Public Health England

Promoting the health and wellbeing of gay, bisexual and other men who have sex with men

Initial findings

1. Health and wellbeing of men who have sex with men

This paper sets out Public Health England's (PHE) initial findings on the health and wellbeing of gay, bisexual and other men who have sex with men (MSM)†. It summarises some of the principal challenges that MSM face and the evidence-base for effective public health interventions – including potential areas where PHE could take action.

The context for this work is the development of a strategic and implementation framework, whose overall vision is for MSM to enjoy long and healthy lives, to have respectful and fulfilling social and sexual relationships; and to reduce significantly the annual number of new HIV infections in MSM by 2020.

Gay, bisexual and other MSM constitute an estimated 2.6% of the male population in the United Kingdom (UK)[1] – defined as men who have had at least one male sexual partner in the past five years. This diverse population continues to experience significant inequalities relating to health, wellbeing and broader social and economic circumstances. This is despite the significant improvement in social attitudes and laws that protect[2] and uphold the rights[3,4,5,6] of gay, lesbian, bisexual and transgender people.

Indeed, there are three distinct but overlapping areas in which MSM appear to bear a disproportionate burden of ill-health. These are sexual health and HIV; mental health; and the use of alcohol, drugs and tobacco. This paper focuses on these three areas and places them in the context of the life course. It builds on the work to highlight health inequalities in the Public Health Outcomes Framework (PHOF) LGBT Companion Document[7].

Adult MSM are the group most affected by HIV in the UK[8] with one in twenty MSM living with HIV in the UK in 2012 and up to one in twelve in London, compared with one in 667 in the general population. It is likely that the HIV epidemic among MSM is largely due to the on-going incidence from men who are unaware of their infection. In addition, MSM accounted for the majority of diagnoses of syphilis and gonorrhoea in 2013 and the number of diagnoses of sexually transmitted infections (STIs) reported in MSM has risen sharply in recent years[9].

MSM are at greater risk of mental health problems. For instance, they are twice as likely to be depressed or anxious compared with other men[10]. Lesbian, gay, bisexual and transgender (LGBT) adolescents are at greater risk for depressive symptoms and suicidal ideation compared with other adolescents[11].

MSM are also at greater risk of unhealthy behaviours and lifestyles. For instance, adult MSM are twice as likely to be dependent on alcohol compared with the rest of the male population and smoking rates are higher[12].

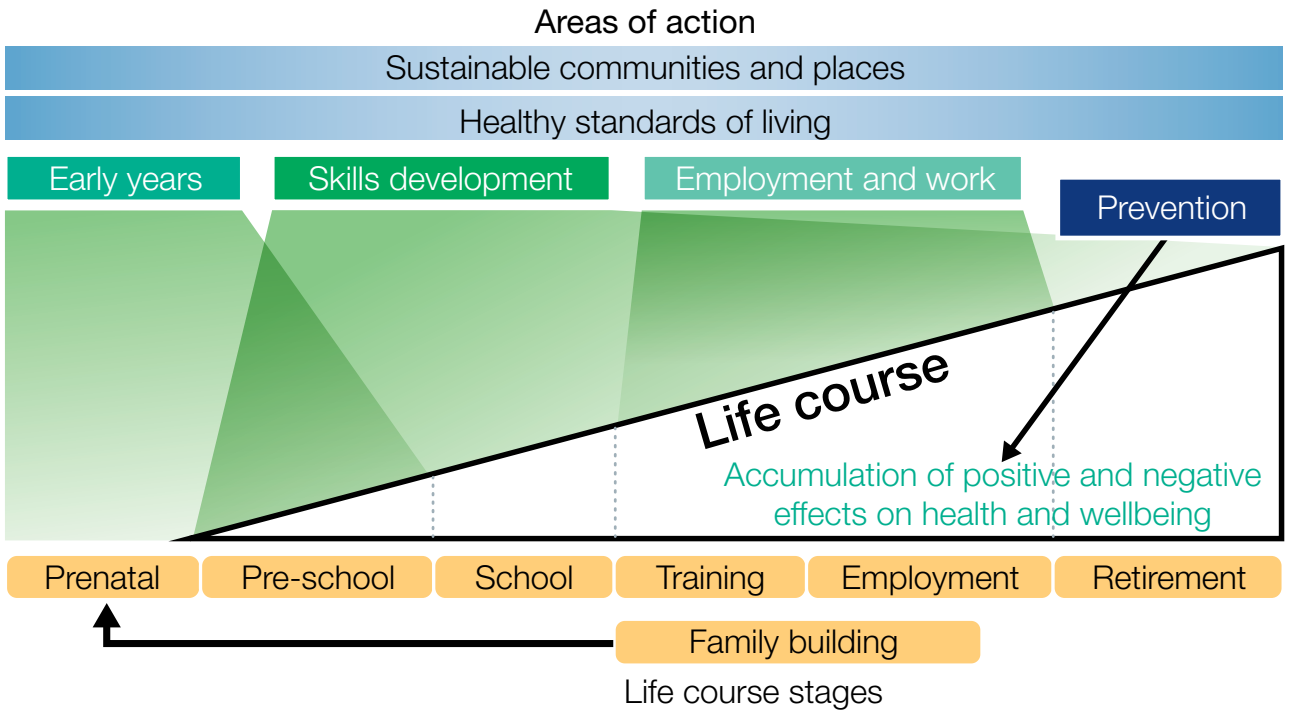
† We use the phrase men who have sex with men to define men who have ever had male-male sexual contact. This definition is used because it describes sexual behaviour, regardless of how men perceive their sexual identity. We acknowledge that it is not necessarily a term with which the male gay community identifies but believe its use is helpful in ensuring we are as inclusive as possible.

Underlying these inequalities are broader inequalities that affect the health and wellbeing of MSM, at different stages of their lives. These wider determinants include the experience of, or the fear of, stigma and discrimination in different contexts – from schools to the workplace. At least 36% of older men, for example, report hiding their sexual identity through their lives[13], and 55% of young LGBT students say they have experienced homophobic bullying[14]. MSM are less likely to seek help from health and social care services, or to reveal their sexual identity to those providing their care[15].

2. What we know: trio of inequalities across the life course

Public Health England is committed to the life course approach[16] which recognises that people's health partly reflects the accumulation of risks and protective factors through different life stages, and is significantly influenced by the experiences in childhood (Figure 1).

Figure 1: Life Course Approach



Source: Fair Society, Healthy Lives. The Marmot Review 2010

For MSM, it is important to acknowledge the significance of certain key life-events, including the development and acceptance of gay or bisexual identity, first same-sex experiences and relationships, and coming out to friends, family and wider acquaintances. The relative ease with which MSM transition through key life stages will largely depend on men feeling accepted and supported from an early age and into adulthood[17].

the life course is a useful approach through which to deliver appropriate health promotion and prevention messages to address the health inequalities experienced by MSM. Therefore, in the following sections, we consider the health and wellbeing of MSM in those three areas of sexual health, mental health and substance use as it relates to young MSM (starting well), MSM as they become adults (living well) and older MSM (ageing well). Ultimately, our vision is to improve the health and wellbeing of MSM throughout the life course. Specifically, our aspiration is for:

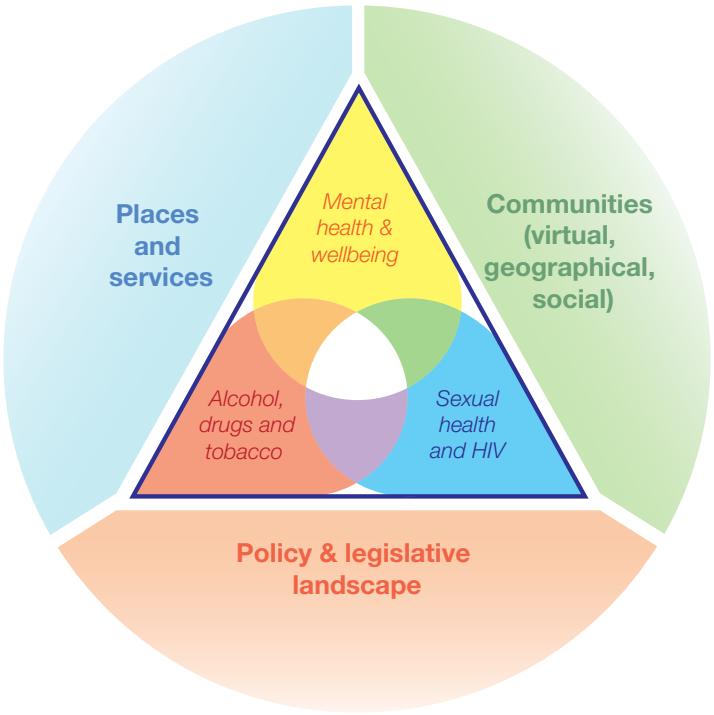
- MSM feeling safe and supported as they develop their sexual identity and are empowered to make healthy choices as they become sexually active
- MSM to feel respected and valued by the community and to have the control and opportunity to make healthy choices about their lives
- MSM to lead longer, healthier lives, to feel supported by the community and receive appropriate health and social care support as they age

Indeed, the evidence suggests that there are three interrelated areas in which the inequalities for MSM are most apparent: sexual health including HIV[8], mental health and wellbeing[12] and the use of alcohol,[18] drugs[18] and tobacco[19].

These dimensions of health and wellbeing frequently co-exist and influence each other[20]. For example, there is some evidence that shows depression is associated with heavier use of drugs and alcohol[21] and a small study found MSM reporting drug use to mask low self-esteem and/or self-confidence issues[22]. In turn, substance use including chemsex (the use of drugs before or during sex) may increase sex drive, impair the negotiation of safer sex and facilitate sex that men later report they regret.

This trio of health inequalities is shaped by a range of factors including: families and social networks, schools, workplaces, faith organisations, media including social media, legislation and the wider cultural and social context in which MSM grow, live and age. Figure 2 illustrates some of these drivers.

Figure 2: Determinants of health inequalities trio



2.1 Starting well

The earlier life stages in particular are fundamental for the development of good mental health and resilience. However, the development of a same-sex attraction among young people carries with it the risk that acceptance and support may be withdrawn by those closest to them. Family support helps young MSM to make safe choices about drugs and alcohol and their sexual relationships[23].

Sexual health including HIV

Good sexual health starts with clear, accurate and relevant information. Schools have a vital role in providing the knowledge and skills that all young people need through Sex and Relationships Education (SRE)[24]. The Department of Education's SRE Guidance[25] makes it clear that schools must meet the needs of all pupils, regardless of their sexual identity. Despite this guidance, 85% of MSM report never having been taught about the biological or physical aspects of same-sex relationships[15]. A recent survey found that MSM aged 16-24 years know consistently less about HIV than those aged 25-54 years[26].

With same-sex relationships content missing from SRE, young MSM may be more likely to seek information from other sources. While social media and websites can often provide excellent information about physical and emotional aspects of same-sex relationships for young MSM[27], sites can also provide misleading or harmful information.

In the UK, younger MSM have higher rates of STIs; one in four of STI diagnoses (gonorrhoea, chlamydia, syphilis, herpes simplex virus (HSV) and human papillomavirus (HPV)) among MSM are reported from men aged 16-24 years in 2012[28].

The number of new HIV diagnoses among younger MSM increased by 30% from 340 in 2008 to 440 in 2012[8]. Around a quarter of MSM who were diagnosed under the age of 25 years had acquired their infection in the previous six months; this is indicative of ongoing HIV transmission in young MSM[8].

Mental health and wellbeing

UK data suggest greater experience of discrimination including verbal, physical and sexual abuse in schools for MSM compared with heterosexuals, with many young MSM not reporting incidents and little support offered[29].

A British survey in 2012[14] found 99% had heard the term "gay" being used in a derogatory way or heard other homophobic language. Within the same survey, 55% reported homophobic bullying. Of those who had been bullied, 44% reported deliberately missing school as a consequence. Teachers report that boys who behave 'like girls', girls who behave 'like boys', young people with gay parents, friends or family members, and young people merely perceived to be gay can be all victims of homophobic bullying.

Population based studies suggest LGBT adolescents are at greater risk for depressive symptoms and suicidal ideation compared with their heterosexual counterparts[11].

The internet and social media can help young MSM reach out to members of the gay community and reduce feelings of isolation. However, it also poses risks including cyber-bullying, providing unrealistic or over-sexualised representations of same-sex relationships and sexual exploitation. A recent survey found that 59% of young LGBT people had created a sexual photo or video of themselves with 47% sending it to someone they had not met[30].

Alcohol, drugs and tobacco

A systematic review in the USA[31] found LGB young people were almost twice as likely to use drugs and alcohol compared to heterosexual peers. They were also more likely to use harder drugs such as cocaine and to inject. Substance misuse was most strongly associated with homophobic and biphobic bullying (discrimination and stigma faced by bisexual people), lack of supportive environments, negative and disclosure reactions.

A recent analysis in the UK found MSM aged 18-19 years were 2.4 times more likely to smoke and almost twice as likely to drink alcohol twice a week or more, compared to heterosexual men[32].

There is a lack of data on smoking amongst young LGBT in the UK. Research in the USA found that people aged 15 years who reported being bisexual were twice as likely to smoke regularly as their heterosexual and homosexual peers[33].

2.2 Living well

The experience of MSM in the early years and during adolescence is likely to have an impact on their experiences as they move into adulthood. While at working ages, MSM may be more likely to have accepted their sexual identity and established supportive networks, the legacy of any homophobic bullying, and the continuing potential for discrimination in adulthood still exists.

Sexual health including HIV

The types of sexual relationships MSM experience vary considerably. Many MSM maintain monogamous or a series of stable partnerships, while others report higher numbers of partners, both regular and casual, compared to heterosexual men. These relationship patterns may change across an individual's life course. It is a combination of these partnership patterns[34], together with the risks associated with anal sex without condoms[35] that determines the high prevalence and incidence of HIV and STIs in this population.

In 2008, 47% of MSM recruited to a study in bar settings in London reported having anal sex without condoms in the past year,[36] with similar levels reported in 2011[37]. However, the ways in which MSM find casual sex partners, and the types of sex they have, continues to evolve. For some, saunas and sex-on-premises bars and clubs remain important venues for men to find partners, but social media is an increasingly efficient and sophisticated way for men to meet others. While social media can have an important role in delivering health promotion messages among MSM, other sites and applications can normalise risky behaviour and facilitate onward transmission of HIV and other STIs.

Although only 2.6% of the male English population is estimated to be MSM, in 2013, about 81% of syphilis, 63% of gonorrhoea, and 17% of chlamydia diagnoses were reported within this group[29]. Over the past decade, there have also been outbreaks of *Lymphogranuloma venereum* (LGV) and *Shigella flexneri*[38], which are diagnosed almost exclusively in MSM[39]. Furthermore, MSM are at increased risk (compared to heterosexual men and women) of anal HPV[40] and anal cancer (associated with HPV), and may be at increased risk of other HPV-associated cancers (penile, oral and throat). MSM are also at risk of hepatitis B and C[41] (associated with liver cancers); among HIV positive MSM, 7.7% are estimated to be co-infected with hepatitis C compared to 2.1% among HIV negative MSM[42].

In 2012, it was estimated that one in twenty MSM were living with HIV in the UK with up to one in 12 in London[8]. This compared to one in 667 in the general population in the same year. The number of MSM living with a diagnosed HIV infection has doubled from 16,180 in 2003 to 33,960 in 2012. Although this rise is partly due to the availability of antiretroviral therapy (ART), which increases life expectancy, it also reflects significant levels of continuing HIV transmission.

The number of MSM newly diagnosed with HIV each year continues to rise. Between 2011 and 2012, the number of new HIV diagnoses increased by 10% from 2,960 to 3,250, and in London by 14%, from 1,400 to 1,600. Trends in new HIV diagnoses do not necessarily reflect ongoing transmission since they are also influenced by HIV testing patterns. The number of MSM that had an HIV test in sexual health services in England increased by 13% (from 64,270 in 2011 to 72,710 in 2012), while in London, the increase was 19% (from 28,640 in 2011 to 33,980 in 2012)[17].

The increase in HIV testing cannot entirely account for the rise in the new HIV diagnoses. Modelling methods suggest that the number of new infections has remained stable at around 2,500-3,000 each year[43], despite high and increasing proportions of HIV positive MSM receiving ART[44]. Nearly 90% of MSM living with a diagnosed HIV infection are receiving treatment and of these, almost 90% are virally suppressed with a negligible risk of passing on their infection through sex[45, 46]. With such a high coverage of ART, it is likely that the HIV epidemic among MSM is largely due to ongoing incidence from men unaware of their infection. Increased and frequent HIV testing is therefore vital to control transmission. Of the estimated 41,000 MSM living with HIV in the UK at the end of 2012, nearly one in five was unaware of their infection[8].

Sex without a condom among MSM living with HIV has resulted in high rates of other STIs in this group. About 80% of MSM diagnosed with LGV, 60% diagnosed with *S. flexneri*, and almost a third diagnosed with syphilis are HIV positive[40]. Surveys conducted in gay commercial venues and gyms demonstrate that while overall patterns of sexual behaviour are complex, there has been an increase in the proportion of MSM reporting anal sex without condoms with partners of unknown or of a different HIV status to themselves[37, 35].

Mental health and wellbeing

Twice as many gay and bisexual men report moderate to severe levels of depression and/or anxiety compared with men in general. A recent study in the UK found that 21% of MSM report feeling recently unhappy or depressed compared to 12% among heterosexual men[10].

The reasons for these mental health inequalities have been only partially explored. The UK has been at the forefront of anti-discrimination and other laws which recognise the sexual identity of its population. As a result of this legislation and societal changes over the past decades, the wellbeing of MSM in the UK may have improved in recent years. Nevertheless, gay employees report more than double the levels of bullying in the workplace compared to heterosexuals[47].

Where stigma and discrimination are apparent, the effects are clear and include: internalised homophobia leading to increased risk of depression and substance use[22]. There is suggestion that some MSM, particularly older MSM, MSM who are Black, Asian or from other minority ethnic groups (BAME), and MSM of faith are especially disadvantaged in this respect.[48]

MSM also have a relatively high risk of sexual and domestic violence[15]. One national survey reported over half of MSM self-reported violence or abuse from a family member or partner since the age of 16 years, with only one in five reporting it to authorities[49].

In 2011/12, MSM living with diagnosed HIV infection reported high rates of moderate/severe depression (25%) and anxiety (21%)[50]. HIV stigma remains a serious issue for those living with the virus. In 2009, 63% of people living with HIV reported feelings of low self-esteem in the previous three months[51].

Alcohol, drugs and tobacco

In 2011, a survey found that 42% of MSM drank on three or more days in the last week and 67% of MSM had ever smoked; this compares to 35% and 50% respectively, in the heterosexual male population[15]. A study in 2008 found that MSM were twice as likely to be dependent upon alcohol compared to the rest of the male population[12]. UK data from the Home Office indicate that 21% of MSM reported that they were concerned about their alcohol use in 2011.

In 2003, 53% of MSM reported using recreational drugs in the past month; this compares to 45% in the heterosexual population[15]. Data from the Home Office indicate that in 2009, 13% of MSM reported using class A drugs. MSM are also likely to use drugs differently compared to the heterosexual community. This includes ‘poly-drug’ use (taking combinations of drugs) and using a wider range of club drugs such as GHB[19]. Specifically, methamphetamines, poppers and cocaine have been found to be associated with sex without condoms and acquisition of HIV[52]. Data relating to the increasing availability of legal highs requires further research.

Recent research in London has identified a growing trend for ‘chemsex’, a term used by MSM to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during sex. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine. This small London study found that although chemsex was reported to increase sexual arousal and facilitate more adventurous sex, many men were using drugs to mask self-esteem or self-confidence issues[23]. British research has found that a third of respondents who scored as substance dependent would not seek information, advice or treatment, even if they were worried about their drug or alcohol use[53].

Smoking rates are higher for MSM communities compared to their heterosexual counterparts. LGB people aged over 16 years are more likely to be current smokers, less likely to have never smoked and less likely to have given up smoking compared to the general population[54]. A study of 18,000 UK men in 2010 reported a 31% prevalence of smoking in MSM[55]. In another survey of 6,000 men, 67% of MSM reported smoking at some point of their lives with 26% reporting current smoking. This compares to 22% among heterosexual men[15].

Tobacco use is an important modifiable lifestyle factor for anyone, but particularly for those whose health is already compromised; this includes people living with HIV. Compared to HIV positive people who do not smoke, tobacco use among HIV positive people significantly increases the likelihood and rate of developing oral thrush and bacterial pneumonia[56]. Furthermore, protease inhibitors (part of an ART combination frequently used to treat HIV) can raise blood lipid (fat) levels and smoking exacerbates an already elevated risk of heart disease[57].

2.3 Ageing well

Older MSM constitute men at very different phases of their lives, ranging from MSM in employment, living well in retirement and those requiring support at home or in care. For those living with HIV, many will have experienced far more acute stigma and discrimination than today's cohort of young MSM. As a result they may have come out in later life, or carry this experience of stigma with them, creating additional barriers to accessing services. This group is also far more likely to have suffered loss and bereavement from acquired immune deficiency syndrome (AIDS) prior to effective treatment for HIV infection.

The major concerns that affect older LGBT communities are the same as those that affect older heterosexual populations: loneliness, ill-health and financial issues[58]. However older LGBT people report feelings of frustration around assumptions of heterosexuality, particularly when they come into contact with health and social care services for the first time.

Sexual health including HIV

Older MSM remain at risk of STIs. In 2012, 14% of diagnoses of chlamydia, gonorrhoea, syphilis, HSV and HPV in MSM were reported among men aged 45 years and over in the UK; this compares to 8% in heterosexual men.

In 2012, 28% of all MSM living with a diagnosed HIV infection in the UK were aged over 50 years, with 6.7% aged over 65 years. This reflects improved survival following the ART but also continuing transmission among those aged 50 years and over. Approximately half of people living with diagnosed HIV infection aged over 50 acquired their infection while aged 50 years and over[59].

Older people are more likely to be diagnosed with HIV at a late stage of infection (a CD4 count <350 cells/mm^3 within three months of diagnosis); in 2012, 54% of MSM aged over 50 years were diagnosed late, compared to 24% among those aged under 25 years. A late diagnosis is associated with a ten-fold risk of mortality within 12 months of diagnosis compared to those diagnosed promptly[60]. The impact of late diagnosis and delayed treatment on mortality and clinical outcomes is more profound among older people[61].

For men living with HIV, there is emerging evidence of increased risk of chronic diseases compared to the HIV negative population. Specifically, research highlights increased risk of CVD, metabolic disorders, cancer[62] and cognitive impairment[63]. These co-morbidities are partially due to the effects of HIV (including ART), but also due to the ageing population of HIV positive men.

Mental health and wellbeing

At least 36% of older men report hiding their sexual identity throughout their lives and recognise this had led to internalised homophobia[13]. There is very little research on the mental health of older MSM, but there are indications that older MSM have elevated levels of depression compared with older adults in the general population[64]. Data from the UK suggests that MSM are 2.6 times more likely to live alone compared to heterosexual men[15], which may impact on feelings of isolation. However other studies have suggested that loneliness among older MSM may be less common that has typically been assumed[65].

Alcohol, drugs and tobacco

There is some evidence for higher rates of alcohol and drug use among older MSM[15]. In 2011, 35% of LGB individuals aged 55 years and over reported drinking alcohol three days a week or more, compared to 31% of older heterosexual men.

In this age group, 9% of LGB people reported taking recreational drugs in the past 12 months compared to 2% of heterosexuals of the same age. There is limited understanding of the impact of drug use in this age group, particularly around the interactions with prescription medication and chronic disease. Little is known about tobacco use in older MSM.

2.4 MSM minority groups

MSM includes men from different faith groups and ethnicities and men living with disabilities. There is potential for these minority groups to experience further marginalisation and isolation.

Men from some ethnic and faith communities may face additional challenges including greater experience of actual, and perceived risk, of discrimination, rejection and isolation from their communities, and potentially from the mainstream LGBT community.

The varied nature of disabilities will also impact on the extent to which such MSM will identify and participate in same-sex relationships and the gay community. However, this group may be less likely to access MSM-appropriate services due to assumptions of heterosexual or a sexual identity at first contact with health and social care services. National surveys in the UK have found significantly higher inequalities affecting disabled, gay and bisexual men compared to such men without disabilities[66].

Sexual health and HIV

Over the past decade, the ethnic composition of the UK MSM HIV epidemic has changed, with greater numbers of men originating from Asia and Central and Eastern Europe. While the number of new HIV diagnoses increased by 40% between 2002 and 2011 in the UK, the number of diagnoses among black African MSM has remained stable at about 50 cases a year, and the number among black Caribbean MSM has decreased by a third from around 90 to 60. While numbers are small, new diagnoses of Asian men have increased by over 400% over the decade, from around 20 to 140[67].

Importantly, it is estimated that in 2011, 64% of men born abroad probably acquired their HIV infection in the UK[69] and this highlights the need for targeting HIV prevention messages for all MSM resident in the UK, including those born abroad.

Reassuringly, there are no differences in clinical outcomes or quality of care received by MSM who are Black, Asian or from other minority ethnic groups (BAME)[69] living with diagnosed HIV infection in the UK.

Mental health and wellbeing

The development of sexual identity during early years is particularly difficult for minority groups[68]. Specifically, homosexuality remains stigmatised within some religious communities and within some BAME groups[69]. Adolescents in these communities may be more likely to feel shame, and/or be in denial, all of which negatively impacts on their mental health. There is evidence from BAME MSM communities that psychological distress and risk taking behaviour may result in part from early childhood experiences such as physical and emotional abuse from families, peers and community leaders[50].

Population surveys of MSM show that disabled men were three times more likely to self-harm and three times more likely to have attempted to take their own life compared to MSM without disability[68]. MSM with disabilities are also at risk of domestic violence and abuse; 16% report violent assault by a partner or family member compared to 8% among MSM without disabilities.

Alcohol drugs and tobacco

Little is currently known about the patterns of alcohol, drugs and tobacco use among BAME groups.

Research has found slightly higher levels of recreational drug use amongst disabled gay and bisexual men compared to men in general[68].

3. Public health interventions

There is a considerable body of evidence to substantiate the effectiveness of a range of interventions to improve the health and wellbeing of MSM. We highlight some of them here, focusing both on the potential of 'direct' interventions (for example: how to improve the offer and the uptake of HIV testing) as well as interventions that tackle the wider determinants of health (for example: reducing homophobic bullying in schools).

3.1 Sexual health including HIV

Sex using condoms, and regular sexual health screens, continue to be a very effective way to prevent the acquisition and transmission of STIs including HIV[70]. Regular STI screens including HIV tests, at least once a year (and every three months for those having sex without condoms with new or casual partners) are a vital way to diagnose and treat existing conditions, prevent new infections and provide an opportunity to offer behavioural and other interventions such as hepatitis B vaccination[70]. PHE recommends that MSM have a sexual health screen including an HIV test at least annually, and every three months if having sex without a condom with new or casual partners[17].

While the number of MSM who had an HIV test at sexual health clinics increased by 13% from 64,270 in 2011 to 72,710 in 2012, further work to increase the uptake of HIV testing is required. Current BHIVA guidelines (2008) recommend an HIV test be offered to MSM at each attendance at a sexual health clinic[71]. These guidelines also recommend HIV tests be offered to all those accessing primary or outpatient settings where diagnosed HIV prevalence is greater than 2/1,000 population aged 15-59 years. These guidelines are due to be updated in 2015.

People who are diagnosed with HIV must have rapid access to high quality treatment and care, which maximises their own health and wellbeing and also reduces the risk of transmission through sex to other people[72].

Antiretroviral therapy has both direct clinical benefits for people with HIV and also reduces infectiousness to other people. Studies amongst heterosexual men and women living with HIV who adhere to ART and achieve an undetectable viral load have a negligible risk of passing their infection and preliminary data indicate this is also the case for MSM[74]. Current treatment guidelines in the UK recommend that, for individual clinical benefit, ART is started at a CD4 count of 350cells/mm^3. Additionally, the guidelines advise that health care professionals discuss the evidence that treatment with ART lowers the risk of transmission with everyone with HIV, and that if someone with a CD4 cell count above 350 cells/mL wishes to start ART to reduce the risk of transmission to partners, this decision should be respected and ART commenced[73].

Using antiretroviral drugs in this way is termed Treatment as Prevention (TasP). The wider use of TasP as an intervention for population and public health is an evolving field with different countries taking different positions. However, ART reduces the risk of transmission only of HIV. Irrespective of ART, condoms remain the most effective way to prevent the spread of other sexually transmitted infections.

New HIV prevention technologies and interventions are emerging. Pre-exposure prophylaxis (PrEP) is ART taken by HIV negative men at risk of HIV transmission in advance of sex. In the UK an ongoing randomised control trial of PrEP is assessing rates of HIV incidence, adherence to PrEP and impact on risky sexual behaviour. Guidelines have been developed for the use of post-exposure prophylaxis (PEPSE) for HIV following sexual exposure[74].

In addition, it is important to acknowledge the contribution of frameworks such as the "Making it Count Framework", developed to improve the health of MSM using a holistic approach. First published in 1998 and regularly updated, it is an example of a useful resource that aims to prevent HIV transmissions through tackling structural and direct determinants of HIV.

The Joint Committee for Vaccination and Immunisation (JCVI) recognises that the current HPV immunisation programme will provide relatively little benefit to MSM. Given the higher rates of HPV-related cancers and genital warts in MSM, a review of the likely cost-effectiveness of HPV vaccination of MSM is underway. While the national screening committee does not currently recommend anal cancer screening for MSM, the Analogy study is examining the feasibility of anal screening in HIV positive men.

3.2 Mental health and wellbeing

For everyone, regardless of sexual identity, good experiences in childhood help to build the resilience that can be drawn on in difficult times and can lay down patterns of behaviour that will build wellbeing over the life course.

In the UK, there are a number of interventions aimed at reducing victimisation of young LGBT people in schools, but not all have been evaluated for evidence of effectiveness. The interventions range from training (for governors and leadership teams)[75], to learning resources for teachers[76], and classroom-based programmes focussing on bullying prevention and social emotional learning skills[77]. There are also a number of British generic and LGBT specific programmes that can help to support young MSM as they develop their sexual identity. For instance, the Rise Above programme aims to instil the skills and confidence in young people to develop resilience.

Resources are available that relate to the mental health and psychiatric needs of sexual and gender minorities including MSM[78], and for all people living with HIV[79].

Many of the concerns of older LGBT populations reflect those of the general ageing population and the recommendations from the "Living Longer" report from the Department of Health are relevant in this context.

3.3 Alcohol, drugs and tobacco

Making 'every contact count' is an evidence-based strategy that uses the premise of brief interventions to assess and offer brief advice on alcohol, drug and tobacco use at each contact within the health service.

This is particularly pertinent in the sexual health care settings where MSM may feel more able to speak about their drug and alcohol use in the context of their sexual identity and behaviour. There is evidence that this approach works for alcohol[80], drugs[81] and tobacco[82]. Once assessments are made, it is important that prompt referrals are made, where necessary, to alcohol and drugs services which are culturally competent to work with MSM. Good treatment pathways and close liaison and partnership between alcohol and drug services and health settings most frequently used by MSM are important.

Part of the Picture is a five year partnership which aims to establish an England-wide database of LGB people's use of alcohol of drugs. The database will be used to directly inform local and national partners in addressing the drug and alcohol use of LGB people. This resource will also provide an improved knowledge and understanding of the needs of LGB drug and alcohol users amongst drug and alcohol agencies, through dissemination of the research findings[55].

4. Public Health England: our commitments and next steps

PHE will produce a strategic and implementation framework later in the year. This will further define the priorities for both PHE and a wide range of stakeholders including from national and local government, the community and voluntary sector and NHS England. This document will set clear objectives, priorities and actions to achieve our vision by 2020.

PHE has also committed to address the health inequalities in specific minority groups. Future reports will address the needs of other groups, for instance, gay and bisexual women, BAME groups, people who are transgender, and people with disabilities.

It is important to note the limitations that we face in terms of data. Health and demographic related data are routinely collected at a national level through several national and international surveys including the Integrated Household Survey, Adult Psychiatric Morbidity Survey and the Active People Survey, and through the routine collection of HIV and sexual health data. However, in some areas, data exist but are not analysed or reported consistently. As such, there remain significant knowledge gaps in important areas of public health. This makes it difficult to identify the prevalence of key areas that affect MSM, including smoking, alcohol, drugs, and mental health.

PHE believes, however, that we have sufficient data to take action in specific areas. At this stage in the process, PHE has identified a number of these, detailed on the next page:

Data and surveillance: PHE will

- support alcohol, drug and tobacco and mental health services to collect data about sexuality
- enhance data and intelligence on prevalence of alcohol and drug use (including 'chemsex') across the life course
- monitor both HIV incidence and prevalence in MSM and rates of STIs and identify and manage outbreaks
- monitor the clinical outcomes and quality of life of MSM living with HIV
- provide data through its national mental health intelligence network on the mental health of young LBGT
- support the inclusion of sexual identity data to be collected in the audit and evaluation of services for older people

Evidence: PHE will

- provide evidence to inform appropriate use of HPV vaccines among MSM
- publish guidance to support local areas aiming to achieve large scale changes in health outcomes for adults and older MSM
- make recommendations on anal cancer screening in HIV positive men based on findings of the ANALOGY study
- publish and promote briefings to support local authorities to meet the needs of MSM involved in 'chemsex'
- develop and disseminate the evidence base and learning from community development programmes aimed at reducing HIV and STI risk

Public health interventions and implementation: PHE will

- develop the FRANK and Rise Above drug education and prevention campaigns and ensure they are relevant to the needs of young MSM
- ensure social marketing programmes and information campaigns are relevant and appropriate for MSM across the life course
- use its leadership role to champion community approaches which are inclusive and respond to the needs of diverse groups of MSM across the life course
- be an exemplar in promoting and supporting an inclusive and diverse workplace

Community engagement and consultation process

To inform the scope and proposals of this work, Public Health England has held two listening events for stakeholders, one in Manchester and one in London, and has also established an Advisory Working Group that includes subject matter experts and academics, to guide this work.

A two week on-line opportunity to comment on our summary of the evidence was held in the summer of 2014. A wide range of stakeholders were invited to participate, and were asked to respond to three specific questions about the framework. Additional comments were captured as free text. Comments and feedback were received from a range of organisations.

Next steps and implementation

Public Health England:

- is committed to developing a framework and implementation plan in consultation with local and national partners
- will establish an implementation advisory group with appropriate representation from the LGBT community, national stakeholders, representatives of local public health teams as well as teams within PHE who have the opportunity to implement and integrate the framework in their work; the advisory group will be jointly chaired by the PHE national lead for sexual and reproductive health and the PHE national lead for adults and older people's health and wellbeing
- will hold bilateral meetings with the relevant government departments and national bodies to consider the proposals made at a national level; PHE will work with the Government Equalities Office to find synergy with the cross-government LGBT action plan
- will continue to work closely with the Local Government Association, NHS England, clinical commissioning groups, NHS England, Local Authorities and Health and Wellbeing Boards and relevant voluntary sectors partners to energise action to reduce the inequalities affecting MSM
- will continue to work with NHS England's Equality and Diversity Council working group on sexual identity data, to support the implementation of monitoring across the NHS
- will publish an annual implementation update on the framework, including a report on progress against the identified indicators

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