

**THE ROLE OF HIV
POSITIVE GAY &
BISEXUAL MEN IN
CONTRIBUTING TO
HOLISTIC WELLNESS:
PREVENTING ILL
HEALTH, PROTECTING
& PROMOTING
QUALITY OF LIFE**



Gay Men's
Sexual Health
Alliance

ACKNOWLEDGEMENTS

This project review was completed and the resulting report prepared by Jeff R. Potts, Consultant, with input from the GMSH Poz Prevention Working Group (PPWG) and project oversight by Gay Men's Sexual Health (GMSH) Poz Prevention Working Group (PPWG) Co-Chairs Murray Jose-Boerbridge, Andre Ceranto, GMSH Director Owen McEwan and GMSH Acting Director Dane Griffiths.

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EXECUTIVE SUMMARY

“POZ PREVENTION IS SHAPING THE APPROACH TO REDUCING HIV TRANSMISSION THAT USES THE LIVED EXPERIENCES OF PEOPLE LIVING WITH HIV, AND THE POZ PREVENTION DISCOURSE IS DESIGNED BY AND FOR PEOPLE LIVING WITH HIV. IT ALSO STRIVES TO REDUCE OTHER HEALTH ISSUES FACING PEOPLE LIVING WITH HIV AND THEREBY REDUCING DISEASE PROGRESSION.” -SURVEY RESPONDENT

CONTEXT

In early 2016, the Poz Prevention Working Group (PPWG) of the Gay Men’s Sexual Health Alliance (GMSH) identified the opportunity and need to gather information to assist them in looking forward. Increasingly, organizations are required to more clearly articulate what their specific contribution is to achieving the goals of the Ontario HIV strategy and this review is intended to inform both the future work of the PPWG as well as the GMSH strategic plan implementation.

The PPWG began in 2004 and in 2008 laid out a holistic framework for Poz Prevention which viewed the overall health of the person living with HIV as the primary goal recognizing that the health of a PHA impacts the health of other individuals and their communities. This was a significantly different philosophical approach than that of many jurisdictions which viewed “POZ Prevention” as interventions focused not on the health of the PHA, but on changing their behaviour(s) as the vectors of transmission.

There have been many changes since which impact HIV prevention and care as well as the overall health of gay men. New conversations about the broad, holistic health and wellness of gay men are taking place in Ontario and have already led to changes in care and support services, particularly in Ottawa and Toronto and increasingly across the province.

Conversations with members of the GMSH PPWG, a review of research literature, a stakeholder survey and discussions with key stakeholders were undertaken to explore these questions of Poz Prevention in today’s context.

RESULTS

There is little doubt: whether thinking about what it is called, or about how it has been understood and/or applied, "POZ Prevention" is different things to different people:

- It seems that some prefer language focused more on sex-positive empowerment, or on positive living.
- Some suggest shifting language so that more attention is paid to building capacity with effort to change behaviours; others feel strongly that "POZ Prevention" language further stigmatizes gay men; and still others suggest that "POZ Prevention" is not sufficient to demonstrate (or to ensure) shared responsibility for HIV prevention.

Meaning and understanding of "POZ Prevention" appears inconsistent.

- 64% of all people who responded to the survey, for example, indicate understanding what "POZ Prevention" means, while 20% are really not sure;
- Five percent of people who responded to the survey and identified themselves as HIV-positive gay (or bisexual) men who live in Ontario are not sure about what "POZ Prevention" means.
- Is "POZ Prevention" more about education and knowledge exchange than it is about interventions? Should it be?

It appears that biomedical advances have changed the way people think about HIV prevention, particularly as it relates to behaviours (and making choices/behaviour change). This may suggest or predicate a revised approach to "POZ Prevention" that focuses more on healthy sex and sexuality, and less on HIV. Opinion appears divided: while it appears generally accepted that biomedical considerations/interventions (particularly PrEP) have positive impact on prevention efforts, agreement is far from absolute. There appear to be gaps in necessary knowledge exchange (education) activities that link (both directly and indirectly) biomedical approaches with broader health/sexual health issues and HIV prevention; some suggest that gay men, in particular, don't know (or appreciate) as much as they should.

Literature focused on syndemic health issues and concerns is broad and plentiful. However, it appears that some caution is necessary in terms of connecting syndemic issues with "POZ Prevention": awareness of how issues related to HIV infection relate with other health issues (e.g., mental health) is important, but it may 'boil down' to a health literacy issue more than a "POZ Prevention" concern (many agree; many don't). It

appears that careful attention is advisable in terms of how syndemic issues are considered going forward.

As is highlighted in “A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men”, *“Addressing HIV within the context of a larger syndemic will require a more holistic approach to HIV prevention and treatment that recognizes the interplay between biological, behavioral, psychosocial, and structural factors that affect the health and well-being of sexual minority men.”* (Halkitis, Wolitski, & Millett, A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men., 2013)

Many will argue that too much attention is paid to HIV prevention interventions without balanced (or sufficient) focus on broader issues that gay men are faced with routinely (e.g., other sexual health and social disparities). It appears that there is as much concern about focusing too much on HIV prevention when thinking about the sexual health of gay men as there is with focusing too much on gay men when thinking about “POZ Prevention. It appears that NOT everyone agrees that preventing HIV is, in fact, a shared responsibility. This may (should) raise some compelling questions vis-à-vis “POZ Prevention^{2.0}”.

One survey respondent summed up nicely what might need careful attention going forward, “Focussing only on HIV prevention may obscure sexual and mental health issues... Preventing HIV is great, but we cannot lose focus on broader sexual issues for gay men.”

Evidence that supports the notion that gay men face significant disparities in terms of their health and how their health is ‘managed’ and/or perceived by others is substantial. It does appear that gay men are treated differently than other men, and this circumstance may even be worse for HIV-positive gay men. Evidence does seem to support what many believe: that gay men, particularly HIV-positive gay men are more susceptible than other men to other health issues (mental health concerns, cancers, other STIBBIs); and, many argue that the old notion of HIV as the “gay disease” still adversely affects many gay men in terms of their general and sexual health, as well as their socioeconomic well-being.

Observations from this review appear to support that a re-focus for “POZ Prevention” is important at this stage of the HIV response. Considerable thought should be given to issues of sexual subjectivity, harm reduction (not necessarily limited to gay men’s sexual

health), and on how to build, how to maintain, and how to sustain resiliency and coping skills. Research appears less abundant or absent (but necessary) in a number of key areas of focus:

- Undetectable viral load and risk-taking;
- PrEP and HIV transmission: do we know enough about how perspectives have changed; do we know enough about how PrEP has affected attitudes toward HIV prevention?;
- Risk-taking vs. risk-averse knowledge, attitudes and beliefs – and behaviours;
- “POZ Prevention” (and HIV prevention more broadly) in rural and remote communities: do we know enough, are we doing enough, how are issues for gay men in rural and remote areas different than gay men in urban centres than other men generally?; and
- Gay men’s health beyond HIV.

RECOMMENDATIONS

1. Identify our specific role and contribution

It is recommended that the GMSH/PPWG strategic plan/strategic planning exercise(s) anticipate need for further exploration and possible broader consultation focused on identifying the role of HIV positive gay men within the broader paradigm shift occurring around gay men’s overall health.

2. Develop new and meaningful language

It is recommended that alternatives to the term “POZ Prevention” are found. Focus should be on language that reflects the specific role and contribution of HIV positive gay men within the larger discussions and work on improving the health and wellness of gay men that is not necessarily limited to HIV and/or HIV prevention initiatives.

3. Knowledge Translation & Exchange (KTE)

It is recommended that PPWG/GMSH focus on implementing programming and knowledge translation and exchange activities that are developed/designed and delivered for/to service-providers.

**“DEVELOPING PREVENTION PROGRAMS FOR,
AND INCLUSIVE OF, HIV POSITIVE PEOPLE MUST NOT
BECOME AN EXCUSE FOR SHIFTING ALL RESPONSIBILITY
FOR PREVENTION (OR BLAME FOR NEW INFECTIONS) ONTO
THE SHOULDERS OF PEOPLE WITH HIV. A CULTURE
OF SHARED RESPONSIBILITY THAT ENCOURAGES
COMMUNICATION AND EQUALITY IN RELATIONSHIPS
SHOULD BE A GOAL OF HIV PREVENTION PROGRAMMING.”**

POZ PREVENTION WORKING GROUP, GAY MEN'S SEXUAL HEALTH ALLIANCE

SETTING THE STAGE

CONTEXT

In May 2016, the Gay Men's Sexual Health Alliance (GMSH) set out to conduct a review of current "POZ Prevention" considerations and approaches, both in Canada and from other parts of the world, with a view to update the framework developed by its Poz Prevention Working Group (PPWG) in 2008.

The review focuses on:

- POZ Prevention: evolving terminology, and comprehension and interpretation of the language;
- Practical application(s);
- Biomedical HIV prevention considerations; and
- Research (existing and gaps) on gay men's general and sexual health.

Underpinning this work and its intent is the GMSH PPWG's goal to: *Improve the overall sexual health and well-being of gay/bi/MSM by specifically using the lived experience of HIV positive gay, bisexual and other MSM to strategically respond to opportunities and needs such as access to relevant information, resources and supports.*

For many years leading into the mid-2000s, it was generally agreed (globally) that prevention initiatives were historically focused on people **NOT** living with HIV and/or individuals who were unaware of their HIV status, but that this needed to change.

Thoughts and efforts seemed focused on *"Primary prevention, in public health theory and practice [...] prevention of new infections by any available and acceptable means..."* (Office of AIDS, Inter-Branch Committee for Prevention with Positives, 2004)

In 2008, in a letter introducing *"POZ Prevention, knowledge practice guidance for providing sexual health services to gay men living in Ontario"*, while recognizing the importance of primary prevention efforts, the GMSH Poz Prevention Working Group really set the stage for a more innovative approach to prevention that was (is) anchored by the *GIPA/MEPA Principle(s)* and that was ultimately adopted as *the* approach in Ontario.

In Ontario, The PPWG agreed that *"POZ prevention for HIV+ gay men aims to empower individuals, promote healthy relations with sexual partners and improve conditions, to strengthen the sexual health and well-being of HIV+ gay men and reduce the possibility of new HIV infections and other sexually transmitted infections."* This holistic framework was based on the understanding that strengthening the overall health of the person living with HIV (PHA) would also impact HIV transmission. Said one member of the PPWG, *"The healthier I am in every way (mind, body, and spirit), the better able I am to make choices that contribute to my health and the health and sexual health of those I care about"*. This was a significantly different philosophical approach from many jurisdictions which viewed "POZ Prevention" as interventions focused not on the health of the PHA, but on changing their behaviour(s) as the vectors of transmission.

The GMSH recognizes that, given significant changes and opportunities that have emerged since 2008, an informed and thoughtful process through which the PPWG's "POZ Prevention" framework would be updated and adjusted is necessary. Holistic, PHA-centred engagement in HIV prevention is fundamental to forward thinking; but, more clearly understanding how to maximize the contribution and synergy of this "POZ Prevention" approach within current contexts is critical (e.g., given biomedical advances; considering emerging discussions on broader gay men's health; thinking about concrete service-provider operations). The PPWG will utilize this comprehensive review as its guide; a key mechanism used to develop its forward-thinking work.

METHODOLOGY

This review was undertaken between May and September 2016, in four parts:

1. A LOOK AT THE LITERATURE

A review of domestic and international literature was undertaken with specific focus on: the natural history of "POZ Prevention" (its evolving terminology and the comprehension and interpretation of its meaning or its intent); practical considerations; biomedical HIV prevention considerations and syndemic issues; and gay men's general and sexual health. Hundreds, if not thousands of potential resources emerged initially. 318 documents were scanned for relevance; 181 documents were discarded; 137 documents were retained for comprehensive review and inclusion (**Bibliography is attached as Appendix A**).

- a. Primary sources for this review were electronic 'libraries', including (but not necessarily limited to): Oxford Journals University Press, The National Academies Press, POPLine, CBRC.net, RefWorld, Gay and Lesbian Medical Association (press), HIVPolicy.org, The Lancet, The CMAJ, Google, Research Gate, Wiley Online Library, The American Psychological Association, Springer Science+Business Media, PLoSOne, American Journal of Public Health, Cold Spring Harbor Laboratory Press, International Journal of Preventive Medicine, World Health Organization.
- b. Key words and search strings included: positive prevention, gay men's health, gay men's sexual health, HIV prevention, biomedical HIV prevention, HIV syndemic issues, Poz prevention, prevention for positives, HIV+, HIV positive gay men, gay men and HIV syndemic considerations, gay men and biomedical HIV prevention, biomedical HIV interventions, HIV research, research and gay men, research and gay men's health, research and gay men's sexual health.

2. A CHAT WITH THE PPWG

Members of the PPWG were engaged during their meeting in Toronto on June 27, 2016. A 'discussion guide' was circulated in advance of the meeting to provide context and to prepare PPWG members for a deliberative dialogue.

(The discussion guide is attached as Appendix B.)

3. STAKEHOLDER SURVEY

This review included the development and delivery of a comprehensive stakeholder survey that included 39 questions in six (6) sections: demographic information,

POZ Prevention - comprehension and resonance, practical considerations, biomedical approaches to HIV prevention, sexual health (of gay men), and research (existing evidence and research gaps/opportunities).

(The Survey tool is attached as Appendix C; a report of unfiltered survey responses is attached as Appendix D).

4. KEY INFORMANT INTERVIEWS

“Key informants” were identified – individuals who have considerable experience in the HIV/AIDS sector and, more specifically, in the HIV prevention policy and/or programs domains; and individuals whose insight would be invaluable to this review.

(Interview questions are attached as Appendix E)

Individuals from the following organizations were invited to participate in a focused interview:

CANADIAN ORGANIZATIONS	INTERNATIONAL ORGANIZATIONS
AIDS Committee of Newfoundland and Labrador	AIDS Project Los Angeles
Canadian Aboriginal AIDS Network	Body Positive (New Zealand)
CATIE	Gay Men’s Health Crisis (New York)
Rézo	Living Positive Victoria (Australia)
Sexuality Education Resource Centre (SERC)	National Association of People Living with HIV Australia
The Health Initiative for Men (HIM)	Strut, San Francisco AIDS Foundation
The OAN	Terrence Higgins Trust (United Kingdom)
The OHTN	

OBSERVATIONS AND FINDINGS

SUMMARY OF DEMOGRAPHIC DATA (SURVEY)

Of the total number of respondents (71), less than 41% indicated that they are HIV-positive. Of the total number of HIV-positive respondents (29), nearly 38% are between 40 and 49 years-of-age and more than half (52%) were diagnosed more than 20 years ago; at least ten respondents were younger than 30 when they learned that they were HIV-positive.

ARE YOU HIV-POSITIVE?

	RESPONSE PERCENT	RESPONSE COUNT
Yes	40.8%	29
No	57.7%	41
I do not know	1.4%	1
	100.0%	71

WHAT IS YOUR AGE? (HIV-POSITIVE RESPONDENTS ONLY)

21-29	3.4%	1
30-39	13.8%	4
40-49	37.9%	11
50-59	31.0%	9
60 or older	13.8%	4
	100.0%	29

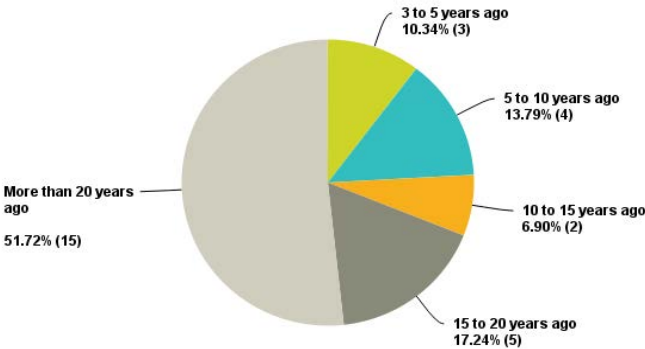


Figure 1: Diagnosed HIV-positive how long ago?

More than half (53%) of the long-term relationships reported by HIV-positive respondents are with HIV-negative partners (i.e. sero-discordant relationships). Of all HIV-positive respondents, nearly 62% indicate that they identify specifically as gay men, 35% identify more generally as LGBTQ, and 4% identify as bisexual. Nearly 75% of the HIV-positive gay men who responded live in Ontario.

	RESPONSE PERCENT	RESPONSE COUNT
I am a PAID employee of an ASO	22.2%	8
I am a PAID health-related service-provider within the HIV/AIDS sector	5.6%	2
Yes, I am a VOLUNTEER at an ASO	27.8%	10
Yes, I am a VOLUNTEER health-related service-provider within the HIV/AIDS sector	8.3%	3
Yes, I am a VOLUNTEER health-related service-provider outside of the HIV/AIDS sector	8.3%	3
I am ALL of the above	2.8%	1
I am NONE of the above	16.7%	6
Other (please specify)	8.3%	3
	100.0%	36

Asked, "Are you connected with an AIDS Service Organization (ASO) and/or other health-related service-providers (select all that apply)?" HIV-positive respondents indicated that, more often than not, they volunteer at an AIDS Service Organization (ASO). Just slightly more than 20% of HIV-positive respondents indicate that they are paid employees of an ASO; and not quite 6% of HIV-positive respondents indicate that they are paid health-related service-providers within the HIV/AIDS sector.

"POZ PREVENTION": ITS NATURAL HISTORY

"POZ Prevention" is neither too old to be less relevant than it was, nor is it too new to be novel. One might characterize "POZ Prevention" as unique in that it is as much a tried-and-true practice as it is a working hypothesis - a theory tested by optimism and by skepticism; by evidence and by anecdote.

In some cases, "POZ Prevention" was (and is) as simple as preventing the transmission or acquisition of HIV; in other cases, it was (and remains) as complex as sexual empowerment and societal knowledge, attitudes and beliefs about sex and sexuality in the context of HIV... but not in isolation of or to the exclusion of other pressing health issues - particularly for gay men. The World Health Organization published a visual in a 2010 bulletin that aptly illustrates the complexity (then... and now). (Kennedy, Medley, Sweat, & O'Reilly, 2010)

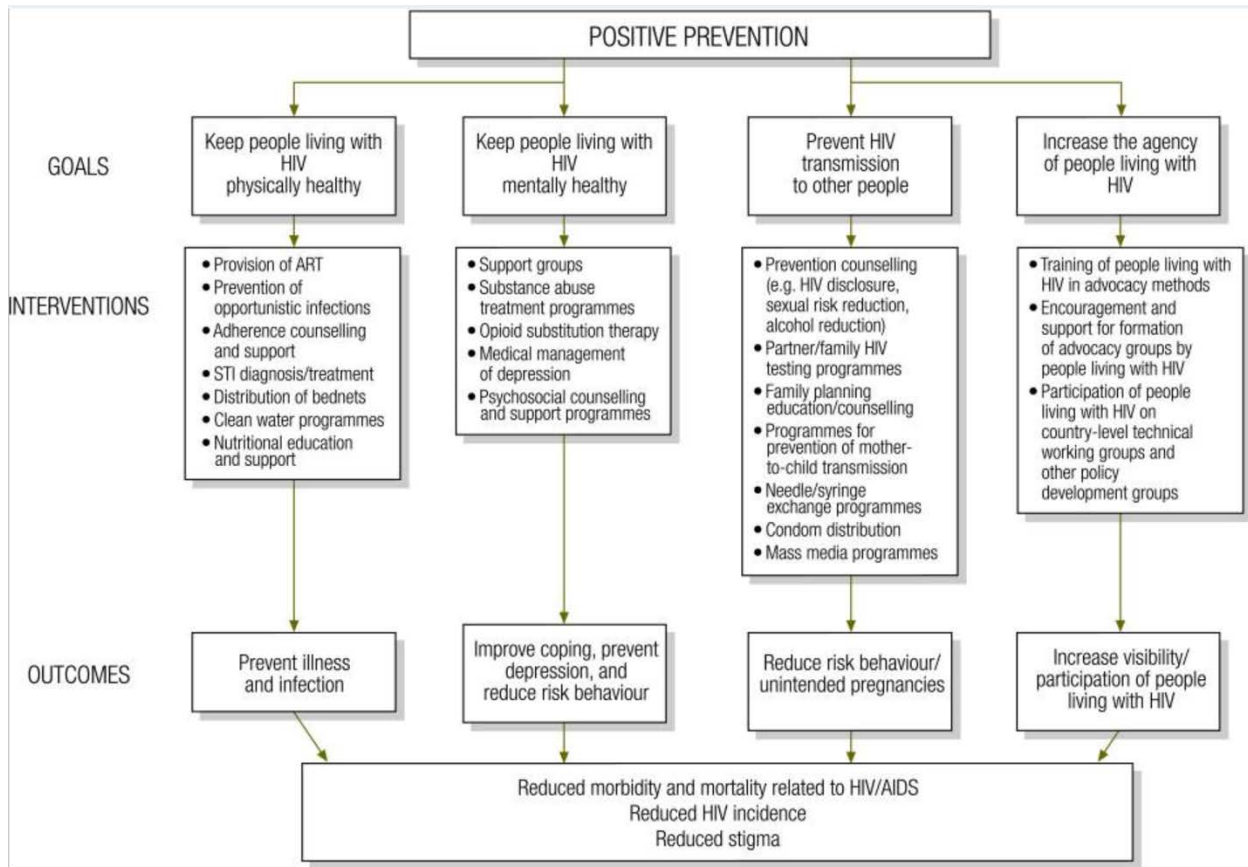


Figure 2: Behavioural interventions for HIV positive prevention in developing countries: a systematic review and meta-analysis

The earliest practical applications of “POZ Prevention” appear grounded by acknowledgement and recognition that people living with HIV have an essential role to play in all aspects/at all stages of policy development and programmatic design and implementation activities – particularly those focused on prevention. It was generally accepted that the success of any positive prevention intervention was and would be dependent on peer engagement and public education models that were broadly-based on social models of prevention that deliberately (but in a very concentrated way) included focus on individuals’ biology and physiology, on social determinants of health, and on careful consideration of individual behaviours and personal choices.

And, it was highlighted in “Coming to terms with complexity...” that “HIV prevention must be one of the most studied fields of health promotion: nearly 35 000 citations on HIV prevention have been published internationally in scientific research alone

(compared with 27 000 about prevention of smoking or tobacco use). But despite both the broad consensus on what needs to be done and the evidence base, we have only partial understanding of what facilitates *systematic implementation of prevention programmes, what bottlenecks hold up progress, and what strength of effort will be necessary.*" (Piot, Bartos, Larson, Zewdie, & Mane, 2008)

So, focus on HIV prevention is certainly not new... aggressive HIV prevention strategies were implemented around the globe as soon as we realized we could prevent it. But, one of the literature's earliest suggestions that there (perhaps) ought to be a paradigm shift in the way we think about prevention pondered,

"Efforts to prevent the spread of HIV have, to an overwhelming degree, addressed themselves to the HIV-negative rather than to the positive population. But it makes sense to direct more preventive work towards positive individuals, for 3 reasons. First, because changes in the behaviour of positive people have a disproportionately greater effect on the spread of the epidemic - so positive-targeted interventions are potentially more cost-effective, and in many cases enormously so. Second, positive individuals already show a degree of preventive altruism that generally outweighs the self-protective efforts of those who are negative. And third, there is reason to believe that this preventive altruism can be strengthened by appropriate interventions. Some of the practical implications of a shift to greater positive targeting, involving both novel interventions and modified familiar ones, can be sketched out." (King-Spooner, 1999)

Brent Allan and William Leonard reflected on evidence that made it clear that this paradigm shift was well-underway by 2005, but that it was, perhaps, not a good thing. In their paper, "Asserting a Positive Role: HIV Positive People in Prevention", Allan and Leonard highlight their concern that focus narrowed to the surveillance of the sexual lives and activities of people who live with or are at particular risk of HIV infection; that emphasis on social prevention models appeared lost. *"Alongside scaling up capacity development for HIV-positive people, continued advances must be made at all levels of civil society to combat the insidious and destructive aspects of HIV discrimination and stigma. It is nearly impossible to encourage HIV-positive people to engage in the care of others by participating in HIV prevention, when they live in a world that is riddled with injustice, prejudice, and even segregation on the basis of HIV status."* (Allan & Leonard, 2005)

At the Positive Leadership Summit in Mexico City (Living 2008), one participant suggested, and delegates agreed, that *“The responsibility for reducing transmission of HIV is a shared one and there should be no undue burden on people who are aware of their status. Safer and responsible sexual behaviour is the responsibility of all partners - irrespective of status.”* (The Living2008 Partnership, 2008)

“The challenge for HIV prevention today is to sustain a momentum for effective, complex, combination efforts over the long haul. A failure of confidence now in our collective capacity to deliver full-scale and effective HIV prevention would be devastating, and its effect would be felt for generations. We cannot expect that miraculous results will be universally evident over the current political or funding cycle, or even over the next one. But we must have the courage to press ahead, because if we fail the challenge of HIV prevention, HIV/AIDS will relentlessly undermine human progress.” (Piot, Bartos, Larson, Zewdie, & Mane, 2008)

The literature supports the notion that, while there was much and reasonable attention paid to positive prevention efforts focused specifically on HIV and on population-based approaches to HIV prevention in the ‘early days’, conversation grew rather stale fairly quickly. It was, perhaps, because service-providers, researchers, and indeed people living with HIV recognized how critical the paradigm shift that Allen and Leonard foreshadowed in 2005 really was in the quickly evolving world that was, that is gay men’s health and HIV prevention in 2016.

CURRENT UNDERSTANDING OF “POZ PREVENTION”

Of survey respondents who answered the question “Do you understand what the term “POZ Prevention” means?” 69% indicate that yes, they do understand (of whom 60% are HIV-positive). It is worthy of note, however, that when added together, more

than 30% of respondents who answered this question either do not know or are unsure.

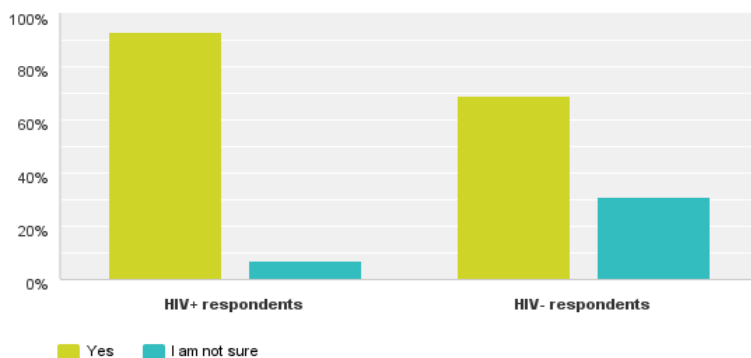


Figure 3: Survey, Q 10: “POZ Prevention” meaning

Looking more closely at HIV-positive respondents who identify as gay men and who live in Ontario, 94% of those who answered this question indicate understanding; 6% do not.

PERSPECTIVES	
FROM A SURVEY RESPONDENT WHO IS HIV+	<p><i>“POZ Prevention” is “a holistic approach [...] the HIV positive is a whole being, not just a disease/vector of disease; [it is] focusing on mental health, physical health, treatment and healthy sex positive conversation/ intervention; [and] keeping the whole HIV positive person health and respected makes for prevention and healthier decision making.”</i></p>
FROM A SURVEY RESPONDENT WHO IS HIV-	<p><i>“POZ Prevention” is about “creating an environment where HIV+ persons receive information, treatment, and social support that minimizes the negative aspects of their illness while also enhancing the positive aspects of their life. It also provides HIV- persons and the general public with information and strategies to reduce the risk of infection while also improving their understanding of HIV and those who have it so they can be part of an effective social support to those with HIV.”</i></p>

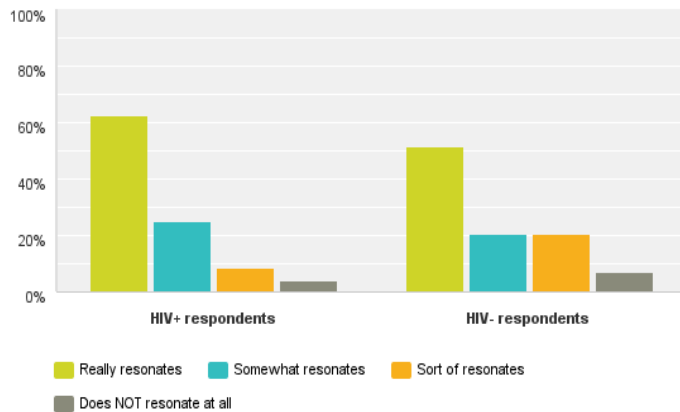


Figure 4: Survey, Q12, resonance

When asked to consider the PPWG’s 2008 definition of “POZ Prevention”, more than half of the survey respondents who answered the question suggest that the definition still “really resonates” these eight years later. For nearly 6% of respondents, however, the definition no longer resonates at all.

For 69% of HIV-positive respondents who identify as gay men and who live in Ontario, the PPWG definition really

resonates, while for 8% it only sort of resonates, and for 8%, it does not resonate at all. Perhaps interesting to note: of all respondents who identify as HIV-positive gay men, 36% indicate that they are **not connected** to the HIV sector whether through paid work or as volunteers.

One respondent (who is HIV-positive, and for whom the definition does not resonate at all) indicated that, *"I believe that people living with HIV have the responsibility of ensuring their sexual partners are first aware but should also be responsible for ensuring that they don't pass on the virus by means of subsiding from intercourse when they have a high level of the virus within their bloodstream. But also the negative individual should not have unprotected sex or participate in high-risk activities with HIV poz people."*

Respondents, particularly those for whom the PPWG definition does not really resonate, were encouraged to share what they think "POZ Prevention" should be called, if **not** "POZ Prevention". Suggestions included:

- Positive Roles in Prevention
- Sex-positive Empowerment
- Pozitively Living
- Positive Inclusion!
- Sexual Health for People Living with HIV

At the World Health Assembly in May 2016, it was agreed that *"The game-changing potential of pre-exposure prophylaxis - using antiretroviral drugs to prevent HIV infection - has been confirmed. Strategically combining antiretroviral therapy with pre-exposure prophylaxis, as part of **combination HIV prevention**, could almost eliminate HIV transmission to HIV-negative sexual and drug-using partners."* (World Health Organization, 2016)

Without explicitly offering alternative language, one respondent (an HIV-negative individual who lives in British Columbia) indicated that, *"It still sounds to me like HIV is something to be managed, largely by people living with HIV. I'd like to see more regarding shared responsibility, and full sexual citizenship/supportive environments/full representation of people with HIV in the sexual culture."*

There was early recognition that HIV prevention, in particular, is a shared responsibility and that it was imperative that positive prevention strategies and practices were informed by and compatible with the practical realities that people living with HIV face every day; that strategies and practices should be able to (reasonably) extrapolate, largely based on specific populations of focus (e.g., gay men) what the realities looked like and meant for people not living with HIV but at considerable risk of infection. (Lyles, et al., 2006) suggested that, *"[...] prevention providers should consider those with the following characteristics: integrating theory-based prevention within routine medical care and*

services; addressing aspects of mental health and medical adherence in addition to HIV risk behaviour; and providing PLWH with the necessary skills for successful risk reduction.”

Without question, people agree that HIV prevention is a responsibility shared equally by people living with HIV and people who do not live with HIV; only 4% of survey respondents (2 individuals) who answered this question think differently. One of the two folks who do not think that HIV prevention responsibility is shared indicated that the PPWG’s definition of “POZ Prevention” only somewhat resonates; this individual challenged “POZ Prevention” accessibility and how its current language limits its reach.

“THE BEST HIV PREVENTION PROGRAMS—THOSE THAT EFFECT CHANGE ON A MULTIPLICITY OF LEVELS BY CHANGING KNOWLEDGE, ATTITUDES, AND BEHAVIORS AND THAT ARE SUSTAINED OVER TIME—ARE ALSO THOSE THAT PLACE HIV-POSITIVE PEOPLE AT THE CENTER OF PROGRAM DESIGN, IMPLEMENTATION, AND EVALUATION.” (ALLAN & LEONARD, 2005)

ONE RESPONDENT WHO THINKS THAT GIPA/MEPA IS EXTREMELY IMPORTANT INDICATED A BELIEF THAT A GIPA/MEPA-CENTRED APPROACH HAS NO EFFECT ON INCIDENCE RATES AT ALL. THIS RESPONDENT IS HIV-POSITIVE (DIAGNOSED THREE-TO-FIVE YEARS AGO); HE IDENTIFIES AS A GAY MAN WHO LIVES IN ONTARIO; AND, HE IS BETWEEN 20 AND 29 YEARS OLD. THIS YOUNG MAN RESPONDED TO THE SURVEY WITH HIGHLY-CHARGED EMOTION THROUGHOUT. HE INDICATED A STRONG BELIEF THAT “POZ PREVENTION” DISRESPECTS PEOPLE LIVING WITH HIV AND WASTES VALUABLE RESOURCES (AT THE ASO LEVEL). HE ALSO EMPHATICALLY SUGGESTED THAT “POZ PREVENTION” IS AKIN TO “GAY TOKENISM” AND “WHITE SUPREMACY”.

While 60% of survey respondents who answered the question “How important is GIPA/MEPA...” believe that it is extremely important, it seems that people are less-convinced or, at least, less confident that a GIPA/MEPA-centred approach to “POZ Prevention” actually reduces HIV incidence rates. Of survey respondents who indicated a belief that a GIPA/MEPA-centred approach **probably** reduces HIV incidence rates, there is a fairly even split in terms of GIPA/MEPA’s importance (50% suggest extreme importance, while 33% feel that GIPA/MEPA is only very important). These findings raise important considerations for discussion given that the 2008 PPWG framework was largely informed by the GIPA/MEPA premise and its related evidence at the time.

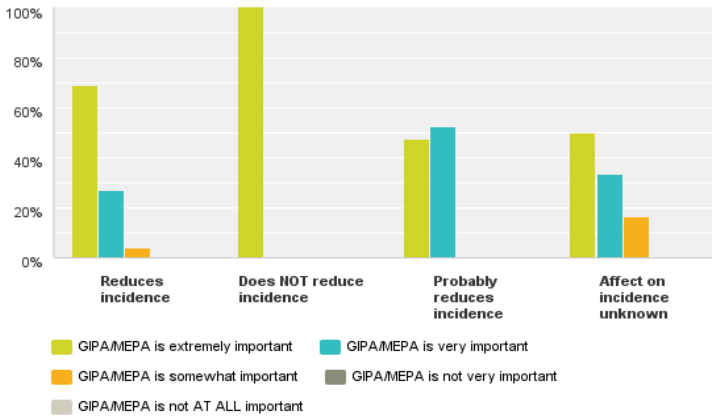


Figure 5: Survey, Q17, GIPA/MEPA reduces incidence?

Reasons people have for focusing on GIPA/MEPA's importance are wide-ranging.

Some are fairly matter-of-fact: "Because it's not actually happening".

Some are very pragmatic: "Nobody wants to give or get HIV/AIDS").

And some are rather intuitive and perhaps a bit profound: "The illness can be unnecessarily isolating which contributes to the mystique and fear surrounding the illness. When people know someone with HIV they understand their fears may be misplaced and they can act more compassionately and appropriately in providing services or merely social interaction. Also being engaged in such an activity can promote self-worth, confidence, and pride all of which encourage good health mentally and physically."

"THERE IS A DISTRUST BETWEEN CERTAIN GROUPS OF PEOPLE AND HIV SERVING ORGANIZATIONS, MEDICAL RESOURCES, HIV NEGATIVE GAY MEN AND THE GENERAL POPULATION. THE LATTER TWO BELIEVING THAT SEXUALLY ACTIVE PEOPLE LIVING WITH HIV IS A RISK UNDER ANY CIRCUMSTANCES. THIS SOMETIMES SILENCES THE VOICE OF PERSONS LIVING WITH HIV AND IN CERTAIN CASES DOES NOT SIT WELL WITH THE GOVERNING BODY OF SOME ORGANIZATIONS. IN THIS GIPA/MEPA IS NOT FUNCTIONING AS UNCOMPROMISING COMMITMENT TO THE INVOLVEMENT OF THOSE WITH LIVED EXPERIENCE.

TO ME AN UNCOMPROMISING COMMITMENT TO GIPA/MEPA IS NOT ALWAYS ABOUT AT WHAT LEVEL A PLW/HIV IS INVOLVED IN AN ORGANIZATION ALTHOUGH IT WOULD BE NICE TO SEE MORE PLW/HIV IN PAID AND UNPAID POSITIONS INCLUDING MORE STRATEGICALLY IN GOVERNANCE. WHAT IS MOST IMPORTANT REGARDLESS OF THE INVOLVEMENT OF PLW/HIV IS THAT THE VOICE OF PLW/HIV IS NOT HEARD BUT VALUED AS TRUE LIVED EXPERIENCES THAT

SHOULD NEVER BE DISCARDED. THERE IS TRUTH TO WHAT ONE EXPERIENCES AND THIS VOICE MAY BE WELCOMED BUT NOT ALWAYS HEARD.” (A SURVEY RESPONDENT WHO IDENTIFIES AS A GAY MAN)

Irrespective of individuals’ HIV status, survey respondents overwhelmingly (71%) believe that an uncompromising commitment to GIPA/MEPA would contribute significantly to progress/success in addressing sex and sexual health in our prevention efforts.

Comparing the opinions of HIV-positive and HIV-negative respondents is intriguing though: while 71% of HIV-positive respondents believe that an uncompromising commitment to GIPA/MEPA would contribute significantly, less than half (47%) of HIV-negative respondents agree. Nearly 18% of HIV-positive and just less than 24% of HIV-negative respondents are unsure of the impact of GIPA/MEPA on prevention work.

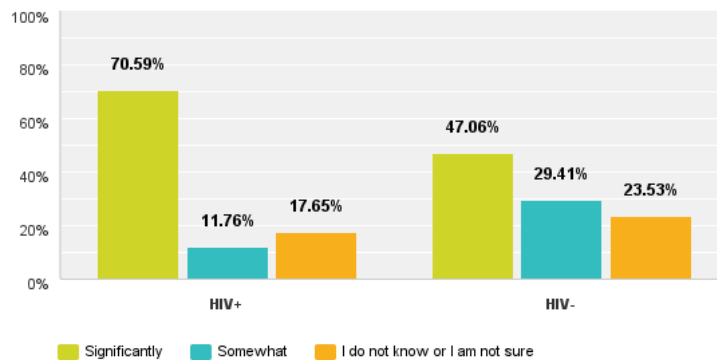


Figure 9: HIV+ and HIV- perspectives on impact of GIPA/MEPA

For one survey respondent, the question itself doesn’t resonate. He responded, “I have no idea. GIPA is a set of principles used to explore participation and meaning for PLHIV, it is not a fixed set of rules or dogma. I don’t understand the question – sorry.” One HIV-positive respondent, perhaps surprisingly, believes that maintaining an uncompromising commitment to GIPA/MEPA effectively means that other ‘models’ or approaches are being ignored. One HIV-negative survey respondent offered this perspective on the question, “GIPA/MEPA does not resonate for HIV- MSM or trans-gender individuals in the context of sexual health prevention.” While many would argue that there should be no distinctions made between gay men and other men in terms of how general health issues are addressed, others would argue that even the most ‘benign’ health issues are exacerbated for gay men. On the question of whether disparities exist/resonate, gay men who responded offer mixed perspective:

48.5% of respondents are HIV-positive; 51.5% are HIV-negative;
 69% of HIV-positive respondents believe that gay men face many challenges that other men do not; 6% do not agree;
 71% of HIV-negative respondents think that gay men face many challenges that other men do not and 6% do not believe they do.

Of particular note, one person offered this very poignant take-away message:
“It is beyond reason to think that Poz Prevention by definition can exclude the involvement of people living with HIV on all levels and involvement at the start. The hub of HIV prevention strategies must have the Meaningful Involvement / Engagement of People living with HIV.”

Also of particular note - as an aside, but also to highlight that there remains much work to do in terms of knowledge translation and exchange: one survey respondent, an HIV-positive Ontario resident who identifies as a gay man in his 40s, indicated that **he doesn't know what GIPA/MEPA is and that he believes it is the responsibility of HIV-positive individuals to ensure that they do not transmit the virus to others.**

FOCUS ON GAY MEN

Of all survey respondents, 77% identify as gay or LGBTQ men, less than half of whom (45%) are HIV-positive and most of whom (36%) are between 40 and 49 years old.

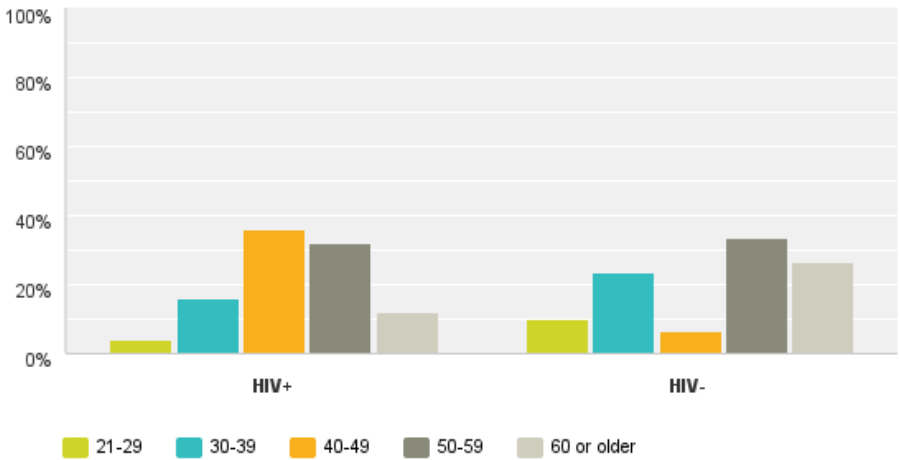


Figure 6: gay/LGBTQ men (profile)

Ontario is home to 64% of respondents who identify as HIV-positive gay men. There is a 50:50 split in terms of HIV-positive respondents who identify as gay men and report that they are in a long-term relationship. However, most (56%) indicate that they are in sero-discordant relationships; i.e. long-term partners are HIV-negative.

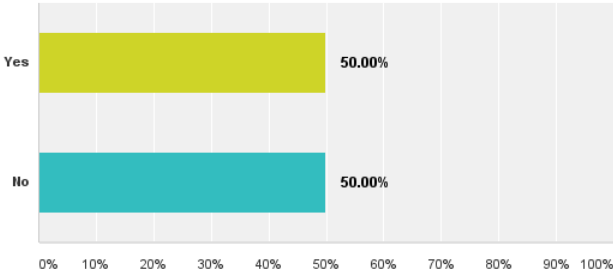


Figure 7: In long-term relationship?

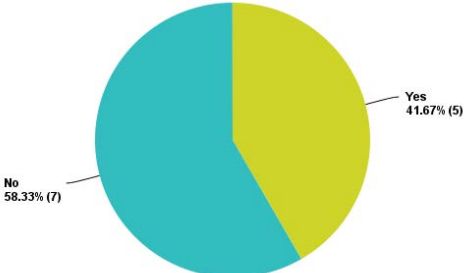


Figure 8: Long-term partner HIV+?

Asked “Are you connected with an AIDS Service Organization (ASO) and/or other health-related service-providers (select all that apply)?”, HIV-positive gay men who responded indicated ...	Response Percent	Response Count
Yes, I am a PAID employee of an ASO	21.9%	7
Yes, I am a PAID health-related service-provider within the HIV/AIDS sector	6.3%	2
Yes, I am a PAID health-related service-provider outside of the HIV/AIDS sector	0.0%	0
Yes, I am a VOLUNTEER at an ASO	28.1%	9
Yes, I am a VOLUNTEER health-related service-provider within the HIV/AIDS sector	9.4%	3
Yes, I am a VOLUNTEER health-related service-provider outside of the HIV/AIDS sector	9.4%	3
I am ALL of the above	3.1%	1
I am NONE of the above	18.8%	6
I prefer NOT to answer	0.0%	0
Cross-sectoral consultant	3.1%	1
	100.0%	32

The literature leaves little room for doubt: historically, gay men are among those most affected by HIV, and by social and economic marginalization that place them at disproportionate risk of a many health issues, including but absolutely not limited to HIV infection. Some are at higher risk because of age, socio-economic status, race, gender-identity, and other so-called demographic variables; others are at particular risk because of internalized homophobia resulting from stigma, discrimination, and other traumatic life experiences. And, of course, mental health issues experienced by gay men bear out in the literature as notable concerns related to public health at a population health level, and to life choices and risk-taking behaviour at an individual level.

Many do and will argue that health disparities affecting gay men in particular and related but not exclusive to HIV infection must be addressed through concerted efforts to tackle contributing social and environmental factors. It is imperative that we *“address the needs of the most vulnerable population through community-level interventions to respond to homophobia and stigma; structural interventions to address the causes of HIV/AIDS in legal, economic, policy, cultural, and other aspects of the environment; and efforts to fight anti-gay bias and promote LGBT-affirming initiatives and comprehensive sexuality education”* (Cahill, 2009)

Countless others, assert that *“The persistence of disparities in STI/HIV risk among a new generation of emerging adult gay, bisexual, and other men who have sex with men (YMSM) warrant holistic frameworks and new methodologies for investigating the behaviors related to STI/HIV in this group.”* (Halkitis, et al., 2015)

Said one survey respondent, *“In many cases the challenges of HIV positive gay are indeed different than HIV negative gay men and the latter group can in certain cases be the source of some of these challenges. The overall manner in which an HIV neg. gay man talks about HIV or rejects someone only on the basis of status (therefore it is choice of words and body language and more) that can have great impact on the mental health issues of Poz gay men. Statistics clearly show that close to 37% of HIV positive gay men suffer from significant mental health issues and another 40% with less severe diagnosed mental health issues such as chronic or acute depression. Poz gay men also have to contend with co-morbidities normally not as pronounced in negative gay men. Increase susceptibility to SBBI's and increased incidence of other diseases. Long term impact of HIV and medicinal responses are significantly different than HIV negative gay men.”*

The Public Health Agency of Canada maintains that gay men are among those most affected by HIV in this country, and that nearly half of Canada's prevalent HIV infections in 2011 were attributed to men who have sex with men. It is worthy of note, though, that, *"Few Canadian studies have examined the demographic characteristics of gay and other MSM outside the context of HIV/AIDS. As a result, the total number of gay, bisexual, two-spirit and other MSM in Canada is not known. The majority of self-identified gay, bisexual and other MSM surveyed in a variety of Canadian studies identified White as their ethnocultural background.* (Public Health Agency of Canada, 2013)

Some of the literature suggests, though not necessarily with overwhelming popularity, that HIV infection for gay men likely emanates from social conditions suggesting that prevention interventions must hone in here and, perhaps, focus less on individual behaviours.

While HIV negative gay men may experience barriers related to homophobia -- amongst other intersecting factors like racism, transphobia, class, etc. -- HIV positive people are compelled to engage with the health care system on a constant and ongoing basis to manage their HIV. HIV positive people are subject to incomprehensible treatment related or due to criminalization. These greatly influence the whole social construct and reality for guys living with HIV in ways that are unavoidable and inescapable, even with the best health care and/or ASO environment possible.

"HIV-positive gay and bisexual men are often knowledgeable about the benefits of preventing HIV transmission via traditional methods such as condoms and many are already in treatment (e.g., Nöstlinger et al., 2011). However, there is a need for more advanced information that can help HIV-positive gay and bisexual men in their HIV risk decision-making processes." (Hart, et al., 2015)

Most (65%) HIV-positive gay men who responded to the survey strongly agree that “POZ Prevention” is as much about sexual health as it is about HIV prevention.

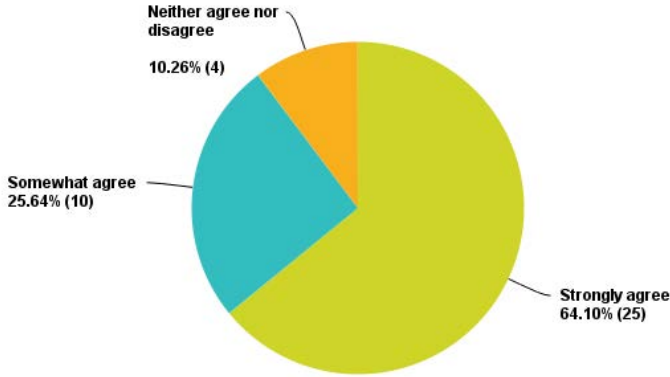


Figure 9: Survey, Q18, as much about sexual health?

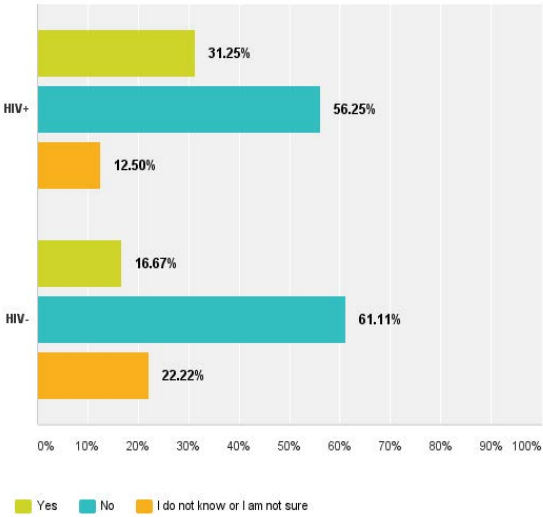


Figure 10: Survey, Q23, have we come far enough?

However, more than half (56%) of these men believe that we haven’t come far enough in terms of how gay men’s sex and sexual health is addressed in our HIV prevention work. When comparing survey responses from HIV-positive gay men with answers from HIV-negative gay men, some interesting perspectives emerge:

- Almost twice as many HIV-positive gay men believe that **we have** come far enough; but,
- Nearly 5% more HIV-negative gay believe that **we have not** come far enough; and
- Just about twice as many HIV-negative men **do not know** or are not sure.

One respondent ponders, “We’re starting to move towards that more holistic (homolistic) view of gay men’s sexual health... but we’re not there yet.”

The survey asked (Q23), "we have "come a long way"... but have we come far enough in terms of how gay men's sex and sexual health is addressed in our HIV prevention work?" ...

<p>... WHAT HIV-POSITIVE GAY MEN THINK (IN THEIR OWN WORDS)</p>	<p>... WHAT HIV-NEGATIVE GAY MEN THINK (IN THEIR OWN WORDS)</p>
<p>By reducing self-victimisation that makes HIV transmission seem inevitable to some people rather than something which happens through poor choices under different circumstances.</p>	<p>We are still sending the message of "use a condom" and that message doesn't work anymore. Gay Men's health is still focused on HIV prevention and neglecting mental, physical and social aspects of health.</p>
<p>We need to focus upon pleasure and upon the intersections of context, culture, care and caution between gender/sexuality congruent partners.</p>	<p>We've done a good job in the sexual health arena, but have a way to go in terms of recognizing an integrated approach to gay men's health and well-being (i.e. inclusion of mental health).</p>
<p>Some cannot address the hard issues such as addictions and sex trade.</p>	<p>More gay guys know other gay guys that are living with HIV because the stigma isn't as terrible as it used to be. This openness serves as a warning to other men engaging in risky behaviours, and also let's HIV-neg men know that HIV pos guys can live healthy normal lives.</p>
<p>Gay mens health is still not addressed especially in smaller communities. Larger centres have more access to gay mens health resources.</p>	<p>Too much of our HIV prevention work is just focused on HIV. That's all fine and good, perhaps, but we don't often enough focus across health, social services and education to address interventions (including economic empowerment and mental health) that would prevent HIV transmission -- let alone a variety of other negative socioeconomic predictors and experiences -- in the first place.</p>
<p>I am really not sure.</p>	

FOCUS ON BIOMEDICAL TECHNOLOGIES (AND SYNDEMIC CONSIDERATIONS)

The World Health Organization defines sexual health as the “capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.”

(World Health Organization, 1975) Asked to consider this definition in the context of the impact of current biomedical technologies on sexual health and looking at input from all survey respondents who identify as gay men:

35% believe that the impact is **significant**

35% think that there is **some** impact

5% feel there is **little or no** impact

5% believe that there is **some negative** impact on sexual health

5% believe that the **negative impact is significant**.

15% of all respondents either *do not know or they are unsure*.

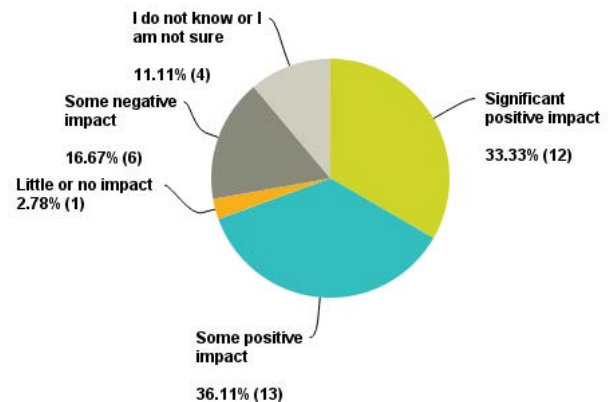


Figure 11: Survey, Q19, impact of biomedical discourse on gay men

Said one respondent, “HIV is a biological condition that has social consequences. It is important to be able to define the two separately so that the condition doesn’t become the person.”

Again looking at feedback from gay men who answered the question on biomedical discourse, but honing in on the perceived (potential) impact as it relates to gay men more specifically, the perspective is more varied. Nearly 70% believe that there is or would be some degree of positive impact; 17% think that the impact would be somewhat negative; 11% of respondents either do not know or are unsure.

Looking more closely at how perspective differs between HIV-positive and HIV-negative respondents, opinion appears even across the board.

The literature suggests that biomedical technologies must be innovative and embrace state-of-the-art behavioral HIV testing interventions; should be focused on sex and drug-related risk mitigation strategies; and ought to take care to adhere to medical care and social policies that are cognizant and protective of rights and safety issues (impact of homophobia; strategies to address HIV-related stigma and the stress/trauma it yields; and access/availability issues vis-à-vis co-called HIV prevention commodities.)

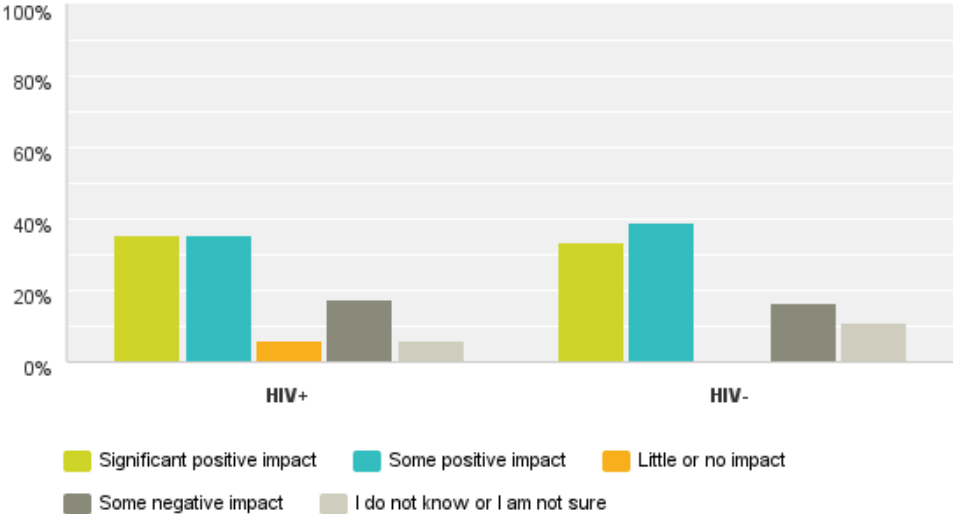


Figure 12: Survey, Q19, impact of biomedical discourse on HIV+ vs. HIV- gay men

From three survey respondents, in their own words:

"BIOMEDICAL FACTORS THAT REDUCE OR ELIMINATE THE RISK FACTORS OF SEX NEEDS MORE PUBLIC TESTIMONIALS FROM THE POLICY MAKERS, THE MEDICAL RESEARCHERS AND DOCTORS PLUS ALL HEALTHCARE PROVIDERS. IT IS/WOULD BE MUCH EASIER TO SPEAK OF POZ PREVENTION AND THE EMERGING SCIENCE IF THE MESSAGE ALSO IS SUPPORTED AS SOUND AND GOOD METHODS FROM THE VARIOUS LEVELS OF THOSE IN THE HEALTH CARE NETWORK BE SEEN MORE PUBLICLY IN ENDORSING THE SCIENCE TO UNDO THE MISINFORMED THEORIES OF THOSE STILL NOT ABLE TO ACCEPT ADVANCES IN PREVENTION METHODS. THERE IS AN INTERNAL AND EXTERNAL IMPRESSION THAT THE ADVANCES SUCH AS PREP ARE NOT SOUND PRACTICE."

"IT CERTAINLY IS A GREAT ADVANCEMENT OF MORE TOOLS IN THE TOOLBOX OF HEALTHY SEXUALITY AND DISEASE PREVENTION. THE DISCOURSE HAS SHOWN A DIVIDE OF STRONG OPINIONS AND IN MANY CASES DEMONSTRATES THE NEED FOR MORE EDUCATION AND AMONG MANY THAT SEX IS NATURAL AND HEALTH AND TO THE ARSENAL OF EFFECTIVE AND PROVEN METHODS NOT SOLICIT JUDGEMENT VALUES ON PEOPLE WISHING TO EXPAND THEIR OPPORTUNITIES TO ENJOY SEX VERSUS THE NAYSAYERS THAT WOULD DENY HIV POSITIVE PEOPLE TO HAVE HEALTHY SEX. IRONICALLY, THOSE THAT TAKE THIS APPROACH DO NOT REALIZE THE IMPACT OF HARBOURING SUCH JUDGEMENTAL VALUES ACTUALLY IMPACTS NEGATIVELY ON THEIR OWN SEXUAL HEALTH AND ENJOYMENT THEREOF."

"TOO MUCH OF OUR HIV PREVENTION WORK IS JUST FOCUSED ON HIV. THAT'S ALL FINE AND GOOD, PERHAPS, BUT WE DON'T OFTEN ENOUGH FOCUS ACROSS HEALTH, SOCIAL SERVICES AND EDUCATION TO ADDRESS INTERVENTIONS (INCLUDING ECONOMIC EMPOWERMENT AND MENTAL HEALTH) THAT WOULD PREVENT HIV TRANSMISSION - LET ALONE A VARIETY OF OTHER NEGATIVE SOCIOECONOMIC PREDICTORS AND EXPERIENCES - IN THE FIRST PLACE."

In their paper, "A Holistic Approach to Addressing HIV Infection Disparities in Gay [...] Men", Halkitis et al. asserted that *"The HIV epidemic is inextricably tied to other health problems that disproportionately affect gay, bisexual, and other MSM including psychological comorbidities, substance use, sexual victimization, stigmatization, and multiple forms of discrimination. These interrelated health problems and social issues can be characterized as a syndemic of mutually reinforcing conditions or epidemics. Moreover, the syndemic is directed by biological, behavioral, psychosocial, and structural determinants. Addressing HIV within the context of a larger syndemic will require a more holistic approach to HIV prevention and treatment that recognizes the interplay between biological, behavioral, psychosocial, and structural factors that affect the health and well-being of sexual minority men."* (Halkitis, Wolitski, & Millett, A holistic approach to addressing HIV infection disparities in gay, bisexual, and other men who have sex with men., 2013)

The survey set out to dig a little deeper on this question. "How does your opinion change in terms of the challenges faced by gay, HIV-positive men compared to other men?" Of the gay men who offered perspective on this question, 46% are HIV-positive and 54% are not. In (some of) their own words:

HIV-POSITIVE GAY MEN BELIEVE...	HIV-NEGATIVE GAY MEN BELIEVE...
I think it is a lot easier for HIV positive gay men than for HIV positive heterosexual men. We (gay men) have had HIV as a part of our culture for several decades, initiatives have come that brought it to the forefront of our minds and had to face it head on. Heterosexual men are having to start from the very beginning with little to no supportive community.	There are of course a whole range of challenges experienced by HIV+ men. There are at least in Ontario a set of dedicated HIV clinics to help address many of these challenges. The health system has dropped the ball, though, on gay men before they sero-convert. Other places have dedicated gay-friendly health centres. We do not.

I think gay poz men along with other men face issues of stigma of being HIV, but homophobia from the wider society is very much present within the diverse communities ...and within the society itself.

There are legal ramifications to PWA's behaviour. If they unknowingly (or knowingly!) infect someone there are emotional and legal consequences. Once brought into the health system HIV+ people are a valuable asset in educating the rest of the population. Some people refuse to have relationships with people who are HIV+ which has emotional and mental implications for healthy attitudes.

Some communities based on faith or culture force gay men to hide or be banished and that keeps them from being tested or getting treatment and support.

I think the simple fact that anal sex amongst gay men makes the disease more communicable, make it all the more necessary to preach safer sex practices to gay men, rather than straight men. Straight men might need more counselling on dealing with the societal stigma parts of it, because people might start thinking they're gay if they got HIV.

“IT HAS BEEN POSITED THAT HIV AND OTHER HEALTH PROBLEMS OVERLAP AND “FUEL” EACH OTHER AND CREATE A MUTUALLY REINFORCING CLUSTER OF EPIDEMICS, KNOWN AS A SYNDEMIC, THAT RESULTS IN HIGHER RATES OF HIV INFECTION AND AIDS.”

(HALKITIS, WOLITSKI, & MILLETT, A HOLISTIC APPROACH TO ADDRESSING HIV INFECTION DISPARITIES IN GAY, BISEXUAL, AND OTHER MEN WHO HAVE SEX WITH MEN., 2013)

The literature ultimately suggests that a “syndemic theory” is useful in shaping our comprehension of the connections and interconnections that create and connect complex factors in our understanding and associations with HIV risk theories; but that these ‘connections’ are not always spot-on.

In recent years, the concept of syndemic theory has given rise to deeper investigation of behaviour-based risk assessment and the development of associated mitigation strategies specific to vulnerable populations, including gay men. The literature suggests that this has made it possible to shift focus such that public health researchers may more effectively explore relationships between behaviors and the holistic nature of public health frameworks and strategies that consider the interplay between key behavioral and health-related social determinants and HIV, HIV related behaviors, and of health-related disparities specific to gay men.

VIS-A-VIS RESEARCH: THE EVIDENCE IS IN... OR IS IT?

“Globally, there are approximately 36.9 million people living with HIV (PLWH), of which 2 million were newly diagnosed in 2014. Since 2012, HIV/AIDS has remained in the top 10 global leading causes of death and is the second leading cause of death within low-income countries.” (Hergenrather, Emmanuel, Durant, & Rhodes, 2016)

As was aptly summed up by one HIV-positive survey respondent, a gay man who is at least 60 years old and who lives in Ontario, *“I think it is incumbent to inform through media and championed by leaders to use current research and transfer the information to educate others on the new science that demonstrates the risk factors are more clear today but it isn't being “sold” through legitimate campaigns that the risk factor may be far greater with those that claim they are HIV negative. Use the research to prove this and*

transfer this knowledge by every means possible including one-on-one discussions, and social media.”

Another survey respondent thinks that, **“Research is important, but policy change and optimizing existing health care services is actually more important and where the emphasis should be placed.”**

The survey included four questions specific to the “evidence” (i.e. what existing research tells us and where gaps in research persist); two are measured and two are open-ended. Responses to each question are (perhaps) just diverse enough to suggest that we are not where we need to be in terms of:

- What we **all** know and/or understand;
- How we interpret information and employ the knowledge that emerges for us; or
- Important questions that we still need to ask and/or to which we are awaiting answers.

For measured response, the survey asked, “In terms of Poz Prevention, does the current research (as you know and understand it) support a life practices approach¹ to sexual health and HIV prevention today?” About 37% of all survey respondents believe that the current research either very much or to some degree **does** support a life practices approach, while 32% believe it does, **but not enough**. Just less than 23% really do not know or are not sure.

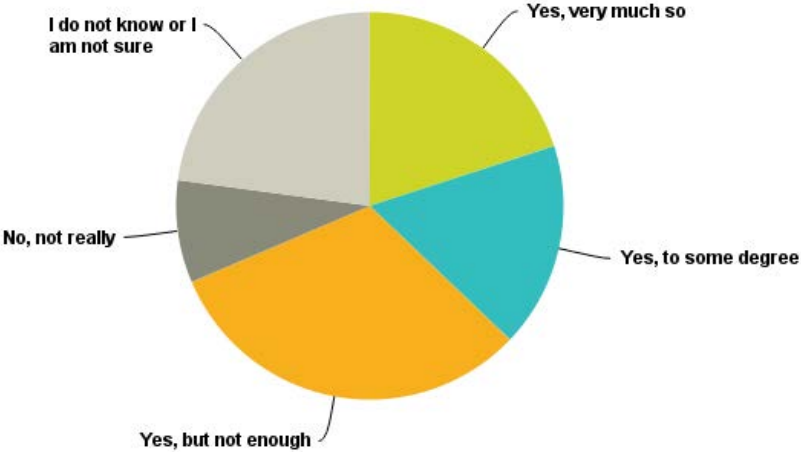


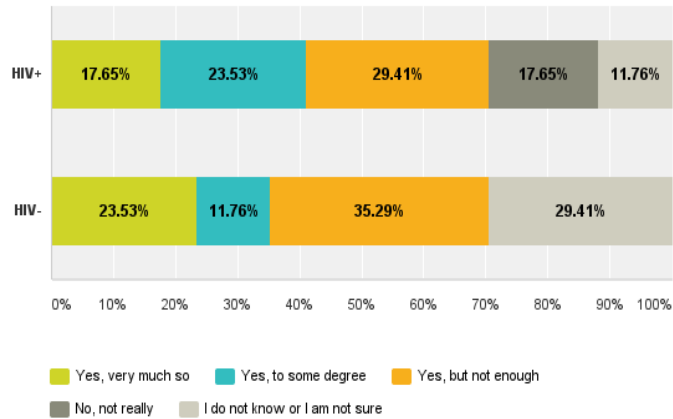
Figure 13: Survey, Q29, does research support life practices approach?

Comparing how HIV-positive respondents answered this questions compared to HIV-negative respondents, more HIV-negative respondents believe that the current research supports a life practices approach to sexual health and HIV prevention than HIV-positive respondents do. It may also be compelling to note that:

- Nearly 30% of HIV-negative respondents either do not know or are unsure about whether current research supports a life practices approach, and the same is true for 20% of HIV-positive respondents.
- Just under 20% of all respondents believe that the current research does not support a life practices approach.

¹ Sustaining or regaining optimal health [through] focus on behavioral (e.g., positive health practices), psychological (e.g., optimism, purpose, mastery, positive affect, religion/spirituality), social (e.g., relational affect and intimacy, emotional support), and environmental (e.g., positive work settings, supportive community programs) factors. (Committee on Future Directions for Behavioral and Social Sciences Research at the National Institutes of Health 2001)

- There are no remarkable differences when looking more specifically at the perspective all of respondents (i.e. filters).



no

Figure 14: Survey, Q29, HIV+ vs. HIV-, research supports life practices approach

Also for measured response, the survey asked, “Are you familiar enough with what current research tells us about HIV prevention, gay men’s general and sexual health, syndemic health issues, etc. to make what you would feel confident is an informed contribution to the development of “POZ Prevention^{2.0}”? By-and-large and for all survey respondents, confidence is even in terms of understanding current research sufficiently (respondents are either quite confident or confident enough) to make informed contributions to the “POZ Prevention” discussion.

However, looking only at respondents who indicate feeling ill-equipped, the picture is different:

- More than a third of respondents do not feel that they know enough about the current research to make informed contributions to this work;
- 17% of respondents are not sure one way or another.

Comparing perspectives, it is apparent that HIV-positive gay men who responded to this question share a much greater confidence in their understanding of current research than HIV-negative respondents:

- 57% of HIV-positive gay men indicate that they are quite familiar or familiar enough with current research to make informed contributions to this work;
- 55% of HIV-negative respondents are either not familiar enough or really do not know one way or another.

The question, “In your opinion and specifically related to gay men’s general and sexual health AND to POZ Prevention, what gaps in the research exist and require the most immediate attention?” was overwhelming for at least one respondent.

He exclaimed, **“Holy shit! This is not something I can answer briefly. I honestly don’t know where to begin...”**

For others, specific research gaps include (in respondents' own words):

- The impact that ASOs are having on preventing HIV transmission, and on creating educational training and programs
- Science-based research specifically focused on transmission when on treatment
- More PrEP-related research that would facilitate challenge to laws and that would demonstrate that the criminal justice system needs to base criminality on the science
- Regression to bare backing with PrEP users or those that claim they are. There is no way of confirming compliance or usage. One may have a resistant strain of HIV; undetectable bare backing increases risks of STIs
- Gay/bi men (or other MSM) living/working/playing in rural and remote areas of Canada
- 2 spirit/indigenous gay/bi/MSM
- Culturally appropriate services for migrant and immigrant gay/bi/MSM
- Everything beyond HIV!
- Mental health (self-esteem, stigma (re. "gay", HIV, etc.), depression, anxiety, suicide, etc.)
- Survivor trauma, etc.
- Substance use issues
- Domestic violence
- Body image/eating disorders, etc.
- What *are* the challenges for positive gay men that are unique; why?

Michel Sidibé, UNAIDS Executive Director, has suggested that simply knowing about the HIV epidemic is not enough to mount a response that is truly effective; that we must also comprehend the conditions under which research evidence affects policy and practice. We might also surmise a fairly compelling case, in that: *“in the same way that we need to take multiple combination approaches to prevention programming, we need to take a combination approach to the development of new technologies and build a research agenda that not only anticipates new needs but addresses known needs, and encompasses the full range of factors which affect the epidemic.”* (Piot, Bartos, Larson, Zewdie, & Mane, 2008)

Asked how addressing the research gaps identified will help advance a “POZ Prevention” agenda and/or the PPWG’s forward-thinking initiative(s), a few very clear perspectives were shared by survey respondents:

FROM HIV-POSITIVE RESPONDENTS (IN THEIR OWN WORDS)...
This needs to be reconsidered from a PLHIV perspective as the role PLHIV play in prevention along a continuum of passive to active in one axis and private to public in the other.
It will bring new thinking and the next generation of thinkers; helping people reframe challenges.
Simple language; short and easy ways of participating; incentives that promote health (voucher to grocery store).
Not sure. But, perhaps it provides additional information where questions are outstanding.
It will ensure approach is current.

AND FROM HIV-NEGATIVE RESPONDENTS (IN THEIR OWN WORDS)...

It will give it a framework to identify what is missing. To date, we haven't seen much change in prevention, so identifying the gaps and bringing it to the forefront may help shape the direction of prevention.

Might help make the case for gay-friendly access to health care that includes services for the issues...

I expect it will lower the risks of our seeing increase rates climbing, for sero-conversion. It will therefore save people from getting HIV, becoming poz, and having to live with consequences of that.

Less people will lie about their behaviour when giving blood. People who are at low-risk of getting HIV will be more engaged in their community if they can fully participate in it (by giving blood). There will be less stigma with being gay, and greater focus on preventing HIV. Broadening the focus beyond just HIV prevention will benefit the gay community in the long run, rather than just put a band aid on the current situation.

The better educated people are, the better and more informed their choices will be.

Better contextualize efforts re. health outcomes, determinants, psycho-social issues, technology impacts...

DISCUSSION

Even in the early days, Piot et al. summed it up quite nicely when they noted, “despite both the broad consensus on what needs to be done and the evidence base, we have only partial understanding of what facilitates systematic implementation of prevention programmes, what bottlenecks hold up progress, and what strength of effort will be necessary.”

Whatever “POZ Prevention” is called, however it is talked about or understood... the theory behind it has evolved since its earliest days; its name and its practical applications must reflect this. The story that the literature tells and the picture that survey respondents draw with their thoughtful insight make the following key conclusions very clear:

1. “POZ Prevention” is perhaps not as easy to describe or to understand today as it once was.
2. For some, the “POZ Prevention” concept is straightforward and aptly named... it is about HIV-positive people and their role in HIV prevention.
3. For many, the notion of “POZ Prevention” is stigmatizing, is polarizing, is too-often understood (or promoted) as a tool or set of tools for HIV-positive people to use in *their* efforts to protect others from HIV infection.
4. For a growing number of people, it seems, “POZ Prevention” is part of a complex policy question that, when addressed effectively and appropriately, lends itself to programmatic interventions for service-providers which decisively tackle a very broad range of sexual, social, and societal determinants of health; an approach to health and healthy sexuality, to prevention of ill-health, and to the protection and promotion of quality-of-life and sexual health that is unequivocally holistic.

In terms of future work, it should be highlighted that 30% of survey respondents indicated that they **do not understand** what “POZ Prevention” means; 6% of respondents who do not understand are HIV-positive men who live in Ontario.

Polar-opposite extremes are evident in terms of questions around what “POZ Prevention” is, who it is for, and, indeed, what it is called; key (and pressing) questions for consideration in policy and program development work persist. Some interesting examples of this are noted below. While most of these reflect a single respondent’s opinion, they provide interesting examples of the range of perspectives.

- More than one survey respondent indicated that “POZ Prevention” is about HIV positive people... it is for HIV positive people... it is designed to ensure that HIV positive people do not transmit their virus to HIV negative people.
- For at least one HIV positive gay man who lives in Ontario, “POZ Prevention” represents nothing more than “ASOs wasting money; telling poz people to stay quiet; treating people living with HIV like shit!”

- At least one survey respondent sees “POZ Prevention” as a “holistic approach to looking [at] the HIV positive person as a whole being not just a disease/vector of disease; focusing on mental health, physical health, treatment and healthy sex positive conversation/intervention; keeping the whole HIV positive person healthy and respected makes for prevention and healthier decision making.”
- As was noted earlier, it appears that there is less confidence today that prevention approaches centred around GIPA/MEPA actually influence HIV incidence rates; and it would be a stretch to suggest that most people consider GIPA/MEPA very important in our prevention efforts. And,
 - Comparing the opinions of HIV-positive and HIV-negative respondents in terms of what people think about GIPA/MEPA in the “POZ Prevention” context is intriguing. Again, while 71% of HIV-positive respondents believe that an uncompromising commitment to GIPA/MEPA would contribute significantly to prevention efforts, less than half (47%) of HIV-negative respondents agree. Nearly 18% of HIV-positive and just less than 24% of HIV-negative respondents are unsure of the impact of GIPA/MEPA on prevention work.
 - One survey respondent stated his perspective quite simply, “It’s not actually happening.”
 - Another survey respondent indicated that “it is beyond reason to think that Poz Prevention by definition can exclude the involvement of people living with HIV on all levels and involvement at the start. The hub of HIV prevention strategies must have the Meaningful Involvement/Engagement of People living with HIV.

- One survey respondent (who is HIV negative) feels that “GIPA/MEPA does not resonate for HIV- MSM or transgender individuals in the context of sexual health prevention.”
- Another respondent suggested that too much focus on GIPA/MEPA effectively means that other ‘models’ or approaches are being ignored.

Specific holistic focus on gay men changes the conversation in remarkable ways. The literature supports the notion that gay men are still among the most vulnerable and

marginalized when it comes to certain health determinants and to health care services. As was noted earlier, "The persistence of disparities in STI/HIV risk among a new generation of emerging adult gay, bisexual, and other men who have sex with men (MSM) warrant holistic frameworks and new methodologies for investigating the behaviors related to STI/HIV in this group." The Public Health Agency of Canada highlights that studies focused on gay men are extremely limited, so not enough is known.

Worthy of specific note here (and of future attention perhaps), one survey respondent offered this elaborate perspective:

"In many cases the challenges of HIV positive gay men are indeed different than HIV negative gay men and the latter group can in certain cases be the source of some of these challenges. The overall manner in which an HIV negative gay man talks about HIV or rejects someone only on the basis of status (therefore it is choice of words and body language and more) that can have great impact on the mental health issues of Poz gay men. Statistics clearly show that close to 37% of HIV positive gay men suffer from significant mental health issues and another 40% with less severe diagnosed mental health issues such as chronic or acute depression. Poz gay men also have to contend with co-morbidities normally not as pronounced in negative gay men. Increase susceptibility to SBBIs and increased incidence of other diseases. Long term impact of HIV and medicinal responses are significantly different than HIV negative gay men."

Nearly 70% of survey respondents who identify as HIV positive gay men believe that biomedical technologies have notable impact on sexual health and HIV prevention efforts - particularly as they relate to gay men. Said one survey respondent, it means "more tools in the tool box of healthy sexuality and disease prevention. The discourse has shown a divide of strong opinions and in many cases demonstrates the need for more education and among many that sex is natural and healthy and to the arsenal of effective and proven methods not solicit judgement values on people wishing to expand their opportunities to enjoy sex versus the naysayers that would deny HIV positive people to have healthy sex. Ironically those that take this approach do not realize the impact of harbouring such judgemental values actually impacts negatively on their own sexual health and enjoyment thereof."

The literature suggests a fairly clear pathway - or correlation in the context of prevention and/or "POZ prevention":

- There is unequivocal need to ensure that policy and programming represents a comprehensive approach that is centred on the sexual health of gay men (and others) that is inclusive of specific initiatives addressing substance use and counselling for mental health concerns.
- Gay men experience stigma and discrimination related to their sexual orientation, giving rise to internalized homophobia that is ultimately associated with poorer mental health outcomes, including depression, feelings of loneliness and isolation, suicidal ideation (and/or suicide attempts), and self-esteem issues. (The literature on the association between HIV risk and discrimination and internalized homophobia has yielded a complex and contradictory pattern of findings.)

Still, there is literature which suggests that while some studies have found associations between HIV risk behavior and discrimination or internalized homophobia, it is not absolute. Some of the literature suggests, in fact, that lower levels of discrimination or internalized homophobia were associated with higher HIV risk.

It appears that prevention research has started to shift from examination of so-called explanatory 'cognitive models'² of risk-taking behavior, to more balanced thinking around affective processes (and thinking) among gay men. More-and-more, mental health issues (including substance use and personality and psychological concerns) are connected to HIV-related risk-taking behaviors. Research also delves, fairly effectively, into focused examination of high-risk behavior as coping strategies for a myriad social conditions or determinants.

Without dispute or question, research makes clear that prejudice, discrimination, and violence (whether in the past, in the present, or potentially in the future) pose risks to the mental health and well-being of gay men (and other people who identify as members of the LGBTQ community.) With little doubt, gay men are among those who have experienced social and economic marginalization and who are or may be assumed to be disproportionately vulnerable to infectious diseases and/or communicable infections.

² Internalized rationalization for behaviour(s)

RECOMMENDATIONS

1. IDENTIFY OUR SPECIFIC ROLE AND CONTRIBUTION

It is recommended that the GMSH/PPWG strategic plan/strategic planning exercise(s) anticipate need for further exploration and possible broader consultation focused on identifying the role of HIV positive gay men within the broader paradigm shift occurring around gay men's overall health. "POZ Prevention" for gay men made sense in 2008 and it was innovative in Ontario in that it focused on holistic health and strict adherence to GIPA/MEPA. Leadership in defining the work was led by the GMSH and therefore focused on gay men. But... the concept and the practical application(s) of positive prevention globally was not and is not so specifically focused on gay men, and it was not/is not implemented or realized on a specific population-based level. Evidence seems to warrant the early paradigm shift being seen in Ontario that hones in on systems and systemic responses to HIV, to gay men's general and sexual health and wellness, and to prevention (writ-large) of ill-health and protection/promotion of quality of life. The GMSH/PPWG will need to think very strategically about how "Poz Prevention" and the role of HIV positive gay men fits within this context of HIV prevention, while thinking outside of the (proverbial) "POZ Prevention" box.

2. DEVELOP NEW AND MEANINGFUL LANGUAGE

It is recommended that alternatives to the term "POZ Prevention" are found. Focus should be on language that reflects the specific role and contribution of HIV positive gay men within the larger discussions and work on improving the health and wellness of gay men that is not necessarily limited to HIV and/or HIV prevention initiatives. Focus ought to be on language that reflects holistic approaches to gay men's quality of life, i.e. absence of ill-health (for myriad reasons that include physical, social, psycho-social, and socio-economic considerations). "POZ Prevention" terminology had its place in 2008, despite differing global views then... it has evolved and the language does not reflect the current Ontario context.

3. KNOWLEDGE TRANSLATION & EXCHANGE (KTE)

It is recommended that PPWG/GMSH focus on implementing programming and knowledge translation and exchange activities that are developed/designed and delivered for/to service-providers. Continuing work is needed to increase broad understanding of Poz Prevention and the Poz Prevention work of the GMSH PPWG. This review also identified a clear discrepancy between the knowledge and understanding of HIV positive and HIV negative gay men in relation to the role and possible contribution of HIV positive gay men and the application/definition of Poz Prevention. There is no question that adherence to the GIPA/MEPA principle(s) remains tantamount to successful interventions at any and all levels of the response to HIV - in Ontario, and beyond Ontario's borders.

APPENDIX A: BIBLIOGRAPHY

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APPENDIX B: DISCUSSION GUIDE, PPWG CONSULTATION (JUNE 27, 2016)

“TO BE EFFECTIVE, HIV PROGRAMMES AND SERVICES NEED TO BE ROOTED IN UNIVERSAL CONCEPTS OF DIGNITY AND SOCIAL JUSTICE. [...] GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN MUST BE FULLY INVOLVED [...] COMMUNITY SYSTEMS NEED TO BE STRENGTHENED, INCLUDING INCREASED PEER SUPPORT AND THE ENCOURAGEMENT OF LOCAL LEADERSHIP AMONG GAY MEN AND OTHER MEN WHO HAVE SEX WITH MEN.”

(UN JOINT PROGRAMME ON HIV/AIDS (UNAIDS), THE GAP REPORT, 2014,
<http://www.refworld.org/docid/53f1e1604.html> [accessed 1 April 2016])
. [ACCESSED 1 APRIL 2016]

The GMSH has engaged a consultant – me – to undertake a literature review and an environmental scan, consultative initiatives, and reporting activities that focus on:

- The evolution of ‘POZ Prevention’ terminology and programmatic framework(s);
- The understanding of and integrative approaches to practical ‘POZ Prevention’ applications;
- The integration of (new) biomedical approaches to HIV prevention; Existing research on the health (and sexual health) of ‘POZ gay men’; and
- Potential research gaps/opportunities of importance to ‘POZ gay men’.

Underpinning this work and its intent is the POZ Prevention Working Group’s (PPWG) goal to *improve the overall sexual health and well-being of gay/bi/MSM by specifically using the lived experience of HIV positive gay, bisexual and other MSM to strategically respond to opportunities and needs such as access to relevant information, resources and supports.*

For decades, it was generally agreed (globally) that prevention initiatives were historically focused on people **NOT** living with HIV and/or individuals who were unaware of their HIV status, but that this needed to change. Thoughts and efforts seemed focused on *“Primary prevention, in public health theory and practice [...] prevention of new infections by any available and acceptable means...”*

(Office of AIDS, Inter-Branch Committee for Prevention with Positives 2004)

In 2008, in a letter introducing *POZ Prevention, knowledge practice guidance for providing sexual health services to gay men living in Ontario*, while recognizing the importance of primary prevention efforts, two gay men (David Hoe and Murray Jose) really set the stage for a more innovative approach to prevention that was (is) anchored by the *GIPA/MEPA Principle(s)* and that was ultimately adopted as *the* approach in Ontario.

David and Murray wrote, *"Gay men framed the AIDS epidemic in Canada [...] we built our own organizations as the best people to respond to our crisis of care and HIV prevention. [...] Gay men living with HIV were pioneers [who] risked public ridicule in fighting stigma and discrimination while protecting our rights to care and treatment and an active sexual life, and the right to services to help us survive."* (Betteridge and Thaczuk 2009)

So, while there are quite a few 'schools of thought' reflected in the literature in terms of what a new prevention approach should be called or how it should be characterized, there is no question that the HIV/AIDS community was ready for "positive prevention". At the Living 2008 Positive Leadership Summit in Mexico, it was concluded that, "A new approach is needed. [...] It should maximize the linkages between prevention, treatment, care and support [...] and be] Designed holistically [to] protect the health *and well-being of people living with HIV.*" (The Living2008 Partnership 2008)

In Ontario, The PPWG agreed that *"POZ prevention for HIV+ gay men aims to empower individuals, promote healthy relations with sexual partners and improve conditions, to strengthen the sexual health and wellbeing of HIV+ gay men and reduce the possibility of new HIV infections and other sexually transmitted infections."* Moreover, the PPWG's *GIPA/MEPA-centred* values and principles unequivocally held that, *"Developing prevention programs for, and inclusive of, HIV positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people with HIV. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of HIV prevention programming."* (Poz Prevention Working Group 2008)

According to the Public Health Agency of Canada, *"gay and other MSM continue to be the population most affected by HIV, with an estimated 46.7% (33,300) of all prevalent cases in 2011."* (Public Health Agency of Canada 2013) The literature appears to reflect that the global community continues to struggle a bit with nomenclature and

characterizations of/for “positive prevention”, but that there is global agreement and desire for a more holistic approach to HIV prevention policy and program development. These eight years later, while there is no question that the approach in Ontario remains committed - without compromise - to engaging people living with HIV at every juncture, I wonder... for you, what about “POZ Prevention” still resonates? Is it time for the PPWG to think about “POZ Prevention 2.0”. Some questions:

QUESTION 1

The PPWG was very deliberate in its respect for and application of the *GIPA/MEPA Principle(s)* in its early thinking about ‘POZ Prevention’. In Ontario, energy was focused less on clinical approaches to primary prevention and more on attention to the health and quality of life of people living with HIV - particularly gay men living with HIV.

Does the 2008 definition of **‘POZ Prevention’** still resonate for you? Why, or why not?

QUESTION 2

Whatever the evolution of ‘positive prevention’ or what the global community calls it, do **you** that the PPWG’s original values and principles guiding HIV prevention still reflect a *GIPA/MEPA*-centred approach? Do you think that HIV prevention efforts in Ontario were/are more successful because people living with HIV were/are more engaged in development and implementation initiatives? Why or why not?

“The field of HIV prevention is increasingly shifting from one of behavioural interventions to a focus on biomedical methods. However, caution should be taken [...] [w]hether interventions are designed around the use of condoms, clean needles and syringes, microbicides or pre-exposure and post-exposure prophylaxis (PrEP and PEP), all require behavioural changes.” (Kubicek, Arauz-Cuadra and Kipke 2015)

The literature exploring biomedical approaches to HIV prevention is copious - a bit overwhelming really. Of course, a great deal of focus was (and remains) on preventive and therapeutic vaccine research, and there are many papers spanning 30 years of questions (but not always answers) about microbicides, about circumcision, and (more recently) about antiretroviral-based interventions.

“A KEY CONCERN IS THE EMERGENCE OF HIV BIOMEDICAL PREVENTION, WHICH REFERS TO THE MASSIVE REORGANIZATION OF HIV PREVENTION POLICIES AND PRACTICES THAT IS TAKING PLACE IN INTERNATIONAL ATTEMPTS TO MAXIMIZE THE PREVENTATIVE EFFECTS OF MEDICAL AND PHARMACEUTICAL TECHNOLOGIES [...] THIS PARADIGM APPROACHES HIV PREVENTION AS A MEDICAL AND TECHNICAL PROBLEM – A FORMULATION WITH CONSIDERABLE POLICY APPEAL, INSOFAR AS IT AVERTS THE NEED TO CONFRONT OR PUBLICLY ADDRESS THE DIFFICULTIES OF SEX.” (Race 2016)

QUESTION 3

It is an old reference, but the World Health Organisation defines sexual health as *the “Capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic.”* (World Health Organization 1975).

‘POZ Prevention’ is as much about sexual health as it is about HIV prevention. Thinking about the World Health Organization’s definition, what impact does current biomedical HIV prevention discourse have on sexual health generally, and on the sexual health of gay men more specifically? If we need to mitigate the impact, how do we do it? Has the paradigm significantly shifted because of evolving biomedical approaches to HIV prevention?

Sure, there is still work to do, but we have come a long way and should celebrate how we consider sexual orientation and gender identity in health policy and programming today. But what about sexual health? There is no shortage of literature focused on gay men and HIV, but it seems there is far less which delves into comprehensive reviews of gay men and their sexual health, never mind their sex drive or sexual encounters. We know that the PPWG specifically defined ‘POZ Prevention’ in the context of gay men and their sexual health. We should explore and celebrate how that has changed the HIV prevention landscape in Ontario (if not beyond). Shouldn’t we?

QUESTION 4

“Sexual health means having sex and sexual relationships that are as hot and satisfying as possible. Sexual health also means taking care of your health and the health of your sex partner(s). To be sexually healthy you will probably need to take care of your body, your mind and your emotions. It is important for gay men, including gay men living with HIV, to have the information we need to make informed decisions about our sexual health.”
(Thaczuk 2009)

We’ve come a long way - no doubt. But, have we come far in terms of how gay men’s sex and sexual health is addressed in our HIV prevention work? How so? How much has our uncompromising commitment to GIPA/MEPA contributed to our progress and to our success? If we agree that there can always be room for improvements, what would we/should we do differently moving forward?

QUESTION 5

“[...] not only is sexual risk behavior an important mechanism underlying the relationship between the syndemic of psychosocial problems and HIV infection for gay and bisexual men, but it also partially mediates the syndemic effects of psychosocial problems on HIV infection.”
(Jie, et al. 2012)

Do you think that gay men truly understand the relationship between syndemic issues and HIV (whether real or perceived; whether present or potential)?

If you agree that gay men face specific and/or unique general and sexual health challenges because they are gay men, how can **our** approach to ‘POZ Prevention’ *‘mediate the syndemic effects of psychosocial problems on HIV infection’*?

QUESTION 6

"Sustaining or regaining optimal health requires a [research] focus on behavioral (e.g., positive health practices), psychological (e.g., optimism, purpose, mastery, positive affect, and religion/spirituality), social (e.g., relational affect and intimacy, emotional support), and environmental (e.g., positive work settings, supportive community programs) factors... [which] develop new population-based initiatives, implemented at local community levels, that promote health via the teaching of positive life practices and the provision of environmental supports to sustain them."

(Committee on Future Directions for Behavioral and Social Sciences Research at the National Institutes of Health 2001)

Literature from the early 2000s supports the notion that the NIH (in its *"New Horizons..."* report) was onto something in terms of a research agenda focused on a *life practices* approach. What do you think? In terms of 'POZ Prevention' for gay men, does the research support a life practices approach to sexual health and HIV prevention today? Why or why not? What gaps in the research do think require the most immediate attention? Why?

APPENDIX C: STAKEHOLDER SURVEY (TOOL)

<https://www.surveymonkey.com/r/SAMPLE4REPORT>

Introduction

The Poz Prevention Working Group of the Gay Men's Sexual Health Alliance is working to update its "Poz Prevention" framework with:

- a review of current terminology;
- exploration of integrative approaches to practical "Poz Prevention" applications;
- a look at current integration of biomedical approaches to HIV prevention; and
- examination of research (findings/gaps/opportunities) focused on the general and sexual health of gay men as it relates to HIV prevention.

For decades, it was generally agreed (globally) that HIV prevention initiatives were historically focused on people *NOT* living with HIV and/or individuals who were unaware of their HIV status, but that this needed to change. Thoughts and efforts seemed focused on *"Primary prevention, in public health theory and practice [...] prevention of new infections by any available and acceptable means..."* (Office of AIDS, Inter-Branch Committee for Prevention with Positives, 2004)

In 2008, in a letter introducing *"POZ Prevention, knowledge practice guidance for providing sexual health services to gay men living in Ontario"*, while recognizing the importance of primary prevention efforts, gay men (David Hoe and Murray Jose) really set the state for a more innovative approach to prevention that was (is) anchored by the GIPA/MEPA Principle(s) and that was ultimately adopted as *the* approach in Ontario. David and Murray wrote,

"Gay men framed the AIDS epidemic in Canada [...] we build our own organizations as the best people to respond to our crisis of care and HIV prevention. [...] Gay men living with HIV were pioneers [who] risked public ridicule in fighting stigma and discrimination while protecting our rights to care and treatment and an active sexual life, and the right to services to help us survive." Your assistance in helping us understand the current and evolving "Poz Prevention" landscape - in Canada and in other parts of the world - will be much appreciated. It should not take you more than 20 or 30 minutes to complete this survey; your insight is invaluable to us.

Thank you, in advance, for your participation. If you have questions or concerns at any point while you complete the survey, please do not hesitate to contact Jeff Potts, the Consultant who was engaged by the Gay Men's Sexual Health Alliance to undertake this review. Jeff may be reached at:

613-866-9204 (telephone) | 613-832-1150 (facsimile), or by clicking on this link [Jeff Potts](#) to connect with him by email at findingfocus@bell.net.

First, just a bit about you...

No personal/identifying information about you will be retained. Responses to the following few questions are for information purposes only.

Are you HIV-positive?

- Yes
- No
- I do not know
- I prefer NOT to answer

If you are HIV-positive, how long ago were you diagnosed (approximately)?

- Just in the last 3 years
- 3 to 5 years ago
- 5 to 10 years ago
- 10 to 15 years ago
- 15 to 20 years ago
- More than 20 years ago
- I do not know
- I prefer NOT to answer
- I am NOT HIV-positive

Are you in a long-term relationship?

- Yes
- No
- I prefer NOT to answer

If you are in a long-term relationship, is your partner HIV-positive?

- Yes
- No
- I do not know
- I prefer NOT to answer

Where do you currently live?

- British Columbia
- Yukon Territory
- Alberta
- Northwest Territories
- Saskatchewan
- I live outside of Canada, in:
- Manitoba
- Ontario
- Nunavut
- Quebec
- New Brunswick
- Nova Scotia
- Newfoundland and Labrador
- Prince Edward Island
- I prefer NOT to answer

What is your age?

- 17 or younger
- 18-20
- 21-29
- 30-39
- 40-49
- 50-59
- 60 or older
- I prefer NOT to answer

Gender and Experiences?

- I identify as a woman
- I identify as man
- I identify as two-spirit
- I identify as cisgender
- I identify as trans with lived experience
- I identify as intersex
- I do NOT gender-identify
- I am not sure
- I prefer NOT to answer

Nonbinary/other gender identify (please specify)

How do you identify your sexuality?

- Heterosexual
- Homosexual
- LGBTQ
- Bisexual
- Asexual
- I do NOT identify with a specific sexuality
- I prefer NOT to answer

Other (please specify)

Are you connected with an AIDS Service Organization (ASO) and/or other health-related service-providers (select all that apply)?

- Yes, I am a PAID employee of an ASO
- Yes, I am a VOLUNTEER at an ASO
- I am ALL of the above
- Yes, I am a PAID health-related service-provider within the HIV/AIDS sector
- Yes, I am a VOLUNTEER health-related service-provider within the HIV/AIDS sector
- I am NONE of the above
- Yes, I am a PAID health-related service-provider outside of the HIV/AIDS sector
- Yes, I am a VOLUNTEER health-related service-provider outside of the HIV/AIDS sector
- I prefer NOT to answer

Other (please specify)

General understanding and/or beliefs

A few questions to explore your understanding of and/or beliefs around "Poz Prevention" (and its evolution)...

Without providing context here, do you understand what the term "Poz Prevention" means?

Yes

No

I am not sure

Briefly describe what "Poz Prevention" means to you.

Practical considerations

"[G]ay and other MSM continue to be the population most affected by HIV, with an estimated 46.7% (33,300) of all prevalent cases in 2011." (Public Health Agency of Canada 2013) The literature appears to reflect that the global community continues to struggle a bit with nomenclature and characterizations of/for "positive prevention", but that there is global agreement and desire for a more holistic approach to HIV prevention policy and program development.

In 2008, the Poz Prevention Working Group (PPWG) of the Gay Men's Sexual Health was quite innovative in its approach to Poz Prevention and agreed that "POZ prevention for HIV+ gay men aims to empower individuals, promote healthy relations with sexual partners and improve conditions, to strengthen the sexual health and well-being of HIV+ gay men and reduce the possibility of new HIV infections and other sexually transmitted infections." (The PPWG's definition of Poz Prevention)

The PPWG's values and principles unequivocally held that, "Developing prevention programs for, and inclusive of, HIV positive people must not become an excuse for shifting all responsibility for prevention (or blame for new infections) onto the shoulders of people with HIV. A culture of shared responsibility that encourages communication and equality in relationships should be a goal of HIV prevention programming."

Please indicate the degree to which the PPWG's definition of Poz Prevention resonates (still resonates) for you?

- Really resonates
- Somewhat resonates
- Sort of resonates
- Does NOT resonate at all
- I do not know or I am not sure

Thinking about the PPWG's definition, particularly if it does NOT really resonate for you, what would you call its intent if NOT Poz Prevention?

Do you agree that HIV prevention is a shared responsibility (i.e. shared by HIV-positive and HIV-negative people equally)?

- Yes
- No
- I do not know or I am unsure

How important do you think an approach centred around the principles of Greater Involvement of People Living with HIV/AIDS/Meaningful Engagement of People Living with HIV/AIDS (GIPA/MEPA) is to the success of Poz Prevention?

- | | |
|---|--|
| <input type="radio"/> Extremely important | <input type="radio"/> Not very important |
| <input type="radio"/> Very important | <input type="radio"/> Not at all important |
| <input type="radio"/> Somewhat important | <input type="radio"/> I do not know or I am unsure |

If even only somewhat, why is a GIPA/MEPA-centred approach to Poz Prevention important?

Without specific evidence one way or another, do you think that a Poz Prevention approach that is GIPA/MEPA-centred at every level (e.g., from development to implementation) reduces HIV incidence rates?

- | | |
|---------------------------|--|
| <input type="radio"/> Yes | <input type="radio"/> Probably |
| <input type="radio"/> No | <input type="radio"/> I do not know or I am not sure |

Biomedical approaches to HIV prevention

"The field of HIV prevention is increasingly shifting from one of behavioural interventions to a focus on biomedical methods. However, caution should be taken [...] [w]hether interventions are designed around the use of condoms, clean needles and syringes, microbicides or pre-exposure and post-exposure prophylaxis (PrEP and PEP), all require behavioural changes." (Kubicek, Arauz-Cuadra and Kipke, 2015)

The literature exploring biomedical approaches to HIV prevention is copious – a bit overwhelming really. Of course, a great deal of focus was (and remains) on preventive and therapeutic vaccine research, and there are many papers spanning 30 years of questions (but not always answers) about microbicides, about circumcision, and (more recently) about antiretroviral-based interventions.

"A key concern is the emergence of HIV biomedical prevention, which refers to the massive reorganization of HIV prevention policies and practices that is taking place in international attempts to maximize the preventative effects of medical and pharmaceutical technologies [...] This paradigm approaches HIV prevention as a medical and technical problem — a formulation with considerable policy appeal, insofar as it averts the need to confront or publicly address the difficulties of sex." (Race 2016)

It is an old reference, but the World Health Organization defines sexual health as the "Capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic." (World Health Organization, 1975)

How much do you agree with the following statement?

"POZ Prevention is as much about sexual health as it is about HIV prevention."

- | | |
|--|--|
| <input type="radio"/> Strongly agree | <input type="radio"/> Somewhat disagree |
| <input type="radio"/> Somewhat agree | <input type="radio"/> Strongly disagree |
| <input type="radio"/> Neither agree nor disagree | <input type="radio"/> I do not know or I am not sure |

Thinking about the World Health Organization's definition, what impact does current biomedical prevention discourse have on sexual health generally?

- | | | |
|--|---|--|
| <input type="radio"/> Significant positive impact | <input type="radio"/> Little or no impact | <input type="radio"/> Significant negative impact |
| <input type="radio"/> Some positive impact | <input type="radio"/> Some negative impact | <input type="radio"/> I do not know or I am not sure |

Why/how (briefly)?

What impact does the current biomedical HIV prevention discourse have on the sexual health of gay men more specifically?

- Significant **positive** impact Little or no impact Significant **negative** impact
 Some **positive** impact Some **negative** impact I do not know or I am not sure

Briefly but more specifically in your view, how does the discourse and/or the emergence and ongoing evolution of biomedical technologies/approaches affect **how** gay men think about Poz Prevention?

Sexual health

"Although there is an emerging awareness of sexual orientation and gender identity as key social determinants in the international literature, this awareness has yet to be incorporated into mainstream health policy and the design and delivery of programs and services." (Ministerial Advisory Committee on Gay and Lesbian Health, 2002)

Sure, there is still work to do, but many would argue that we have come a long way and should celebrate how we consider sexual orientation and gender identity in health policy and programming today. But what about sexual health? There is no shortage of literature focused on gay men and HIV, but it seems there is far less which delves into comprehensive reviews of gay men and their sexual health, never mind their sex drive or sexual encounters. We know that the PPWG specifically defined Poz Prevention in the context of gay men and their sexual health. We should explore and celebrate how that has changed the HIV prevention landscape... shouldn't we?

"Sexual health means having sex and sexual relationships that are as hot and satisfying as possible. Sexual health also means taking care of your health and the health of your sex partner(s). To be sexually healthy you will probably need to take care of your body, your mind, and your emotions. It is important for gay men, including gay men living with HIV, to have the information we need to make informed decisions about our sexual health." (Thaczuk, 2009)

We have "come a long way"... but have we come far enough in terms of how gay men's sex and sexual health is addressed in our HIV prevention work?

- Yes No I do not know or I am not sure

If so, how so? If not, why not? (briefly)

In your opinion, how much does an uncompromising commitment to GIPA/MEPA contribute to progress/success in addressing sex and sexual health in our Poz Prevention efforts?

- Significantly Not at all
- Somewhat I do not know or I am not sure
- A little bit

In a few words and specifically related to focus on sex and sexual health, what does an **uncompromising commitment** to GIPA/MEPA look like to you?

While many would argue that there should be no distinctions made between gay men and other men in terms of how general health issues are addressed, others would argue that even the most 'benign' health issues are exacerbated for gay men, and the literature might support that hypothesis. In fact, some evidence makes it clear that gay men face challenges in terms of their general (and sexual) health issues that other men do not.

Does this resonate for you?

- Yes, very much: gay men face many challenges that other men do not No, not at all: gay men face the same challenges as other men
- Yes, somewhat: gay men face some challenges that other men do not I do not know or I am not sure
- No, not really: many challenges faced by gay men are faced by other men too

Now, think more specifically about gay men who are HIV-positive for a moment. Briefly (if at all), how does your opinion change in terms of the challenges faced by gay, HIV-positive men compared to other men?

On the question of research...

"Sustaining or regaining optimal health requires a [research] focus on behavioral (e.g., positive health practices), psychological (e.g., optimism, purpose, mastery, positive affect, religion/spirituality), social (e.g., relational affect and intimacy, emotional support), and environmental (e.g., positive work settings, supportive community programs) factors... [which] develop new population-based initiatives, implemented at local community levels, that promote health via the teaching of positive life practices and the provision of environmental support to sustain them." (Committee of Future Directions for Behavioral and Social Sciences Research at the National Institutes of Health (NIH), 2001)

You might agree that literature from the early 2000s supports the notion that the NIH (in its "New Horizons..." report) was onto something in terms of a research agenda focused on a life practices approach. In terms of Poz Prevention, does the current research (as you know/understand it) support a life practices approach to sexual health and HIV prevention today?

- Yes, very much so Yes, but not enough No, not at all
 Yes, to some degree No, not really I do not know or I am not sure

Are you familiar enough with what current research tells us about HIV prevention, gay men's general and sexual health, syndemic health issues, etc. to make what you would feel confident is an **informed contribution** to the development of (so-called) "Poz Prevention 2.0"?

- Yes, I am quite familiar with what the research tells us now No, I do not think I know enough about what the research tells us now I prefer NOT to answer
 Yes, I know enough about what the research tells us now I do not know or I am not sure

In your opinion and specifically related to gay men's general and sexual health AND to Poz Prevention, what **gaps in the research** exist and require the most immediate attention (briefly)?

Briefly, but specifically, how will addressing the research gaps you have identified help advance a Poz Prevention agenda (i.e. the development and implementation of so-called "Poz Prevention 2.0")?

Keeping you informed

IF you wish to be kept informed and/or engaged more directly as the development and

implementation of "Poz Prevention 2.0" unfolds, you will need to share some personal contact information with us. Please rest assured that your personal information be NOT be shared with anyone at any time unless with your EXPLICIT consent. Your contact information will be kept only for purposes of sharing "Poz Prevention 2.0" updates with you; and your information will be deleted from our records upon your request.

* Do you wish to provide contact information and be kept informed?

If you select "yes", you will be directed to a contact page that will be stored separately from your survey responses. If you select "no", you will be directed to "submit" your responses and end the survey, with our thanks.

Yes

No

My contact information is:

First and Family Names
(as you prefer to be known)

Organization (if applicable)

Email Address

APPENDIX D: STAKEHOLDER SURVEY REPORT (UNFILTERED)

"Poz Prevention (2.0)" [08-2016]

1. ARE YOU HIV-POSITIVE?		
Answer Options	Response Percent	Response Count
Yes	40.8%	29
No	57.7%	41
I do not know	1.4%	1
I prefer NOT to answer	0.0%	0
answered question		71
skipped question		0

2. IF YOU ARE HIV-POSITIVE, HOW LONG AGO WERE YOU DIAGNOSED (APPROXIMATELY)?		
Answer Options	Response Percent	Response Count
Just in the last 3 years	0.0%	0
3 to 5 years ago	5.0%	3
5 to 10 years ago	8.3%	5
10 to 15 years ago	3.3%	2
15 to 20 years ago	8.3%	5
More than 20 years ago	25.0%	15
I do not know	0.0%	0

I prefer NOT to answer	0.0%	0
I am NOT HIV-positive	50.0%	30
answered question		60
skipped question		11

4. ARE YOU IN A LONG-TERM RELATIONSHIP?

Answer Options	Response Percent	Response Count
Yes	53.5%	38
No	45.1%	32
I prefer NOT to answer	1.4%	1
answered question		71
skipped question		0

5. IF YOU ARE IN A LONG-TERM RELATIONSHIP, IS YOUR PARTNER HIV-POSITIVE?

Answer Options	Response Percent	Response Count
Yes	16.3%	8
No	79.6%	39
I do not know	0.0%	0
I prefer NOT to answer	4.1%	2
answered question		49
skipped question		22

6. WHERE DO YOU CURRENTLY LIVE?

Answer Options	Response Percent	Response Count
British Columbia	8.5%	6
Yukon Territory	0.0%	0
Alberta	2.8%	2
Northwest Territories	0.0%	0
Saskatchewan	0.0%	0
Manitoba	1.4%	1
Ontario	71.8%	51
Nunavut	0.0%	0
Quebec	5.6%	4
New Brunswick	0.0%	0
Nova Scotia	2.8%	2
Newfoundland and Labrador	1.4%	1
Prince Edward Island	0.0%	0
I prefer NOT to answer	0.0%	0
I live outside of Canada, in:	5.6%	4
answered question		71
skipped question		0

6. WHAT IS YOUR AGE?

Answer Options	Response Percent	Response Count
17 or younger	0.0%	0
18-20	0.0%	0
21-29	5.6%	4
30-39	22.5%	16
40-49	21.1%	15
50-59	28.2%	20
60 or older	22.5%	16
I prefer NOT to answer	0.0%	0
answered question		71
skipped question		0

7. GENDER AND EXPERIENCES?

Answer Options	Response Percent	Response Count
I identify as a woman	10.0%	7
I identify as man	87.1%	61
I identify as two-spirit	1.4%	1
I identify as cisgender	0.0%	0
I identify as trans with lived experience	0.0%	0
I identify as intersex	0.0%	0

I do NOT gender-identify	0.0%	0
I am not sure	1.4%	1
I prefer NOT to answer	0.0%	0
Nonbinary/other gender identify (please specify)		0
answered question		70
skipped question		1

8. HOW DO YOU IDENTIFY YOUR SEXUALITY?

Answer Options	Response Percent	Response Count
Heterosexual	10.0%	7
Homosexual	57.1%	40
LGBTQ	27.1%	19
Bisexual	2.9%	2
Asexual	1.4%	1
I do NOT identify with a specific sexuality	1.4%	1
I prefer NOT to answer	0.0%	0
Other (please specify)		1
answered question		70
skipped question		1

9. ARE YOU CONNECTED WITH AN AIDS SERVICE ORGANIZATION (ASO) AND/OR OTHER HEALTH-RELATED SERVICE-PROVIDERS (SELECT ALL THAT APPLY)?

Answer Options	Response Percent	Response Count
Yes, I am a PAID employee of an ASO	18.2%	12

Yes, I am a PAID health-related service-provider within the HIV/AIDS sector	10.6%	7
Yes, I am a PAID health-related service-provider outside of the HIV/AIDS sector	0.0%	0
Yes, I am a VOLUNTEER at an ASO	19.7%	13
Yes, I am a VOLUNTEER health-related service-provider within the HIV/AIDS sector	6.1%	4
Yes, I am a VOLUNTEER health-related service-provider outside of the HIV/AIDS sector	10.6%	7
I am ALL of the above	1.5%	1
I am NONE of the above	48.5%	32
I prefer NOT to answer	0.0%	0
Other (please specify)		6
answered question		66
skipped question		5

10. WITHOUT PROVIDING CONTEXT HERE, DO YOU UNDERSTAND WHAT THE TERM "POZ PREVENTION" MEANS?

Answer Options	Response Percent	Response Count
Yes	68.2%	45
No	15.2%	10
I am not sure	16.7%	11
answered question		66
skipped question		5

11. BRIEFLY DESCRIBE WHAT "POZ PREVENTION" MEANS TO YOU.

Answer Options	Response Count
	46
answered question	46
skipped question	25

12. PLEASE INDICATE THE DEGREE TO WHICH THE PPWG'S DEFINITION OF POZ PREVENTION RESONATES (STILL RESONATES) FOR YOU?

Answer Options	Response Percent	Response Count
Really resonates	56.4%	31
Somewhat resonates	21.8%	12
Sort of resonates	14.5%	8
Does NOT resonate at all	5.5%	3
I do not know or I am not sure	1.8%	1
answered question		55
skipped question		16

13. THINKING ABOUT THE PPWG'S DEFINITION, PARTICULARLY IF IT DOES NOT REALLY RESONATE FOR YOU, WHAT WOULD YOU CALL ITS INTENT IF NOT POZ PREVENTION?

Answer Options	Response Count
	18
answered question	18
skipped question	53

14. DO YOU AGREE THAT HIV PREVENTION IS A SHARED RESPONSIBILITY (I.E. SHARED BY HIV-POSITIVE AND HIV-NEGATIVE PEOPLE EQUALLY)?

Answer Options	Response Percent	Response Count
Yes	96.4%	54
No	3.6%	2
I do not know or I am unsure	0.0%	0
answered question		56
skipped question		15

15. HOW IMPORTANT DO YOU THINK AN APPROACH CENTRED AROUND THE PRINCIPLES OF GREATER INVOLVEMENT OF PEOPLE LIVING WITH HIV/AIDS/MEANINGFUL ENGAGEMENT OF PEOPLE LIVING WITH HIV/AIDS (GIPA/MEPA) IS TO THE SUCCESS OF POZ PREVENTION?

Answer Options	Response Percent	Response Count
Extremely important	58.9%	33
Very important	35.7%	20
Somewhat important	3.6%	2
Not very important	0.0%	0
Not at all important	0.0%	0
I do not know or I am unsure	1.8%	1
answered question		56

16. IF EVEN ONLY SOMEWHAT, WHY IS A GIPA/MEPA-CENTRED APPROACH TO POZ PREVENTION IMPORTANT?

Answer Options	Response Count
	29
answered question	29
skipped question	42

17. WITHOUT SPECIFIC EVIDENCE ONE WAY OR ANOTHER, DO YOU THINK THAT A POZ PREVENTION APPROACH THAT IS GIPA/MEPA-CENTRED AT EVERY LEVEL (E.G., FROM DEVELOPMENT TO IMPLEMENTATION) REDUCES HIV INCIDENCE RATES?

Answer Options	Response Percent	Response Count
Yes	47.3%	26
No	1.8%	1
Probably	38.2%	21
I do not know or I am not sure	12.7%	7
	answered question	55
	skipped question	16

18. IT IS AN OLD REFERENCE, BUT THE WORLD HEALTH ORGANIZATION DEFINES SEXUAL HEALTH AS THE "CAPACITY TO ENJOY AND CONTROL SEXUAL AND REPRODUCTIVE BEHAVIOUR IN ACCORDANCE WITH A SOCIAL AND PERSONAL ETHIC." (WORLD HEALTH ORGANIZATION, 1975)HOW MUCH DO YOU AGREE WITH THE FOLLOWING STATEMENT? "POZ PREVENTION IS AS MUCH ABOUT SEXUAL HEALTH AS IT IS ABOUT HIV PREVENTION."

Answer Options	Response Percent	Response Count
Strongly agree	62.5%	30
Somewhat agree	25.0%	12
Neither agree nor disagree	8.3%	4
Somewhat disagree	0.0%	0
Strongly disagree	2.1%	1
I do not know or I am not sure	2.1%	1
answered question		48
skipped question		23

19. THINKING ABOUT THE WORLD HEALTH ORGANIZATION'S DEFINITION, WHAT IMPACT DOES CURRENT BIOMEDICAL PREVENTION DISCOURSE HAVE ON SEXUAL HEALTH GENERALLY?

Answer Options	Response Percent	Response Count
Significant positive impact	32.6%	15
Some positive impact	30.4%	14
Little or no impact	6.5%	3
Some negative impact	10.9%	5
Significant negative impact	2.2%	1
I do not know or I am not sure	17.4%	8
answered question		46
skipped question		25

20. WHY/HOW (BRIEFLY)?

Answer Options	Response Count
	31
answered question	31
skipped question	40

21. WHAT IMPACT DOES THE CURRENT BIOMEDICAL HIV PREVENTION DISCOURSE HAVE ON THE SEXUAL HEALTH OF GAY MEN MORE SPECIFICALLY?

Answer Options	Response Percent	Response Count
Significant positive impact	34.9%	15
Some positive impact	30.2%	13
Little or no impact	4.7%	2
Some negative impact	14.0%	6
Significant negative impact	2.3%	1
I do not know or I am not sure	14.0%	6
answered question		43
skipped question		28

**22. BRIEFLY BUT MORE SPECIFICALLY
IN YOUR VIEW, HOW DOES THE
DISCOURSE AND/OR THE
EMERGENCE AND
ONGOING EVOLUTION OF
BIOMEDICAL TECHNOLOGIES/
APPROACHES AFFECT HOW GAY MEN
THINK ABOUT POZ PREVENTION?**

Answer Options	Response Count
	27
answered question	27
skipped question	44

**23. WE HAVE "COME A LONG WAY"... BUT HAVE WE COME FAR
ENOUGH IN TERMS OF HOW GAY MEN'S SEX AND SEXUAL
HEALTH IS ADDRESSED IN OUR HIV PREVENTION WORK?**

Answer Options	Response Percent	Response Count
Yes	19.0%	8
No	64.3%	27
I do not know or I am not sure	16.7%	7
	answered question	42
	skipped question	29

24. IF SO, HOW SO? IF NOT, WHY NOT? (BRIEFLY)

Answer Options	Response Count
	27
answered question	27
skipped question	44

25. IN YOUR OPINION, HOW MUCH DOES AN UNCOMPROMISING COMMITMENT TO GIPA/MEPA CONTRIBUTE TO PROGRESS/SUCCESS IN ADDRESSING SEX AND SEXUAL HEALTH IN OUR POZ PREVENTION EFFORTS?

Answer Options	Response Percent	Response Count
Significantly	53.5%	23
Somewhat	18.6%	8
A little bit	7.0%	3
Not at all	0.0%	0
I do not know or I am not sure	20.9%	9
	answered question	43
	skipped question	28

26. IN A FEW WORDS AND SPECIFICALLY RELATED TO FOCUS ON SEX AND SEXUAL HEALTH, WHAT DOES AN UNCOMPROMISING COMMITMENT TO GIPA/MEPA LOOK LIKE TO YOU?

Answer Options	Response Count
	29
answered question	29
skipped question	42

27. WHILE MANY WOULD ARGUE THAT THERE SHOULD BE NO DISTINCTIONS MADE BETWEEN GAY MEN AND OTHER MEN IN TERMS OF HOW GENERAL HEALTH ISSUES ARE ADDRESSED, OTHERS WOULD ARGUE THAT EVEN THE MOST 'BENIGN' HEALTH ISSUES ARE EXACERBATED FOR GAY MEN, AND THE LITERATURE MIGHT SUPPORT THAT HYPOTHESIS. IN FACT, SOME EVIDENCE MAKES IT CLEAR THAT GAY MEN FACE CHALLENGES IN TERMS OF THEIR GENERAL (AND SEXUAL) HEALTH ISSUES THAT OTHER MEN DO NOT. DOES THIS RESONATE FOR YOU?

Answer Options	Response Percent	Response Count
Yes, very much: gay men face many challenges that other men do not	60.5%	26
Yes, somewhat: gay men face some challenges that other men do not	23.3%	10

No, not really: many challenges faced by gay men are faced by other men too	7.0%	3
No, not at all: gay men face the same challenges as other men	2.3%	1
I do not know or I am not sure	7.0%	3
answered question		43
skipped question		28

28. NOW, THINK MORE SPECIFICALLY ABOUT GAY MEN WHO ARE HIV-POSITIVE FOR A MOMENT. BRIEFLY (IF AT ALL), HOW DOES YOUR OPINION CHANGE IN TERMS OF THE CHALLENGES FACED BY GAY, HIV-POSITIVE MEN COMPARED TO OTHER MEN?

Answer Options	Response Count
	34
answered question	34
skipped question	37

29. YOU MIGHT AGREE THAT LITERATURE FROM THE EARLY 2000S SUPPORTS THE NOTION THAT THE NIH (IN ITS "NEW HORIZONS..." REPORT) WAS ONTO SOMETHING IN TERMS OF A RESEARCH AGENDA FOCUSED ON A LIFE PRACTICES APPROACH. IN TERMS OF POZ PREVENTION, DOES THE CURRENT RESEARCH (AS YOU KNOW/UNDERSTAND IT) SUPPORT A LIFE PRACTICES APPROACH TO SEXUAL HEALTH AND HIV PREVENTION TODAY?

Answer Options	Response Percent	Response Count
Yes, very much so	19.0%	8
Yes, to some degree	14.3%	6
Yes, but not enough	31.0%	13
No, not really	9.5%	4
No, not at all	0.0%	0
I do not know or I am not sure	26.2%	11
answered question		42
skipped question		29

30. ARE YOU FAMILIAR ENOUGH WITH WHAT CURRENT RESEARCH TELLS US ABOUT HIV PREVENTION, GAY MEN'S GENERAL AND SEXUAL HEALTH, SYNDROMIC HEALTH ISSUES, ETC. TO MAKE WHAT YOU WOULD FEEL CONFIDENT IS AN INFORMED CONTRIBUTION TO THE DEVELOPMENT OF (SO-CALLED) "POZ PREVENTION 2.0"?

Answer Options	Response Percent	Response Count
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Yes, I am quite familiar with what the research tells us now	25.6%	11
Yes, I know enough about what the research tells us now	23.3%	10
No, I do not think I know enough about what the research tells us now	32.6%	14
I do not know or I am not sure	16.3%	7
I prefer NOT to answer	2.3%	1
answered question		43
skipped question		28

31. IN YOUR OPINION AND SPECIFICALLY RELATED TO GAY MEN'S GENERAL AND SEXUAL HEALTH AND TO POZ PREVENTION, WHAT GAPS IN THE RESEARCH EXIST AND REQUIRE THE MOST IMMEDIATE ATTENTION (BRIEFLY)?

Answer Options	Response Count
	25
answered question	25
skipped question	46

32. BRIEFLY, BUT SPECIFICALLY, HOW WILL ADDRESSING THE RESEARCH GAPS YOU HAVE IDENTIFIED HELP ADVANCE A POZ PREVENTION AGENDA (I.E. THE DEVELOPMENT AND IMPLEMENTATION OF SO-CALLED "POZ PREVENTION 2.0")?

Answer Options	Response Count
	20
answered question	20
skipped question	51

33. DO YOU WISH TO PROVIDE CONTACT INFORMATION AND BE KEPT INFORMED? IF YOU SELECT "YES", YOU WILL BE DIRECTED TO A CONTACT PAGE THAT WILL BE STORED SEPARATELY FROM YOUR SURVEY RESPONSES. IF YOU SELECT "NO", YOU WILL BE DIRECTED TO "SUBMIT" YOUR RESPONSES AND END THE SURVEY, WITH OUR THANKS.

Answer Options	Response Percent	Response Count
Yes	35.7%	15
No	64.3%	27
answered question		42
skipped question		29

34. MY CONTACT INFORMATION IS:

Answer Options	Response Percent	Response Count
First and Family Names (as you prefer to be known)	100.0%	15
Organization (if applicable)	73.3%	11
Email Address	100.0%	15
	answered question	15
	skipped question	56

APPENDIX E: KEY INFORMANT INTERVIEW GUIDE

1. Does “POZ Prevention” resonate?

- a. How much do you think has changed in eight years - changed with respect to what POZ Prevention is/is called; changed with respect to how people think about POZ Prevention?
- b. When you think about POZ Prevention at a high level, do you see it as a programmatic intervention (or series of interventions), or is it more like a policy or policy direction for you?
- c. POZ Prevention appears to mean a lot of different things to a lot of different people; and it is known by a number of different names. What do you think we should call POZ Prevention, if something other than what it is?

2. In 2008, POZ Prevention focus was very much about gay men... at least for the GMSH and its PPWG. Notwithstanding the GMSH/PPWG mandate(s), do you think that POZ Prevention should be focused on gay men?

- a. Should it be focused on individuals at all, or would it be more appropriate to place programmatic emphasis at an organizational level?
- b. What do you think would change if focus was on organizations instead of individuals?

3. Do you agree that POZ Prevention is OR should be about more than just HIV prevention?

- a. If POZ Prevention is more than simply preventing HIV transmission and/or acquisition, how broad is its reach (or should its reach be)?
- b. When you think about syndemic issues in the context of POZ Prevention, which issues really become most apparent for you? That is, where should our energy be placed in terms of addressing syndemic issues?

4. How much about POZ Prevention is about the sexual health and quality of life for gay men... for you?

- a. Have the last 8 years given us more confidence in our policy and programmatic approach to the sexual health (and sexuality) of gay men?
- b. Does POZ Prevention facilitate broader focus on gay men’s sexual health, or is it really two different things?

5. What about research/what about the evidence?

- a. Do we know enough about what research tells us in terms of HIV prevention?
- b. Do we know enough about what research tells us in terms of sexual health vis-à-vis POZ Prevention?
- c. Do we know enough about what research tells us in terms of gay men's health and sexual health?
 - i. Does the research support the notion that gay men are faced with unique health challenges compared with other men?
 - ii. What are some of the most pressing/prominent challenges?
- d. If you were to identify three research GAPS/OPPORTUNITIES, what would they be?

6. Last word... anything you would like to add?

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