

There are several other factors beyond the WHO recommendations that must be considered when choosing an appropriate HIV treatment regimen for gay and bisexual men. The choice of HIV medications to include depends on the client's individual needs. Gay men living with HIV and their healthcare providers must consider the following factors:[28]

1. Other diseases or medical conditions that the person living with HIV may have.
2. Possible side effects of HIV medications.
3. Potential interactions between HIV medications or between HIV medications and other medications that the client is taking.
4. Drug resistance - Data suggest that 10-17% of ART-naïve people living with HIV in developed countries are resistant to at least one ART drug. These rates are lower (5.1-8.3%), but rising, in developing countries.[29]
5. Convenience - A regimen that includes two or more HIV drugs combined in a single pill is more convenient to adhere to than a regimen with multiple pills.
6. Personal issues - ART is a lifelong therapy. Interruption of ART is not recommended except in cases of serious toxicities or inability to take oral medications. Interruptions can cause rapid virologic rebound when the CD4+ cell count declines.[30]

Healthcare providers should work with their gay clients to find the most effective and convenient HIV treatment plan. A plan which the client is motivated to follow/adhere to is likely to lead to optimal health outcomes.

The exceptionally high rates of HIV among gay men represents an epidemic that is fundamentally different from those in other key populations or high-risk groups. Biological, social, network, and structural factors combine to spread HIV efficiently and rapidly in this population. Individual risk behaviors contribute modestly to these dynamics.[31]

New and more effective HIV prevention programs for gay men are necessary to reduce infectiousness. This requires expanding sexual health counseling, increasing screening and testing, expanding treatment options and methods, and adopting practices that will reduce the risk of HIV transmission to HIV negative gay men who have sexual partners living with HIV. While currently available tools can reduce the incidence of HIV substantially, more and better tools will be necessary to achieve an AIDS-free generation of gay men.

Stigma, discrimination, and homophobia in the healthcare system and in societies continue to limit gay men's access to basic services for HIV prevention, treatment, and care. To make a substantial impact in controlling the HIV epidemic among gay men, healthcare providers must focus on delivering effective interventions that address the gaps in the testing and treatment cascade. They must also ensure that gay men have access to safe and affirming spaces for prevention, treatment, and care.[32]

Benefits of early HIV treatment

As discussed in the preceding section, current WHO guidelines recommend initiating ART for otherwise-healthy gay adults and adolescents regardless of CD4+ cell count and regardless of the clinical stage of the disease. Early initiation of ART has several clinical and prevention benefits.[33] Healthcare providers should make efforts to reduce the time between HIV diagnosis and ART initiation.[34]

The reduction in HIV incidence associated with lower viral load has prevention benefits at the individual level and it also positively impacts HIV transmission at the community level for gay men.[35] There are other individual-level benefits to early initiation of ART:

1. Maintenance of higher CD4+ cell counts and reduced viral reservoir can prevent irreversible immune system damage.[36]
2. Prevention of HIV-associated complications such as TB, non-Hodgkin lymphoma, Kaposi's sarcoma, peripheral neuropathy, HPV-associated malignancies, and HIV-associated cognitive impairment.[37]
3. Prevention of non-opportunistic conditions and non-AIDS-associated conditions such as cardiovascular, renal, and liver disease; malignancies; and infections.[38]

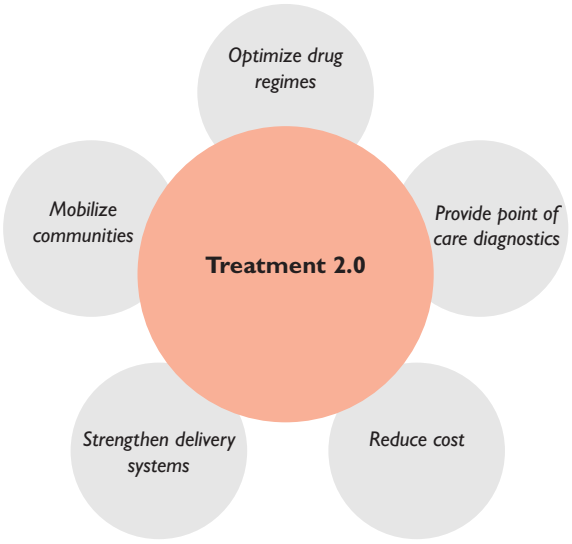

Figure 9.3: Guiding principles of Treatment 2.0

ART's primary purpose is to treat HIV, improve health, and prolong the life of an individual living with HIV. While there are several challenges to scaling up TasP globally, it is a useful tool in the fight against HIV in gay communities.

By getting on ART early, gay men can reduce the risk of HIV transmission to their sexual partners. This is known as treatment as prevention (TasP) and was covered in detail in the preceding earlier module.[40]

Tuberculosis co-infection with HIV

HIV co-infection with TB occurs when an individual living with HIV has either a latent or active TB infection. TB causes almost one in four deaths among people living with HIV, making it the leading cause of death among this population.[41] Latent TB infection can usually be treated with one type of medication, whereas an active TB infection might require concurrent treatment with several kinds of medications.[42]

Some common first-line TB treatment medications include isoniazid, rifampin, ethambutol, and pyrazinamide.[43] In the case of multi-drug resistant TB (MDR-TB), or extremely drug resistant TB (XDR-TB), second-line medications such as streptomycin, kanamycin, clarithromycin, amikacin, capreomycin, or other antibiotics should be used. These drugs are more expensive, more toxic, less effective, and require a longer course of treatment than first-line drugs.[44]

The WHO has issued the following guidance for the treatment of TB in all people, including gay men, living with HIV:[45]

- Antiretroviral therapy should be started in all TB patients living with HIV regardless of CD4+ cell count. ART can restore some immune system function, which can mitigate the dual impacts of TB and HIV.
- TB treatment should be initiated before ART. ART should follow soon after and within eight weeks of beginning TB treatment.
- TB patients living with HIV with CD4+ cell counts less than 50 (profound immunosuppression) should start ART within two weeks of beginning TB treatment.

Given the severe risk that TB poses, all gay men living with HIV should regularly be screened for TB. Research on TB case findings show that the presence of one or more of the following symptoms - persistent coughing, fevers, night sweats, or weight loss. These symptoms can indicate an active TB case in the vast majority of patients.

Gay adults and adolescents living with HIV who test positive for a latent TB infection should be put on isoniazid preventive therapy (IPT) for up to 36 months. They should receive IPT regardless of whether they are on ART or not. IPT should also be given regardless of the degree of immunosuppression or history of previous TB treatment.[46] Infection control for TB is essential to ensure that infected people are rapidly detected and provided with treatment. Precautions should also be swiftly taken to reduce airborne transmission in healthcare settings.

MDR-TB and XDR-TB pose dangerous treatment challenges in people living with HIV. The likelihood of fatality from MDR-TB is high unless treatment with appropriately tailored therapy can begin very quickly after infection. Ensuring that clients complete TB treatment with methods such as directly observed therapy short course (DOTS) is, to date, the most effective way to avoid the spread of MDR-TB.

Clinical management of HIV and TB co-infection is difficult because of the many treatment interactions between medications for HIV and TB. These interactions can cause many negative health outcomes such as liver-related illnesses.[47] As gay men are disproportionately affected by HIV and can experience greater difficultly in accessing healthcare, it is particularly important that efforts be made to integrate TB screening and case finding into the HIV minimum service package for this population.

- *Viral hepatitis co-infection with HIV*

Hepatitis is inflammation of the liver that can progress to cirrhosis, fibrosis, or liver cancer. It is most commonly caused by viruses but can also be caused by infections, toxic substances, or autoimmune diseases.[48]

The three major types of viral hepatitis are hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV). Types D and E are also important but less common.[49] Symptoms of hepatitis are often flu-like and include fever, nausea, fatigue, vomiting, loss of appetite, and joint pain. Symptoms may also include dark-colored urine, grey-colored stool, and jaundice.[50]

HAV and HCV are the most common causes of cirrhosis and liver cancer.[51] Worldwide, up to four million people living with HIV also have chronic HBV co-infection, while up to five million people living with HIV are co-infected with HCV.[52] The debilitating effects of HIV make it difficult for the body to clear the hepatitis virus.[53] People living with HIV with HAV co-infection may experience more severe symptoms than other people and may take longer to recover.[54]

Gay and bisexual men are disproportionally affected by HAV, HBV, and HCV. In the U.S., for example, an estimated 10% of new HAV infections and 20% of new HBV infections are in gay men.[55] If possible, all gay men should be vaccinated against HAV and HBV and should be screened annually for chronic HBV. HCV testing is recommended for gay men who engage in higher-risk sexual activities or who are living with HIV.[56]

It is necessary to improve awareness of and vaccinate against hepatitis as part of a minimum package of services for HIV prevention and treatment around the world. Efforts must also be made to improve healthcare provider education regarding hepatitis and to improve access to healthcare for gay men.

6 STI treatment

When a pathogen enters the body through a sex organ or the reproductive system and the transmission is through sexual methods from one person to another, it is called a sexually transmitted infection or STI. Most STIs are spread through bodily fluids such as semen, pre-cum, or blood, or through direct contact with the skin or sores.

A variety of pathogens such as viruses, bacteria, parasites, protozoa, and fungi can cause STIs. Some STIs present with symptoms while others can be asymptomatic or not develop symptoms for an extended period. As many STIs are asymptomatic, healthcare providers should regularly test their gay clients for a range of STIs. Clients should also be advised to get tested when entering into a new sexual partnership to protect their health and to avoid transmitting an STI to their partner. Gay men with multiple partners and those who have condomless anal sex with more than one partner should get tested more frequently. If the tests reveal the presence of STIs, appropriate treatment should be prescribed and/or administered as soon as possible.

The table below provides an overview of common STIs that occur in gay men. Symptoms reported by women are also included in the table so that healthcare providers can remain sensitive to the healthcare needs of trans men who have not undergone gender reassignment surgery.

STI	Causative agent	Symptoms
Chlamydia	Chlamydia trachomatis	• Often asymptomatic • Urethral infection may include discharge from penis, painful or frequent urination, pain and swelling of one or both testes (epididymitis). • Rectal infection may include discharge with bleeding (proctitis), pain, and swelling.
Gonorrhea	Neisseria gonorrhoeae	• Often asymptomatic • Urethral infection may include whitish, yellowish, or green discharge from penis and painful or frequent urination. • Rectal infection may include discharge, anal itching, soreness, bleeding, or painful bowel movements. • Pharyngeal infections may cause a sore throat • Increased vaginal discharge, vaginal bleeding between periods, a painful or burning sensation when urinating, and PID.
Syphilis	Treponema pallidum	• Primary phase: Marked by the appearance of a single sore (chancre), but multiple sores may also be present. Sores occur mainly on the external genitals, or in the anus, rectum, or vagina and possibly on the lips or mouth. • Secondary phase: Skin rashes and/or sores in the mouth, anus, or vagina (also called mucous membrane lesions); fever; swollen lymph glands; sore throat; hair loss; headaches; weight loss; muscle aches; fatigue. • Latent phase: Begins when primary and secondary symptoms disappear and may last for up to 30 years. • Tertiary phase: Difficulty coordinating muscle movement, paralysis, numbness, blindness, dementia, damage to internal organs, death.
Hepatitis A (HAV)	Hepatitis A virus	• Loss of appetite • Fatigue • Nausea and vomiting • Abdominal pain • Enlarged liver • Dark urine • Jaundice • Rashes • Arthritis
Hepatitis B (HBV)	Hepatitis B virus	• All the symptoms of HAV • May result in liver cancer
Hepatitis C (HCV)	Hepatitis C virus	• Often asymptomatic • All the symptoms of HAV and HBV • May cause cirrhosis, liver disease, and possibly death in chronic cases

Herpes	Herpes simplex virus: HSV-1 (usually oral herpes) and HSV-2 (usually genital herpes)	• Tingling • Itching • Pimples or blisters that will crust over • Symptoms may recur every few weeks, months, or years
Human Papillomavirus infection	Human Papilloma virus (HPV)	• Often asymptomatic • Genital and/or anal warts • Rarely, warts in the throat known as recurrent respiratory papillomatosis

Healthcare providers should assess the STI risk of all male clients. Providers can follow these recommended steps for STI screening[58] prior to determining and administering appropriate treatment:

1.Interview the client and conduct a culturally sensitive sexual history to:
- 1.1. Identify sexually active gay men and other men who have sex with men.
- 1.2. Identify their degree/risk of STI exposure.
- 1.3. Assess alcohol and drug use and whether these are relevant to the client's sexual health.
- 1.4. Assess underlying social and psychological challenges.

2.Ask the client if they are experiencing any STI symptoms and ask about specific symptoms that may indicate the presence of an STI:
- 2.1. Keep in mind that the client may be asymptomatic.
- 2.2. Common symptoms include dysuria, urethral discharge, pain, skin rash, and anorectal pruritus.

3.Provide the following STI prevention services during clinical visits:
- 3.1. Visual inspection of the skin, mouth, genital, and anal areas to screen for STIs.
- 3.2. Annual testing for HIV if previously negative or not tested in the preceding year.
- 3.3. Annual testing for syphilis with a confirmatory test to establish whether it is incident untreated syphilis, partially treated syphilis, or whether the client is manifesting a slow serologic response to appropriate prior therapy.
- 3.4. Annual testing for urethral N. gonorrhoeae and C. trachomatis in men who have had insertive intercourse.
- 3.5. Annual testing for rectal N. gonorrhoeae and C. trachomatis in men who have had receptive anal intercourse.
- 3.6. Annual testing for pharyngeal N. gonorrhoeae and C. trachomatis in men who have had receptive oral sex.
- 3.7. Vaccination against HAV and HBV for all gay men in whom a previous infection or vaccination cannot be documented.

4.Consider screening for other STIs:
- 4.1. Lymphogranuloma venereum (LGV) in diagnosis of compatible syndromes (proctitis and proctocolitis) and perform tests to diagnose chlamydia.
- 4.2. Herpes simplex virus (HSV)
- 4.3. Human papillomavirus (HPV)
- 4.4. Clients at higher risk, such as those who engage in condomless anal sex with multiple partners, should be screened every three months.

STI treatment guidelines and regimens can vary by country. Below are STI treatment guidelines for adults and adolescents recommended by the U.S. CDC.[59]

Chlamydia

Recommended: Azithromycin 1 g orally in a single dose.
Alternative: Doxycycline 100 mg orally twice daily or 200 mg once daily for seven days.

Gonorrhea
Recommended: Ceftriaxone 250 mg in a single intramuscular (IM) dose and Azithromycin 1 g orally in a single dose.

Alternative: If ceftriaxone is unavailable for uncomplicated urethral, rectal, or cervical infections, Cefixime 400 mg in a single oral dose and Azithromycin 1 g orally in a single dose can be used.

Syphilis (primary and secondary)
Recommended for people with HIV: Benzathine penicillin G 2.4 million units IM in a single dose.

Syphilis (latent)
Recommended for people with HIV: Benzathine penicillin G 2.4 million units IM in a single dose.

Syphilis (late latent)
Recommended for people with HIV: Benzathine penicillin G 7.2 million units total, administered as three doses of 2.4 million units IM each at 1-week intervals.

Hepatitis A (HAV)
Usually requires only supportive care with rest, abstaining from alcohol, and coping with nausea until the body eliminates the virus. Hospitalization might be necessary for clients who become dehydrated because of nausea and vomiting. Hospitalization will be necessary for clients with signs or symptoms of acute liver failure. Medications that might cause liver damage or are metabolized by the liver should be used with caution among persons with HAV.

Hepatitis B (HBV)
No specific therapy is available for persons with acute HBV. Treatment is supportive. Persons with chronic HBV infection should be referred for evaluation to a physician experienced in the management of chronic liver disease. Certain therapeutic agents for the treatment of chronic hepatitis B can achieve sustained suppression of HBV replication and lead to remission of liver disease in some people.

Hepatitis C (HCV)
Persons determined to have HCV should be evaluated for the presence of active infection, presence, or development of chronic liver disease, and possible treatment. Combination therapy with pegylated interferon and ribavirin is the treatment of choice for people with chronic HCV.
Healthcare providers should consult with specialists knowledgeable about management of HCV infection.

Herpes
Recommended: Acyclovir 400 mg orally three times daily for 7-10 days.
OR Acyclovir 200 mg orally five times daily for 7-10 days.
OR Valacyclovir 1 g orally twice daily for 7-10 days.
OR Famciclovir 250 mg orally three times daily for 7-10 days.
Treatment can be extended beyond 10 days if healing is incomplete.

Human Papillomavirus (HPV)
Treatment is directed to the macroscopic or pathologic lesions caused by infection. Subclinical genital HPV infection typically clears spontaneously and antiviral therapy is not recommended. In the absence of lesions, treatment is not recommended for subclinical genital HPV.

Anogenital warts in external anus
If administered by provider: Cryotherapy with liquid nitrogen or cryoprobe.
OR surgical removal by tangential scissor excision, tangential shave excision, curettage, laser, or electrosurgery.
OR Trichloroacetic acid or Bichloroacetic acid 80-90% solution.
If self-administered by patient: Imiquimod 3.75% or 5% cream.
OR Podofilox 0.5% solution or gel.
OR Sinecatechins 15% ointment.

Lymphogranuloma Venereum (LGV)
Recommended: Doxycycline 100 mg orally twice daily for 21 days.
OR Erythromycin base 500 mg orally four times daily for 21 days.

7 Other sexual health issues for gay men

- *Stress, anxiety, depression, heart disease*

Evidence from around the world shows that gay and bisexual men are at increased risk for debilitating anxiety disorders, likely because they often need to conceal their sexual behaviors or identities to varying degrees because of fear, shame, or guilt. In one study, gay and bisexual men were twice as likely as heterosexual men to experience an anxiety disorder over the course of their lifetimes.[60]

Studies have also shown that gay men often have lower self-esteem than heterosexual men and may experience additional social anxiety.[61] Gay men are also prone to depression for many of the reasons already discussed: constant stigma and discrimination, social isolation, rejection, and loneliness. Many gay men live in societies where their sexuality or sexual behaviors are viewed as criminal, pathological, undesirable, taboo, or even dangerous. Additionally, unrealistic expectations around body image and fitness contribute to increased stress and anxiety that can lead to depression.

One study found that gay men exhibit higher heart rates than heterosexual men, both during rest and when active. The difference in heart rate was medium to large. The higher heart rate among gay men is consistent with a pattern whereby minorities (such as racial and ethnic minorities) report increased cardiovascular reactivity due to discrimination.[62] Higher heart rate is independently associated with increased risk of cardiovascular disease and mortality.[63] Therefore, due to anxiety and depression resulting from discrimination and other social stressors, gay men are at increased risk of heart disease and consequently of premature death.

- *Anal screening, anal warts, anal cancer*

Anal cancer rates are rising among gay men, bisexual men, and other men who have sex with men. Those living with HIV are seeing particularly high rates.[65] Gay men are 17[66] to 52 times more likely to get anal cancer than other men.[67]

Despite the high rate of occurrence of anal cancer among this population, one study found that a majority of gay men had never heard of anal cancer. They reported that the lack of information from healthcare providers was the greatest barrier to receiving anal screening.[68]

The most common cause of anal cancer is persistent infection by high-risk strains of human papillomavirus (HPV) which cause anal dysplasia. Left untreated, anal dysplasia is thought

to develop into anal cancer. People living with HIV, or with other conditions that weaken the immune system, are at highest risk of HPV infection.[69]

Healthcare providers should prioritize anal screening in their gay patients and it should be accompanied by educational information about the meaning of test results.[70] Regular screening can potentially reduce the disproportionate burden of anal cancer borne by gay men by treating anal dysplasia in a timely manner. Providers can use an anal pap test as an annual screening tool for anal dysplasia. If the results are abnormal, then high-resolution anoscopy (HRA) can be used for further evaluation and advanced disease may need to be referred for colorectal surgery.[71] Anal pap tests can also be done at home and many gay men are willing to self-administer them. Self-collected home testing should be encouraged if that increases patient participation.[72]

Besides being helpful with screening for and treating anal dysplasia and anal cancer, regular anal screening can also locate anal warts. Anal warts are caused by two lower risk strains of HPV.[73] While they are usually asymptomatic, they can occasionally become painful depending on their location. Anal warts occur predominantly among gay men who have receptive anal sex and they can be identified with a visual inspection. A biopsy is recommended if the anal warts appear abnormal, if they do not respond to standard therapy to remove them, or if they occur in people living with compromised immune systems.[74]

- *Prostate cancer*

About 14% of all men receive a diagnosis of prostate cancer at some point during their life and it accounts for a fourth of all new cancer diagnoses in men. Prostate cancer is the most common kind of cancer in cis-gender gay men, bisexual men, and other men who have sex with men.[75]

While gay men are diagnosed with prostate cancer at about the same rates as all men, they report poorer urinary, bowel, and quality of life outcomes after diagnosis and treatment.[76] These poorer outcomes are partly due to the lack of appropriate sexual rehabilitation treatment. Such treatment is generally geared towards the needs and sexual practices of heterosexual men owing to the heteronormativity of healthcare systems and practices. Providers should be intentional about catering to the sexual and other implications of prostate cancer treatment on gay men. This can ensure optimal health outcomes for their gay patients and avoid perpetuating the marginalization that gay men experience throughout society.[77]

Homophobia can directly worsen health outcomes for gay men. For instance, homophobia in healthcare providers can serve as a barrier to digital rectal examinations.[78] Such exams are necessary to screen for prostate cancer or anal warts. Forgoing them because of a provider's homophobia or personal prejudices can jeopardize the health and life of gay patients.

A history of gonorrhea can elevate the risk of prostate cancer.[79] Gay men have higher rates of acquiring STIs over the course of their lifetimes, including of drug resistant gonorrhea.[80] Given these higher risk factors, it is imperative that healthcare providers regularly screen gay patients for prostate cancer.

- *Sexual assault and rape*

Like women, men, including transgender men who have sex with men can be victims of sexual assault and rape despite cultural stigma and myths which can try to invalidate or dismiss this fact. The perpetrators of sexual assault and/or rape of men can be other men, women, family members, friends, acquaintances, intimate partners, fellow prisoners, or strangers. Gay and bisexual men, including transgender men, are at higher risk of sexual violence and their rates are similar to that of heterosexual women. Some studies estimate

that 14–20% of gay and bisexual adult men experience sexual assault.[81] While gay men are more likely to be victims of sexual assault, men of all sexual orientations including heterosexual men can be victims.[82]

Being a victim of sexual assault and rape can have devastating consequences. It is associated with post-traumatic stress disorder, psychological distress, sexual dysfunction, sexual risk behavior, self-harming behaviors, and heavy alcohol use. Lifelong negative effects can lead to a downward spiral of self-harm and self-medication.[83]

While alcohol or drug usage can increase in victims of sexual assault or rape, alcohol use is also a risk factor in gay men that can increase the likelihood of experiencing sexual violence.[84]

Seeking support after a sexual assault is fraught for men due to societal expectations, gender norms, homophobic responses from healthcare providers, and/or a dismissive reception by law enforcement. Gay men are likelier to seek informal support from friends who are accepting of their sexual orientation rather than formal support services.[85] Some gay men may not recognize that they are experiencing sexual violence when it is committed by their male partner because of social norms that portray only women as victims of violence from male partners. As such, healthcare providers should adopt sexual violence prevention messaging that increases understanding among gay men of sexual violence in intimate relationships.[86]

Appropriate post-rape care management guidelines for men are often non-existent. Healthcare providers who treat male victims of rape can therefore provide inappropriate or inadequate care as a result. Men-specific post-rape management guidelines and policies are needed to provide holistic care for men who are victims of rape or sexual assault.[87] Providers should be trained, able, and willing to provide male survivors of sexual assault and rape with necessary services or referrals. These include crisis counseling related to psychological distress, appropriate and non-judgmental medical treatment, STI testing and treatment, and HIV services such as PEP, counseling, and testing.

In addition to sexual violence and rape of men perpetrated by individual-level actors, some countries actively seek to criminalize, humiliate, and harm gay men. In at least nine countries, governments use forced anal exams to “investigate” or punish suspected same-sex behavior between consenting men. Forced anal exams are distinct from legitimate clinical practice. It offers no benefits while it can cause serious psychological trauma and physical harm to those subjected to it. The U.N. considers forced anal exams to be a form of torture.[88]

8 Key points from the module

- Gay, bisexual, and other men who have sex with men find it hard to access healthcare – including for HIV and STI prevention and treatment – that are tailored to their needs and free of stigma or discrimination.
- Healthcare providers should take a nonjudgmental sexual history of all male clients as a routine part of care in order to effectively assess needs and provide appropriate care
- Providers should conduct a thorough physical exam of all male clients. The exams should include genital testing, anal screening, and extragenital testing.
- Gay men are disproportionately affected by HIV and STIs.
- The presence of STIs can increase the risk of HIV transmission.
- Providers should be able to provide - or make appropriate referrals - for sexual health counseling for gay clients. Sexual health counseling includes testing for HIV and STIs and linkage to treatment and care, if needed.
- Antiretroviral therapy or ART is the core biomedical component for the management of HIV.
- Several personal and medical factors (such as drug resistance, other diseases, potential drug side effects) must be taken into account when initiating ART in gay men living with HIV. ART should be initiated in line with current normative guidance.
- Providers should make efforts to reduce the time between HIV diagnosis and ART initiation as this will have individual-level benefits on the health and longevity of their gay clients.
- Early ART initiation also has secondary, community-level benefits by reducing risk of HIV transmission to sexual partners of gay men. This is known as Treatment as Prevention or TasP.
- Tuberculosis and hepatitis co-infections are dangerous for gay men living with HIV. Services for these infections must be integrated into a standard package of HIV services.
- STIs should be treated as soon as possible after diagnosis to reduce the harm they cause by themselves, and to reduce the possibility of them facilitating more efficient HIV transmission. Treatment should be initiated in line with current normative guidance.
- Gay men are disproportionately affected by stress, anxiety, and depression and this can lead to heart disease. Providers should refer gay clients to appropriate care to manage these health problems.
- Gay men, especially those living with HIV, are diagnosed with anal cancer at disproportionately high rates. Healthcare providers should regularly screen gay clients for anal dysplasia, anal warts, and anal cancer and provide appropriate care or referrals if needed.
- Prostate cancer is the most common kind of cancer diagnosed in gay men. Treatment can lead to poorer urinary, bowel, sexual health, and quality of life outcomes among gay men. Providers should regularly screen gay patients for prostate cancer.
- Gay men report levels of sexual assault and rape that are similar to that reported by heterosexual women. Providers should be trained, able, and willing to provide male survivors of sexual assault and rape with appropriate medical and psychological services and referrals.

Quiz

1. Which is NOT likely to be an early symptom of HIV?
1.1.Fever
1.2.Rash
1.3.Genital warts
1.4.Sore throat

2. Over the natural course of HIV, viral load starts low and follows a consistent and smooth curve upward until progression to AIDS.
2.1.True *2.2.False*

3. _____ is an STI that is usually marked by the appearance of a single sore called a chancre.

4. Gay men should be vaccinated against which type(s) of hepatitis?
4.1. HAV *4.4.HAV and HBV*
4.2.HBV *4.5.HBV and HCV*
4.3.HCB

5. The same types of HIV treatment regimens work for all individuals.
5.1.True *5.2.False*

6. It is important to screen gay men for rectal, urethral, and pharyngeal STIs.
6.1.True *6.2.False*

7. The WHO recommends initiating ART for:
7.1 Only those with a CD4+ count of 350 or less
7.2 All adults and adolescents living with HIV
7.3 All adults living with HIV if they do not have TB
7.4 Adolescents living with HIV who do not have HAV, HBV, HCV

8. Globally, _____ is the leading cause of death among people living with HIV.

9. HIV antibody tests are capable of detecting HIV as soon as a person acquires the virus.
9.1.True *9.2.False*

10. HIV is efficiently transmitted through saliva.
10.1.True *10.2.False*

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Quiz Answer

Module 1

1. False
2. Sexual orientation or sexual identity
3. 3.3
4. False
5. All of the above
6. False
7. All of the above
8. True
9. Syphilis
10. False
11. False
12. False

Module 2

1. False
2. True
3. 3.3
4. True
5. All of the above
6. Stigma
7. 7.4
8. 8.3
9. False
10. 10.5

Module 3

1. Stigma, discrimination, and homophobia
2. True
3. False
4. 4.5
5. False
6. 6.3
7. Culturally competent care
8. True
9. Confidentiality
10. True

Module 4

1. True
2. Motivational interviewing
3. All of the above
4. True
5. False
6. Confidentiality
7. True
8. All clients
9. False
10.False

Module 5

1. False
2. False
3. All of the above
4. Coming out
5. True
6. True
7. False
8. 8.2
9. True
10.True

Module 6

1. 1.5
2. True
3. True
4. 4.2
5. True
6. False
7. True
8. Poppers
9. 8.4
10.True

Module 7

1. True
2. False
3. Third
4. 4.3
5. False
6. True
7. Confidentiality
5. Coming out
6. True
7. False

Module 8

1. Normative Guidance
2. Combination approach
3. True
4. True
5. False
6. C
7. False
8. True
9. True
10. False

Module 9

1. True
2. Motivational interviewing
3. All of the above
4. True
5. False
6. Confidentiality
7. True
8. All clients
9. False
10. False