RACIAL AND SOCIAL DETERMINANTS OF HEALTH FOR OPTIMUM ACCESS TO CARE

(PREP, HIV, STBBI TESTING & TREATMENT)

FOR 2SGBTQ+ MEN AND TRANSMASCULINE INDIVIDUALS

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GMSH
GAY MEN'S SEXUAL HEALTH ALLIANCE

ABOUT THIS FACTSHEET

This fact sheet is for frontline, outreach staff, public health staff, others providing sexual health care and care to the communities of Two-Spirit, gay, bisexual/pansexual, trans and queer men (2SGBTQ+) and transmasculine individuals. Racial and social determinants of health continue to impact 2SGBTQ+ and transmasculine individuals' s access to human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP), testing & treatment for HIV, and testing for sexually transmitted & blood-borne infections (STBBIs).

WHAT IS A SOCIAL CONSTRUCT, WHAT IS A SOCIAL DETERMINANT, AND CAN THEY AFFECT MY HEALTHCARE?

Any idea that is made and accepted by society can be described as a social construct[1]; associating the colours pink and blue with girls and boys, respectively, is a basic example.[2] Some accepted norms can lead to economic, political, and social inequities—treating people unfairly or unjustly based on certain characteristics.[3-7]

A determinant is a probable cause of one thing resulting in another; for instance, smoking tobacco greatly increases one's likelihood of developing lung cancer, although not all people who smoke get this condition.[8] Social determinants are shaped by their environment: hours of daily sunlight may be a determinant of crop yield in regions prone to drought, just as race may be a social determinant of health in a societies where racism is present.[8,9]

This fact sheet will focus on the social constructs of race, 2SGBTQ+ men and transmasculine individuals and immigration status, and their influence on access to certain aspects of healthcare – specifically, the prevention of HIV and other STBBIs – in Ontario. African, Caribbean, & Black (ACB) men, Indigenous (First Nations, Inuit and Métis) men, other racialized (visible minority) men, and newcomers to Canada will be discussed. The subgroup of gbMSM (gay and bisexual men who have sex with men) and the overarching group of 2SLGBTQ+ individuals (which includes 2SGBTQ people, lesbians, "and other terms related to sexual and gender diversity") will be used where 2SGBTQ-specific information is lacking or unavailable.

A MORE DETAILED LOOK AT CERTAIN HEALTHCARE NEEDS FOR 2SGBTQ+ MEN AND TRANSMASCULINE INDIVIDUALS IN ONTARIO

HIV

For over 40 years, HIV has disproportionately affected certain populations such as gbMSM and racial & ethnic minority communities in Canada.[10-12] In 2020, approximately 1 in 2 people living with HIV identified as gbMSM.13 In the same year, the rate of new HIV infections in gbMSM was 166.2 per 100,000 people while the overall population had a rate of 4.0 new infections per 100,000 individuals.[13]

In 2022, the largest drop in first-time cases in gbMSM was reported in Ontario since 2018, decreasing from 343 to 204, with the greatest decrease appearing in Caucasian (white) men (162 cases to 51 cases [49.4% to 27.7% of new infections]). While the number of first-time diagnoses for ACB, Indigenous, and East and Southeast Asian gbMSM also decreased, it was to a lesser degree than that of their white peers. These trends are similar in gbMSM irrespective of substance use. In contrast, the number and proportion of total first-time cases increased in Latino/a/e/x gbMSM (43 to 47 [13.1% to 25.5%]); those who use substances did not have a specific grouping for Latino/a/e/x for comparison.[10]

STBBIS

In addition to HIV, other infections acquired from sex and/or blood contact include syphilis, chlamydia, gonorrhea, human papillomavirus (HPV), hepatitis B & C, and herpes simplex virus 1 & 2 (HSV-1 and HSV-2).[12,14] STBBIs disproportionately affect certain populations, including gbMSM, Indigenous Peoples, people who use substances, and people who come from countries where the rates of these infections are higher than in Canada.[12,14] In 2022, gbMSM accounted for 27% of syphilis cases and, in 2016, for 40% of gonorrhea and 80% of lymphogranuloma venereum (a subtype of chlamydia) infections in Ontario.12,15 HSV-1, HSV-2, and HPV infections increase the chance of getting and transmitting HIV, as does acquiring a chlamydial infection.[12] Many clients with hepatitis B (almost 50%, as of 2011) or C (about 25%, as of 2019) are unaware of their status, leading to potentially harmful long-term outcomes, such as liver cancer and death.[12]

PRE-EXPOSURE PROPHYLAXIS (PREP) AND POST-EXPOSURE PROPHYLAXIS (PEP)

HIV PREP AND PEP

Strategies to help greatly reduce HIV infection risk in sexually active HIV-negative individuals exist, such as PrEP and PEP. PrEP is effective when started prior to HIV exposure, and PEP is effective when taken as soon as possible after a potential exposure.[16]

HIV PrEP is an antiretroviral medication available as either an oral pill or an injection once every two months.[17-19] Private insurance plans may cover the cost of either treatment type, but only certain oral options are covered by provincial government drug insurance plans; partial or full coverage varies.18 Check out the factsheet on the GMSH website for more information on **HIV PrEP** and the **Personal advocacy** section near the end of this factsheet for links to public health insurance options.[20]

HIV PEP consists of different pill options to be taken every day for 28 days, beginning as soon as possible and within 72 hours after potential exposure.[19,21] Due to the urgency of initiating this treatment (sooner treatment initiation increases the chances of the treatment being successful), clients may be offered a 'starter pack' of HIV PEP immediately and a prescription for the rest of the month's pills to be filled at a later date to finish the drug course without disruptions.

Without insurance, the treatment may cost around $900 or more, but like PrEP, certain private or public plans may help cover the costs.[21]

DOXYPEP

Doxycycline is an antibiotic which is taken as PEP to help prevent infection by chlamydia and syphilis, and to a lesser degree gonorrhea. The medication dose should be taken ideally within 24 hours and no later than 72 hours after condomless sex (oral, anal, and/or vaginal).[22] In a 2023 study of 501 MSM and trans women, those taking DoxyPEP experienced these three infections two-thirds less often than those who only received the standard of care.[22]

Currently, doxyPEP is not authorized by Health Canada as preventative sexually transmitted infection (STI) management, but some clinics do prescribe it in an off-label fashion.[23] Like oral HIV PrEP, doxyPEP is covered by most public and private insurance plans in Ontario but may cost around $25 per month without insurance coverage, making it more financially accessible than HIV PrEP and HIV PEP.[24]

For more information, including concerns such as the potential for antibiotic resistance development, please check out the GMSH factsheet on **DoxyPEP**.[25] Additionally, for information about interactions that doxycycline may have with other medications, check out either **this paper from GMSH** or **this table from Johns Hopkins University**.[26,27]

BARRIERS TO HEALTHCARE ACCESS FOR 2SGBTQ+ MEN AND TRANSMASCULINE INDIVIDUALS

COST, EQUITY, AND PRIVATE INSURANCE

Provincial monetary contributions to healthcare relative to municipal (city, town) spending has decreased since 2021; this may force individual municipalities to either increase taxes and/or cut services.[28,29] The province has also fused some public health units (PHUs) together, from 34 to 29 regions, with more potential mergers in the future.[30-33] These PHUs partner with local communities to provide client-based care services such as healthy lifestyle education, sexual health, vaccinations, substance use support, and much more.[28] When individual PHUs cover a larger area of the province, clients who may have more specific individual needs such as 2SGBTQ+ men and transmasculine individuals, people experiencing income insecurity, people experiencing housing insecurity, and rural communities may be disadvantaged.[30,32]

In a 2022 study, 27% of 2SLGBTQ+ individuals had admitted to experiencing homelessness before; this is more than double the rate of non-heterosexual clients surveyed at 13%.[34] Employment and housing status have also been linked to increased rates of HIV infection in a study of 1,380 ACB clients in Ontario.[35]

Jobs with higher wages are more likely to include private insurance. People with private insurance are more likely to use medications.[36] In 2022, 76% of people taking HIV PrEP used private insurance to help cover costs of the drug.[37] However, these benefits may be less available to 2SLGBTQ+ people in Canada relative to cisgender heterosexual individuals due to an existing wage gap.[34] While some Ontario programs exist to offer financial aid to get required medication, Ontario does not have a universal HIV PrEP program.[37] This differs from most other provinces and territories which offer the medication at little to no cost.[37]

LOCATION

Across several studies between 2009 and 2019, a lack of medical transportation, a lack of service location knowledge, and limited clinic hours were listed as barriers to HIV and STBBI testing for gbMSM, racialized communities, people who use drugs, and sex workers.[15,38] In 2018, 2SLGBTQ+ clients more often found it "difficult or very difficult" to meet their needs for many necessary expenses including transportation compared to non-2SLGBTQ+ people (33% and 27%, respectively).[34] Getting to a clinic or hospital is

particularly challenging for rural clients with more limited financial resources (e.g., no car or without public transportation). Seeking more specialized care in these cases also makes access harder.[39-42]

Between 2018 and 2022, the number of people who use HIV PrEP has increased across Ontario.[37] However, most prescriptions are filled in Toronto and Ottawa (75.4%), despite only having a combined 27.0% of the province's population.[37] According to **https://ontarioprep.ca/**, there are approximately 44 locations where PrEP is prescribed in Ontario, with the northernmost point being in Thunder Bay.[39] As PHUs become larger and less focused on local voices as stated in the section above, the need for these clinics may become even more valuable.[30]

Outside the scope of HIV PrEP care, the increased demands on the healthcare system, particularly in southern Ontario, have hospitals regularly working at 100% capacity or more (the accepted normal is 85%).[40] This strain on the system is worsened by the current shortage of family doctors in Ontario which is due to only get worse in the near future.[43,44] With fewer family doctors, clients who see their providers on a regular basis for care—such as those with chronic health issues (e.g., mental health concerns, HIV, or prostate cancer)—may have gaps in care or be otherwise negatively impacted.[43]

HEALTH LITERACY AND STIGMA

As a community, 2SGBTQ+ men and transmasculine individuals face a mixture of racism, homophobia, biphobia, transphobia, and medical stigma (against HIV, STBBIs, and PrEP, for example) in a world where cisgender heterosexuality is the assumed norm.[5,45] Stigma is a multipronged attack, where personal feelings, community dynamics, and institutional barriers can lead to delaying or not engaging with health services altogether.[5,11,45-47]

In a systematic review of studies covering HIV testing in gbMSM (including Two-Spirit and questioning people), ACB, Indigenous Peoples, immigrants, people who inject drugs, and sex worker populations, two major themes were common: fear and stigma.[38] Fear of a positive test result coupled with the stigma of being "found out" by others—partners, family, or community members—is a powerful deterrent to accessing healthcare, particularly when people belong to small, tight-knit communities where information travels fast.[38] Furthermore, conflicts with healthcare providers (HCPs) are a frequent concern, as client identity denial (e.g., around being transgender, or bisexual), not being taken seriously, being ignored, and pushback when requesting for HIV testing were noted by clients in the past.[38,48]

Overcoming this fear may be disproportionately more difficult by older Canadians who identify as transgender or non-binary compared to those in Generation Z or Y (Millennials).[49] Fostering more accepting environments for transgender and gender diverse people may allow them to be more open about their identities in society and may facilitate access to the care they deserve.[49]

RACE, 2SGBTQ+ MEN AND TRANSMASCULINE CULTURE, AND SEXUAL RACISM

Within the gbMSM community, "wherein whiteness is positioned as the ideal," racialized men face a host of obstacles, including those related to appearance, social support, and sexual racism.[50-52] In a 2010 Toronto community-based research study (n=61)—Color Matters—ACB, East Asian, Southeast Asian, South Asian, Latino, Hispanic, and Brazilian gbMSM documented experiences of body image issues (e.g., compared to media figures or others in the community), sexual racism from potential partners, and marginalization (e.g., due to perceived sexual objectification and stereotyping). Whiteness was also associated with "[higher] class and wealth" by a respondent, further elevating its status in the Toronto scene.[51]

Research has also documented how internalized racism and feelings that heterosexuality is the norm (heterosexism) are significant predictors of low self-esteem, which can contribute to less personal health promotion (e.g., HIV testing, adherence to PrEP and self care).[53]

The dangers of othering and stigmatization in the 2SGBTQ+ men and transmasculine community greatly affect racialized and newcomer gbMSM. Currently, these populations see a continued growth in the proportion of new HIV diagnoses in Ontario. However, programs, policies, and HIV research often do not reflect the impact of sexual racism nor the sociopolitical or sociocultural realities of racialized or newcomer gbMSM communities; these issues contribute to their heightened vulnerability to both HIV and STBBIs.[53-55]

OTHER

Age, known language(s), and general education level may also affect healthcare access in Ontario.[35] In a study of 1,380 ACB people in Toronto aged 15 to 49 years assessing HIV rates, factors such as older age, using French to approach care, and not having achieved a high school education were associated with higher frequency of new HIV infection.[35]

While Ontarian 2SGBTQ men may face similar obstacles, their backgrounds and ongoing experiences create an intersectional

situation of several factors. Thus, different groups may face societal pressures which may not exist for others.[5,9,56] Transgender and non-binary individuals disproportionately face mental health and financial troubles compared to cisgender clients.[49] Additionally, Ontarian ACB people suffer 25% of new HIV cases while comprising less than 5% of the total population.[11,35] ACB men are also 4.78 times more likely to die from HIV/AIDS compared to other racialized groups.[57]

The intersections of race, ethnicity, class, sexualities, gender expressions, homophobia, transphobia, and masculinity provide diverse variations in the beliefs, motivations, and behaviours amongst 2SGBTQ+ men and transmasculine individuals with regards to accessing social and health care services. It is of the highest importance for social services and HCPs to be mindful of the diverse cultural context of 2SGBTQ+ and transmasculine clients who seek health care.[58]

HOW CAN HEALTHCARE ACCESS AND TREATMENT IMPROVE FOR 2SGBTQ+ MEN AND TRANSMASCULINE INDIVIDUALS?

RESEARCH

Identifying and closing gaps in care are the first steps to achieving healthcare access equity.[7,57,59,60] More research is required to draw a complete picture about the situation of social determinants and healthcare access disparities, particularly with data on racialized, transgender & gender diverse, and bisexual/pansexual communities.[5,57] With more contextual information and detailed models (e.g., with sociocultural and socioeconomic elements), care can be shaped to build suitable and successful client care strategies.[40,61]

A SENSE OF COMMUNITY AND PARTNERING WITH LOCAL LEADERS

Living in communities where people share similar values and maintain relationships may lead to better health outcomes.[35,62] Offering health and social services in a client's chosen language (e.g., through translators, staff proficient in different languages) and with cultural sensitivity may foster greater engagement and open discussion between HCPs and clients.[38,58] Client-centred care should be culturally sensitive with respect to factors such as race, ethnicity, sexual orientation, gender expressions, immigration status, and current level of health service knowledge.[58] Ongoing partnerships with local leaders (e.g., pastors, others who may not be part of the targeted community of clients) may help curate a more customized and customizable product of client-centred care.[58,62]

GOVERNMENT INTERVENTION

A 2023 article on public health measures in three Canadian provinces "support[s] calls for modernized and inclusive governance, stable public health funding, and investment in the public health workforce, which may help inform future reforms."[32] To its credit, in 2024, the Government of Canada "invested close to $200 billion over 10 years to improve health services to Canadians," including pharmacare and mental health care.[63]

Groups such as The African and Caribbean Council on HIV/AIDS in Ontario, Anishnawbe Health Toronto, and the sexual health program at the Centre for Spanish Speaking Peoples provide health services to racialized clients—ACB, Indigenous, and Latino/a/e/x individuals, respectively—and have been necessary due to historical discrimination and stigma of marginalized groups.[64-67]

Through collaboration between such groups and municipal, provincial, and federal governmental bodies, relationships can be forged which may bloom into increased funding for research and other initiatives.[59]

Improving equity also involves training and employing a greater number of individuals from marginalized communities to properly represent the population of Ontario. For example, Indigenous Peoples currently make up less than 1% of doctors in the country despite comprising more than 5% of the population.[67]

Due to an imbalance of services between city centres and rural areas in Ontario, a mixture of increasing the number of non-urban healthcare facilities (e.g., with mobile health clinics and satellite facilities), improving public transit around the province, and improved access to housing (particularly in cities) may allow for easier, faster, and cheaper client care access.[35,40,57,59,68]

PERSONAL ADVOCACY

Start by assessing gaps in your care and seek out resources which best suit your needs. Identify local resources, such as your local HIV service organization, Public Health, Community Health Centre and Family Health team in your region.

The GMSH has a list of various resources online, including—but not limited to—the following: [69-74]

- The Sex You Want (in French and Spanish)
- Party and Play, for guidance on using substances more safely during sex
- PnP and Mind-Body Practice for Self- Care, for guidance on holistic self-care and PnP
- Your relationship with your HCP

Infectious agents and cancer information factsheets: [75-80]

- Hepatitis C
- HPV and anal cancer
- Syphilis
- Gonorrhea
- Chlamydia
- Mpox FAQ

Infection prevention factsheets: [81-84]

- All about PrEP
- DoxyPEP for STI prevention
- Doxy-PEP drug interactions
- GetaKit

Check out other sites for queer men's healthcare in Ontario: [64,65,85-91]

- HQ Toronto, a community-focused healthcare centre
- Rainbow Health Ontario
- Community AIDS Treatment Information Exchange (CATIE)
- The Ontario HIV Treatment Network (OHTN)
- The African and Caribbean Council of HIV/AIDS in Ontario (ACCHO), for HIV services for ACB clients
- Black Physicians of Ontario, for health services for ACB clients, including newcomers
- Anishnawbe Health Toronto, for Two-Spirit and trans services
- The Centre for Spanish Speaking Peoples, for health services in Spanish
- OAN, for a list of HIV networks across Ontario.

Have a discussion with your HCPs on your specific healthcare needs, such as how you wish to be addressed and if you prefer remote (not in-person) services. The more involved you are in your own care, the greater likelihood that you will stay engaged and have more favourable results over time.[92]

Here are some financial, transportation, HCP-finding, and other tools to access Ontario healthcare.[39,93-103]

Provincial health benefit programs:

- Ontario Health Insurance Plan Plus, for those under 24 years of age
- Ontario Trillium Benefit Program, for those between 25 and 64 years of age
- Ontario Drug Benefit Program, for those above 64 years of age
- Ontario Works, for Ontario residents above 15 years of age and in financial need
- Ontario Disability Support Program, for Ontario residents with a disability and in financial need

Federal health benefit programs:

- Indigenous Services Canada, First Nations and Inuit Health Branch, Non-Insured Health Benefits, for Indigenous Peoples
- Citizenship and Immigration Canada, Federal Health Program, for newcomers to Canada
- Correctional Service Canada, Health Services, for individuals under incarceration
- Veterans Affairs Canada, Treatment Benefits Program, for Canadian Armed Forces veteran

Ontario transportation options

- https://www.destinationontario.com/en-ca/travel-resources/transportation

Ontario clinic finders

- https://www.rainbowhealthontario.ca/lgbt2sq-health/service-provider-directory/
- https://ontarioprep.ca/clinic-finder/

Advocate for yourself and for others if you are able to in your communities. Simply understanding that inequities and their potential downstream effects exist is not enough.[54] If you are unsure how to start, that's okay. Below are some groups which advocate for 2SLGBTQ+ causes, including GMSH. Change only comes with action, and a rising tide lifts all boats, as they say.[104-106]

Advocacy groups

- Egale
- Momentum
- GMSH

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