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Comprehensive clinical care for men who have sex with men: An integrated approach

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Abstract

Men who have sex with men have unique health care needs, partially due to biological factors, such as their increased susceptibility to HIV and STD acquisition and transmission because of anal intercourse, but also due to the internalization of societal stigma related to homosexuality and gender non-conformity, resulting in depression, anxiety and substance use, and other adverse health outcomes. Successful responses to the global HIV/AIDS epidemic will require the development of culturally-sensitive clinical care programs for MSM that address these health disparities concerns, as well as root causes of maladaptive behavior, such as societal homophobia. Providers need to become familiar with local outreach agencies, hotlines and media that can connect MSM with positive role models and social opportunities. Research is needed to understand how the majority of MSM lead resilient and productive lives in the face of discrimination, in order to develop assets-based interventions that build on community supports that MSM have created. MSM deserve to be treated with respect and clinical providers need to interact with them in ways that promote the disclosure of actionable health information. Optimal clinical care for sexual and gender minority persons is a fundamental human right, requiring health professionals as allies.

Introduction

Although homosexual behavior has been variably expressed in different cultures throughout recorded history, in the years following the advent of the gay liberation movement, clinicians became increasing aware that gay and other men who have sex with men (MSM) had unique health needs[1]. Subsequently, the HIV/AIDS epidemic required providers to become

informed about same sex behaviors in order to provide appropriate counseling and care. The urgent need to respond to the disproportionate burden of HIV/AIDS among MSM also led to the development of internationally recognized models of community health services [2]. With the advent of effective antiretroviral therapies by the mid-1990's, programs that were established to address health emergencies became increasingly cognizant of co-prevalent, potentiating conditions, and expanded services to address other sexually transmitted diseases (STDs) and mental health [3].

Careful analyses of the life experiences of MSM and other sexual and gender minority populations suggest that proximate causes of psychological distress and risk taking behavior for some stems from early childhood experiences, including physical and emotional abuse by family and/or peers, resulting in debilitating sequelae [4]. Similar health disparities, e.g. increased risks for HIV/STD, depression and substance use, are increasingly being recognized among MSM in developing countries [5]. These findings suggest that successful responses to the global HIV/AIDS epidemic will require the development of culturally-sensitive programs that address common clinical concerns, and root causes, such as societal homophobia. Research is needed to understand how the majority of MSM lead resilient and productive lives in the face of discrimination, in order to develop assets-based interventions that build on community supports that MSM have created. In order to understand the health care disparities experienced by MSM, the co-authors of this article conducted a systematic review of the medical literature related to MSM over the past 3 decades, using PUBMED and other search engines, using key word terms: men who have sex with men, homosexual men, gay men, HIV and STDs. The search revealed more than 1,000 articles which were reviewed by the co-authors, who selected 155 for inclusion in this paper's bibliography and the web supplement.

Growing up and coming out

Although attitudes regarding homosexuality have become more supportive in many parts of the world, social stigma associated with deviation from socially prescribed gender roles remains common, particularly for young people [6, 7]. Sexual and gender minority youth live in social environments that expose them to rejection, isolation, discrimination, and abuse [8]. This may result in internalized homophobia, low self esteem, and emotional distress. Developmental studies suggest that sexual attraction begins with onset of puberty [9]. The normal process of developing sexual identity during early adolescence proves additionally stressful for sexual minority youth, since added to a sense of identity confusion are the stressors related to having a stigmatized identity [10]. The adolescent may then feel shame, guilt or denial [11]. The mean age for expression of these feelings had previously been 14 years in males [12], but recent research found that individual sexual behavior milestones are progressively manifesting at younger ages (by 1 year of age every 8–25 years, $p < 0.05$), and social milestones (e.g., publicly expressing sexual identity by “coming out”) are moving even more rapidly in a similar direction (by 1 year of age every 2–5 years, $p < 0.001$) [13], similar to what has been noted with young heterosexuals [14].

The advent of sexual awareness may result in denial and repression, or an acceptance of sexual orientation and identity. Self-acceptance of sexual identity leads to early integration,

disclosure, followed by a period of identity consolidation. Select friends are more frequently informed than parents, although in some cases a trusted sibling will be informed [12]. Despite these efforts, coming out may result in the loss of friends, and negative or ambivalent responses from parents. In some cases, disclosure may cause verbal abuse, religious condemnation, physical brutality, discrimination or rejection [6, 15]. Because adolescence is a critical period in identity formation, adverse experiences impair further psychosocial development. Troiden described the process of adults acquiring a homosexual identity, in which coming out was followed by self-acceptance, with a resolve to develop intimate relationships [16]. Adolescents may find it difficult to reach this stage of acceptance. The future may appear very uncertain, with loss of self esteem and spiritual worth. Although adolescents with positive prior relationships and cohesive families tend to fare better, many sexual and gender minority adolescents are at increased risk for impaired physical, social and emotional health[7]. Accumulating evidence indicates that these adolescents are more likely than heterosexual peers to experience depressive symptoms, suicidal ideation, and to make suicide attempts [17]. Other potential problems facing these youth include truancy, prostitution, substance abuse, depression and STDs.

The coming out experience is highly individualized, and many factors, including gender, age, ethnicity may affect its expression. A longitudinal report of 145 American sexual minority Black and Latino youths reported involvement in fewer gay-related social activities and less comfort with others knowing their sexual identity compared to White youths [18], possibly due to feeling marginalized by several communities. Half of one group of students who reported homophobic bullying reported they skipped school because of the experience [7]. Conversely, schools that openly acknowledge sexual and gender minority students, and explicitly oppose homophobic bullying, create an environment in which all students feel safe and able to learn [19]. Coming out for many young people can also mean risking rejection and/or the loss of support from family. As young people are less likely to have the resources to support themselves if they are cut off from family, this can lead to homelessness, mental health problems and substance abuse. Local laws and general attitudes will influence a young person's decision about whether they are able to come out to fully express their identity and desires, especially in countries where sexual and gender minorities face discriminatory laws [20].

Adolescent MSM may find discussion of the options for disclosure beneficial, since they need advice about potential negative outcomes, while seeking positive support systems prior to “coming out”. Sexually active adolescents will require routine STD and HIV services. Providers need to become familiar with local outreach agencies, hotlines and media that can connect adolescents with positive role models and social opportunities. Because of their higher risk, these adolescents should be questioned specifically about depression and mental resilience. Health care providers may be able to facilitate adolescent acceptance by family members, given their roles as trusted sources of vital information [13].

Life course development of MSM

Despite adverse external pressures, like institutionalized homophobia, the majority of MSM lead healthy and productive lives. At the same time, multiple studies have also shown that

MSM are more likely to report substance abuse[21], depression[22], violence victimization[23], and childhood sexual abuse[24] than their heterosexual peers. Investigators have noted that many of these health conditions are correlated, and are synergistically associated with increased HIV prevalence and risk behaviors [25]. This observation has been corroborated by several studies that described the multiple psychosocial epidemics that intertwine, which function to increase their HIV risk [4, 21]. These findings fit the classic definition of a syndemic, a cluster of epidemics that interact synergistically (see www.cdc.gov/syndemics). Syndemics theory posits that homophobia and cultural marginalization are a primary cause of poorer health among MSM[27]. The effects of homophobic violence on MSM youth who do not have access to community support and who cannot understand why they are being attacked can leave scars that predispose them to greater psychosocial morbidity as they reach adulthood. These problems may be amplified once MSM “come out” and move to urban communities with other MSM who may share their experiences, synergistically increasing STD/HIV risks. Despite these predisposing factors, the majority of MSM are not HIV-infected, nor are they depressed, suggesting that most are resilient in the face of societal rejection (Figure One). Further research to better understand why some MSM who have been exposed to negative developmental experiences continue to function well may be helpful in developing assets-based prevention strategies for MSM that promote intrinsic strengths and successful adaptive strategies.

Sexual Health

Sexuality

Sexual health not only includes the absence of disease, but the possibility of having safe and pleasurable sexual experiences [28]. Population-based surveys have found that MSM have higher numbers of sexual partners and higher rates of non-monogamy than demographically matched heterosexual peers, and more liberal sexual attitudes [29]. Some of these behaviours put some MSM at increased risk for STDs [3]. The devastation of the early HIV epidemic led to the widespread introduction of condoms for anal intercourse [30]. This was accompanied by dramatic reductions in HIV/STD transmission [31]. However, since the mid 1990's, with HIV becoming a chronic manageable condition, increases in STD risk behaviours in MSM have been noted [32]. While individual behaviours are critical influences on the risk of adverse sexual health outcomes, it cannot be ignored that such behaviours are influenced by society and culture. For example, the globally dominant legislative framework that does not recognize gay marriage may discourage the long term maintenance of stable homosexual relationships. Where homosexuality remains illegal and stigmatized, there are strong disincentives for MSM to disclose their sexuality to health practitioners, resulting in missed opportunities for preventive screening and counseling, sustaining the high prevalence of asymptomatic STDs among some MSM.

Sexual behaviours

The most common sexual practices among MSM include oral sex and digital-manual stimulation of the partner's penis and anus [33]. The majority of MSM report some lifetime experience with anal intercourse [30]. Since the rectum is lined with a single layer of

columnar epithelium rather than the stratified squamous epithelium of the vagina, the risk of HIV transmission during anal sex is at least an order of magnitude higher than for vaginal sex [34]. Oral stimulation of the anus with the tongue (“rimming”) is also a common behaviour reported by a substantial proportion of MSM [30], and may lead to the transmission of enteric pathogens [35]. Some MSM have engaged in “fisting,” insertion of the hand into the rectum. This can lead to traumatic bowel injury [36]. In addition, fisting can be associated with bleeding which may lead to the transmission of blood-borne pathogens such as hepatitis C [37].

The diversity of the sexual repertoire of MSM means that there is wide variation in levels of risks of transmission of STDs. A single act of unprotected receptive anal intercourse with an HIV-infected partner carries a per-contact transmission risk of approximately 1.5%. For insertive anal intercourse, the risk is 0.1% for a circumcised man and 0.6% for an uncircumcised man [34] (see Sullivan et al, in this issue). Saliva is sometimes used as a lubricant during anal intercourse, and this may lead to transmission of salivary pathogens such as cytomegalovirus, hepatitis B virus and HHV-8 [38]. Anal STDs can be acquired through unprotected receptive anal intercourse, but may also be contracted by anal contact with the sexual partner’s fingers or tongue [39]. Urethral STIs can be acquired during unprotected insertive anal sex, and also during orogenital sex [40]. Pharyngeal STIs are commonly transmitted through orogenital and oroanal sexual contact [41].

Some MSM have chosen “seroadaptive” sexual behaviours which include practices that attempt to reduce the risk of HIV transmission associated with unprotected anal intercourse. “Negotiated safety” may describe the situation when two HIV-uninfected men in a relationship agree to have unprotected anal intercourse with each other but not with outside partners, although similar agreements may be found in serodiscordant relationships [41]. In “strategic positioning,” an HIV-uninfected partner agrees to engage in lower risk insertive role in unprotected anal intercourse, while an HIV-infected partner restricts himself to being receptive [42]. “Serosorting” is the practice of agreeing to have unprotected anal intercourse only with partners of the same HIV status [43]. Some HIV-infected MSM decrease the risk to their partners by withdrawing before ejaculation [45]. The HIV risk for MSM who practise negotiated safety within a committed relationship is comparable to men who report no unprotected anal intercourse, while MSM who report serosorting and strategic positioning are at slightly increased risk for HIV [44]. Unprotected intercourse with withdrawal appears to be associated with a relatively higher risk of HIV transmission [44]. For Seroadaptive behaviours to be protective, MSM need to have current, accurate knowledge of their serostatus, requiring frequent HIV testing, which may not always be the case.. Since seroadaptivepractises do not protect against other STDs, these behaviours may contribute to recent MSM STD epidemics [45].

Infectious Diseases

HIV

In developed and developing countries, HIV prevalence among MSM exceeds that of the general population by up to 44 fold [5, 46]. Factors that have potentiated HIV spread among MSM include biological factors, such as the increased susceptibility of the rectal mucosa,

the amplifying role of concomitant STDs, and efficient HIV transmission by acutely infected partners [51]; sociobehavioral factors, e.g. multiple concurrent partners; epidemiological factors, e.g. choosing partners from high prevalence subpopulations[47]. Although it is recommended that sexually active MSM be screened for HIV at least once a year [3], and more often depending on their behavior, MSM who perceive local clinical care settings as unsupportive, may be reticent to be screened, and risk reduction counseling opportunities may be missed [48].

Syphilis

After initial decrease in the early days of the AIDS epidemic, syphilis is increasingly prevalent among MSM in many countries[49]. The resurgence of syphilis is partially attributable to the reliance on unprotected oral sex as an HIV risk reduction strategy, serosorting among HIV-infected MSM[50], and meeting multiple partners in high risk venues (e.g. bathhouses) and social media [51]. Concerns have been raised that syphilis co-infection may accelerate HIV-associated immunosuppression, underscoring the need for routine screening [52].

Gonorrhea and Chlamydia

Gonorrhea and *Chlamydia trachomatis* are frequently asymptomatic in the rectal reservoir[53]. Nucleic amplification tests can detect low copy numbers of either pathogen and have been considered major diagnostic advances [39, 54], but they are more expensive, and technically complex than traditional methodologies. Concerns have been raised about low positive predictive values using some of these newer tests in non-genital sites [55], leading to calls for further refinements of non-culture based diagnostics. Increasingly, quinolone resistance has been detected in gonococcal isolates from MSM, leading to the recommendation that treatment should always utilize a third generation cephalosporin[56]. Because of the frequent co-prevalence of gonorrhea and Chlamydia, treatment for both pathogens is desirable when either is identified. Several years ago, outbreaks of *Lymphogranuloma venereum* proctitis were reported among MSM in Europe, US and Australia, but the organism does not appear to have become widely disseminated [57].

Herpes simplex (HSV)

HSV-2 is more common among MSM than general populations and facilitates HIV transmission and acquisition[58]. Although, Acyclovir chemoprophylaxis was not shown to protect HSV-2-infected MSM against HIV acquisition, the failure could have been due to the persistence of chronic anogenital inflammation established by HSV-2 infection[59], so other approaches, e.g. vaccines, deserve further study. Clinicians may miss treating mild symptoms of HSV-2 if they are not aware that reactivation can be associated with genital tract discomfort, proctitis, rash, without classic vesicles. In that setting, HSV-2 antibody and DNA testing can be helpful in determining that the patient is infected.

Human Papillomavirus (HPV)

HPV is a major cause of vaccine-preventable anal neoplasia and anogenital warts in MSM. Given the demonstration of the efficacy of a multivalent vaccine in preventing HPV

acquisition in young males[60], providers should consider vaccinating all adolescent males before they become sexually active, since adolescent sexuality may evolve. However, this may not be readily feasible in resource-constrained environment, although long-range benefits could be substantial. There is no consensus regarding whether it would be cost-effective to vaccinate all sexually active MSM, independent of age [61], but recent models suggest that vaccinating MSM could be beneficial in the long term [62]. Routine HPV vaccination of all young males would obviate anal screening as adults. Some experts have advocated regular anal cytologic screening of sexually-active MSM, because of increasing reports of anal neoplasia, particularly in HIV-infected individuals [63, 64]. The optimal follow-up test for MSM with abnormal anal cytologic results is high resolution anoscopy, and ablative treatment of identified high grade dysplasia. Others have cautioned that limited data regarding natural history of anal HPV and the efficacy of treatment options, particularly for HIV-uninfected MSM, suggest that repeated anal HPV screening of all MSM cannot not be recommended currently [65]. However, given the increasing incidence of anal cancer in MSM, large high quality studies of the natural history of anal HPV infection in diverse samples of MSM are urgently needed to better inform anal cancer screening guidelines.

Viral hepatitis

Hepatitis A is spread by oral-fecal contamination, and exposure is increased among MSM who engage in anal sex. Although Hepatitis B may be transmitted parenterally, sexual transmission has also been well-documented among MSM, underscoring the importance of access to Hepatitis A and B vaccination for all MSM [66]. More recently, several outbreaks and clusters of Hepatitis C transmission have been documented primarily among HIV-infected MSM in Europe, Australia, and North America in association with traumatic sexual practices, such as manual-anal contact (“fisting”) and group sex, as well as substance use, particularly the sharing of injection or inhalation paraphernalia [2]. Thus, clinicians should query their MSM patients about specific sexual and drug use practices, and where appropriate, should screen for Hepatitis C antibody [67]. Because HCV is more readily treated in individuals with acute infection, astute clinicians caring for HIV-infected MSM who have unexplained mild elevations in their liver functions tests, may want to test for Hepatitis C RNA, since antibody seroconversion can lag by many months[68].

Enteric pathogens

MSM who engage in oral-anal contact (“rimming”) or anal intercourse without adequate personal hygiene may acquire giardia, salmonella, or shigella [61]. Clinicians should think of these organisms when patients present with diarrhea, flatulence, or other abdominal symptoms. Their diagnosis is important, since specific treatments are available, which could decrease the likelihood of wider community dissemination.

Methicillin-resistant *Staphylococcus Aureus* (MRSA)

In recent years, this organism has been reported to be increasingly prevalent among MSM, but not necessarily transmitted through penetrative anal contact, more often associated with environments where sweating and lots of skin-skin contact are common, e.g. saunas, gyms. MRSA can rapidly replicate in abraded skin, resulting from sexual trauma or other intense physical activity, which can occasionally result in septicemia or significant tissue infections

[69]. MRSA is often resistant to beta lactam and quinolone antibiotics, but may be susceptible to trimethoprim-sulfamethoxazole, but sometimes newer, more expensive antibiotics may be necessary.

Mental health issues

Over the last decade, there has been a growing body of evidence that MSM in many parts of the world have higher rates of mood and anxiety disorders than men in the general population [70].

Mood disorders

About 40% of MSM will develop major depression in their lifetimes, twice the rate found in heterosexual men [71]. Predictors of major depression in MSM include not having a partner, experiencing anti-gay threats or violence, and non-gay identification [21]. Because alienation from the gay community has been associated with depression, it is feasible that group therapy that enhances social integration could increase the efficacy of standard treatments.

Anxiety disorders

Panic disorder (with and without agoraphobia), social phobia, and generalized anxiety disorder are more prevalent in MSM compared to other men [71]. Over 20% of MSM will develop a phobia, roughly twice the prevalence among heterosexual men [71]. Given the increased likelihood of substance use (see below), anxiolytics should be used sparingly.

Body image and weight

Internalizing societal pressure to conform to cultural ideals that may idealize specific body types, e.g. muscular or slender physiques, may lead young MSM to develop chronic anxiety about their bodies, which in turn, could result in increased exercise and diet, or in obesity as a way to reject social expectations and “self-medicate” depression [72]. Mental health services that affirm their sexual identity and self-respect may enhance the likelihood that MSM with body image concerns engage in self-caring behaviors that result in improved health outcomes.

Adaptive aging issues

Because of familial and societal rejection, growing old in traditional family structures may not be an option for many MSM. Societal rejection of institutionalized MSM primary relationships, e.g. bans on same-sex unions, can result in MSM anticipating aging alone, potentiating adverse medical and mental health outcomes [73]. New norms for gay aging are evolving in resourcerich environments, as evinced by the development of creative projects to engage LGBT elders, such as the SAGE program in New York (www.sageusa.org).

Substance use

Substance use has been found to be prevalent in many MSM samples [21, 74]. While some studies indicate substance use is higher among MSM than general populations, this is controversial, in part because of methodological differences [75]. Further, most substance

use research among MSM has occurred in higher income countries, limiting generalizability, however data from other countries has recently emerged [76, 77]. It is likely that several factors, including social norms, homophobia, and concomitant depression and anxiety contribute to higher rates of use [23, 78]. Although most studies have concentrated on individual substances, many MSM use multiple drugs [79, 80]. While focusing on specific substances may make sense from a health risk standpoint, the complexity of poly-substance use limits the utility of substance-specific interventions [81].

The frequency of specific substances use varies widely between samples. For example, between 27.3–65.9% of MSM reported smoking tobacco, which may be to twice the rate of heterosexual men from similar backgrounds [82, 83]. While drinking is common among MSM, heavy alcohol consumption is less frequent than in the general population [84]. In some regions, anabolic steroid use is also a prevalent [85]. In the United Kingdom, community samples of MSM found that 10–14% reported steroid use; only a third of these men said they discussed this with their healthcare provider [86].

Episodic recreational substance use is common. The majority of MSM substance users report less than weekly use, although bingeing episodes may be common [87]. With the possible exception of marijuana use, approximately one-quarter of illicit substance users report at least weekly use [88, 89]. In many studies in diverse settings, substance use during sex appears to be associated with HIV seroconversion. Methamphetamine, cocaine, and poppers use are consistently and independently associated with unprotected sex and HIV seroconversion [90]. Factors contributing to this association include increased sexual drive, sensation seeking, a sense of invulnerability, and impaired negotiation skills [91, 92]. Social norms, peer pressure, and selection of partners within substance-using networks may also contribute [4,23]. Substance use could also increase the risk for HIV infection via effects on the immune system, as well as altering pain thresholds, allowing for more sustained traumatic intercourse. Substance use may facilitate HIV spread in other ways. For HIV-infected MSM, substance use may cause decreased medication adherence and decrease virologic suppression [93]. One study reported MSM methamphetamine users specifically planning “HAART holidays” around their drug use [94].

There are many health-related consequences of illicit substance use, including methamphetamine-induced psychosis, cocaine-induced cardiac infarction, and hallucinogen-associated rhabdomyolysis [95]. MSM steroid users may engage in unprotected sex, and be prone to suicidal ideation and depression [85, 86]. High rates of tobacco dependence and alcohol consumption among MSM contribute to a significant burden of disease in the population [96]. HIV-infected MSM who smoke have increased risk for poor outcomes such as poor oral health, rapid disease progression, abnormalities in brain morphology and cognition, and higher rates of mortality compared to their non-smoking counterparts [97]. Negative consequences from alcohol use disorders among HIV-infected men have also been documented. Heavy alcohol consumption of HIV-infected individuals can exacerbate neurocognitive and motor function abnormalities; lead to greater immunosuppression; and increase risk for opportunistic infections, exacerbate viral hepatitis and cause metabolic complications [98]. While it is unknown if injection drug use is higher among MSM than the

general population, MSM-IDU are at exceptionally high risk for both HIV and hepatitis C [99].

Few MSM-specific interventions have been proven to reduce substance use or related risks.. Moreover, most treatment programs have not been adapted toward the needs of MSM; an evaluation of public-funded substance treatment providers in United States found that only 7.4% of identified LGBT treatment providers offer services that are tailored for LGBT clients [100]. Several studies of abstinence-based interventions for methamphetamine-dependent MSM report reductions in both substance use and HIV-related risks, though sample sizes were small [101]. Among methamphetamine using HIV-infected MSM, a harm reduction behavioral intervention reduced the proportion of unprotected sexual risk behaviors, even in the context of ongoing drug use [102]. Reviews of behavioral interventions for MSM methamphetamine users suggest that intensive interventions may be most effective in reducing methamphetamine use[89]. Studies are ongoing to evaluate the use of drugs that affect dopaminergic and serotonergic neural pathways to decrease stimulant use in drug-dependent MSM, with recent data suggesting that mirtazapine may be beneficial in some settings [103]. Few risk-reduction interventions have targeted general substance use or sexual risks taken under the influence of substances. The largest to date, which enrolled 1,686 MSM substance users who reported substance-use during high-risk sex, found a six-session group risk-reduction intervention had no greater effect in reducing sex risk or substance use compared to an attention-control [104]. Another risk-reduction behavioral intervention tested among club-drug using MSM reported no reduction in sexual risk, though self-reported club drug use declined among some dependent users [105]. Motivational interviewing, cognitive behavioral therapy, and couples therapy have been empirically evaluated to treat alcohol use disorders among MSM [106, 107]. Because data suggest that many MSM presenting for alcohol treatment also have comorbid drug-use disorders, culturally-tailored interventions specific to the needs of MSM are needed [108]. Similarly, few gay-oriented interventions for tobacco cessation have been evaluated for efficacy in reducing tobacco use among MSM. There is evidence that MSM have a stronger preference for gay-specific smoking cessation programs over non-tailored approaches [109]. Social marketing campaigns aimed at raising concerns about tobacco-related harms in the LGBT community are increasingly prominent [110].

MSM who use substances have unique and complex health needs that are often unmet. Health and substance use treatment providers should be sensitized to issues faced by MSM and other LGBT clients, such as discrimination, homophobia, and other social factors that influence health outcomes, and access [111]. Given the high prevalence of mental health concerns among MSM substance users, integrated services and interventions could provide enhanced benefits. Substance using MSM should be routinely screened for HIV and STDs. The full-spectrum of substance use and its health impact on MSM outside of high-income countries require further study to develop culturally-tailored interventions. Efficacious and scalable pharmacologic and behavioral interventions—as well as structural and community-level approaches— are urgently needed to reduce substance use-associated comorbidities among MSM. Finally, more research is needed on sources of resiliency among substance using MSM and how to use these strengths to facilitate recovery.

Provision of culturally competent care for MSM

MSM comprise a diverse population that has historically received inadequate, if not discriminatory, care in the developed world, and often worse treatment in resource constrained settings [112]. Because MSM vary in socio-demographic and behavioral characteristics, they have a wide array of health needs, yet in most countries, there is a lack of specific educational training of health care providers about their concerns, resulting in a dearth of friendly and comfortable health care settings for MSM. Culturally competent care for MSM must be promoted using human rights principles focusing on (1) medical conditions for which MSM are at increased risk because of specific exposures (e.g., unprotected anal intercourse); (2) behavioral concerns which may be triggered by external or internalized homophobia (e.g., substance use and depression); and (3) unique areas which require specific culturally competent understanding (e.g. same sex spousal counseling) [113].

For many MSM, because of alienation from traditional family structures, interactions with health care professionals, as well as peer support, may provide particularly important sources of information that can result in health promoting behaviors [114]. When trusting relationships are developed, health care professionals may be able to serve pivotal roles in helping MSM to find the resources to develop well-integrated identities, which will provide them with the tools to avoid self-destructive behaviors. For these reasons, it is important for all health care professionals to understand alternative expressions of sexuality. Since same sex male sexuality may have diverse expressions in different cultures, so it is important for providers to understand the roles that “unmarried uncles” may play in some societies and urbanized gay men may play in others. It is not necessary for health care professionals to endorse homosexual behavior, but it is certainly counterproductive for them to be hostile, insensitive or uninformed, since only by creating safe and engaging environments will MSM be willing to discuss their behavioral risks; and it is only in supportive settings that MSM receive counseling, support, and referrals that will enable them to adapt healthier life styles. Many tools are available in the form of published and online resources (e.g. www.glma.org, www.gmhc.org, www.thefenwayinstitute.org). Most of these materials have originated in developed countries, but recently, groups have begun to develop educational materials that are appropriate for use in diverse cultures and resource-constrained settings (www.health4men.co.za).

Regions and countries are at different stages of addressing the MSM health care needs. To achieve organizational cultural competence within the health care leadership and workforce, it is important to maximize diversity. This may be accomplished through: (a) Educating all providers to become culturally competent (b) Establishing programs for MSM health care leadership development and strengthening existing programs. The desired result is a core of professionals who may assume influential positions in academia, government, and private industry. (c) Hiring and promoting minorities in the health care workforce. (d) Involving community representatives in the health care organization’s planning and quality improvement meetings. The basic premises articulated here should help to inform current best practices, i.e. that MSM deserve to be treated with respect, that their health needs reflect the circumstances of their environments, and that clinical providers need to interact with

them in ways that promote the disclosure of actionable health information, since screening and care can be best guided by information regarding behavior, and not biased assumptions based on stereotypes. Optimal clinical care for sexual and gender minority persons is a fundamental human right, requiring health professionals as allies.

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Key Messages for Lancet Special Issue on MSM (KH Mayer et al)

1. Studies of the life experiences of MSM and other sexual and gender minority persons suggest that proximate causes of psychological distress and risk taking behaviour may stem from early childhood experiences, including physical and emotional abuse by family and/or peers, resulting in debilitating sequelae.
2. Sexual and gender minority adolescents should be questioned specifically about depression and mental resilience by their care givers. Given their roles as trusted sources of vital information, health care providers may be able to facilitate adolescent acceptance by family members, and referral to appropriate services.
3. Despite adverse external pressures, like institutionalized homophobia, the majority of MSM lead healthy and productive lives.
4. At the same time, multiple studies have also shown that MSM are more likely to report substance abuse, depression, violence victimization, and childhood sexual abuse than their heterosexual peers, so health providers need to be comfortable eliciting sensitive information in order to make appropriate referrals.
5. Sexual health for MSM includes the absence of disease, as well as the possibility of having safe and pleasurable sexual experiences.
6. MSM patterns of sexual behaviour are highly variable, so providers need to establish a rapport in order to know whether they should be screening MSM patients for anogenital gonorrhea or Chlamydia, syphilis, viral hepatitis, or other communicable infections that may occur more commonly in this population.
7. MSM comprise a diverse population that has historically received inadequate, if not discriminatory, health care in the developed world, and often worse treatment in resource constrained settings. Programs to train health care professionals to provide culturally competent care for sexual and gender minority patients are urgently needed.

Figure 1.