PUTTING 2SGBMSM WELLBEING ON THE POLICY RADAR:

Identifying Needs and Responses

GMSH
GAY MEN'S SEXUAL HEALTH ALLIANCE

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Executive Summary

PURPOSE

The purpose of this community-based study was to document wellbeing needs in the 2-Spirit, Gay, Bisexual, Queer, and other Transgender and Cisgender Men who have Sex with Men (2SGBMSM) community from the perspective of men working in AIDS Service Organizations (ASOs) to use findings to help the Gay Men's Sexual Health Alliance (GMSH) develop resources and programs, and provide evidence to support policy change.

METHOD

Representatives of the GMSH approached the research team with concerns about the wellbeing of clients from the 2SGBMSM community. The study was comprised of two environmental scans, and six focus groups with 21 ASO staff members (that served the 2SGBMSM community) as participants. Focus group questions were selected in collaboration with the GMSH.

FINDINGS

Overwhelmingly, study participants reported that wellbeing needs in the 2SGBMSM community they served were not being met, despite ASOs' best efforts, and recommended an increase in 2SGBMSM-targeted resources and advocacy. Many felt that their work was undermined by general workplace stress stemming from low pay, high staff turnover, and many expressed concerns about the impact of racism on BIPOC service providers. A lack of government policy targeted to the 2SLGBTQ+ (queer) community was identified as a barrier.

DISCUSSION

The study helped prioritize 2SGBMSM wellbeing needs that could be addressed by three groups: the GMSH, funders, and policy makers, respectively. Participants recommended resources for the GMSH to develop, as well as research priorities such as an evaluation of the needs of alliance organizations. The current lack of 2SGBMSM-targeted wellbeing policy presents a unique opportunity for advocacy.

CONCLUSION

The GMSH is dedicated to the best interests of the 2SGBMSM community. In addition to providing resources identified by participants as crucial, it is well-placed to advocate for and help build community development skills. Finally, working toward improved 2SGBMSM wellbeing policy could provide a focus for addressing many issues raised in this study.

RECOMMENDATIONS

- The GMSH should continue to advocate for 2SLGBTQ+ centered wellbeing policy.
- The GMSH is participating in a salary study for the sector led by the Ontario AIDS Network. To address turnover of service providers, they should continue to address the need for enhanced pay and resources.
- BIPOC workers face racism in their workplace. As a first step, the GMSH could establish an in-house equity committee with an initial focus on these issues.
- The COVID-19 pandemic has both exposed and exacerbated the impact of longstanding structural barriers faced by the 2SGBMSM community. The GMSH should integrate the social determinants of health (SDH), a public health model recommended by the World Health Organization that emphasizes the role of structural, economic, and social factors.
- The GMSH should ensure their campaigns and services include 2SGBMSM people in non-urban as well as in urban settings (i.e. avoid a "Toronto-centric" approach).
- Alliance members could benefit from additional educational opportunities, such as workshops on mobilization, and that include the perspective of experts from outside of the community.
- The GMSH should improve tools to connect members, especially new ones.
- Currently, sexual health clinics are not meeting the wellbeing needs of the 2SGBMSM community. It would be beneficial for alliance members, including the GMSH, to collaborate on a campaign to address barriers.
- GMSH should consider conducting a more detailed needs assessment/evaluation of organizations' needs.

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Introduction

Members of the 2SGBMSM community in Canada face significant population-specific risks to wellbeing. Mental illness is more common in the queer community, along with substance abuse and suicide (Kulick, Wernick, Woodford, & Renn, 2017; Pakula, Carpiano, Ratner, & Shoveller, 2016; Veale, Watson, Peter, & Saewyc, 2017). Members of the 2SLGBTQ+ community are also more vulnerable, compared to heterosexuals, to physical abuse, emotional abuse, and violence (Logie, James, Tharao, & Loutfy, 2012; World Health Organization, 2013). There is increasing evidence of an enhanced socioeconomic risk of being queer, such as housing instability and lower income (Blosnich et al., 2017; Emlet, 2016; Ferlatte, Salway, Trussler, Oliffe, & Gilbert, 2018; Wade & Harper, 2017), sometimes leading to homelessness (Abramovich, 2012, 2016).

Members of the 2SGBMSM community are calling attention to the urgent need for a targeted and comprehensive response to their wellbeing needs, and research supports them. AIDS Service Organizations (ASOs), originally founded to address HIV/AIDS, decry the current lack of attention to mental, emotional, and social wellbeing in the 2SGBMSM population. Many ASOs struggle to meet even the most critical wellbeing needs of clients, in part because they have no clear mandate for the post AIDS-crisis-era.

The Gay Men's Sexual Health Alliance is a member-based coalition of 33 ASOs and other organizations concerned with 2SGBMSM sexual health throughout Ontario, and provides a community hub for education, capacity building, and resource development. Because it is currently working with funders and partners to better define its role and capacities, the organization has identified the present as an ideal time to carry out this inquiry.

Literature Review

SEARCH STRATEGY

The following key words were used: "social determinants of health" OR "health equity" OR "wellbeing"; AND "sexual orientation", "sexual minorit*", LGB*, GLB*, "sexual identit*", "gender identit*", and "gender expression". The search involved a search of title, abstract, and subject heading in 17 databases through ProQuest for peer-reviewed journals from January 1, 2009 to January 1, 2021. Articles that were included were scholarly North American, English-language articles, excluding book reviews. Articles that focused on lifestyle issues (e.g., smoking, substance use) or on diseases other than HIV/AIDS (e.g., cancer patients) were also excluded. Articles also had to focus specifically 2SLGBTQ+ populations or sexual minorities, as opposed to looking at "vulnerable" populations in general. A manual search was conducted for references cited in some of the selected articles that met these criteria. The search produced 1092 results (256 results after "wellbeing" was removed from the search terms). The resulting publications including "wellbeing" was reviewed for inclusion.

Following a review of titles and abstracts, 167 articles met the inclusion criteria and were included as part of this review. **(See appendix A)**

HEALTH EQUITY: THE KEY TO UNDERSTANDING 2SGBMSM WELLBEING

Health equity is the principle underlying a commitment to reduce (and, ultimately, eliminate) disparities in health through addressing its social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions (Bartley, 2009; Braveman, 2006; Shaw, Dorling, Gordon, & Smith, 1999).

Ideally, public policy to promote heath equity is based in a thorough understanding of the various communities that form that public. Unfortunately, this is not always the case. According to Dharma and Bauer (2017), the Canadian Health Survey is based on a flawed concept and operational definition of sexual identity, so its findings may be incomplete or inaccurate (See also Cahill & Makadon 2017; Wolff et al. 2017). Further, recent research on the Canadian policy environment revealed a major gap in the recognition of, understanding of, and programming for the 2SLGBTQ+ community (Mulé & Smith, 2014; McKenzie, Mulé & Khan, 2021).

Research evidence supports the premise that members of the 2SGBMSM community face health inequity in the form of unequal access to health and social services, and a greater risk of HIV/AIDS and STIs (Public Health Agency of Canada, 2018, 2021). Tjepkema (2008) reported that bisexual individuals face greater marginalization and have several unmet health needs. Similar outcomes were found among bisexual older adults (Fredriksen-Goldsen, Shiu, et al., 2017) and bisexuals who are racialized (Hudson & Romanelli, 2020) compared to their heterosexual counterparts. Lastly, sexual health education remains inadequate for queer youth (Johns et al., 2019; McKenzie, 2015).

Members of the trans community, in particular, have unique wellbeing needs related to reproductive health and transition surgery; however, health inequity based in transmisogyny is inherent in the current system. To illustrate, trans individuals must often educate their healthcare providers, may experience microaggressions, and often suffer the impact of biased healthcare providers, including a common tendency to focus on sexual risks at the expense of other health issues (Bauer et al. 2009; Hudson, 2019; Institute of Gender and Health 2012; Martinez-Velez et al., 2019; Smart et al., 2020).

With regards to structural factors (social determinants of health), in 2017 the Canadian Coalition Against 2SLGBTQ+ Poverty reported a high risk of poverty in the 2SLGBTQ+ community. These findings are consistent with other research that found a higher risk of homelessness (Abramovich, 2012, 2016) and a wage gap between sexual minorities and heterosexuals (Waite & Denier, 2015).

The discussion of health equity may be expanded to encompass the concepts of resilience and positive adaptations to the adversity that 2SLGBTQ+ people face in the context of identity-based discrimination. The Minority Stress Theory and the Health Equity Promotion Model (Fredriksen-Goldsen et al., 2014; Hudson & Romanelli, 2020) are often used to explain the disparities that exist with regard to social exclusion of 2SLGBTQ+ people and associated outcomes.

Understanding the social determinants of health requires an examination at the socioecological levels (Fredriksen-Goldsen et al., 2014; Gower et al., 2019; Hudson & Romanelli, 2020; Logie et al., 2016), which helps to extend the conversation beyond individual responsibility and instead focus on the structures that impact people's well-being outcomes.

COMMUNITY WELLBEING

As mentioned above, the wellbeing of the 2SGBMSM community is not on the public policy radar. Individuals from this community have high rates of mental health issues ranging from anxiety and depression to substance abuse and suicide (Fish, 2020; Kulick et al. 2017; Pakula et al. 2016; Veale et al. 2017). It should be noted that community engagement can provide great benefit to mental health outcomes and needs (Kosciw et al., 2015; Toomey & Russell 2011). Social support appears to be vital for 2SLGBTQ+ people in their ability to mitigate the detrimental impacts of systemic oppression on their psychological well-being (Emlet, 2016). Social support also appears to be pertinent for 2SLGBTQ+ older adults (Emlet, 2016) and racialized 2SLGBTQ+ people (Hailey et al., 2020), helping them navigate systemic oppression, including ageism and racism, in the general community and the 2SLGBTQ+ community. Hudson and Romanelli (2020) identified community assets that can enhance 2SLGBTQ+ people's health equity, including inclusion, reciprocity, and community mobilization.

There are many individual characteristics and associated systemic issues that contribute to 2SLGBTQ+ individuals' wellbeing, including nativity and migration status (Allen & Leslie, 2019; Kline, 2020; Logie et al., 2016; Oster et al., 2013), income and related factors (e.g., employment, housing stability, food security) (Downing & Rosenthal, 2020; Fredriksen-Goldsen, Kim, et al., 2017; Hudson & Romanelli, 2020; Lazarevic et al., 2016; Logie et al., 2016), age (Emlet, 2016; Fredriksen-Goldsen, Kim, et al., 2017; Johns et al., 2019; Kim et al., 2017), gender (Hudson, 2019; Kertzner et al., 2009; Lett et al., 2020; Martinez-Velez et al., 2019; Smart et al., 2020), race/ethnicity (Johns et al., 2019; Kim et al., 2017; Lett et al., 2020; Roberts & Christens, 2020; Smart et al., 2020; Swann et al., 2020). Some studies show that racialized 2SLGBTQ+ people do not have significantly different outcomes compared to white 2SLGBTQ+ people, which might be due to a resilience associated with racial/ethnic communities (Hudson & Romanelli, 2020; Kertzner et al., 2009; Kim et al., 2017). Recent publications have described the increased disparities among sexual and gender minorities due to the COVID-19 pandemic, resulting in issues related to access to healthcare services, employment and income concerns, and poor mental health outcomes (MacCarthy et al., 2020; Salerno et al., 2020).

INTERSECTIONALITY AND DISCRIMINATION

The concept of intersectionality can be a useful tool to critically examine the system in ways that bring to the forefront structural oppression and strategies for systemic change (Chan & Henesy, 2018). Race/ethnicity, income/class, dis/ability, and religion and their associated structural oppression are among the factors that contribute to people's overall wellbeing, including mental health and coping behaviours. Intersectionality is vital in consideration of health equity among 2SLGBTQ+ people (Chan & Henesy, 2018; Durrani & Sinacore, 2016; Felner et al., 2018; Lett et al., 2020; Roberts & Christens, 2020). Durrani and Sinacore (2016) described how an intersectionality lens can help understand the experiences of South Asian-Canadian gay men and HIV prevalence and prevention strategies, such as conceptualizing the discrimination they face in the general community, their racial/ethnic community, and the gay community. For 2SLGBTQ+ youth of colour, social exclusion from spaces and services contributes to their lack of access to resources, psychological stress and negative coping, and identity formation and stigma management (Felner et al., 2018).

Discrimination in various settings, particularly healthcare settings, contributes to racialized individuals' reluctance to seek care, including getting testing and treatment for HIV (Oster et al., 2013). Similarly, Indigenous 2SLGBTQ+ people also encounter barriers to their healthcare, compounded by racism and historical colonialism in other aspects of their lives, such as employment (Scheim et al., 2013; Spurway et al., 2020). For Indigenous 2SLGBTQ+ people, decolonial work is vital to ensure inclusive care. Furthermore, recommendations for working with 2SLGBTQ+ clients in a counselling setting are to understand the whole person, taking intersectionality into account to foster genuine acceptance and affirmation of the 2SLGBTQ+ client, while looking to the resilience and strengths of the individual rather than the risks and deficits (Berke et al., 2016).

Method

Representatives of the GMSH approached the research team with concerns about the wellbeing of the 2SGBMSM community. The study was comprised of two environmental scans and six focus groups with 21 ASO staff members (that served the 2SGBMSM community) as participants. Focus group questions were selected in collaboration with the GMSH.

Environmental scan of the policy context: In order to better understand the scope of existing public policy and potential openness to policy development, we reviewed documents, reports, and other content related to queer men's health and social policy from the websites of the following Ontario government ministries: Children, Community and Social Services; Education; Colleges and Universities; Health and Long-Term Care; and Municipal Affairs and Housing. Findings were used to help formulate questions for the focus groups.

Environmental scan of programs and services: To understand the scope and relevance of existing resources for members of the 2SGBMSM community, and to identify gaps, we started with the member organizations and the GMSH, and worked through their networks. The research team analyzed and produced an annotated inventory of organizations currently working toward this community's wellbeing in Ontario, and the services and programs they offer. Findings were used to help formulate questions for the focus groups.

Focus groups: Informed by the findings of the two environmental scans, the research team designed focus group questions in consultation with alliance members from across Ontario. Focus group participants were asked about wellbeing needs of the 2SGBMSM community, service gaps; organizational challenges (including funding); representation and impact of diversity on the work of the organizations; adequacy of current social policy for meeting the community's wellbeing needs and strategies to influence public policy; the impact of the COVID-19 pandemic on the organizations and the broader community; awareness of GMSH resources; and models and actions for community mobilization. Focus groups were recorded, and the recordings were professionally transcribed verbatim. The research team doublechecked transcripts for accuracy. Data were analyzed using a pre-determined coding framework based on the findings of the environmental scans, and emerging themes were also noted.

Findings: Environmental scans

LOCAL, PROVINCIAL, AND NATIONAL HEALTH PROGRAMS AND POLICIES

For the environmental scan, researchers examined sections of websites belonging to relevant Ontario ministries that referred to "mental health" (n=5), provincial mandates/strategies (n=2), federal departments (n=2), national agencies (n=3), Ontario agencies (n=4), and Ontario public health units (n=34).

With regards to the websites of the five Ontario ministries, we found that much of the information related to mental health had been provided under the mandate of the previous government, and hence may no longer be relevant. With respect to up-to-date mental health content, it is treated very generally, under the broader topics of wellness and wellbeing. That said, the Ministry of Children, Community, and Social Services website provides mental health-related information in the context of the child welfare system.

We found that none of the ministry websites we scanned identify a specific wellbeing policy for 2SLGBTQ+ people. References to some programs relate to positive youth development, but none are specific to 2SLGBTQ+ youth. That said, the Ministry of Education's pages about elementary and secondary school curriculum do offer limited information related to 2SLGBTQ+ health and wellbeing. In addition, the website of the Ministry of Health contains content related to 2SLGBTQ+ wellbeing concerns, including healthy relationships, coming out to healthcare providers, risks and misconceptions for 2SLGBTQ+ sexual health, and trans health concerns.

STRATEGIES

Two public strategies focus on mental health and HIV/AIDS, respectively. The Mental Health and Addiction Strategy for Ontario (Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System) does not mention 2SLGBTQ+ people. Rather, it offers recommendations for addressing mental health and addiction for the general population and some sub-populations, namely those with certain types and severities levels of mental health challenges.

Proposed programs and services range from emergency and inpatient psychiatric services, psychotherapy and counselling services, peer and family support, and education and prevention.

The HIV/AIDS strategy for Ontario, the second public strategy we analyzed, describes various supports related to 2SGBMSM sexual health and wellbeing, including for those at risk for and or living with HIV/AIDS. It presents a conceptualization of health and wellbeing that encompasses physical, mental, and social dimensions. The concepts of systemic theory and social determinants of health are applied to describe how various factors interact and impact on individuals' wellbeing. Mental health programs and services are not explicitly identified as unique interventions for addressing the overall health and wellbeing of 2SGBMSM; this was done more generally, by lumping together mental health and addiction.

We examined the websites of Health Canada and the Public Health Agency of Canada. Health Canada provides resources and links to mental health services plus mental health information embedded within the "Pan-Canadian Healthy Living Strategy". The Public Health Agency of Canada describes the social determinants of health model. Overall, general mental health promotion information (e.g., positive mental health, risk factors, different challenges and conditions) are provided in relation to various populations, including people in the workforce, different age groups, veterans, members of the Canadian Armed Forces, and Indigenous communities. Information related to 2SLGBTQ+ people was not provided.

Two national agencies were included in the review: The Community-Based Research Centre and the Canadian Alliance on Mental Illness and Mental Health (an advocacy group). The Community-Based Research Centre has dedicated programming and information for 2SGBMSM. Two programs offered relate to developing community leaders and empowering them to advocate for mental health and other health needs of their communities. Participants develop health literacy, practical skills, and community networks to support their work to address systemic issues in their communities. The Canadian Alliance on Mental Illness and Mental Health mainly provides information and addresses misconceptions related to mental health and illness for the general population. We found no information related to 2SGBMSM or People Living with HIV/AIDS (PHA) on their website.

The five Ontario agencies reviewed were Connex Ontario, Addictions and Mental Health Ontario, Canadian Mental Health Association Ontario, Rainbow Health Ontario, and the Centre for Addiction and Mental Health. Ontario Connex is focused primarily on people who experience challenges with gambling, drugs, alcohol, and/or mental health. Ontario Connex describe programs and services including the Postsecondary Mental Health Initiative, Good2Talk, eServices, LHIN Scorecards and Data Quality Reports, plus system navigation services. Addiction and Mental Health Ontario does not identify any specific information for 2SGBMSM or PHAs. Their work focuses mainly on advocacy and system enhancement for mental health services in Ontario. The Canadian Mental Health Association Ontario provides information for 2SLGBTQ+ mental health, but none for PHAs. They identify specific programs offered at local branches across Ontario for people struggling with mental health conditions. Rainbow Health Ontario offers mental health resources for 2SLGBTQ+ people, but none specific to PHAs. Finally, the Centre for Addiction and Mental Health provides a range of inpatient and outpatient mental health programs and services. They offer "Rainbow Services", which offers counselling to 2SLGBTQ+ people concerned about their drug and alcohol use.

Among the 34 Ontario public health units (PHUs) examined, most provide information about mental health using positive language, such as positive mental health, wellness, wellbeing, and resiliency, (rather than using the term mental illness). Mental health is often linked with addiction, and may be discussed in the context of mental health promotion (via education) or mental health crisis (via services). Mental health content is geared toward four different groups: youth in school and their parents, members of the workforce, healthcare providers, and older adults. Two PHUs provide no information related to mental health, while all provide links to local, provincial and national resources and services. The most common are crisis services. Content for geographically-remote areas identifies fewer in-person and more online and telephone resources and services. Three PHUs have developed a mental health promotion strategy for their region, while three others have published an epidemiological overview of mental health in their region.

AIDS SERVICES ORGANIZATION MENTAL HEALTH PROGRAMS ACROSS ONTARIO

Our environmental scan involved a review of 36 websites of agencies that are members of the GMSH and based in Ontario. (See appendix B)

Most ASO agencies (61%; 22/36 agencies) offer some programming specific to 2SGBMSM. Of these, six do not state whether or not their 2SGBMSM health programs are inclusive of trans individuals (i.e., they are not explicit as to whether their use of 2SGBMSM encompasses both cis and trans men). These men's health programs mainly comprise education and outreach activities, such as online chats, events, workshops on sexual health, social activities, and support groups for 2SGBMSM individuals. These are centred around the concept of building healthy sexual and romantic relationships, principles of harm reduction, and disease prevention as appropriate.

In comparison, 39 percent (14 of 36) do not identify programming specifically for 2SGBMSM individuals. Of these, just under half (6/14 agencies) do include more general topics of potential value for the general 2SGBMSM community. The remaining eight organizations (57%) offer services only for PHAs.

A majority of agencies (83%; 30/36 agencies) provide some kind of mental health program or service. Just under half (43%; 13/30 agencies) offer mental health programs for 2SGBMSM who are living with HIV/AIDS. These programs include on social support, one-on-one counselling, workshops, and discussion groups. The remaining 17 agencies (56%) offer general mental health programs for PHAs. These programs offer counselling (individual and group), peer support, alternative therapies (e.g., massage, reiki), referral to psychotherapy and other community-based mental health services, and general wellness programs and social activities (most do not provide details). Generally, the mental health programs that offer social support or counselling tend to use mindfulness, cognitive behavioural therapy, and motivational interviewing. Many strive to build self-esteem, positive body image, coping skills, resiliency, and strategies to manage substance use. The format of specific programs includes drop-ins or weekend retreats, over a certain number of sessions, or else single sessions/workshops.

Findings: Focus Groups

The organizations represented in the focus groups have long been dependent on volunteers, including PHAs. The ASOs tend to employ harm reduction approaches in their outreach work. Participants reported having flexibility in their roles, despite the need to meet accountability indicators for funding. Participants described their work as becoming more focussed on social determinants of health as a better way to address HIV/AIDS concerns with increased prevalence of mental health, substance use, and housing topics.

Most clients served by participants are gay, bi, trans, 2-spirit MSM. Some participants also engage in outreach work with sex workers, street-involved individuals, people who use substances, and international students. Some participants prioritize their time with BIPOC GBTQ+ men, as per organizational mandate.

There was a wide range of experience among participants, ranging from under one year to over 35 years. The mean duration was approximately four years, with a median of approximately two years. In other words, about half of the focus group participants had worked in their roles for less than two years.

The use of a pre-determined coding framework allowed for the thematic organization of findings under six themes:

1. Wellbeing needs of the community and gaps in services;
2. Organizational challenges in meeting community needs, including funding constraints;
3. Representation and impact of diversity on the work of the organization;
4. Adequacy of current public policy for meeting the community's wellbeing needs and strategies to improve it;
5. The impact of the COVID-19 pandemic on the organization and broader community; and
6. Awareness of GMSH resources and concepts and actions for community mobilization.

Wellbeing Needs and Gaps in Services

All participants spoke of gaps in support of wellbeing needs for 2SGBMSM; specifically, insufficient services, plus barriers to the few services that do exist. To illustrate, Participant 18 described the depth of unmet services needs in the community: "…a lot of the main concerns are isolation, loneliness, how to create [or] make friends, how to find just a regular doctor, how to find a therapist. Just really, really basic needs and of course, financial health which is a whole other issue with COVID." Participant 6 noted the lack of 2SGBMSM mental health services that are queer-centred: "… I especially have not seen an investment in mental health services, particularly for folks who can't afford or don't have insurance … and community services can only do so much." Some participants indicated that they understand the structural barriers to mental health, such as Participant 8 who said: "Social determinants of health have always, always played a role in mental health and health in general for marginalized folks and the idea that it's taken a pandemic to make that realization come to light for a lot of folks is a little discouraging, but at the same time, gives me a little bit of hope that maybe we are going to finally see some lasting change and some policies in place that will make a difference…"

Participant 17 pointed to a gap in research, as it has often focused on the experiences of white, cisgender gay men, making it challenging to engage in evidence-informed practice with more diverse groups of MSMs. They said: "I think a lot of research, especially things around medication are geared towards men, but I think there's definitely things lacking in terms of research and visibility of men who have sex with men."

Participants also identified barriers related to stigma against the 2SGBMSM community, which magnifies the impact of service gaps. For example, non-heteronormative sex is still stigmatized. Participant 14 stated: "Gay sex is a shunned conversation still. It's not talked about. The only thing that we keep on seeing is also what's in the media, the stereotypes in the media… But gay sex needs to be—I need to be able to go to my doctor and say, 'Hey, you know what? This guy just fisted me and I have a fissure,' right? Without feeling ashamed or shunned, because hetero people do all this stuff as well." This sentiment was echoed by Participant 5: "So, I think, too, at the frontline level, we have to have broader conversations and deeper conversations around gay sex … We ought to really break this down because too many gay men walk away from services and programs saying, 'Oh, I am not going back there because they, the people who are providing those services, aren't comfortable or (are) repulsed by it.'"

One specific example of underlying stigma is the difficulty of accessing pre-exposure prophylaxis (PrEP). As Participant 17 noted: "They don't know how to talk to their health care providers. They feel uncomfortable asking about PrEP. Another participant pointed to the "socio-economic barriers to accessing PrEP", adding "If you can't afford PrEP, that's very hard and if you're not on ODSP and you're going to get it for free that way, then the only thing is Trillium, right? And …—it's not free; you have to pay for it…. And the other thing, too, I help walk people through the Trillium process and it is not intuitive in any way. And in fact, in my opinion, it's set up that way on purpose in order to deter people from using it because it doesn't even exist online…. We have to print out a bunch of papers and mail them somewhere … which is antiquated I think for this time that we're living in right now." This concern was echoed by Participant 5: "… But for the community at large, we are still behind in many ways because there are too many people getting left behind, and this is because of socio-economic situations."

Indeed, some participants reported that they are very aware of how intersectionality impacts access. Again, geography plays an important role. One participant from northern Ontario expressed frustration with a sexual health clinic at the local public health unit that refuses to prescribe PrEP. Rural areas also face challenges, as noted by Participant 9: "… reaching out to people who aren't in urban centres, which is where a lot of our services are located, has become a lot more difficult and … if you were doing it in rural areas, that's often racialized guys. Again, it exacerbates a lot of other systemic inequalities when people can't afford to live in a usually more expensive urban centre."

Service gaps are not specific to rural areas, however. Even urban centres close to Toronto face challenges, as described by Participant 8: "that too brings on issues of systemic racism and all the other social determinants of health that we find for folks who are forced to live in these more remote areas, because that's all they can afford. It's cheaper to live in Orillia than it is to live in Barrie, for example. And therefore, it's harder to access services. So those are all challenges that we continue to face." These problems are evident in other parts of the province; as Participant 20 said: "But as for physical health or wellness, it doesn't exist especially if you're 2SLGBTQ, BIPOC or at intersection of anything… I think if you have an intersectional identity, it's very hard, or marginalized intersectional identity, I should say. I think it's very hard to get competent services (in smaller urban centres) ...". Another participant raised the issue of the lack of access to services for people living with disabilities.

Organizational Challenges in Meeting Community Needs

A majority of participants acknowledged that their organizations are meeting community needs to the best of their ability. It is evident that all focus group participants share a passion for making a positive difference for the communities they serve.

UNMET COMMUNITY NEEDS

Participants reported the observation that trans/non-binary individuals, BIPOC, immigrants, and people with disabilities are underrepresented among their clients. Many identified a lack of expertise within their organizations to properly address the needs of the trans/non-binary community and working with Indigenous communities. As Participant 20 described: "I feel that we are meeting some needs…especially as it pertains to… people who are using substances… we're doing a great job. I think [2SGBMSM] or trans or queer folks specifically, I think that definitely we could be doing a better job. But definitely, like, we don't actually know what their needs are." Racialization was also highlighted by Participant 6: "we have large gaps in terms of reaching African and Caribbean Black, same-gender loving folks…. Our agency is in the process of trying to build relationships with Indigenous and Two-Spirit organizations and individuals within the community…" Geography was again cited as an organizational challenge for meeting the community's needs. This includes rural or even suburban localities which lack bathhouses or other physical spaces where 2SGBMSMs can socialize. Participant 13 pointed out: "I think that my agency right now is meeting the needs of the community and I think that we're doing a wonderful job… But my concerns are that …ASOs have thrived [in] queer cities, you know, like in central Toronto. Like Toronto downtown is able—they're able to serve the people that they do because they're able to go do bathhouse outreach programs …—they have thriving communities for them to be able to do the work that they need to do. Whereas where our organization is …, we don't have those thriving queer communities, or our Pride populations aren't always gathered in the same way that you expect them in these larger cities."

ADVOCACY NEEDS

Some participants reported that they felt that their senior management understood gaps in services and supported their creative efforts to meaningfully engage clients and address their needs. Many agreed with the importance of client-centred approaches, a meaningful involvement of people with HIV/AIDS, and harm reduction philosophy. Such values and approaches are embedded within their organizations' policies and practices, which helps them address the needs of their respective communities.

One challenge within organizations, however, is that of barriers to advocating for 2SGBMSM community because of hesitancy on the part of management. As one participant shared: "…I don't think we've put out as many position statements, I don't think we've signed as many petitions, I don't think that we've reached out to as many politicians as we should have because it's always this, 'We don't want to rock the boat.' …if you're asking for the community to trust you with their health and wellness needs, but you're also not willing to speak to power and show that you're willing to advocate for them, then I think that that puts you in a very delicate situation." This was echoed by Participant 13: "…with policy changes, one of the barriers is a lot of people within their own organizations don't know if their policy on a human resources level and public health funding are allowed to be advocating or not. …. I'm not allowed to put 'advocate' anywhere in my programming. Like if I use that word anywhere, I am done for. And policy changes, I could help with internal policy changes because the board of directors allows it, but … if I'm dealing with an executive director and board members who are predominantly white cisgendered gay men, what I say is I'm one against ten, so what does that mean, right?" Similarly, senior management is not diverse. As Participant 13 said: "…[W]ithin the organization it's predominantly White. There's only … four of us that are people of colour within the organization…[so] to try to bring this to the forefront, it's like, 'Yes, we hear you, but how do we apply this?' And they don't—there's really no work that's been there, even though we have an anti-racism, anti-oppression, you know, values and principles. …[I]t's great that it's verbalized, but where is the action behind it, right?"

Another barrier identified is bureaucracy. Participant 3 noted that an issue must go through several steps, through a supervisor to the ED to the board and "A month and a half, two months later, and then it's, like, 'Oh, what was this about again?' And then you kind of have to lather, rinse, repeat and it's just that horrible cycle."

Some participants spoke of homophobia and/or racism within their organizations, even at the senior management level. Due to the reliance on volunteers and peers, many participants identified concerns about volunteer burnout that might hinder the progress of initiatives. As an extension to funding, the experience of being underpaid contribute to high staff turnover, which in turn affects continuity of programs.

COMMUNITY PARTNERSHIPS

Participants also questioned the lack of collaboration among community partners. This was noted by Participant 11: "In Toronto, because we have a lot of different ASOs, I think our number one challenge is that there's no connection between them. So, like, everybody's doing their thing and nobody's checking in with anybody else to see what's already been done and sort of what is currently going on." As Participant 3 said, "And instead of 'How can we create this partnership?', it is the silo…It's so disjointed to me. I know, I've personally tried to reach out over there and they're not interested in creating a partnership. They're going to offer their program. So, it is frustrating." Participant 11 concurred: "… I'm sure this is like a province-wide issue also, probably to an even bigger extent, but, you know, the issue of what they call 'working in silos.' So, we're all doing our own thing. There's no—or there's limited opportunity. Yeah, we get together, you know, at the symposiums or whatever, right, and all those kinds of things, and now online, but that really is just not enough because it only happens, like, X amount of times per year. But in our own agencies, we're constantly pushing stuff out, right?"

A few participants identified competition for (limited) funding as a barrier to forming partnerships with other ASOs. Some fear that other agencies competing for the same funding might not actually have the expertise to serve key populations (especially people with multiple marginal identities). Others felt pressure from larger agencies to focus on their priorities when working together.

When partnerships do exist or are formed, some participants experience them as one-sided. As Participant 20 said: "For us, … we're very encouraged to work collaboratively with community partners and I think for the most part, I've been very lucky and [have had] some really great partnerships. However, like, we used to have a really great one with our Public Health but their funding changed a little bit so their priorities shifted and it meant a shift away from us unfortunately. We tried to really work it a million different ways and it just wasn't going to work quite the way we wanted it to. So, now our partnership looks vastly different and it's not as helpful to us, but is maybe more helpful to them…—some of our community partners I see come and go because once they get the benefit out of the partnership, they're, like, 'Okay, we're done' and they're not necessarily willing to wait out our—for myself or our agency to benefit as well. They're kind of just out of it really fast. Or we create MOUs and they don't necessarily stick to the MOUs. They're, like, 'Oh, well, I got what I needed. I'm gone.'"

Many participants referred to high staff turnover as a limitation to the maintenance of collaborative partnerships. There are also frustrations related to the amount of time it takes to develop partnerships, let alone make any major progress on addressing issues. As some participants noted, some partnerships stagnate because of a misalignment of goals.

The COVID-19 pandemic has been a major barrier in developing partnerships, especially for agencies directly involved in the pandemic response. This has contributed to some frustration in feeling as if their clients' wellbeing needs are not a priority.

Issues Preventing Organizations from Meeting the Community's Needs

FUNDERS' RESTRICTIONS

Funding is a major factor in meeting 2SGBMSM wellbeing needs, particularly when it comes to addressing social determinants of health. Participants described concerns around balancing clients' and funders' needs, particularly in resource-limited contexts and when they must also contend with unrealistic expectations. For example, Participant 6 said: "I think in response to funding, [we] aren't paid enough, nor is our program funded enough to do the kind of work that the federal government in particular, which funds our program, expects us to do. Because they are asking for our interactions with [2SGBMSM] to reflect the kind of risk reduction in their sexual health practices that isn't possible just through brief interactions especially when there is so much stigma and misunderstanding about HIV and how it is transmitted and then also other STIs. If we really wanted to make a difference in the lives of [2SGBMSM] we would have the funding to offer more in-depth—and it could be formal counselling—but at least, funding that would allow us to have the capacity to sit and engage with guys in the community over a period of time. Because so often, what we understand is it's not just a simple knowledge transfer that will do it, we have to understand the ways that internal and external homophobia play in their lives, HIV stigma and fear, lack of transmission understanding and the societal and cultural forces that are at play. Specifically, for more vulnerable marginalized folks who are street-involved or sex workers or Black, Indigenous, people of colour within the [2SGBMSM] community…. but if the government was serious about actually addressing the health disparities within this community in particular, I think that they would be more willing to not only provide us more funding but also provide us as service providers with supports that we need as well to do the jobs that we're doing."

Further, the need to meet accountability agreements with funders, plus pressure to conform to their (unrealistic) expectations, contributes to a fear of trying new approaches or interventions. To illustrate, there are insufficient funds to permit the trial of dynamic and engaging education programs as opposed the basic slide presentations.

COMPETITION FOR FUNDS

A challenge identified by participants is that ASOs and other community agencies may have overlapping jurisdictions and target populations, which leads to competition for the same funding. Smaller organizations may be disadvantaged in competing with larger ASOs, as Participant 14 explained: "Organizations that are very big and well-funded who are taking money from smaller organizations like ASAAP, Black CAP, who are struggling, and yet those big organizations are using those smaller organizations for their research." High competition for limited funding can make it challenging to engage in meaningful work and develop effective partnerships. Participant 14 noted: "One of the barriers again is the organizations not working well together in terms of how to—we need to come together when it comes to funding. Instead of using one organization to make sure that they continue to get funding for that program that is affecting another."

UNDERFUNDING AND HIGH TURNOVER

Many participants stated that programs are underfunded, while staff are underpaid for their work. As Participant 6 noted: "I would say that we were already vastly underfunded, underpaid and stretched at capacity. I think all of us are. The onset of the pandemic made that clearer." This theme was further echoed by Participant 14: "[I]n terms of funding, that's always been a challenge. I mean, I don't get paid enough [compared] to the cost of living…—public health, for instance, will fund my program based on what they think is right but not exactly my needs as an individual who runs the program. And if I need to hire a student for the summer, there isn't any [funding]. It's a constant struggle to ask for that…. [E]ven public health does not give us more funding for even just a slight raise to keep up with cost of living…."

Underfunding puts further stress on participants who must fulfill multiple roles in their organization, as Participant 16 described: "I do think there probably is a lack of funding in our agency just because there's people doing jobs, asked to do jobs, that just cover such a huge, you know, a range of

different things, that there's just no way one person is able to do it all. And I feel even from my own program, I know it's a one-man program, and I don't think I have a budget… even when it comes to honorariums for, you know, getting guys in to do focus groups or come to meetings and stuff, that's not even an option for me." These unsustainable workloads for participants could lead to burnout. As stated by Participant 20: "I think over the years there definitely has been times of, like, feeling burnt out. We went from having two full-time workers in my position to myself and a 7-hour-a-week worker to myself and a part-time worker. And we've had multiple part-time workers so that's definitely affected feelings of burning out and overwhelming work."

Underfunding and underpayment leads to high turnover, which has impacts beyond individual agencies and on community partnerships and advocacy efforts. This is demonstrated by Participant 11 said: "[P]eople just aren't there for very long periods of time so you may have a contact at an ASO and then not even six months later, that email has bounced back and you have no idea who that person is now and where it's going."

FUNDING DURING THE COVID-19 PANDEMIC

Ironically, according to some participants there have been benefits as a result of the COVID-19 pandemic. They have not been using funds allocated to regular "in-person" programming and online programming is less expensive. Participant 9 said: "In terms of funding, it's kind of an interesting question, I think because we're doing pretty good right now and a part of that I think is actually due to the pandemic. When we're cancelling programs or cutting back on expenses and moving things online, then that money gets left over and so there's funding sitting around. I'm sure this isn't unique to us but—and in this work, we're always used to being creative with money and stretching a dollar and making it work with what we have." A few participants noted that their online programs have generated some profit for them due to the ability to reach beyond their regular jurisdictions, while others noted increased participation and engagement among clients through their online programs. That said, the pandemic has had an impact on traditional fundraising efforts, which some participants noted as being challenging at the best of times due to the economic context.

Participants had many recommendations for the windfall, such as to develop better expertise in program planning and marketing/communications, to conduct comprehensive needs assessments, to better compensate peers and volunteers, as well as to offer clinical mental health supports (i.e., counsellors or psychotherapists).

Representation and Impact of Diversity

Participants demonstrated a clear understanding of the intersectionality of diversity and being. Some noted that they are not always reaching diverse communities, like BIPOC. As an example, Participant 17 said: "I think about the work that I get to do with a lot of Black queer people in Ottawa, is that they're not entering White spaces. They're just not, no matter how hard—like, I've been running a Black queer group for the last two years. No matter how hard I encourage and …invite them to events, they're not coming. They [don't] want to be in that space because they [don't] want to endure any more trauma. So, I would say that there's a lot of healing that has to be involved, and how do we look at our Indigenous elders and looking at truth and reconciliation amongst ourselves."

Some participants wanted diversity training, such as general anti-oppression or sensitivity training or anti-racism and 2SLGBTQ+ inclusion training. A few participants reported never having received any tangible diversity training, which appeared to be frustrating as they identified personal experiences of discrimination, or the urgency of concerns as highlighted by the Black Lives Matter movement of summer 2020. Some participants stated a need for ongoing discussions and training to increase their confidence in their ability to provide truly inclusive support.

Participant 14 explained the limitations around diversity training and the dangers of tokenism: "…[T]hey had it on paper but they never had a specific understanding of what it means to be diverse, and diversity versus tokenization. And that's been very challenging because a lot of them, they didn't realize they were being tokenized or tokenizing" Some participants described their frustrations with the lack of action or meaningful change following the (sometimes abundant) diversity training that sometimes seem like simply a checkbox to complete.

Participant 14 further explained how racism can be internalized: "… I can say that personally because I've been there myself, where I hated my own skin colour and so on. Not until I said, 'Hey, I'm fucking sexy looking the way I am. No white man is going to tell me what to do.'"

Finally, participants noted that there is still a lot of work on diversity to be done within the 2SGBMSM community, including tackling systemic racism. As an example, Participant 5 stated: "For Black gay men, anti-Black racism, we ought to look inwardly in our community, too. We ought to look at the racism in the gay community. We ought to look at the transphobia within the gay community." A few participants felt they often must do some heavy lifting in relation to educating and challenging colleagues within their organization when there are clear missteps regarding discrimination, mainly racism.

Participants did not specifically mention challenges for working with individuals from different cultural and social locations. They understand that their organizations often lack expertise for working with the trans/non-binary community and Indigenous groups. Some had observed that their organizations are composed of mainly white personnel, hence are less likely to fully grasp issues of diversity.

Conversely, other participants reported that diversity and inclusion are embedded within the vision, mission, values, and sometimes practices and programs of their organizations. For example, one participant described using client-centred approaches by including more diverse cultural food options in their food bank.

Adequacy of Current Social Policy and Strategies to Improve Policy

Almost all participants had difficulty naming any specific provincial and federal health policies that address the needs of 2SGBMSMs, while some described any government policies as ineffective to addressing their needs. For example, Participant 9 said: "In terms of government response…, but essentially there really hasn't been in terms of [2SGBMSM's] needs."

Some participants identified policies that should be considered or implemented, including the decriminalization of drugs, and a national pharmacare program. It was clear to many that many healthcare providers need training in providing inclusive care for 2SGBMSM, particularly those who are BIPOC. This lack of inclusivity has contributed to a mistrust of healthcare providers on the part of clients, and even a reluctance to access healthcare. There remain gaps in mental health supports, safer spaces for 2SGBMSM, venues for services, and means of addressing HIV stigma and racism. Furthermore, the few existing policies do not consider intersectionality and multiple marginal identities. As a result, some populations are left behind or excluded from mainstream programs and services.

Participants identified numerous factors that affect their advocacy efforts for policy change, including indifference, low motivation for innovation, insufficient time and energy, organizational bureaucracy, a lack of organizational support, and more recently, the pandemic. They also reported that some organizations have stifled efforts to engage in advocacy work since their funding comes from government sources.

Participant 11 identified a lack of knowledge of how to engage in policy change, by commenting, "I think right now there's just a lot of apathy and there's a lot of, you know, 'We're stuck and this is how it is and we don't know how to change things.' So, I just think there needs to be a reinvigoration in some way, and unfortunately, I don't really know [how]."

There were differing opinions among participants as to the best way to improve policy, as illustrated by Participants 8 and 5. Participant 8 stated: "… [I]t's important that we become much more vocal and quite frankly, angry with our governments and go back to the sort of activism that we saw in the early days of the HIV epidemic and make sure that those voices are still very loudly and constantly being put in the faces of our government so that they realize that these are real human beings' lives that we're talking about here." Participant 5 disagreed: "I don't think that we could go back to those days because ACT UP in the States, I saw they shut down Manhattan, and to do that, they literally went on the street and chained themselves and blocked off streets, blocks. [Those] kind[s] of approaches won't happen today. And then, that happened because they were white men, right? They got through and they got away with that because they were white men, and most of them were from the middle class and upper middle class, right?" They called for greater unity within the community: "We all must come together as one voice…We first have to look collectively at what it is we want. What are we fighting for?"

The topic of working towards policy change led to the question: "Who is an expert?" Participants expressed frustration that their expertise was unrecognized and/or diminished. From Participant 9: "… [Y]ou are an expert if you have... a PhD or a certain amount of credentials and that's the only way that expertise can be gained. Even though grass-roots and on-the-ground-work and doing this work for years gives [us] an expertise in it." Participant 6 felt the same way: "I've been dismissed because I'm at the community level, because I identify within the community and instead of understanding that brings its own expertise and through the work that we do..."

Even when the expertise gleaned from being a member of the of the 2SGBMSM community is valued, it is not clear how well it is used. Participant 10 critiqued: "Okay, we've attended hundreds of focus groups. We've given hundreds of surveys. We've helped you create hundreds of reports. What's coming out of it?... Why do I need to participate again if I don't know where this is going?"

It appeared that creating change through a new movement was an unfamiliar concept for many participants. One idea that came out of the focus group was having some sort of workshop to provide skills to members to create change from within the community and their agencies.

Participant 14 stated: “I think we need to have a workshop in understanding what radical movements is. And maybe for us to be more united, we need to focus on being all on the same page on what movements are we actually going to focus on now…And I think the Black Lives Matter movement’s helped a lot of folks understand what it means to have a radical movement from a grassroots perspective and that momentum has been going.”

Impact of the COVID-19 Pandemic

The pandemic has shed light on health inequity for the 2SGBMSM community, especially for trans/non-binary individuals and BIPOC. Intersectionality and structural oppression contribute to inequities among diverse members of 2SGBMSM, and for many programs and services, including healthcare, which suffer from a lack of consideration of intersectional lived experience.

SERVICE IMPACTS

Due to the COVID-19 pandemic, there has been an increased reliance on technology for outreach work, using methods such as webinars, podcasts, and virtual social/discussion groups. The closure of many physical locations where 2SGBMSM socialize has contributed to difficulties with outreach engagement. While the shift to technology and virtual activities has allowed some participants to expand their reach, others identified difficulties due to pandemic fatigue and constant virtual stimulation. Some participants identified difficulties using technology as a barrier for clients, as well as limited or no internet access, or no access to a computer in some communities. Another limitation in their work was a resistance from senior management to adopt newer, more engaging technologies. As Participant 12 pointed out: "… I think even with COVID… a lot of our folks in the community don't have access to maybe a phone plan or even to working cell phone devices or even a tablet. So, for us, most of them used to come to our drop-in groups. We're not able to engage them because they don't [have] these working tools. Some of them have lost their jobs, right? So, for them, you know, it's just been a great challenge. But we're doing what we can do as best as possible to try to engage them. We have our peers who are on the ground who are providing—connecting with these different communities and providing the meaningful resources that are needed to better support our community."

Furthermore, some participants felt that they had taken on a role of "system navigator", connecting clients to programs and services for basic needs like housing, money, mental health services, and healthcare.

A few participants stated that brief interactions plus education together are insufficient to promote sustained behavioural change for clients, and funding limitations hinder the development of in-depth programming that could result in lasting improvements in clients' wellbeing. As an example, on-site counselling would likely make a difference in the lives of clients who might be unable to access online mental health programs. One participant described discrimination (e.g., internalized homophobia, interpersonal discrimination, HIV stigma) as having lasting impacts that are challenging to overcome in brief interactions.

The pandemic resulted in the closure of sexual health clinics, which has created gaps in screening and treatment of STIs, including HIV. Participant 8 noted: "And certainly, the biggest challenge professionally that I've seen since the pandemic started was…the lack of sexual health services that are now available in our community … Our last clinic was in February so I—my concern over that is that we've got folks who may be living with an undiagnosed STI for the last seven months now and I find that incredibly problematic." Participant 17 also commented: "…[N]ot being able to do HIV testing, appreciating why it's not essential, that was difficult for me just because, as I think we'd all appreciate, like, sexual health work is very important. People are still hooking up during COVID." Participant 13 made the connection between the closure of the sexual health clinics and isolation. "…I can speak from my own public health, like, they shut down all sexual health clinics completely. So, like, even just not only are now, like, men forced to—they [are] isolating in their own homes and going through so many different emotions and, you know, having to really sit with their mental health now."

The pandemic has also heightened some participants' concerns for the wellbeing of clients who have not have disclosed their sexual identity to family members, who may be reluctant to participate in virtual programs at home due to privacy concerns. Finally, some participants described reduced access to harm reduction supplies for clients who use substances.

ORGANIZATIONAL IMPACTS

The pandemic has resulted in job cuts for some organizations, as well as (despite the windfall mentioned above from the closure of in-person services) a reduction of revenue because of the impact on traditional fundraising campaigns. Overall, the pandemic has exacerbated longstanding systemic issues, such as underfunding of programs, underpaying of staff, and inefficiencies or bureaucracies within the system.

Some participants reported a general decline in their own mental health during the pandemic. Challenges stemming from being underpaid and overworked, especially during the pandemic, have in turn led to burnout and exhaustion for many participants. Participants tend to be passionate about the work they do and are invested in the wellbeing of their clients. The absence of a shift toward truly inclusive policy has, for some, reduced motivation. Some participants described the need for policy to align with evidence. Some feel dismissed at times because their voice, expertise, and lived experience is often discounted or devalued, and their work is often at the grassroots or community level. This leaves them feeling dismissed and dismayed.

Awareness of GMSH Resources and an Approach for Community Mobilization

There appears to be a moderate degree of awareness of GMSH's resources among participants; however, newer participants had not yet participated in large provincial gatherings organized by GMSH due to the pandemic. Other participants described those events as helpful because they could meet peers doing similar work, learn from them, and potentially partner with them to on address issues in their communities. They indicated a desire for more activities to engage other GMSH members and more opportunities to share and learn, including virtual meetings. Participant 3 asked: "Weren't we supposed to have meetings every month or something like that?" Some participants noted feeling somewhat isolated and wanted more opportunities to connect with others doing similar work. Participant 6 pointed out: "In terms of populations within 2SGBMSM, focusing on areas of growth in terms of outreach and support for Indigenous, BIPOC folks, and I think it's so easy to be isolated in this work. Not only within our respective agencies or organizations—some, not all of us—but also as an alliance." Participant 8 added: "I think the GMSH needs to do a better job of introducing us to new folks who come into these roles at various organizations." Participant 6 also said: "So if the GMSH alliance continues to try to find ways, especially now during the pandemic— when they can't get us all together in a room twice or three times a year— ways that we can help in facilitating that connection."

TRANS INTERWEAVING PROJECT

The Trans Interweaving Project refers to a trans-led inquiry into how the GMSH could better serve and integrate trans, trans masc, and non-binary people into the fabric of the GMSH and the broader Alliance. As noted by Participant 6, many participants found it helpful: "And we were grateful for the trans interweaving project that the GMSH initiated because it allowed us to really take the time to understand better how we're not serving trans-masculine and non-binary folks who fall within the gay male community." Participant 8 further identified: "The trans interweaving project was so important and I'm glad to see that's taking place now."

SPECIFIC RECOMMENDATIONS

Participants had recommendations for the GMSH, including identifying specific needs of organizations and following up to help address them. Participant 12 stated: "I think the GMSH also needs to do some sort of evaluation. … I'm thinking that it's good for GMSH to also evaluate what are some of the tools or resources that our frontline workers need to better do the job. And maybe even connecting with those agencies after they've done the needs assessment, to really say, 'You know what, we recognize that we did a needs assessment and we found that your staff or the staff from these agencies, these are some of the tools that they need. Can we all partner to do some work to make sure that they have the tools or they have the trainings to be able to meaningfully deliver the work?'" From Participant 5: "I think that it would be good to have a retreat with … some key people from some of the frontline agencies… and this retreat must be pretty focused about three things. What are the issues? [How] do we … make some of those changes, [and how do] we … galvanize our efforts in a way that it's a little bit more focused on shifting the paradigm, …—I think this is the most opportune time because of COVID, because of all the other things. The opioid epidemic is still going on. The anti-Black racism is like a real different type of energy. There is too much going on for us not to shift now, and I believe by having a retreat and coming together, and we'll all start there with the same three questions I said earlier."

Regarding the GMSH's social media presence, Participant 19 felt that their WhatsApp group does not properly identify "who's who or what they do in their organization" and their Facebook group is out of date. Some expressed frustration regarding a lack of communication via the GMSH provincial office to Alliance members regarding current projects.

SUGGESTIONS FOR RESOURCES

The participants identified a need for resources from GMSH, in particular, anti-racism and anti-oppression supports, help working with Indigenous populations, evaluation of tools and resources, tangible tools for creating change, development of meaningful indicators of their work, training and support for the changing landscape of work especially during the pandemic, and resources that consider rural and non-rural contexts. Participant 14 suggested: "So I think we need tools and resources revolving around how to talk with your health care service providers and workshops for health care service providers, which a lot of us have been doing, but really more radical conversations about, 'You know what? You're going to listen to me and this is what you're going to do.' There's been situations where people with HIV have gone to the pharmacist at Shoppers Drug Mart and they're like, 'Oh, we don't carry this kind of medication here.' Like, that's messed up, right? And it's like, how do you address this immediately to make the change necessary?"

Participant 17 commented on implementation: "I think that GMSH has done a really good job in terms of communicating with us and making us aware of what resources they have or they're developing … But I would say that the biggest issue is implementation. Like, I don't necessarily use those tools and resources…".

COMMUNITY MOBILIZATION

Many participants recommended mobilizing the community as a means to create positive change. They talked about having regular, frequent, and multiple opportunities to engage with GMSH members and create a more supportive community. Participants described the need to create a singular voice and to act as a large collective to mobilize change. For example, Participant 15 said: "[I] think what we need to do as a collective, we need to have a bigger group of us that we advocate for the Ministry of Health and we go in as a group, right, advocating. … It's a collective of all these different agencies speaking up and saying all of us are agreeing, we need this and this is something we need to do or something we need to move on. But we need to have a real plan." It was noted that fragmented efforts and division within partnerships can take away from efforts. There appears to be some interest in educational opportunities and shared conversations on inclusivity, radicalism, and mobilization. Participants indicated a need for more tools to help create advocacy campaigns and advocate for change. A few participants argued that progress with collective mobilization of the sector is often hindered by high staff turnover, so addressing that would help support a shift within the sector.

Discussion

As mentioned above, most participants felt GMSH is doing a good job. That being said, the current study provides evidence to support the conclusion that several key areas still need to be addressed to improve wellbeing for members of the 2SGBMSM community. Their wellbeing needs are not being met, despite the best efforts of the GMSH and the organizations they serve. Participants appear to see very clearly what their clients' wellbeing needs are, and are doing their best in difficult conditions to meet them. Organizations are under stress because of high staff turnover, low pay, inadequate resources, and unrealistic expectations. As a consequence of high staff turnover, participants may lack the institutional memory to know how to mobilize the community, which is a potential remedy to help address service gaps. BIPOC staff continue to feel marginalized. Finally, this research supports others' findings that there is a dearth of 2SLGBTQ+ specific wellbeing policy at both the provincial and federal levels of government.

While some positive impacts of the COVID-19 pandemic were noted, overall, it appears that many populations have been disproportionately disadvantaged, including street-involved individuals, sex workers, BIPOC, people who use substances, people with disabilities, and people living in poverty. More than ever, additional mental health supports are very much needed. Furthermore, participants expressed the need to address health disparities for their communities, including limited access to healthcare. The closure of many services due to the pandemic has impacted how often people seek help, if at all. Some community members don't have reliable internet, or access to devices, or the ability to use them, resulting in further service gaps. The pandemic has also adversely impacted social activities by contributing to a sense of social isolation and loss of community spaces and places where MSMs can spend time and socialize. As many participants highlighted, the desire to engage in sexual activity has not waned during the pandemic, and the pandemic-related reduction of sexual health services (e.g., STI testing) has quite possibly resulted in a rise in undetected and untreated STIs, including HIV.

Changes in the work, especially during the pandemic, have highlighted and exposed structural inequities, and reinforced the need for more effective mental health services for 2SGBMSM. A passion for the work is unfortunately often thwarted by burnout from being overworked, underappreciated, and underpaid, then further impacted by having inadequate resources necessary to properly to carry out one's duties.

Although there is a growing literature on population-specific needs of the 2SLGBTQ+ community, the current study offers an up-close look at how ASOs are dealing with 2SGBMSM wellbeing needs. As such, this study reveals some significant strengths, but also identifies a number of needs and gaps. Generally, participants reported that existing sexual health services are inadequate. This has been further compromised by the shutting down of sexual health clinics due to COVID-19. The healthcare system is not well-streamlined and can be challenging for some people to navigate, resulting in reduced access to necessary care. Part of the gaps in care relate to the lack of training plus bias on the part of healthcare providers when it comes to 2SGBMSM, and stigma associated with this community. Within their own organizations, participants identified gaps in outreach programs for those in racialized and trans communities.

Again, despite the many difficulties that impact their ability to do their work, participants in this study tend to be passionate about their work and the wellbeing of their clients. They are motivated by a desire to give back to their community and work towards social justice, and are inspired by client successes.

This study identified three areas of need from the participants' point of view.

WHAT'S NEEDED FROM THE GMSH

Professional development was not specifically mentioned as such, but participants alluded to the desire to continue growing and learning within their roles. Participants wanted more opportunities to engage and collaborate with other alliance members. Specifically, they mentioned the possibility of a retreat when conditions allow for in-person gatherings.

It is interesting to note that although there was agreement on the need for community organizing, when participants were asked about the word "radical" in relation to organizing, there were two distinct responses. One response saw the term "radical" as constructive criticism of the system's status quo, involving some anger, creativity, innovation, and passion for cause and change of the system. They talked about the idea of pushing boundaries and being loud through being radical. A few participants talked about the idea of tearing down the system to start anew, perhaps having a connotation of violence. One participant described how being radical can empower people and influence a sense of unity and collective responsibility to influence change. Another participant described being radical as going back to the grassroots level to mobilize change.

Some participants shied away from the concept of "radical" because they equate it with violence or risk. Some noted that being radical can go overboard and "in your face", and preferred the idea of incremental change, rather than a major overhaul of the system. The possibility of radical change is not always appreciated: One participant felt that radical change is more effective within the short-term, but does not necessarily contribute to long-term change.

This discussion raises the question of the need to mobilize the sector for effective change. Participants expressed the need for community mobilization and the development of activism skills to create positive change in their community. When asked about the idea of a skill-building workshop, they were excited about the possibility of learning new ways for making sure that the community's voice is heard and recognized. One target for this mobilization could be a 2SLGBTQ+ Mental Health and Wellbeing Strategy at either the federal or provincial levels.

WHAT'S NEEDED FROM FUNDERS

Funders need to determine if the funding they allocate to these organizations reflects the demands and importance of the work that is being done. Funders also need to re-evaluate the scope and availability of wellbeing services for 2SGBMSM because clearly there are gaps.

Based on participant input, the current funding model is too competitive. This research shows the harm that competition can cause when it comes to wellbeing programming, as larger organizations are favoured at the expense of smaller organizations working with racialized communities.

WHAT'S NEEDED FROM POLICY MAKERS

Again, it is clear from this study that wellbeing needs of the 2SGBMSM community are not being met. As already mentioned, the COVID-19 pandemic provides a magnifying glass with which to see those most marginalized. Our environmental scan, backed up by recent literature (McKenzie, Mulé, & Khan, 2021), illustrates the invisibility of this community to policy makers. To avoid imposing heteronormative notions of health and wellbeing needs on this population requires a targeted approach to policy. One such heteronormative notion is the conflation of gender and sexual orientation as social determinants of health (Mikkonen & Raphael, 2010; Raphael, Bryant, Mikkonen, & Raphael, 2020). That is, the social determinants of health associated with sexual orientation and gender expression and identity are subsumed under gender, which does not adequately recognize the unique needs of the constituent groups of 2SLGBTQ+.

Participants also expressed frustration that their community-level, "grassroots", lived expertise as members of the 2SGBMSM community is not valued. Policy makers could benefit from taking this into consideration when formulating policy.

Conclusion

It is clear that the GMSH understands and is dedicated to the best interests of the 2SGBMSM community. It is also clear that many of the issues raised that are detrimental to the organizations that serve the community, for example, low pay and inadequate policy, inadequate training, and the need for better resources to serve and mobilize the community are beyond the control of the GMSH. However, these issues provide important opportunities for advocacy. Working toward a 2SLGBTQ+ Wellness Policy could provide a focus for addressing many of the issues raised in this research.

Recommendations

- The GMSH should advocate for a 2SLGBTQ+ specific Wellbeing Strategy from the provincial and federal governments.
- Alliance members would greatly benefit from a two-day workshop to provide the community with the tools and skills to influence broader social policy as it relates to 2SLGBTQ+ well-being. In particular, such a workshop would expose community members to experts and activists in the area of 2SLGBTQ+ social movements and community development.
- Educational workshops could be developed with collaboration among the GMSH, researchers, and previous 2SLGBTQ+, HIV, feminist, BIPOC activists.
- GMSH could consider conducting a more detailed needs assessment/evaluation of organizations' needs.
- The BIPOC community within GMSH needs greater support. A starting point could be establishing an equity committee within the GMSH to address anti-racism and anti-oppression issues.
- Unique challenges were identified for members who live outside Toronto and other large urban areas. GMSH should work to develop campaigns and strategies that are not "Toronto-centric".
- The GMSH should develop better tools to make sure members are connected, especially new members. The specific idea of a retreat was raised.
- Current sexual health clinics are not meeting the needs of the community. It would be beneficial for alliance members and the GMSH to find ways to strategize or collaborate on a campaign to address current barriers and gaps.
- To help address high turnover of service providers, GMSH could meet with funders to advocate for better funding to adequately compensate workers.
- By and large, the COVID-19 pandemic has further exposed the longstanding structural barriers that 2SGBMSMs face. It would be beneficial for GMSH to incorporate social determinants of health for wellbeing needs in future programming.

Appendix A

The studies included a variety of approaches and methods:
Twenty-one literature reviews (Barefoot et al., 2015; Berg et al., 2016; Cao et al., 2017; Colpitts & Gahagan, 2016; Connolly et al., 2016; Emlet, 2016; Gahagan, & Colpitts, 2017; Gkiouleka et al., 2018; Hailey et al., 2020; Halkitis et al., 2013; Johns et al., 2019; Lee et al., 2018; Lick et al., 2013; Meyer, 2003; Rees et al., 2020; Rosenkrantz et al., 2017; Ruben & Fullerton, 2018; Stewart et al., 2018; Valentine & Sherd, 2018; Wade & Harper, 2017).

Twenty-one commentaries or theoretical papers (Chan & Henesy, 2018; Emlet, 2016; Fish, 2020; Fredriksen-Goldsen et al., 2014; Fredriksen-Goldsen, Kim, McKenzie, et al., 2017; Hatzenbuehler, 2009, 2016; Kline, 2020; Krieger, 2012; Lee et al., 2017; Lewis, 2017; Logie, 2012; Luke & Goodrich, 2015; Mark et al., 2019; Mink et al., 2014; Salerno et al., 2020; Spurway et al., 2020; Valdiserri et al., 2018; Wells, 2009; Williams & Mann, 2017; Wolfe, 2018); two policy reviews (Espinoza, 2016; Ylioja & Craig, 2014); and a clinical review addressing the financial hardship associated with HIV/AIDS (Ayala et al., 2012).

Eighty-one articles reported on cross-sectional surveys data (Allen & Leslie, 2019; Bauermeister, 2014; Becker et al., 2014; Boone et al., 2016; Boppana & Gross, 2019; Christian et al., 2018; Cramer et al., 2017; Crawford & Ridner, 2018; Dilmaghani, 2018; Douglass et al., 2017, 2020; Downing & Rosenthal, 2020; Durso & Meyer, 2013; Feinstein et al., 2015; Ferlatte et al., 2018; Fisher et al., 2014; Fredriksen-Goldsen, Bryan, et al., 2017; Fredriksen-Goldsen et al., 2016; Fredriksen-Goldsen, Kim, Bryan, et al., 2017; Gahagan & Subirana-Malaret, 2018; Gonzales et al., 2019; Hidaka et al., 2014; Hoffman et al., 2009; Horwitz et al., 2020; Ioerger et al., 2015; Ivanković et al., 2015; Jager & Davis-Kean, 2011; Jennings et al., 2019; Johns et al., 2013; Joseph et al., 2018; Kachanoff et al., 2020; Katz-Wise et al., 2017; Kavanaugh et al., 2020; Keating & Muller, 2020; Kertzner et al., 2009; Kim et al., 2017; Lawson et al., 2019; Lazarevic et al., 2016; Lefevor et al., 2020; Legate et al., 2012; Li et al., 2019; Logie et al., 2018; Lunn et al., 2019; Martinez-Velez et al., 2019; Meanley et al., 2016; Mihan et al., 2016; Miller et al., 2019; Mitrani et al., 2017; Nowaskie et al., 2019; Oster et al., 2013; Pinto et al., 2019; Ports et al., 2017; Poteat et al., 2016; Price et al., 2019; Progovac et al., 2020; Rendina et al., 2019; Rice et al., 2019; Rider et al., 2018; Riggle et al., 2009, 2017; Roberts & Christens, 2020; Rodríguez-Díaz et al., 2016; Scheim et al., 2013; Sowe et al., 2017; Stanton et al., 2017; Steele et al, 2017; Stepleman et al., 2019; Swann et al., 2020; Swendener & Woodell, 2017; Tabaac et al., 2015; Taylor et al., 2020; Wagaman et al., 2020; Wernick et al., 2017; Wilson et al., 2018; Woodford et al., 2015, 2018; Zeeman et al., 2017); 5 studies reported of sub-analyses of American national databases or surveys (Forsyth & Valdiserri, 2015; Gower et al., 2018; Khan et al., 2017; Lett et al., 2020; Reisner & Hughto, 2019); a general survey of mortality in the U.S. (Hatzenbuehler et al., 2014); one geographic information system mapping study (Gower et al., 2019); three daily diary surveys (Legate et al., 2017; Salim et al., 2019; Swim et al., 2009); and three record/patient chart review (Blosnich et al., 2017; Hudson, 2018; Van Donge et al., 2019).

Twenty-eight qualitative studies reported the findings from focus groups, interviews, discourse analysis, and/or concept mapping (Alon et al., 2019; Berke et al., 2016; Bry et al., 2017, 2018; Burnes et al., 2016; Daley & MacDonnell, 2011; Davis et al., 2009; Dispenza et al., 2016; Durrani & Sinacore, 2016; Elm et al., 2016; Felner et al., 2018; Higa et al., 2014; Hill et al., 2018; Hood et al., 2019; Hudson, 2019; Hudson & Romanelli, 2020; Johnson et al., 2020; Logie et al., 2016; MacCarthy et al., 2020; Mann-Jackson et al., 2020; Pilling et al., 2017; Proctor & Krusen, 2017; Romanelli & Hudson, 2017; Ross et al., 2010; Smart et al., 2020; Smith & Turell, 2017; Tillapaugh, 2016; Willging et al., 2019).

Appendix B

GMSH Members included in the environmental scan:

1. Asian Community AIDS Services
2. AIDS Committee of Cambridge, Kitchener, Waterloo and Area
3. AIDS Committee of Durham Region
4. AIDS Committee of Ottawa
5. AIDS Committee of Toronto
6. AIDS Committee of Windsor
7. CAYR Community Connections (Formerly AIDS Committee of York Region)
8. Africans In Partnership Against AIDS
9. Alliance for South Asian AIDS Prevention
10. Black Coalition for AIDS Prevention
11. Centre for Spanish-Speaking Peoples
12. HIV/AIDS Regional Services
13. Moyo Health & Community Services (Formerly Peel HIV/AIDS Network)
14. Positive Living Niagara
15. Réseau ACCESS Network
16. Regional HIV/AIDS Connection
17. Max Ottawa (Ottawa Gay Men's Wellness Initiative)
18. 2 Spirited People of the First Nations
19. AIDS Committee of North Bay & Area
20. Canadian AIDS Treatment & Information Exchange
21. Hassle Free Clinic
22. Ontario Aboriginal HIV/AIDS Strategy
23. Toronto People with AIDS Foundation
24. Gilbert Centre
25. HIV/AIDS Resources & Community Health
26. Elevate Northwestern Ontario
27. Peterborough AIDS Resource Network
28. The AIDS Network
29. Ottawa Public Health
30. Toronto Public Health
31. Public Health Agency of Canada–Ontario Regional office
32. Centre Francophone Toronto
33. Group Health Centre
34. Action positive
35. Somerset West Community Health Centre
36. Ontario HIV Treatment Network

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