

Addressing the Social Determinants of Health Inequities Among Gay Men and Other Men Who Have Sex With Men in the United States



Acknowledgements

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Foreword

With support from the M·A·C AIDS Fund, Trust for America's Health (TFAH) undertook a literature review and convened a one-day consultation to consider strategies to mitigate the social determinants of health inequities among gay men and other men who have sex with men (MSM).[†] Invited participants included research scientists, lesbian, gay, bisexual and transgender (LGBT) health service providers, public policy advocates, and federal officials.* After reviewing current research pertaining to health inequities among MSM (including HIV epidemiology) and theoretical constructs to explain disparities, the remainder of the meeting focused on identifying opportunities for the federal government to intervene. Two caveats underpinned the discussion: 1) the need for additional research was stipulated, and 2) it was acknowledged that, while the evidence base to support interventions to address social determinants of health (SDH) among MSM is slim, health disparities (particularly HIV) are sufficiently grave to warrant taking immediate action. As such, meeting participants were charged with articulating ways in which the federal government could respond now to continuing health inequities among MSM based upon existing data. While this report reflects those conversations, the views expressed are solely those of Trust for America's Health.



Addressing Health Inequities: *Gay Men & MSM in the U.S.*

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Addressing Health Inequities: Gay Men & MSM in the U.S.

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Executive Summary

In the United States, gay men and other MSM continue to be more profoundly impacted by HIV than any other group. Though representing approximately 2 percent of the population, MSM comprise a majority of new HIV infections (66 percent in 2010) and represent more than half (56 percent) of all persons living with an HIV diagnosis. HIV incidence is disproportionately higher among Black MSM than any other risk group.

MSM also face a variety of other mental, physical and sexual health disparities, including substance abuse and depression, both of which correlate with high-risk behaviors for HIV infection, as well as suicide. MSM also have elevated rates of syphilis, gonorrhea, and other sexually transmitted diseases (STDs), which are associated with an increased risk for HIV infection as well. Young MSM are more likely than their heterosexual counterparts to report emotional distress, depression, or self-harm, and are at higher risk of suicidal ideation or attempts and becoming homeless.

The many health inequities experienced by MSM constitute a *syndemic* — i.e. multiple social determinants that each independently influence health outcomes, and which mutually reinforce and amplify each other. Among MSM, the *syndemic* comprising HIV, STDs, mental health, substance abuse, and violence has profound implications for HIV prevention — as numerous health challenges may overwhelm the capacity of some MSM to reduce their sexual risks. Moreover, for MSM who are also racial minorities, social determinants of health may intersect in various, overlapping domains, including not only sexual orientation, but race, poverty, educational attainment and immigration status.

Strategies to address health inequities among MSM — including, but not limited to, HIV — include interventions to 1) increase individual resiliency, 2) foster a supportive community, 3) improve access to quality healthcare, and 4) transform the environmental context in which people live. While new biomedical interventions such as pre-exposure prophylaxis or treatment-as-prevention show promise, their uptake will also be affected by social determinants. Addressing social determinants at every stage of life will require an array of linked individual, biomedical and structural interventions throughout the life course. To account for environmental factors, community-level and structural interventions must include health policy and legislation, economic and social interventions, and cross-sector collaborations. Federal coordination will be essential — the National Prevention, Health Promotion and Public Health Council (NPC) is well positioned to provide leadership.

In the long term, however, reducing societal oppression and marginalization of LGBT people will diminish the need for individual and community-level interventions. The increasing recognition that for MSM, HIV constitutes but one of many health challenges provides an opportunity to refocus efforts to fight HIV by incorporating interventions within the context of MSM health and wellness promotion.

Introduction

In the United States, gay men and other men who have sex with men continue to be more profoundly impacted by HIV than any other group. Though representing approximately 2 percent of the population aged 13 years or older, MSM (including MSM who inject drugs) comprise a majority of new HIV infections (66 percent in 2010)¹ and represent more than half (56 percent) of all persons living with an HIV diagnosis.² Since the epidemic began, more than 350,000 MSM with AIDS have died, 55 percent of the overall total.³

Studies have shown that MSM face a variety of health disparities, including increased rates of substance abuse, depression and suicide, all of which significantly correlate with high-risk behaviors for HIV infection. Recent studies have also shown that *social determinants* of such risk behaviors include multiple and intersecting factors, including individual (peer pressure, social and sexual networks, social support, and access to care), as well as sociocultural (race/ethnicity, educational

level, socio-demographic position, and religion) and environmental (poverty, violence, stigma, discrimination and homophobia, and acculturation to the gay community) contexts, many of which may be of greater consequence for MSM. Continuing progress against HIV among MSM will require strategies to address other psychosocial health disparities, including how these outcomes interrelate with one another and with multilevel factors to mediate HIV transmission and acquisition risks.⁴



Addressing Health Inequities: *Gay Men & MSM in the U.S.*

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Addressing Health Inequities: Gay Men & MSM in the U.S.

HEALTH DISPARITIES

Health Disparities Among MSM

An increasing body of research over the past 25 years has shown that LGBT individuals experience significant health disparities, compared to heterosexuals.[‡]

In 2000, for the first time, the U.S. Department of Health and Human Services (HHS) included gay men and lesbians as a population group in the federal government's decennial effort to articulate science-based, 10-year national objectives for improving American's health, *Healthy People 2010: Understanding and Improving Health*, for which a key goal was reducing health disparities.⁵

In 2011, the Institute of Medicine (IOM) published a landmark study: *The Health of*

Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding.⁶ That same year, as mandated by the Affordable Care Act (ACA), LGBT populations were added to the *National Healthcare Disparities Report*.⁷ Overall, LGBT individuals experience a higher prevalence of many Healthy People indicators, including substance abuse, obesity, depression and anxiety, tobacco use, injuries and violence, responsible sexual behaviors, and access to care.

MENTAL HEALTH

A number of probability studies have shown that lesbian, gay or bisexual (LGB) individuals are more frequently diagnosed with mental health disorders, primarily depression and anxiety.^{8, 9} MSM experience higher rates of suicidal ideation or attempts over their lifetimes than do heterosexuals.¹⁰ LGB youth are more likely than their heterosexual counterparts to report emotional distress, depression or self-harm¹¹ and are at higher risk of suicidal ideation or attempts

than their heterosexual peers, even after controlling for substance abuse and depression.^{12, 13, 14} In an analysis of data from the Youth Risk Behavior Surveillance System (YRBS), prevalence among LGB youth was higher than among heterosexual youth for seven of 10 risk categories (behaviors that contribute to violence, behaviors related to attempted suicide, tobacco use, alcohol use, other drug use, sexual behaviors, and weight management).¹⁵

PHYSICAL HEALTH

With a few exceptions, rates of chronic physical diseases appear similar in heterosexuals and sexual minority populations, which may be counter-intuitive, in light of increased prevalence of substance abuse, heavy alcohol use, smoking and (among lesbians) obesity. For example, though LGB individuals were more likely to report risk behaviors, over their lifetimes, they are not more likely to receive a diagnosis of diabetes or heart disease.

They were, however, more likely to receive a diagnosis for asthma.¹⁶ Though studies have failed to show differences in most cancer rates (an analysis made more challenging by a lack of sexual orientation data in most cancer registries), multiple studies have shown that MSM are at increased risk for anal neoplasia, largely as a result of a high prevalence of human papilloma virus among men who engage in receptive anal intercourse.¹⁷

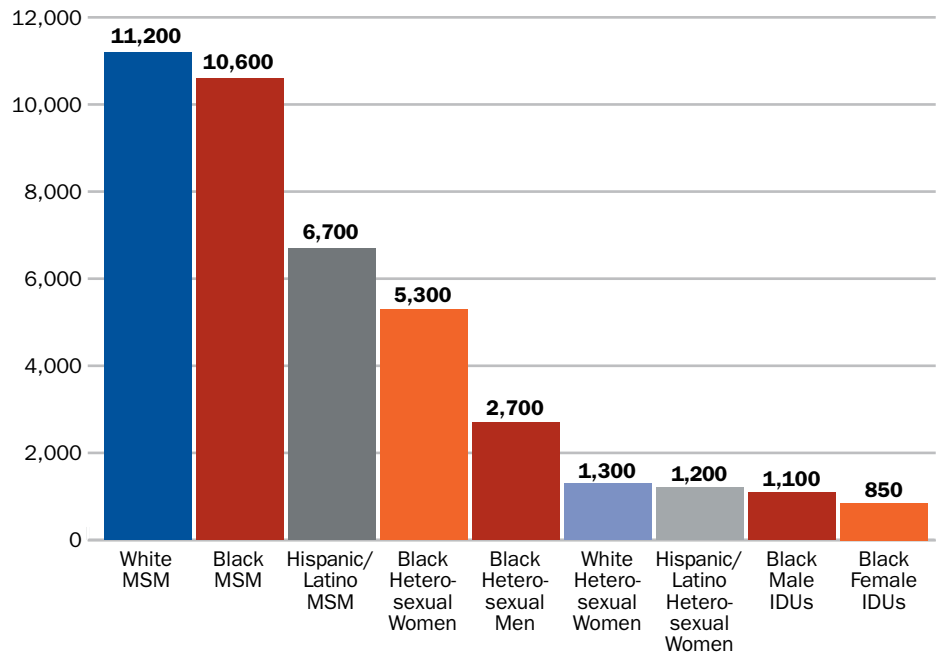
SEXUAL HEALTH

Sexually transmitted diseases. With respect to sexual health, disparities among MSM are pronounced. Compared to heterosexual men, MSM have elevated rates of syphilis, gonorrhea, lymphogranuloma venereum (LGV), human herpesvirus (HHV-8), and hepatitis B (HBV). MSM who are living with HIV are particularly susceptible.¹⁸ In 2012, MSM accounted for 75 percent of all primary- and secondary-syphilis diagnoses in the United States.¹⁹ In an analysis conducted by the U.S. Centers for Disease Control and Prevention (CDC) using data from states with confidential names reporting, in 2007, MSM were 61 times more likely than heterosexual men and 93 times more likely than women to be diagnosed with syphilis.²⁰

HIV. Nowhere are health disparities among MSM greater than with respect to HIV. Among MSM overall, HIV prevalence is extraordinarily high. In 2011, 18 percent of MSM who received an HIV test in 20 cities participating in the National HIV Behavioral Surveillance System (NHBS) were HIV-positive, with prevalence increasing with age.²¹

In an analysis conducted by CDC using 2007 data from states with confidential names reporting, MSM were 60 times more likely than heterosexual men and 54 times more likely than women to be diagnosed with HIV.²² In 2010, 66 percent of all new HIV infections (83 percent of new infections among men) were among MSM or men who have sex with men and inject drugs (MSM/IDU).²³ But, while historically MSM in the United States have always comprised the largest proportion of HIV cases, they are the only group for whom risk appears to be increasing. New infections among MSM increased by 12 percent from 2008 to 2010, and, among young MSM (ages 13 to 24), new HIV infections increased 22 percent.²⁴

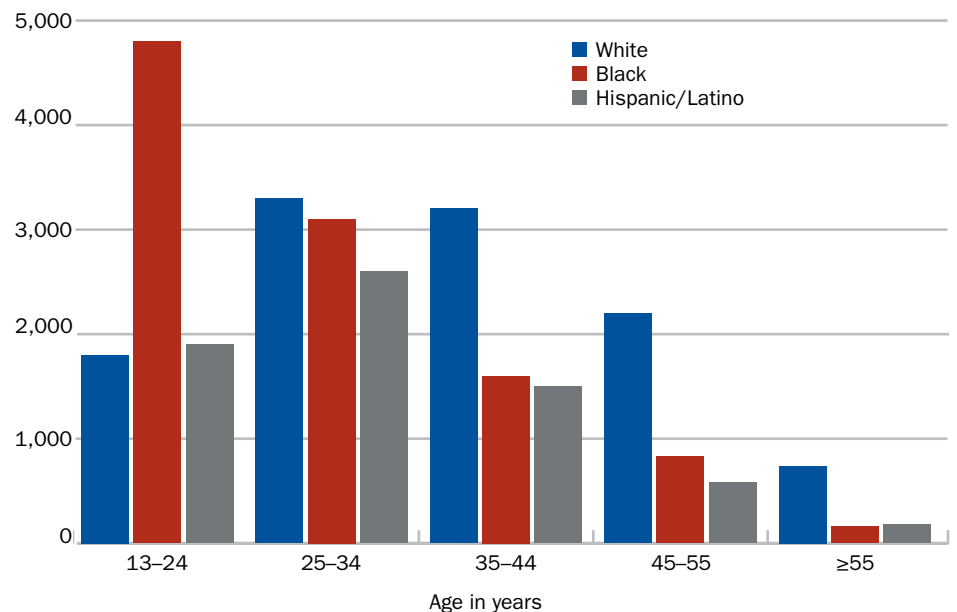
NUMBER OF NEW HIV INFECTIONS



Subpopulations representing 2% or less of the overall U.S. epidemic are not reflected in this chart.

SOURCE: CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. HIV Surveillance Supplemental Report, 2012;17(4).

NUMBER OF NEW HIV INFECTIONS AMONG MSM



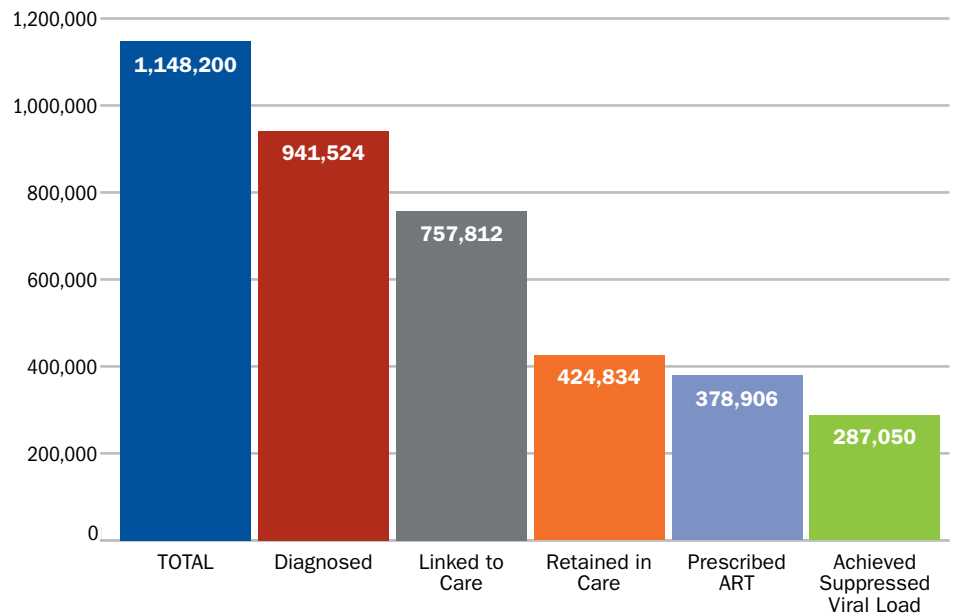
SOURCE: CDC. Estimated HIV incidence among adults and adolescents in the United States, 2007–2010. HIV Surveillance Supplemental Report, 2012;17(4).

Among Black MSM, the crisis is sobering. HIV incidence is disproportionately higher among Black MSM compared to White MSM. In 2010, an estimated 10,600 new HIV infections (36 percent of all new infections among MSM) occurred among Black men — nearly the same number that occurred among White MSM (11,200, 38 percent), even though Whites outnumber Blacks in the population by more than a factor of five.²⁵

Young Black MSM are especially affected. While, among Whites, the largest number of new infections (3,300 or 29 percent) occurred among men ages 25 to 34, among Black MSM, the largest number of new infections (4,800 or 45 percent) occurred among young men ages 13 to 24.²⁶ And, while HIV incidence is increasing among young MSM overall, the rate of increase is much higher among young Black MSM. Between 2006 and 2009, while remaining stable or declining among all other racial and risk groups, HIV incidence increased by 21 percent among young people (ages 13 to 29), driven by a large increase (34 percent) among young MSM, which, in turn, was driven almost exclusively by a 48 percent increase among young Black MSM.²⁷

Among people living with HIV, there are significant disparities in access to care and treatment. Though antiretroviral therapy (ART) has rendered HIV a potentially manageable, chronic condition, successful treatment — as indicated by the suppression of viral load below a detectable level — requires a sequence of events that has become known as the “treatment cascade.”[§] HIV-infected individuals must be diagnosed, linked into care, initiated on ART, retained in care, re-engaged in care (if necessary), and then they must successfully adhere to their treatment regimen. Analyses employing the treatment cascade model suggest that ART uptake

Estimated Numbers of Persons Living With HIV in 2009 and Percentage in the Continuum of Care by Selected Characteristics, United States



Adapted from Hall HI, Frazier EL, Rhodes P et al. Differences in human immunodeficiency virus care and treatment among subpopulations in the United States. *JAMA Intern Med* 2013; 173(14):1337-1344.

remains far below ideal levels — among the 1,148,200 persons living with HIV in the United States in 2009, 82 percent had been diagnosed, 66 percent were linked to care, 37 percent were retained in care, 33 percent received ART, and 25 percent had suppressed viral load (Figure 1).

From a different perspective, as of 2009, approximately 18 percent of all people living with HIV remain unaware of their infection, while 50 percent of those who have been diagnosed remain without appropriate care. More than 850,000 people living with HIV in the United States— 79 percent of Blacks, 74 percent of Latinos, and 70 percent of Whites — do not have a successfully suppressed viral load, indicating no or substandard treatment and a missed prevention opportunity. A review of disparities by race, gender, age and transmission category at each point

along the treatment continuum, however, did not find statistically significant differences, with the exception of age: younger people ages 25 to 34 and 35 to 44 were less likely than persons ages 55 to 64 to be retained in care, prescribed ART, or to have a suppressed viral load ($p < .001$).²⁸

Generally, HIV-positive MSM experience better linkage and retention to care than do young people, females, those who inject drugs, and racial/ethnic minorities.²⁹ But disparities related to race are observed among MSM. In two meta-analyses, HIV-positive Black MSM were less likely to be diagnosed, to have a CD4 > 200, to attend clinical visits, to access or adhere to ART, or to be virally suppressed.^{30, 31} Moreover, Black MSM experience higher rates of disease progression and mortality than other MSM.^{32, 33}

Determinants Of MSM Health (Including HIV)

A variety of complementary conceptual frameworks have been proposed to explain the disparities noted in MSM health indicators.

Determinants of population health are generally considered to fall within five overlapping domains: 1) individual behaviors (e.g. alcohol or drug use, smoking and unprotected sex); 2) biology and genetics; 3) social environment (e.g. discrimination, poverty, education level, marital status and stigma); 4) physical environment (e.g. place of residence, incarceration, crowding conditions and built environment); and 5) health services (e.g. access to care and insurance). The last three constitute the immediate and visible circumstances in which people live, or social determinants

Individual Behaviors

Some behaviors that compromise mental and physical health are more common among LGBT youth and adults, while the correlation of certain risk behaviors with HIV transmission, morbidity and mortality have been long established.

Substance abuse. Many studies have shown an association between LGBT orientation and an increased risk for substance abuse, which in turn has been linked to a variety of negative outcomes and has been well established to be a determinant of HIV risk. For example, a meta-analysis of studies of mental disorders among LGB people found that these populations have a 1.5 times greater risk for alcohol or substance dependence over the previous 12 months.³⁶ An analysis of data from the Urban Men's Health Study found substantial rates of current recreational drug use (52 percent) and alcohol use (85 percent)

of health. As factors that may significantly affect an individual's environment, but that fall outside individual control, the influence of SDH on health and health disparities has been increasingly recognized.³⁴ Moreover, the effects of SDH may accumulate over a lifetime and persist across generations.³⁵ The interplay of these five factors (i.e. individual behavior + biological factors + social determinants), each of which may affect and be experienced very differently among LGBT populations compared to heterosexuals, influences physical and mental health — including HIV.

among MSM, with 8 percent reporting heavy drinking, 18 percent using three or more recreational drugs, and 19 percent reporting recreational drug use at least once per week.³⁷ While there are occasional studies showing otherwise — one analysis of data from the National Epidemiological Survey on Alcohol and Related Conditions showed the risk for substance abuse or dependence to be significantly higher among bisexual men and women, but not among gay men, compared to other groups³⁸ — many studies suggest that MSM exhibit higher rates of substance abuse than do their heterosexual counterparts, especially if lifetime use rates are compared.³⁹ Population studies have also shown that marijuana use is more common among MSM compared to heterosexual men,⁴⁰ and that lesbians and gay men have a higher prevalence of tobacco use.^{41, 42, 43}

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Among Black MSM, however, substance abuse rates were generally lower than among White MSM — in a meta-analysis of studies conducted in Canada, the United Kingdom, and the United States, Black MSM were less likely to report any substance abuse, including methamphetamine, or to use drugs or alcohol during sex.⁴⁴

Among youth, in national population studies, LGB adolescents in North America had higher rates of smoking, alcohol use and other drug use (including injecting) compared with heterosexual teens, were more likely to begin drinking earlier, and had higher levels of risky drinking.⁴⁵ Compared to their heterosexual counterparts, in a meta-analysis, LGB

youth were more than three times as likely to report use of any substance, with substantial differences for cigarettes, injection drugs and polydrug use.⁴⁶

Sexual Risk Behaviors. In a recent analysis of data from the Urban Men's Health Study, a much higher proportion of MSM were found to recruit new sexual partners well into their thirties (compared to heterosexuals, for whom more than half reported no new partners in the previous five years), to have a much higher prevalence of concurrent partners, and to more frequently partner with men of a different age group — all of which could magnify the potential for HIV transmissions within sexual networks.⁴⁷ Similarly, adolescent

MSM may be at greater risk than their heterosexual counterparts, as LGB youth have higher rates of early sexual debut and report a higher number of lifetime or recent sexual partners.⁴⁸ In probability samples among youth in British Columbia, young MSM were more likely than heterosexual males to have ever had intercourse, to report two or more sexual partners, and to have had first intercourse before age 14.⁴⁹ Sexual risk-taking does not appear to differ by race, however. In a meta-analysis of studies conducted in the United States, Black MSM had significantly fewer partners than White MSM, though they were less likely to identify as gay or to disclose their homosexuality to others.⁵⁰

Adolescent MSM may be at greater risk than their heterosexual counterparts, as LGB youth have higher rates of early sexual debut and report a higher number of lifetime or recent sexual partners.

Biology and Genetics

The disparities in HIV incidence among MSM are significantly affected by biological and epidemiologic factors, including background HIV prevalence, sexually transmitted disease prevalence, sexual mixing patterns, and the relative risk for HIV transmission of various sexual practices. Because MSM are more likely to find sex partners locally, if HIV prevalence in the surrounding community is high, the probability of encountering a sex partner who is HIV-positive is significantly enhanced. Sexually transmitted diseases increase the probability of HIV infection, and as noted above, STD prevalence among MSM is far higher than among heterosexual men.⁵¹ Both factors are magnified significantly among Black MSM, among whom HIV and STD prevalence is higher than among White MSM. In a meta

analysis of studies conducted in the United States, Canada and the United Kingdom, compared to White MSM, Black MSM were more likely overall to have a current or lifetime STD diagnosis, three times as likely to be HIV-positive, and six times as likely to have an undiagnosed HIV infection — in spite of lower rates of sexual risk taking and substance abuse, and higher rates of preventive behaviors.⁵²

Because the risk of HIV infection via anal sex is approximately 18 times higher than via vaginal sex, MSM are at proportionally higher risk than heterosexuals even with the same number of sex partners. And because MSM who engage in anal sex sometimes switch roles (between insertive and receptive), the population risk is further elevated.⁵³

Social Environment

Stigma and discrimination. The minority stress model has been used as a framework to understand the impact of select social determinants — i.e. those stemming from stigma and discrimination — on health disparities among LGB individuals.⁵⁴ The model proposes that LGB individuals suffer from excess and disproportionate stress related to their stigmatized social category, and that such stress leads to adverse health outcomes. It is premised on the “heterosexual assumption,” wherein everyone is assumed to be heterosexual, where sexual minorities remain generally invisible and unacknowledged by society’s institutions, or, when they are made visible, are problematized. Stigma rooted in homophobia results in social marginalization and discrimination, which are expressed in four ways:

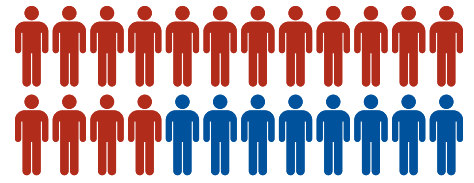
- **Enacted stigma** refers to overt acts of personal ostracism or rejection; discrimination (in housing or employment, for example); criminal victimization, violence or hate crimes — leading to a reduced sense of order and security;
- **Felt stigma** comprises a range of overt manifestations of anti-gay sentiment (e.g. antigay violence, antigay “religious freedom” legislative campaigns and hate crimes), which, even when not personally experienced, contribute to a climate of stigmatization;
- **Structural stigma** refers to laws, policies or regulations that have a discriminatory or stigmatizing effect, such as the denial of the right to marry or serve in the military; disenfranchisement from religious or spiritual resources (e.g. rejection from institutional religion); anti-discrimination provisions that fail to protect LGB people; or workplace practices that impede the hiring or promotion of gay people, thus exerting negative economic stress; and

- **Self-stigma** or internalized homophobia that results from individuals absorbing and believing pervasive negative portrayals.

In the model, as a consequence of persistent social marginalization and discrimination, LGB individuals cope in ways that are adaptive but ultimately stressful, and therefore injurious to health, including by concealing their sexual orientation through passing (i.e. pretending to be heterosexual) or covering (i.e. suppressing characteristics or information from which others might infer their sexual orientation), or by being out but only implicitly, by telling the truth but using only ambiguous language. Such strategies require constant vigilance, and also discourage forming relationships that might otherwise confer protective health benefits or accessing community social support resources. Like social determinants in general, minority stress is additive (i.e. it requires adaptive responses above and beyond those required by the everyday stresses encountered by others); chronic, in that it is based on relatively fixed social ideas and cultural structures; and socially based (i.e. it comprises social structures rather than biologic, genetic, or nonsocial characteristics of the individual or group).⁵⁵

The disproportionate experience among MSM of discrimination and other prejudice, and the adverse health consequences of such experiences, has been repeatedly demonstrated. For example, LGB individuals were twice as likely as heterosexuals to experience a major life event, such as being fired, related to prejudice.⁵⁶ In population studies, LGB individuals were all more likely than heterosexuals to experience sexual assault.⁵⁷ In a recent poll, two-thirds of LGBT adults had experienced discrimination based upon their sexual

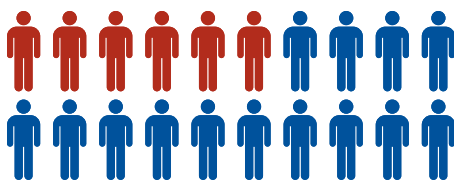
LGBT ADULTS AND DISCRIMINATION



Two-Thirds of LGBT adults have experienced discrimination because of their sexual orientation

Youth are even more likely than adults to be the victims of antigay prejudice or victimization, and may suffer greater consequences.

LGBT ADULTS AND PHYSICAL THREATS



30% of LGBT adults have been physically threatened or attacked

orientation; and nearly one-third (30 percent) had been physically threatened or attacked.⁵⁸ Moreover, harassment, victimization, and a history of childhood sexual abuse have been shown to negatively affect physical and mental health and have been associated with HIV infection.⁵⁹

Multiple population studies have demonstrated that LGB youth are more likely than their heterosexual peers to be targeted for violence, to report physical violence or sexual abuse, to experience forced sex or dating violence, or to endure harassment, bullying or physical assault at school.^{60, 61, 62} A number of studies have demonstrated a link between enacted stigma experienced by LGBT youth and higher rates of mental health problems, including depression and suicidal ideation, substance abuse and risky sexual behaviors.^{63, 64, 65}

Family rejection may be a particularly important determinant of health among LGB youth. Youth who were rejected by their families after coming out have significantly higher rates of depression, suicide attempts, substance abuse and risky sex behaviors.⁶⁶ Family rejection may also contribute to higher rates of homelessness or street-involvement among LGB youth, which may in turn contribute to higher rates of survival sex or prostitution.⁶⁷

Both LGBT adults and youth may be subject to disproportionate sanctions from school disciplinary or criminal justice systems. For example, in longitudinal studies conducted among adolescents, sexual-minority adolescents were 1.25 to 3.0 times more likely to receive punishments from their schools, police or courts.⁶⁸ In a study conducted in New York City, LGB youth were more likely to experience negative

verbal, physical or legal contact with the police, and more than twice as likely to experience negative sexual contact in the preceding six months.⁶⁹

In addition to the deleterious effects of enacted or felt stigma, there is emerging evidence that structural stigma may also be an important determinant of health. For example, LGB individuals who live in states with constitutional amendments banning same-sex marriage have higher rates of psychiatric disorders and are more likely to attempt suicide than those who live in states without such pernicious policies.⁷⁰ Recently, a population-based analysis of mortality data found that sexual minority residents of communities with high levels of antigay prejudice died an average of 12 years sooner than those who lived in communities with low levels of antigay prejudice, even after controlling for multiple risk factors at the individual and community level. The findings showed that sexual minorities were more likely to die by suicide in high stigma communities, and that completed suicides among this group occurred at a significantly lower age (average 18 years earlier).⁷¹

MSM living with HIV may experience additive stigma related to their infection. Among people living with HIV, stigma has been shown to increase depression, psychological stress, and shame, to increase a sense of hopelessness, and is associated with poorer mental and physical health outcomes and diminished social support.⁷² People with HIV report much higher levels of childhood sexual abuse than does the general population, which in turn has been shown to predict other problems (e.g. alcoholism, substance abuse and recurring STDs) that might adversely affect HIV

progression.⁷³ Trauma severity predicts HIV mortality, and individuals who experience more traumatic events are three times more likely to die compared to those who report few such incidents.⁷⁴

Poverty, educational level.

While the links between socioeconomic class (e.g., poverty and educational level) and LGB health have received less attention, analyses of data from the American Community Survey showed that individuals in same-sex couples have higher unemployment rates, even though they also have higher rates of college completion, compared to heterosexual couples.⁷⁵ As poverty rates increased during the recession, LGB Americans were more likely to be poor than heterosexual people — among Black same-sex couples, poverty rates were more than twice that of heterosexual married Blacks.⁷⁶ In a new analysis of population surveys, 29 percent of LGBT adults experienced a time in the last year when they did not have enough money to feed themselves or their family.⁷⁷

CDC reports that HIV prevalence is highest among those at or below the poverty line, those with less than a high school education and those who are unemployed.⁷⁸ The effects of poverty on HIV health outcomes are profound. As many as half of people living with HIV in U.S. inner cities experience food insecurity, which is in turn related to reduced medication adherence and poor health outcomes. Studies have shown that for impoverished people with HIV, food insecurity and housing instability have a greater impact on overall health than medication adherence.⁷⁹ While the introduction of highly potent ART more than a decade ago unquestionably improved survival and quality of life among people with HIV, it may have increased inequalities in AIDS-related

mortality, as those with more resources have increasingly positive health outcomes — while those at the bottom of the socioeconomic scale do not.⁸⁰

Racial differences in HIV rates among those in the same socioeconomic classes suggest that the nexus between race and poverty may amplify the effects of SDH, which influence not only the underlying HIV prevalence of communities (increasing the risk for HIV acquisition among residents), but also individual risk taking within those communities. For example, those for whom stable relationships are imperiled by the stress of stigma, discrimination, violence, incarceration and other factors may be more likely to engage in sexual mixing patterns (i.e. more partners, more frequent episodes, unprotected sex) that can foster HIV transmission. Because many sexual networks are tight and racially homogenous (i.e. sexual encounters are more likely among individuals of the same race and socioeconomic class), the HIV risk within minority communities is even higher than might be attributable to socioeconomic factors alone.⁸¹ Racial disparities in HIV determinants generally are consistent among MSM — in a meta-analysis conducted in Canada, the United Kingdom and the United States, Black MSM were more likely to be low income, have less than high school education, have ever been incarcerated or to be currently unemployed than their White peers.⁸²

As noted above, sexual minority youth are disproportionately represented among homeless youth populations and, compared to heterosexual youth, homeless LGBT youth are at significantly higher risk for behavioral health conditions or to have been physically or sexually abused while homeless,⁸³ to engage in survival sex and to acquire HIV infection.⁸⁴

It has been well established that among heterosexuals in the United States, HIV is predominantly a disease of the poor.

Physical Environment.

Little research has been undertaken to examine the relationship between geography and LGBT health, though small studies have suggested that isolation associated with rural residency may negatively affect health. The U.S. HIV epidemic is highly concentrated among urban centers on the East and West coasts, and in cities and towns across the South, where in each instance, poor neighborhoods are affected far more than rich ones. While many chronic health conditions (e.g. diabetes, heart disease and cervical cancer) are more prevalent among those lower on the socioeconomic scale,

social stressors related to economic survival, the threat of violence, poorer health, and social discrimination may be even more acute in cities with high income disparities, such as New York, Washington, D.C. and San Francisco, where very affluent neighborhoods abut areas with HIV infection rates comparable to those in sub-Saharan Africa. In an examination of county-level data in 40 states, HIV diagnosis rates were significantly correlated with income inequality. Underscoring the intersection between race and socioeconomic class, HIV diagnoses were inversely correlated with the

proportion of Whites who lived in the county — with racial segregation likely leading to disparities in health resources.⁸⁵ Neighborhoods blighted with abandoned buildings and elevated crime rates also have higher rates of HIV infection, often associated with injection drug use.⁸⁶ Low social capital — i.e. the value of a group's social network, as indicated by community organizational life, involvement in public affairs, volunteerism, informal sociability and social trust — is associated with higher HIV rates, above and beyond the effects of poverty and disease.⁸⁷

With the exception of LGBT-focused HIV and STD prevention measures, public health interventions targeting LGBT communities for cancer prevention, alcohol, tobacco cessation, asthma or cardiovascular disease have been largely non-existent.⁸⁸

Health Services

LGBT populations may experience disproportionate barriers to accessing quality healthcare services, as a result of: 1) reluctance to disclose sexual orientation or gender identify for fear of prejudiced reactions, being stigmatized, or confidentiality breaches, or based on negative past experiences; 2) a paucity of providers competent to manage LGBT health issues; 3) structural barriers that impede access to health insurance (which is often denied to unmarried domestic partners, even in jurisdictions that do not recognize same-sex marriage) or limit visiting and medical decision-making; and 4) a lack of culturally appropriate prevention programs (e.g. violence victimization, substance abuse

and mental health). In spite of these barriers, some population-based studies have failed to detect differences in access to healthcare among MSM.⁸⁹ Measures may be too crude to detect quality of care, however, and some studies conducted among providers show wide variability in attitudes about working with sexual minority patients,⁹⁰ while studies among patients showed that many LGB individuals fail to disclose their sexual orientation to their provider, which may compromise their care.⁹¹

With respect to access to HIV care, sharp disparities among racial/ethnic groups have been noted, and these persist among MSM. In a meta-analysis

of studies conducted in Canada, the United Kingdom and the United States, HIV-positive Black MSM were less likely than their White counterparts to have been diagnosed, to have initiated ART, or to have health insurance.⁹²

While implementation of the Affordable Care Act has increased access to care among young adults, who may now be covered by their parents' health insurance until a later age, LGBT youth who are not cared for by their families may not benefit.⁹³ Moreover, family physicians, who provide care to the majority of youth ages 15 to 24, are insufficiently trained to provide care for LGBT youth.⁹⁴

Syndemics in the Context of Biological And Structural Determinants Of Health

While multiple social determinants of MSM health may each independently influence physical and mental health outcomes, it has been increasingly apparent that they may also mutually reinforce and amplify each other.

In an analysis of data from the Urban Men's Health Study, determinants including childhood abuse, depression, intimate partner violence and polydrug use were highly inter-correlated and positively associated with high-risk sexual behaviors and HIV infection. This syndemic, fueled by cultural marginalization, comprises an additive interplay of health epidemics of HIV, STDs, mental health, substance abuse and violence, each reinforcing each other. With respect to HIV prevention among MSM, this concept has profound implications — as men who are challenged by the combined effects of depression, substance abuse and violence may not have the capacity to reduce their sexual risks, underscoring the need for community-level or structural interventions.⁹⁵

The production of syndemic conditions among MSM may occur over the life course, suggesting the possibility of early intervention. For MSM, many of the individual health problems (e.g. depression and anxiety, substance abuse and HIV) that together comprise an adult syndemic condition are characterized by their early onset, often during adolescence. Researchers have theorized that masculine

socialization — during which many young MSM experience rejection, ostracism, harassment, or even physical violence — combined with additional stresses associated with initiation into a gay culture marked by high prevalence of STDs, HIV and substance abuse — contribute to later syndemic production among urban MSM.⁹⁶

A recent study explored the concept of syndemic development over the life-course — i.e. as the consequence of lifelong adversity — among the Multicenter AIDS Cohort Study (MACS), a long-term progressive cohort of MSM living with HIV. Among participants, early childhood satisfaction, victimization (e.g. bullying or ostracism), perceptions of inadequate attainment of masculinity norms and low social connectedness were associated with the development of syndemic conditions later in life.⁹⁷ An analysis of Black MSM among the same cohort showed similar results. Black MSM who experienced gay-specific childhood or adolescent stressors (particularly parental abuse, victimization, perceptions of failed attainment of masculinity norms or internalized homophobia) were significantly more likely to develop syndemic conditions later in life.⁹⁸ Childhood or adolescent

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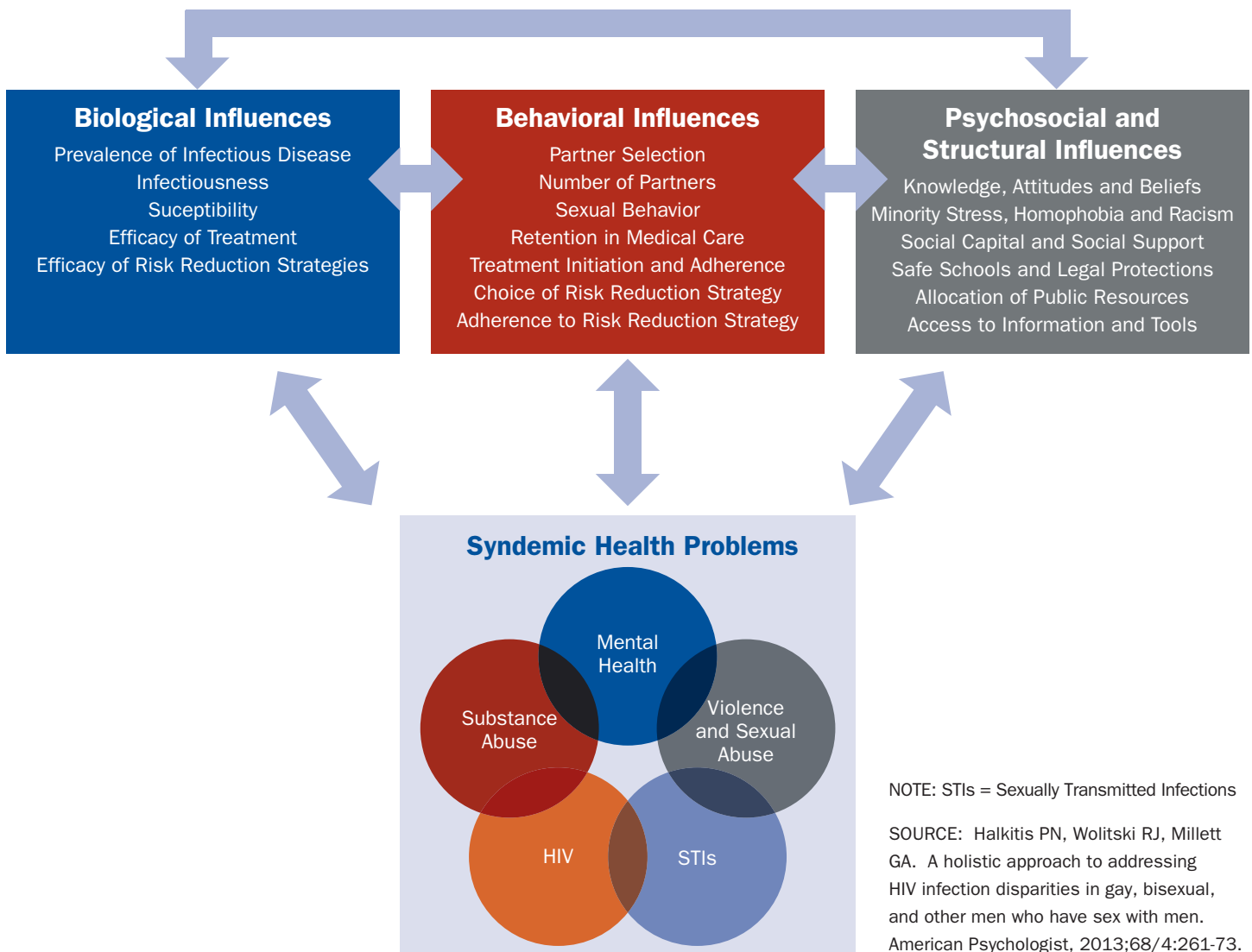
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adversity has been long associated with adverse health outcomes later in life, raising the possibility that addressing the victimization experienced by young MSM might interrupt the development of syndemic conditions later in life, thus contributing to better adult health outcomes.

Compounding syndemic production, many MSM, particularly racial minorities, experience determinants of health related to multiple, overlapping domains, including not only sexual orientation, but race, poverty, educational attainment

and immigration status. While there is significant research examining the impact of each domain on LGBT health (including HIV progression and survival), there are few studies with sufficient power to examine the intersectionality of domains.⁹⁹ Moving forward, additional research to examine the interplay of domains will be critical, as will the development of individual, biomedical, structural and policy interventions that address the reality that MSM health is mediated by biological, behavioral and structural drivers.^{100, 101}

Biopsychosocial Drivers of the Syndemic in Gay, Bisexual and Other Men Who Have Sex With Men



Protective Factors and Resiliency

These studies and others exploring syndemic conditions and their production have also foregrounded the concept of resilience, often described as healthy development in the face of adversity — i.e., the capacity to avoid or overcome the negative outcomes associated with repeated exposures to risk. For example, another analysis from the MACS cohort showed that the majority of adult MSM who had resolved previously internalized homophobia had significantly higher odds of positive health outcomes.¹⁰² Importantly, most theories of resilience describe it is a process, rather than an inherent trait — i.e. individuals develop resilience over time.

There has been relatively little research to examine factors that may increase resiliency to protect or promote health among LGBT individuals, though protective factors may be inferred from deficit-based studies. For example, it has been increasingly noted that most MSM exhibit substantial resilience, and researchers have begun to explore the resiliency factors that characterize the majority of MSM who experience adversity associated with minority stress who do not develop syndemic

conditions, or the majority of MSM who endure syndemic conditions who do not acquire HIV.^{103, 104} For example, in the seminal *Urban Men's Health Study* syndemics analysis described above, while the relatively high proportions of MSM experiencing multiple health problems were HIV positive (22 percent) or had recently engaged in high-risk behaviors (23 percent) — 78 percent had not engaged in risk behaviors and 77 percent had remained HIV-negative, in spite of the adversity they experienced.¹⁰⁵



Addressing Health Inequities: Gay Men & MSM in the U.S.

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MOVING FORWARD

MOVING FORWARD: Intervening to Address Determinants of MSM Health

To date, most individual-level HIV prevention interventions targeting MSM have been based upon a deficit-based approach that attempts to reduce risk factors. While such approaches are effective and have reduced HIV transmission, their impact may be limited and ultimately insufficient to manage the HIV epidemic. Moreover, while framing behavioral risks for HIV infection as failures that must be avoided or corrected, this “broken person” approach neglects the potential value of MSM’s inherent resiliencies. Moving beyond a deficit-based approach will require interventions not only to reduce the negative consequences of determinants of MSM health, but also to enhance men’s natural resiliencies and support healthy living.

Over the past decade, mitigating the social determinants of health inequities has become a national and international priority, and it is increasingly acknowledged that social determinants are not merely coincidental, but rather are mediated by public and social policy: “This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.”¹⁰⁶ As such, addressing social determinants of health inequities among MSM (including HIV) will require a combination approach

that includes individual (behavioral) and biomedical interventions, but also community-level and structural interventions, including health policy and legislation, economic and social interventions, and cross-sector collaborations. Moreover, it seems possible that if a culture of stigmatization produces health inequities, then a culture of acceptance and integration might promote positive health outcomes. Achieving such an affirming environment for MSM will require changes at many levels, including society, community, family and social network.

MARRIAGE EQUALITY

The recognition of same-sex marriage provides one example of how public policy mediates systemic stigma, positively and negatively, which in turn can affect health outcomes. While structural stigma (such as constitutional amendments banning same-sex marriage) has been associated with increased morbidity

and mortality, LGB individuals residing in jurisdictions without such laws or policies had no increased adverse health outcomes.^{107,108} Considerable research has documented the positive health outcomes associated with heterosexual marriage derived from the economic impact of benefits, rights and

privileges.^{109,110} Preliminary results suggest that similar benefits are conferred by same-sex marriage. In an analysis of data from the California Health Interview study, being in a legally recognized same-sex relationship reduced the mental health disparities between LGB and heterosexual couples.¹¹¹

It has been widely noted that improving health outcomes and reducing disparities will require efforts that transcend the health sector.¹¹² Non-health policies and programs – including education, job training and income support, transportation, land use, criminal justice and housing, to name only a few — clearly have an impact on health outcomes and health inequities. In one analysis, as little as 10 percent of the variability in premature deaths was associated with differences in healthcare, while 60 percent was attributed to social, environmental or behavioral factors.¹¹³ A “health-in-all-policies” approach, which prospectively assesses and takes into account potential health outcomes associated with non-health related policies and programs, has been employed in some sectors and may be useful in efforts to improve MSM health.¹¹⁴ Such an approach attempts to balance health concerns with other imperatives and offers an opportunity to collaborate across sectors, particularly among non-traditional partners.

The recommendations that follow are the synthesis of a literature review, interviews with key informants, and the expert consultation convened by Trust for America’s Health in July 2014.

Federal leadership

The federal government will have a strong role to play, though intergovernmental coordination is never easy, and will require high-level leadership. The Obama administration has undertaken important beginning efforts in this regard. Addressing SDH constitutes an important part of the HHS Healthy People 2020 framework¹¹⁵ and is included as an objective in CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention’s Strategic Plan 2010 to 2015.¹¹⁶ In 2013, the President issued an executive order establishing the HIV Care Continuum Initiative, designed to mobilize and coordinate federal efforts to take advantage of recent HIV prevention and treatment advances, via further integration of HIV prevention and care efforts; expand successful HIV testing and service delivery models; encourage innovative approaches to address barriers to accessing testing and treatment; and ensure that federal resources are focused on evidence-based interventions. A working group comprising the Departments of Justice, Labor, HHS, Housing and Urban Development (HUD), Veterans Affairs and the Office of Management and Budget was established.¹¹⁷

With respect to health disparities, however, while there have been significant strides in cross-agency collaboration, data-sharing, and evaluation focusing on other populations (including women and racial minorities), such efforts have been rarer with respect to sexual orientation. At the request of the President, HHS established an LGBT Issues Coordinating Committee, which, in 2013, prioritized federal recognition of same-sex spouses, LGBT enrollment outreach in the health insurance marketplace, LGBT-specific research and data collection and the development of resources for families of and providers serving LGBT youth.

Across the federal government, the National Prevention, Health Promotion, and Public Health Council is perhaps best positioned to address social determinants of MSM health inequities. The NPC, the creation of which was mandated by the Affordable Care Act, is charged with coordinating efforts of 20 federal departments and agencies** to “ensure the health, well-being and resilience of the American people.” In 2011, the NPC released the National Prevention Strategy (NPS), which “envisions a prevention-oriented society where all sectors recognize the

value of health for individuals, families, and society and work together to achieve better health for Americans.” Notwithstanding, while noting the disproportionate incidence of health inequities and their correlation with social determinants, the NPS includes sexual orientation only among various sub-populations that suffer disparities.¹¹⁸

Overall, the NPS employs four strategic directions to guide actions that will demonstrably improve health, all leading to the goal of “increasing the number of Americans who are healthy at every stage of life”: 1) Healthy and Safe Community Environments; 2) Clinical and Community Preventive Services; 3) Empowered People; and 4) Elimination of Health Disparities. In addition to the strategic directions, the NPS provides evidence-based recommendations most likely to reduce the leading causes of preventable death and major illness, in seven priority areas (most of which dovetail with health inequities experienced by MSM): tobacco free living, preventing drug abuse and excessive alcohol use, healthy eating, active living, mental and emotional well-being, reproductive and sexual health, and injury and violence-free living. The NPC is chaired by the acting Surgeon General, who leads the U.S. Public Health Service, and meets regularly to oversee agency initiatives associated with NPS implementation. The NPC reports progress on meeting NPS goals on a yearly basis to the President and Congress. The Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, which comprises non-federal members, advises the NPC in developing public, private, and nonprofit partnerships.

FEDERAL LEADERSHIP IN ADDRESSING HEALTH INEQUITIES AMONG MSM.

The recommendations that follow fit easily with the NPS framework, and offer the opportunity to integrate efforts to mitigate MSM health inequities across government programs. The Office of National AIDS Policy (ONAP) should immediately initiate the collaborations described below:

- **FEDERAL LEADERSHIP AND COORDINATION.** Emphasizing the connection between other social determinants of MSM health inequities and HIV, ONAP and the Presidential Advisory Council on HIV/AIDS (PACHA) should partner with the NPC to delineate an agenda that incorporates MSM health priorities across federal agencies, including but not limited to HIV programs. As the National Prevention Strategy is updated, it should emphasize the need to address health disparities related to sexual orientation or gender identity, including those among MSM. ONAP and the National Prevention Council should also promote public/private partnerships focusing on MSM health, or incorporate MSM health issues into existing partnerships. For example, ONAP recently convened LGBT funders to ensure that young MSM were specifically included in President Obama’s My Brother’s Keeper initiative, which strives to connect young people to mentoring and support networks.
- **NATIONAL HIV/AIDS STRATEGY.** While ONAP is charged with coordinating the HIV response across the federal government, no such mechanism exists for MSM health. As such, while the National HIV/AIDS Strategy strongly emphasizes the need to address prevention and treatment among MSM, it mentions

social determinants only in passing, calling for a “more holistic approach to health.”¹¹⁹ Insofar as MSM are disproportionately impacted by HIV, ONAP should provide leadership in promoting MSM health across federal HIV programs, facilitating cross-agency collaborations, disseminating best practices, and sharing information and data among agencies. As the National HIV/AIDS Strategy is updated, it should embrace an agenda to address social determinants of health inequities among various subpopulations disproportionately affected by HIV, but certainly among MSM. It should emphasize a life course approach to MSM health, which will require a greater focus on youth.

- **FEDERAL DISCRETION (and the Bully Pulpit).** Though many equality issues may appear intractable, including some structural social determinants such as the recognition of same-sex marriage, the overall status of LGBT people has improved measurably over the past few years. And while President Obama certainly has his critics (among those who favor and those who oppose LGBT equality), the current administration deserves substantial credit — for declining to defend the Defense of Marriage Act, and upon its demise, for aggressively implementing regulations throughout the government that recognized same-sex unions; for executive orders

prohibiting discrimination in federal programming; for interpreting discrimination based on sexual orientation or gender identity to apply under federal anti-discrimination statutes, such as the Civil Rights Act or the Fair Housing Act, none of which explicitly prohibit such practices; for programming designed explicitly for sexual and gender minorities; for ensuring the Affordable Care Act's positive approach to LGBT health; for developing the first National HIV/AIDS Strategy; and importantly, for the President and his cabinet publicly and unapologetically defending LGBT equality in a wide range of settings, including the State of the Union address. Advancing LGBT equality — and by extension reducing MSM health inequities — will require continued, sustained federal leadership.

- **FINANCING DATA.** The extent to which federal HIV programs target key populations, specifically including MSM, should be tracked and updated with every budget cycle. While certain programs are not population specific and others target only the general population, it is essential to disaggregate population-specific programs in order to demonstrate how well federal funding aligns with epidemiologic data.

- **SERVICE UTILIZATION DATA.** Health service utilization data should capture information related to sexual orientation and gender identity. Many programs — even those with obviously high numbers of MSM, including HIV programs such as the AIDS Drug

Assistance Program (ADAP) — fail to collect sexual orientation data, foreclosing the possibility of additional analyses to assess sexual orientation and gender identity-specific health disparities. As the government refines meaningful use standards for electronic health records (EHR), it is imperative that sexual orientation and gender identify fields be included (see also healthcare section, below).

- **EPIDEMIOLOGICAL RESEARCH.** As detailed by the Institute of Medicine, MSM health programming has been significantly hobbled by a lack of research. It is critical that sexual minorities be included in population studies. In 1995, the YRBS was the first CDC survey to include sexual minority questions — while initially optional, these questions were recently added to the national questionnaire and to the standard core questionnaire used by states and cities. The National Healthcare Disparities Report included LGBT populations for the first time in 2011.¹²⁰ In 2013, CDC included a sexual-orientation specific question in the National Health Interview Survey for the first time,¹²¹ while the Substance Abuse and Mental Health Services Administration (SAMHSA) added two questions, one on sexual attraction and one on sexual identity, to the National Survey on Drug Use and Health dress rehearsal, in contemplation of including them in the 2015 survey. The Office of the Assistant Secretary for Health expanded Healthy People 2020 LGBT

topic areas to include two national objectives aimed at increasing the number of population studies that include LGBT populations.¹²² Other important surveys only include such questions on an optional basis, or in a limited way. For example, only a handful of states (13 and the District of Columbia in 2009) asked sexual orientation questions in their annual Behavioral Risk Factor Surveillance System (BRFSS) survey.¹²³ Virtually no longitudinal studies have followed young MSM as they grow older or adult MSM as they transition to middle- and old-age. Few HIV interventions have been specifically evaluated among young MSM, while virtually no interventions addressing other social determinants of health among this population have been tested.

Population data are essential to understanding MSM health. As such, where they have yet to do so, CDC, SAMHSA and other federal agencies should add questions pertaining to sexual orientation, identity and behaviors to core instruments for national health surveys. The National HIV Behavioral Surveillance system should be expanded both geographically (it is currently conducted in 20 cities) and to include participants ages 13 to 18. To better understand the life course of MSM health inequities, the NIH should immediately support longitudinal research examining HIV and other health issues among a broad cohort of young MSM.

A LIFE COURSE APPROACH TO INTERVENTIONS TO INCREASE RESILIENCY

Nationally, there is increased attention on the long-term health and social consequences of early childhood trauma. In the Adverse Childhood Experiences (ACE) Study, childhood abuse, neglect, or exposure to other traumatic stressors (e.g. familial substance abuse, mental health disorders, sexually transmitted infections and violence) were linked to a number of short- and long-term health and social problems.¹²⁴ That MSM suffer disproportionate rates of many early childhood traumas, and that such traumas have been linked with later development of syndemic conditions, argues for interventions to address social determinants of MSM health inequities early in life and throughout the life course.¹²⁵

Young MSM in schools.

Sadly, schools are among the most hostile environments encountered by LGBT youth, and even supportive families are insufficient to counter bullying and victimization that many LGBT adolescents experience in and out of schools. Though bullying per se does not violate federal laws, students are protected from discriminatory harassment when it is based on race, national origin, color, sex, age, disability or religion. While sexual orientation is not a protected class, the U.S. Department of Justice and U.S. Department of Education (DOE) have made it clear that harassment based on sex and sexual orientation are not mutually exclusive, and that when LGBT students are harassed based on their actual or perceived sexual orientation, they may also be subjected to forms of sex discrimination recognized under Title IX (1972 Education Amendments to the 1964 Civil Rights Act). Recent DOE guidance made clear that Title IX extends to claims of discrimination based on gender identity.¹²⁶

Though anti-bullying policies are becoming more commonplace, many such policies are generic (i.e. they fail to

account for gay-specific bullying), and in some cases, anti-gay bias combined with very strict anti-bullying policies may actually punish victims who fight back or defend themselves in the face of homophobic abuse. Beyond bullying, LGBT students are more likely to encounter school discipline, and to be suspended, often as a result of dress codes that enforce gender conformity or policies that suppress behaviors that would be considered normal among different sex couples, such as holding hands or kissing.

Students must not only feel safe from violence, harassment, or other abuse in schools, but also valued, respected and accepted by school professionals and peers. A population study in Massachusetts showed that LGB youth in schools with supportive staff, anti-bullying policies and Gay/Straight Alliance (GSA) clubs reported lower rates of victimization, skipping school and suicide attempts.¹²⁷ In a recent analysis of data from the Youth Risk Behavioral Surveillance System, LGB students living in states and cities with more protective school climates reported fewer past-year suicidal thoughts.¹²⁸

In a truly safe school climate, students, teachers, administrators, parents and board members alike would be unafraid to disclose their sexual orientation. Schools with supportive environments for LGBT youth are characterized by safety and consistently enforced anti-bullying policies. To establish positive norms, employment policies protect teachers and administrators against LGBT-related discrimination, and school policies welcome alternative family configurations. Professional training instills in teachers and other professionals the importance of LGBT issues and prepares them for conversations about LGBT topics, and to develop supportive relationships with all students, regardless of their sexual orientation.¹²⁹

SUPPORTING ADOLESCENT MSM IN SCHOOL

Federal education policies and programs should consistently support school environments that are welcoming and supportive of all students, including sexual minorities and gender non-conforming youth. For example:

- Develop and promulgate **BEST PRACTICES for SCHOOLS and SCHOOL DISTRICTS** to support LGBT children. A number of resources are available that outline approaches for schools to achieve an environment that is safe and supportive for LGBT students.^{130,131} SAMHSA publishes Top Health Issues for LGBT Populations, an information and resource kit targeting prevention professionals, healthcare providers and educators.¹³² Training for teachers and administrators, including continuing education requirements, are essential components.
- Provide comprehensive **SEXUALITY EDUCATION** in schools. To ensure that LGBT students feel included, it is essential that sexuality education be gender neutral and non-shaming. It is also critical to employ a life-course approach — i.e. one that recognizes that the needs of 13- to 15-year-olds are very different from those of 15- to 18-year-olds. One resource, the Family and Youth Service’s Bureau’s National Clearinghouse on Families and Youth’s online training module, “Creating a Safe Space for LGBTQ Teens,” was designed to help those who deliver teen pregnancy prevention programming to understand sexual orientation and gender identity, the challenges lesbian, gay, bisexual, transgender and queer and/or questioning (LGBTQ) youth face, the importance of prevention messages being inclusive of all youth,

why it is critical that teen pregnancy and sexually transmitted infection/HIV prevention messages and projects are inclusive of all youth, and strategies for creating a safe and inclusive classroom setting. Through the Division of Adolescent and School Health (DASH), CDC provides funding for state and local education agencies to help districts and schools deliver exemplary sexual health education emphasizing HIV and other STD prevention; increase adolescent access to key sexual health services; and establish safe and supportive environments for students and staff. Such initiatives should include LGBT specific programming and be expanded nationally.

- **SCHOOL SAFETY.** Implement policies to ensure that all students are safe from violence. Resources are available from many organizations, including the S.A.F.E Classrooms project, a collaboration of Teach For America, The Trevor Project and GLSEN, which provides resources and toolkits to help teachers create learning environments that are safe and affirming for everyone.¹³³ Similarly, the American Federation of Teachers has partnered with GLAAD on the *See a bully, Stop a bully* campaign, which includes events and activities to educate teachers, parents and students on bullying and provides them with resources to effectively handle and prevent harassment at school.¹³⁴ While many schools have anti-bullying policies, it is important that such policies specifically reference sexual orientation, gender identity, and gender non-conforming youth. It is imperative that federal initiatives, such

as Safe Schools/Healthy Students, a SAMHSA led initiative that supports community-level partnerships that are designed to address youth violence and promote the wellness of children, youth and families,¹³⁵ incorporate policies that consider the needs of LGBT youth. Because the effectiveness of bullying prevention programs has not been well demonstrated, the Suicide Prevention Resource Center recommends that school programs include strategies to identify LGBT youth at risk for suicide and referrals to mental health services.¹³⁶

- **SEXUAL HEALTH.** Birth control, STD screening and treatment are critical for adolescents who are learning about their sexuality, and youth may have fewer resources for sexual health services, given the erosion of the public STD clinic system. Where possible, co-location of health clinics within schools may facilitate access — for example, in Washington, D.C., Unity Health Care operates a student health center in Eastern High School, offering a full range of healthcare and supportive services throughout the year, including summer and vacations.
- **WELCOMING LGBT PARENTS.** Parent involvement in education can have a positive impact on schools and student achievement. To expose adolescents to a diverse range of positive adult role models — and to demonstrate to LGBT youth that sexual minorities are respected and valued — policies and protocols to involve parents in schools must be welcoming and inclusive of both parents of LGBT youth, as well as LGBT parents.

- **POSITIVE LGBT ROLE MODELS.** Adolescents learn from positive role models in schools, but also from how adults are treated. Schools that provide a safe and inclusive environment for LGBT teachers and administrators demonstrate to youth that sexual minorities are valued and protected. It is essential that anti-discrimination and other employment policies include sexual orientation and gender non-conformity.
- **PEER SUPPORT.** Gay/Straight Alliance clubs provide a safety net for students during the coming out process, educate teachers and student peers to reduce slurs, and work with school administrations to implement policies that prevent

harassment and violence. Strong, well-supported GSAs can have a major impact on the education environment and possess the power to transform individuals, school cultures and educational institutions. While most such groups are started by students and are youth-led, school sanction and support is critical.

- **GENDER NON-CONFORMING YOUTH.** For some LGBT youth, the outward communication of gender through their behavior or appearance may differ from expectations associated with their sex. Like all young people, gender non-conforming students are entitled to bias-free attention to their unique needs and to be safe in their school. They should

be supported in their gender identity and never required to conform to gender stereotypes in order to receive appropriate education. As young people's sexual orientation and gender identity is often more fluid than adults, professionals should be educated about transgender issues and should understand that gender identity may or may not correlate with sexual orientation.

- **SCHOOL DISCIPLINE.** School behavior policies should eliminate provisions that punish the expression of sexual orientation or non-gender conforming dress. Disciplinary officials should receive training to support LGBT students and to discern homophobic harassment or abuse.

Young MSM outside of schools.

While school-based policies and services are essential for LGBT youth, it is important to acknowledge that many young MSM encounter substantial challenges outside of school. As discussed above, LGBT youth are more likely to become homeless than their heterosexual peers, often after being rejected by their families — tellingly, they are sometimes referred to as “throwaway” youth. As such, they are more susceptible to substance abuse and sexual and physical victimization. LGBT and non-gender conforming youth are more likely to encounter problems with school discipline or the criminal justice system, as they turn to sex work, drug trade, or petty crime to survive and are more likely to be harassed by police. They are more frequently criminalized, sanctioned by schools, labeled as sex offenders, detained for minor offenses, and denied due process, and are consequently over-represented in the juvenile justice system, accounting for 13 to 15 percent of youth who come in contact with the system. Policies that detain or remove LGBT youth

from their homes for status offenses (such as “willful defiance,” “incurability,” or “ungovernability”) or divert them into alternative schools or day-placement settings may derail their education, setting off a lifelong cascade of economic insecurity.¹³⁷

And, LGBT youth are much more likely to be placed in foster care, though the system is poorly equipped to meet their needs and many suffer homophobic abuse. In a recently completed study in Los Angeles County, approximately one in five foster youth identified as LGBTQ, and LGBTQ foster youth were twice as likely to report poor treatment and more likely to live in group homes and to have more foster care placements. More than 18 percent reported experiencing discrimination related to their perceived sexual orientation or gender identity/expression, including some who didn't identify as LGBTQ. The percentage of LGBTQ youth who were hospitalized for emotional reasons (13.5 percent) was nearly triple the percentage of similar hospitalizations for non-LGBTQ youth (4.2 percent).¹³⁸

SUPPORTING MSM YOUTH OUTSIDE OF SCHOOLS

- **ORGANIZED ACTIVITIES.** Among all youth, idleness provides an environment that facilitates risky behaviors. MSM youth, who are often excluded from extracurricular activities, may face additional risks. It is essential that LGBT youth have access to after-school activities that provide a safe and welcoming environment.

- **YOUTH CENTERS.** While some youth may feel comfortable at or prefer LGBT-specific venues, for others it is important to have access to non-LGBT-identified venues that are welcoming. In particular, homeless MSM youth may be reluctant to attend LGBT-identified services, but need drop-in sites where they can receive services and referrals.

- **GED PROGRAMS.** Completing secondary education is a powerful determinant of health consequences later in life, and helping young MSM to finish high school, particularly those who may have interrupted their education after having been rejected by their families, may yield substantial benefits. Co-locating GED programs within programs providing other services to LGBT youth may enhance their accessibility — for example, Chicago’s Howard Brown

Health Center operates a GED program at their Broadway Youth Center.

- **SEX WORKERS.** MSM sex workers may be at significant risk for HIV, STDs, physical abuse or violence. Moreover, males are often not well served at programs targeting commercial sex workers, though significant numbers of young MSM, particularly those who are homeless, may rely on survival sex.

- **CROSS-GENERATIONAL PARTNERING.** Young MSM may be more likely than their heterosexual counterparts to have older sexual partners, and young Black MSM are more likely to partner with older men than their White counterparts. Outreach programs should instill in older men the importance of HIV prevention for younger men, while teaching young MSM how to negotiate safer sex and condom use, even in the face of differential power dynamics associated with differences in age.

- **LAW ENFORCEMENT PRACTICES.** Federal guidance to law enforcement, juvenile justice and child welfare agencies should encourage policies that protect LGBT youth, and discourage forced gender conformity or punishment for expres-

sions of sexual orientation. Sensitivity training for law enforcement personnel who encounter homeless or truant LGBT youth should be widely available and implemented. For example, the Office of Juvenile Justice and Delinquency Prevention offers an online training, “Understanding and Overcoming the Challenges Faced by Lesbian, Gay, Bisexual, Transgender, Questioning and Intersex Youth in Schools and Communities,” designed to instill in practitioners the importance of becoming an ally to sexual minority youth, of teaching children to be tolerant and accepting, and changing the culture of schools and communities to be safer for sexual minority youth.

- **FOSTER CARE.** Though the Administration on Children, Youth and Families issued guidance to child welfare agencies on the support of LGBT youth in their care, additional training is sorely needed for practitioners and foster parents alike. Exclusions against foster parents based on sexual orientation should be prohibited as a condition of federal support, and anti-discrimination and confidentiality provisions should be implemented to protect foster care facilities and placements.

Young MSM and their families.

Particularly for LGBT youth, who must confront a corrosive, stigmatizing environment just as they become aware of their sexual orientation, individual and community initiatives that facilitate sexual minority youth's self-acceptance of their sexual orientation and integration of their sexual identity into a self-concept (i.e. coming out) without fear of victimization or marginalization are central to promoting health.¹³⁹

Positive social support and validation of relationships is clearly important. Earlier convenience samples have suggested the protective mental and physical health benefits from family support for relationships¹⁴⁰ and social networks.¹⁴¹ In a community sample among LGBT youth, those whose families were more accepting and supportive had significantly lower rates of depression, substance abuse, suicidal ideation and attempts.¹⁴²

SUPPORT FOR FAMILIES OF MSM YOUTH

Federal programs that address family needs should promote acceptance of LGBT children by their families, and provide support to families with LGBT children. For example:

- **PARENTING SKILLS-BUILDING** — All parents should foster a safe environment for their children and be prepared to offer support and guidance as their children develop sexual identities. While many parents may not anticipate raising LGBT children, it is important that those adults serving as role models for youth (including but not limited to parents) are aware of the possibility and prepared to be supportive. Parents of LGBT youth may have particular needs for resources, tools, support and skills-building in order to best support their children.
 - In crisis situations, consider LGBT-friendly **CASE MANAGEMENT SERVICES** designed to meet the needs of families with gay children.
 - Develop and promulgate **PROFESSIONAL BEST PRACTICES** for professionals to support parents of gay or gender non-conforming children in a variety of contexts: schools, healthcare and justice systems. For example, SAMSHA recently published best practices for mental health and substance abuse practitioners on how to support parents with LGBT children.¹⁴³
- In programs that provide support for families, consider employing a **BROADER DEFINITION OF POSITIVE ROLE MODELS** for LGBT youth. In particular, youth whose parents do not accept their sexuality may turn to other relatives or trusted acquaintances for familial support.
 - Employ social marketing to **PROMOTE POSITIVE ROLE MODELS** of successful or prominent parents of LGBT children; consider recruiting celebrities such as Magic Johnson, Cher and others.
 - Work with **FAITH COMMUNITIES** to support families with gay children, particularly among communities of color. For example, the Human Rights Campaign's Faith and Religion initiative's A La Familia project provides trainings to promote the inclusion of LGBT people within Latino congregations.

Young Adult MSM.

While physical and sexual child abuse is more prevalent among MSM than their heterosexual counterparts, many men do not confront memories of early traumas until their twenties. Moreover, many of the health inequities experienced by young or adolescent MSM, such as depression, substance abuse and HIV, may persist or even worsen during early adulthood, particularly among MSM who migrate to urban “gay ghettos.” Young MSM who have been raised

in an environment that stigmatizes homosexuality may have difficulty forming relationships, may devalue gay men or experience internalized homophobia, all of which may predispose them for relationship difficulties, depression, or physical or sexual violence. While initiation within gay culture may provide their first experience of social acceptance of their sexual orientation, it may also present challenges in forming relationships in the context of high background prevalence rates of HIV, STD,

substance abuse, depression and violence. Among young MSM who are susceptible to health problems, such challenges can snowball, producing syndemic conditions that may overwhelm whatever resilience and social capital they otherwise possess.¹⁴⁴ LGBT-specialized agencies such as the Howard Brown Health Center report seeing high numbers of MSM ages 14 to 25 with severe needs. Ironically, young and adolescent MSM may have more services available to them than do MSM in their early- to mid-20’s.

SUPPORTING YOUNG ADULT MSM

- **RELATIONSHIP SKILLS.** Young adult MSM may experience substantial difficulties in finding romantic partners and establishing relationships, particularly at an age where only a minority of men may be open about their sexual orientation, and encounters via commercial venues (bars, clubs and bookstores) or the Internet may pose health and safety risks. Young adult MSM would benefit from community settings that provide a safe means to meet, socialize and form developmentally appropriate relationships.¹⁴⁵
- **POSITIVE ROLE MODELS.** While the mental and physical health benefits of heterosexual marriage are well established, for young adult MSM, the evolving landscape of same-sex marriage instills a degree of uncertainty related to societal acceptance of their relationships. While the eventual uniform legality of same-sex marriage in every state will go far to change community norms, increased visibility of same-sex relationships and marriages — in families, communities and the media — help youths to identify positive role models.
- **ALCOHOL AND SUBSTANCE ABUSE, HARM REDUCTION.** Young adulthood is a time that for many MSM is characterized by exploration, partying

and establishing an identity for the first time within an openly gay culture. For many MSM, the decade between ages 25 and 35 represents one of substantial experimentation with and uptake of drugs and alcohol use. As such, and particularly in light of elevated background prevalence rates of alcohol and substance abuse among MSM in general, direct and truthful information concerning alcohol and drug use is essential. To avoid excessive risks, young adult MSM need plain, non-judgmental information concerning drug dosing, effects and interactions.

- **SPIRITUAL SUPPORT.** For many young adult men, their twenties represent a time where they are struggling to find meaning in their lives and seeking spiritual support. Insofar as attitudes toward homosexuality largely align with degree and type of religious affiliation, many young adult MSM may become disconnected with the institutional religion in which they were raised. Strengthening the viability of gay-positive faith-based organizations might be especially beneficial, particularly for young adult MSM, including those from Black, Latino and fundamentalist communities, whose histories may have been profoundly shaped by religion.¹⁴⁶

- **ECONOMIC, HOUSING SUPPORT.** Particularly in settings with high unemployment, young adults are at particular risks from the effects of economic disadvantage, which for MSM correlates with elevated risks for HIV infection. To the extent that many gay-identified communities in the United States have witnessed unprecedented gentrification over the past two decades, lower socio-economic MSM may be at particular risk. Socio-economic challenges may also exacerbate other stressors, and LGBT-competent job training, skills building and housing support may help reduce overall health inequities among MSM, including HIV.
- **TRAUMA-INFORMED APPROACH.** As previously discussed, many MSM experience trauma early in life related to violence, abuse, neglect or other emotionally harmful experiences, which, if unaddressed, can lead to health disparities. In particular, MSM may be re-traumatized in public institutions and systems (such as healthcare, foster care, juvenile justice, the behavioral health system and others) that are intended to provide services and support. It is important that such systems incorporate a trauma-informed approach that is designed to ease an individual’s capacity to cope with traumatic experiences.¹⁴⁷

Older adult MSM.

Older MSM experienced a very different developmental trajectory than younger MSM. Many came of age, and some spent a significant part of their adult lives during a period when stigmatization of homosexuality was more pronounced than today, and when the majority of gay men hid their sexual orientation. Moreover, older MSM lived through the beginning years of the AIDS epidemic, losing large numbers of friends and colleagues to an unknown disease that emerged from nowhere, and for which at least initially, causality was unknown and there were no effective treatments. LGBT elders report discrimination, stigma and victimization throughout their lives, though many report less during their youth than current young people do. Many older MSM report

experiencing dual stigmatization — as a result of rejection among the heterosexual world for being gay, and among the gay world for being old. The experience of growing older as a minority or lower-socioeconomic status gay man may be less well understood — even more so than among young populations, research on older MSM tends to skew towards White, well-educated and middle- to higher-socioeconomic class populations.¹⁴⁸

Among older MSM, depression and suicidality are elevated, compared to their heterosexual counterparts, while LGBT elders may be less likely to seek health services, in some instances because of fear of discrimination. HIV remains a significant concern among older MSM, though it receives far less attention and there are fewer targeted

interventions.¹⁴⁹ In a population study, LGB older adults were at greater risk for disability, poor mental health, smoking and excessive drinking, while gay and bisexual men had a higher risk of poor physical health and were more likely to live alone than heterosexuals.¹⁵⁰ Lifetime victimization, financial hardship, obesity and a sedentary lifestyle are significant predictors of poor health outcomes, while internalized homophobia predicts depression and disability.¹⁵¹ In 2020, it is estimated that 50 percent of people living with HIV will be 50+ years of age or older. The support of friends and community may be even more important for older LGBT adults, who are more likely to be disengaged from their biological family and to rely on families of choice for support in times of crisis.

SUPPORTING OLDER ADULT MSM

- **FELLOWSHIP.** Many older MSM are interested in contributing to their community, either as a means of finding fellowship or leaving a legacy. Organizations such as Gay For Good, which has affiliates in many cities, San Francisco's Bridgemen, or Washington D.C.'s Burgundy Crescent, provide volunteer opportunities for social welfare, environmental service, and other community development projects. Organizations like Let's Kick Ass (AIDS Survivor Syndrome) seek to honor and contextualize the experience of those who survived — HIV positive and negative — the worst days of the AIDS epidemic.
- **MENTORSHIP AND PARENTING.** Particularly in light of the isolation experienced by older and younger MSM alike, there may be significant opportunities for older MSM to mentor or even care for younger MSM. As previously discussed, disproportionate numbers of young MSM are rejected by their families and risk becoming "throwaway" kids — it would be tragic not to take advantage of older, more experienced MSM who might not only provide a loving home, but be better positioned than many heterosexual parents to support young MSM in confronting the developmental issues they may face. Adoption and foster care rules should encourage, rather than discourage such arrangements.
- **HOUSING:** As older MSM retire, they may find challenges in finding a welcoming retirement community, as housing discrimination against LGBT people persists. (A recent HUD study found that heterosexual couples who inquired about advertised housing were favored by 16 percent over LGB couples, with all other factors being equal.¹⁵²) In some parts of the country, developers have constructed LGBT-welcoming (but still inclusive) senior housing, such as the John C. Anderson apartments in Philadelphia. Particularly for men who may have spent much of their life in the closet.

Insofar as MSM health inequities are the product of a hostile environment, creating a safe and supportive cultural context may offset the impact of marginalization and promote resilience among young, middle-aged and older MSM alike.

Positive cultural messages may instill individual or community pride, which in turn may serve as a protective factor, counteracting internalized homophobia and promoting resilience. For sexual minority youth, coming out may also provide access to a shared history and subculture, instilling pride, which may constitute a protective factor.¹⁵³ Strong communities may facilitate links with individuals who can serve as mentors, establish and model healthy behavioral norms, provide emotional support, and safe spaces to congregate, meet people and establish relationships. For example, in some urban centers, young, Black MSM, some homeless, have formed “ball communities” (underground LGBT subcultures focused on competitions among “houses” or “families,” most of which are led by a “house mother” or “house father”) that provide them with familial support, addressing their physical and emotional needs.¹⁵⁴ Stronger community structures may provide individuals with greater social capital — connections among social networks that establish and reinforce norms of trustworthiness and reciprocity, and establish standards of behavior — which may in turn increase individual resiliency.¹⁵⁵ Such standards have the potential to reduce alcohol or substance abuse and sexually risky behaviors.

It is important to anticipate that for some MSM, paradoxically, integration into the larger gay community may increase their risks, at least initially. For men who have been systematically harassed for their entire lives, the discovery of an environment with less approbation may be an incentive to increase the frequency of sexual contacts. The relatively higher background HIV and STD prevalence rates, as well as higher rates of substance abuse, smoking and sexual risk taking among MSM communities further increases their risks. While in the long term, for individuals to escape the constant victimization of a stigmatizing environment will benefit their health, some men may need support to manage the initial transition to a very different environment.

For MSM who are living with HIV, stigmatization is a problem within the gay community, as well. On gay social networking sites, which among many MSM have become a common means of meeting partners, men routinely post profiles with designations proclaiming “disease free,” and some HIV-positive men report a community climate so hostile that they characterize their experience of it as “HIV apartheid.” As a consequence, many HIV-positive men may be reluctant to disclose their status, increasing the possibility of unsafe encounters.

BUILDING A STRONG AND SUPPORTIVE COMMUNITY

SUPPORTING A STRONG COMMUNITY

- **COMMUNITY SUPPORT.** Particularly for MSM who have migrated to an urban gay ghetto from a smaller community, support for healthy social interactions that could help establish support networks could help forestall syndemic production, even among those otherwise predisposed. Community organizations that encourage the development of friendships — such as sports teams, social groups, faith-based groups, neighborhood coalitions and others — may help vulnerable MSM cope with health related stressors.
- **HEALTH EQUITY.** Among the LGBT community, there is less broad awareness of health equity issues, compared to other equality concerns, such as marriage. Promoting the concept of health equity may serve to enhance community cohesion. Some suggest that the decision to “live healthy” may itself constitute a political action — i.e., the pursuit of individual and community health as an agent of change.
- **POLITICAL, COMMUNITY MOBILIZATION.** Having access to LGBT social and political organizations may also be an important factor in overcoming the adversity posed by social stigma and discrimination. Among marginalized communities, group identity — i.e., affiliation with an oppressed group and its collective struggle — may enhance individual resiliency.¹⁵⁶
- **SUPPORT FOR HIV DISCLOSURE.** For MSM who are living with HIV, being able to disclose their serostatus requires sufficient confidence that colleagues, family and community will be supportive and non-judgmental. Programs that encourage acceptance of HIV-positive individuals may help educate people and facilitate greater acceptance. In 2012, the President’s Advisory Council on HIV/AIDS and the CDC/Health Resources and Services Administration (HRSA) Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) jointly convened a Disclosure Workgroup, which developed policy recommendations and principles to address structural barriers to safe and voluntary HIV disclosure.¹⁵⁷ CDC’s new “Start Talking — Stop HIV” campaign encourages open discussion about a range of HIV prevention strategies and related sexual health issues.

Though the extent to which access to quality healthcare is associated with health inequities in MSM is not well understood, barriers to quality care clearly correlate with poorer health outcomes in the general population. Moreover, MSM have unique healthcare needs as a result of increased susceptibility to adverse outcomes associated with stigma and discrimination, as discussed previously.

MSM are more likely to contract HIV or STDs, both because of the relatively higher prevalence in the communities in which they live, but also related to increased risk associated with common sexual practices, particularly receptive anal intercourse.¹⁵⁸ If MSM are reluctant to disclose their same-sex attraction to their provider due to perceived stigma, they may be less likely to receive appropriate care, including screening for HIV or STDs.¹⁵⁹ They may also be less likely to report substance abuse, particularly related to drugs commonly associated with MSM, such as methamphetamine or anabolic steroids.

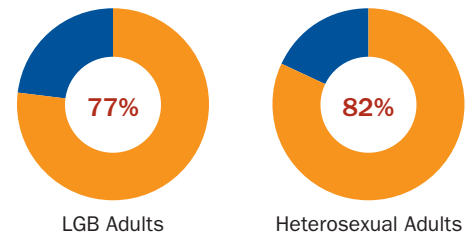
MSM sometimes face a variety of structural barriers to care, as well, including inequalities in access to health insurance

or workplace benefits. LGBT individuals with insurance are less likely to be covered by their employer and more likely to be enrolled in Medicaid. For example, in the 2008 California Health Interview Study, LGB adults were less likely to have health insurance than heterosexuals (77 percent v. 82 percent).¹⁶⁰

Though many public health prevention interventions are designed to address a range of interpersonal and community dynamics (e.g. triggers, social supports and others), few substance abuse treatment providers, tobacco cessation programs, or the like have programs tailored to meet the specific needs of MSM. The association of substance abuse with other health problems (e.g. HIV and depression) among MSM suggests that integrated services could be of benefit.

HEALTHCARE ACCESS AND QUALITY

Likelihood of Having Health Insurance – 2008



IMPROVING ACCESS TO QUALITY HEALTHCARE AMONG MSM.

The federal government plays an important role in the delivery and regulation of healthcare. As such, it is essential that federal policies support and encourage wider access to culturally competent services for MSM. Recently, there have been substantial improvements in federal policies. For example, in 2013, the HHS Office of Minority Health published LGBT-inclusive National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) that provide a more inclusive definition of culture that includes sexual orientation and gender identity.¹⁶¹ While other government and non-government organizations also have efforts underway, significant progress is still needed. For example:

- **BEST PRACTICES IN MSM CLINICAL CARE.** It is important to document best HIV clinical care practices in general and specifically among MSM populations. For example, while significant racial disparities in HIV diagnosis, linkage to care, treatment and adherence to medications have been documented in a variety of settings, some clinics have developed practices where such disparities virtually disappear — such as the Moore Clinic for HIV Care, an outpatient unit supervised by the Johns Hopkins University AIDS Service.
- **PROVIDER INCENTIVES.** Billing, reimbursement and professional accreditation protocols should incentivize practices that are likely to improve MSM health or reduce health inequities. For example, sexual health screenings are too often overlooked and could be of significant benefit among this population. With respect to HIV care, appropriate incentives might serve to enhance patient retention in care.
- **PROFESSIONAL TRAINING, CULTURAL COMPETENCE.** Providers who are able to establish trusting relationships with MSM patients are better equipped to promote healthy behaviors. Providers must be sensitive to MSM-specific health needs, as well as alternate expressions of sexuality and family structures. Medical training should incorporate LGBT health-specific modules, while continuing medical education programs should reinforce skills. Medical practices should solicit participation from LGBT community representatives in planning and quality-improve-

ment meetings. Leadership programs in MSM healthcare may further incentivize professional development. In addition to training materials promulgated by a range of Community-based organizations, SAMHSA and HRSA have developed a list of LGBT curricula that train behavioral health and primary care practitioners, for which continuing medical education and continuing education unit credits are available.¹⁶² Through a cooperative agreement with Fenway Health, HRSA supports the National LGBT Health Education Center, designed to help community health centers improve the health of LGBT populations. Following the overturn of DOMA, HHS Divisions revised federal regulations and policies across its programs to recognize same-sex spousal relationships.

- **DISCRIMINATION PROTECTION.** In 2012, HHS developed a sexual orientation and gender identity-inclusive non-discrimination policy applicable to all HHS-funded programs. Culturally competent care can be delivered by any provider, and it is important that MSM receive appropriate care in any setting, rather than segregating specialty service providers. In fact, in a small cross-sectional survey among LGBT youth, provider qualities and interpersonal skills were as important as knowledge and experience and more important than gender and sexual orientation.¹⁶³ Nonetheless, visible positive role models among authority figures are important and hiring and promotion procedures at healthcare facilities should protect LGBT personnel from discrimination.

- **MSM-SPECIFIC CASE MANAGEMENT.** Case management services have proven effective in the management of HIV and other patients with complex needs. It may be that such practices can be adopted to meet the spectrum of needs presented by social determinants of MSM health inequities.
- **INSURANCE ENROLLMENT.** Particularly with the rollout of the Affordable Care Act, there are increased needs for LGBT-specific outreach to facilitate insurance enrollment, particularly among younger MSM ages 20 to 35, who are less likely to have employment-based insurance. For example, Trust for America's Health recently published an Action Plan designed to explain to providers and the young MSM they serve the importance of health coverage, facilitate enrollment in coverage, address structural barriers to care, and support the engagement of young MSM with the health system once they obtain coverage.¹⁶⁴ Managed care organizations for which new patients are auto-enrolled should be required to conduct specific outreach among MSM and other patients — potentially via subcontract with Congressional Budget Office (CBO) providers, who may be better equipped to reach target populations.
- **ELECTRONIC HEALTH RECORDS.** Increasingly, the use of electronic health records comprises an important strategy to improve healthcare safety and quality. Too often, however, the standardization of electronic records is based on a “heterosexual assumption” that assumes that patients fall within a normative (i.e. heterosexual) profile and fail to capture the lived experi-

ence of sexual minorities. Without sexual orientation data, clinicians may fail to offer appropriate screening or care to LGBT patients, while analyses of aggregated data may fail to recognize disparities or unique needs of LGBT populations. As the Office of the National Coordinator for Health IT (ONC) implements EHR meaningful use standards, which govern the type and nature of data collected, it is important that data fields capture information relevant to sexual minorities, including preferred name, sexual orientation and gender identity. ONC should collaborate with industry to ensure the inclusion of sexual orientation and gender identity data, but also to implement sufficient privacy protections to guarantee that such data are protected.

- **CONFIDENTIALITY.** Particularly among young MSM, the provision of confidential health services is essential. For example, young MSM need access to HIV and STD prevention and screening without such services appearing on their parents' explanation of insurance benefits.

- **MEDICAID EXPANSION ADVOCACY.** While implementation of the Affordable Care Act promises to increase access to healthcare for many disadvantaged populations, realizing the Act's potential is dependent on the expansion of the Medicaid program, which a number of states, disproportionately in the South, have declined to endorse. MSM who live in states that do not expand Medicaid will have fewer options for health coverage, and, in some instances, higher income thresholds for subsidized coverage. Sustained advocacy efforts will be needed to ensure that, ultimately, all states choose to expand their Medicaid program.

- **PATIENT ACTIVATION MEASURE.** The Howard Brown Health Center in Chicago has employed the Patient Activation Measure — a validated scale that re-

flects the stages of patient activation — to assess patient readiness for ART, and to tailor care and support accordingly. Such measures could be further adapted for MSM-specific care.

- **CONSUMER EDUCATION.** Particularly in light of changes to the healthcare system, it is increasingly important for MSM (particularly young men) to understand and advocate for quality healthcare services. Those who have not previously had insurance, for example, may require assistance in understanding how to obtain coverage and how health insurance can be used to support healthy living. Provider and non-government organization outreach to the LGBT community may help consumers locate LGBT-competent providers or medical facilities. Systems that allow consumers to rate providers based on cultural competency may be a useful strategy.

- **FEDERALLY QUALIFIED HEALTH CENTERS.** Community-based and patient-directed Federally Qualified Health Centers (FQHC) serve populations with limited access to healthcare and provide comprehensive primary and preventative care, including oral health and mental health/substance abuse services to persons regardless of their ability to pay or health insurance status. Of the more than 1,000 FQHCs, however, only about a dozen LGBT clinics have been designated. While these clinics provide culturally appropriate and targeted services to thousands of LGBT patients, their relative scarcity means that many patients do not have easy access. Moreover, other “mainstream” FQHCs may simply refer sexual minority patients to other providers rather than develop competent services. As a primary healthcare provider for disadvantaged communities, it is important that FQHCs develop competence to meet the needs of all their patients, including MSM.

- **POSITIVE HEALTHCARE NORMS.** As a result of longstanding health inequities, many communities may have come to rely on sporadic, emergency-driven healthcare. For young MSM in particular, it is important to normalize routine preventive care, and to encourage healthy living. Venues where young people socialize may provide one opportunity — for example, Boys/Girls Clubs or YMCAs could be supported to conduct outreach and health education among MSM. Another idea would be to support healthcare professionals, such as physicians or nurses, to visit schools, similar to how law enforcement officers visit schools in an effort to establish positive relationships with young people and discourage drug abuse. The LGBT community itself must play a greater role in normalizing risk-reduction and health promotion — importantly, this must include a nuanced discussion that considers the relative risk of various sexual and drug behaviors in a non-judgmental way, rather than a one-size-fits-all approach.

- **HEALTH DEPARTMENT OUTREACH.** For some MSM with HIV, retaining consistent care and remaining adherent to ARTs pose significant challenges. In the two-thirds of states that collect viral load data, it may be possible to identify individuals who are failing on ART therapy and follow up with community health workers, who could proactively attempt to dismantle barriers and facilitate healthcare. Such an approach would require significant consent and confidentiality protections, but similar models exist — for example, the San Francisco Homeless Outreach Team (SF HOT) consists of 20 experienced outreach professionals who engage chronically homeless “super-utilizers” in services that would get them off the streets and into stabilized situations.

BIOMEDICAL INTERVENTIONS

Treatment as Prevention.

The potential of “treatment as prevention” has gained significant attention recently. Studies conducted among sero-discordant heterosexual couples demonstrate that the early initiation of ART reduces the risk of HIV transmission to the uninfected partner by 96 percent.¹⁶⁵ Theoretically, were such early use of ART to be widespread among HIV-infected individuals, community viral load would decrease. In San Francisco, overall reductions in community viral load were associated with fewer HIV infections.¹⁶⁶ Mathematical models have suggested the possibility that widely deployed early detection and treatment to lower community viral load could substantially eliminate new HIV transmissions.¹⁶⁷

Notwithstanding, as has been amply demonstrated in the treatment cascade model, successful HIV treatment requires a continuous sequence of events, from diagnosis to adherence, and the interruption of any step may preclude viral suppression. As such, “treatment-as-prevention” strategies are susceptible to a range of behavioral and structural factors that pose similar uptake challenges. In fact, in one mathematical model, an improvement in any single component of the cascade (diagnosis, linkage, retention, treatment, persistence or adherence) would yield only a marginal decline in community viral load.¹⁶⁸ Similar to health inequities

overall, addressing disparities in health outcomes among MSM along the treatment cascade will require mitigating the adverse effects of social determinants of MSM health — particularly among MSM who face intersecting determinants, including socio-economic status and race/ethnicity.

Pre-Exposure Prophylaxis (PrEP).

The CDC recently recommended PrEP — i.e. the use of anti-HIV medications among uninfected individuals to prevent infection — for those who are HIV-negative and at substantial risk for HIV infection.¹⁶⁹ In the iPrEx study among MSM and transgender persons, a once-daily dose of tenofovir/FTC (Truvada[®]) delivered in the context of comprehensive HIV prevention services was associated with a 44 percent overall reduction in HIV incidence. Adherence varied substantially among participants, however. Among those self-reporting more than 90 percent adherence, risk was reduced by 73 percent; among those for whom blood drug levels were confirmed by assay, the reduction was 92 percent. Participants in both treatment and placebo arms reported significantly lower risk behaviors during the course of the trial.¹⁷⁰ As with treatment as prevention strategies, the successful implementation of PrEP will also depend on mitigating a range of adverse effects of social determinants of health.

THE WIDESPREAD USE OF PrEP AS A PREVENTION INTERVENTION POSES SUBSTANTIAL CHALLENGES.

- **PrEP GUIDANCE.** There are substantial knowledge gaps among both providers and patients related to the use and efficacy of PrEP, and broad-based outreach efforts will be needed to ensure appropriate implementation. A number of community-based resources have been developed by the San Francisco AIDS Foundation (www.prepfacts.org), the AIDS Vaccine Advocacy Coalition (www.prepwatch.org), and others. While the CDC has issued guidelines for the use of PrEP among individuals at risk for HIV, it will be important to refine and expand official guidelines and to promote community norms to address how at-risk populations should incorporate biomedical with other prevention interventions (i.e. condoms) in a more nuanced way.

- **UNDERSTANDING THE IMPACT OF PrEP ON SEXUAL NORMS.** Anecdotal reports suggest that the use of PrEP may be changing sexual behavior norms in ways that are not well understood — for example, there is some evidence of non-prescription PrEP use (i.e. with drugs obtained from friends or acquaintances), and, among social networks that facilitate sexual partnering, HIV positive and negative MSM are advertising their use of PrEP, suggesting a misunderstanding between HIV prophylaxis and treatment. As the use of PrEP becomes more common, it is essential to study how its uptake may affect the epidemiology of HIV transmission.

- **ACCESS DISPARITIES.** While it is too early to know how PrEP is or will be prescribed, early experience with ART suggests that access will be related

to insurance coverage, provider knowledge, patient knowledge and motivation, community standards, and other factors. And, without paying careful attention to communities with less healthcare access, implementation of PrEP could exacerbate health inequities. While Medicaid covers PrEP in some states (e.g. New York and Florida), coverage policies are set at the state level, and sustained advocacy will be necessary to ensure uniform coverage. Even with coverage, some providers remain unsure how such services should be billed. The possibility that the ADAP could be expanded to subsidize the cost of PrEP has been raised, but this would require a statutory change as ADAP can now serve only those already infected with HIV. Out-of-pocket costs for PrEP can be as high as \$13,000 per year.

- **NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (NPEP).** CDC issued guidelines some time ago for non-occupational post-exposure HIV prophylaxis — the temporary provision of antiretroviral drugs following an unexpected sexual, injection-drug or other nonoccupational exposure to HIV.¹⁷¹ Anecdotal experience suggests that the availability and provision of NPEP in hospital and emergency room settings is inconsistent, however. LGBT clinics who offer NPEP report that its provision is complex (as NPEP patients typically present as an emergency), expensive and disruptive. In addition to greater provider and community education, over-the-counter availability of NPEP regimens should be considered.

Addressing Health Inequities: *Gay Men & MSM in the U.S.*

CONCLUSION

Conclusion

Though stigma and discrimination against LGBT people are diminishing at an unprecedented pace, the effects of historical and continuing marginalization persist. MSM continue to suffer health inequities, not the least of which are dramatic disparities in HIV rates, many related to social determinants that include pervasive stigma and discrimination. As a result, a minority of MSM experience a syndemic of overlapping adverse health outcomes including depression, substance abuse, STDs, violence and HIV. Ultimately, addressing the social determinants of MSM health inequities will require a greater emphasis on community-level and structural interventions to improve the environment in which sexual minorities, including MSM, live. In the near term, helping MSM to avoid or overcome immediate challenges will require focused interventions to mitigate adverse determinants and increase resiliency. An approach that fosters MSM health and well-being — and which includes HIV interventions — is essential. But, while increasing individual resiliency among MSM will undoubtedly be important, as one researcher noted: “resilience in the face of adversity is not the same as health equality.”¹⁷² In the long term, reducing societal oppression and marginalization of LGBT people will reduce the need for individual and community-level interventions.

Endnotes

* Federal officials were invited to participate in the meeting as a resource and not in their official capacities.

† In this paper, the term “MSM” is used to designate gay men and other men who have sex with men, a group that includes both men who do and those who do not self-identify as gay, and which includes men who also have sex with women. For purposes of the paper, this group does not include transgender men or women, who may be heterosexual, homosexual or bisexual in their orientation. Though data pertaining to transgender health are extremely limited, studies show that transgender people experience significant health inequities, and there are differences in health outcomes between transgender men and women, who are at far greater risk for HIV (a meta-analysis of 29 studies found an estimated HIV prevalence rate of 27.7 percent among transgender women — see Herbst JH, Jacobs ED, Finlayson TJ et al. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: a systematic review. *AIDS Behav*, 2008;12:1-7). Additional research to better understand transgender-specific health issues, as well as policy approaches to address transgender health inequities, are warranted in their own right and are urgently needed.

‡ In this paper, the term LGBT (lesbian, gay, bisexual and transgender) is used, as it often is both colloquially and in the published literature, to refer to the community of people who share the fact that, and who are frequently stigmatized because, their sexual orientation is not exclusively heterosexual — but who are otherwise diverse in terms of gender, race, socioeconomic status, age, and other characteristics. LGBT health research is in a formative phase and has been limited by a lack of systematic population data collection, as questions pertaining to sexual orientation have appeared only recently in most national surveys. LGBT health research also poses numerous methodological challenges (see “Conducting research on the health status of LGBT populations” [chapter 3], in: Institute of Medicine. *The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding*.

Washington, D.C.: The National Academy Press, 2011), not the least of which is that for research purposes, these four populations are imperfectly and variously defined, separately and collectively, by attraction, behavior, and identity, designations that themselves sometimes overlap and in many cases cannot be considered fixed. For example, due to challenges in obtaining sufficient statistical power, research designs sometimes treat the four populations as a single “LGBT” group, though in studies that are able to distinguish among them, significant differences in health outcomes have sometimes been shown among these populations. Given these limitations, whenever possible, this paper references research conducted specifically among MSM. Research that examines the LGB or LGBT populations as a whole is also cited here to the extent that it refers to MSM specifically or draws conclusions that can be understood to apply to MSM — these references should not be interpreted to imply that the conclusions cited necessarily apply equally, or at all, to lesbian, bisexual (except to the extent that they fall within the definition of MSM, above) or transgender people.

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