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outsideIN
BEST PRACTICES

Healthcare Providers

HIM HEALTH INITIATIVE FOR MEN

INTENDED AUDIENCE

This document is intended to support sexual healthcare providers (such as nurses, nurse practitioners, physicians, etc.) who work with gay, bisexual, trans, Two-Spirit and queer male (**GBT2Q**) clients, whether or not those clients have disclosed their sexuality.

AUTHORS

This document is written by GBT2Q-identified health promotion specialists located in Vancouver, BC and is based on multi-level consultation with healthcare providers and GBT2Q community members.

INTRODUCTION

For the purposes of this document, we use the term **more out** and **less out** to distinguish between groups of people whose experiences of outness differ.

When meeting a client for the first time, we may not know what life experiences they've had or what circumstances they will be returning to when they're out the door. As we assist someone who may be **less out** with issues as sensitive as their sexual practices and related health routines, it is important that they feel as comfortable as possible and have a safe and positive experience.

Making assumptions, and acting on those assumptions, can make GBT2Q who are **less out** feel uncomfortable, silenced, and isolated. Experiences like these can discourage clients from accessing sexual health services, while the data shows that **less out** GBT2Q men are in great need of it.

MORE THAN 1 IN 4 (27.2%) MEN WHO HAVE SEX WITH MEN IN CANADA SAY THEY HAVE NEVER 'COME OUT' TO ANYONE, INCLUDING ANY HEALTHCARE PROVIDER.

SEX NOW 2014-5

HOW YOU CAN HELP

We encourage service providers to interrogate their assumptions about clients' **outness**, along with the concept of outness as a whole. We hope to help foster an environment where **less out** community members feel more comfortable accessing the services and supports they need.

UNIQUE HEALTH NEEDS OF THOSE OF US WHO ARE LESS OUT

Health Initiative for Men (HIM) conducted an extensive literature review on outness, self-identification, and sexual health practices.

This literature review found that less out GBT2Q people experience unique negative sexual health outcomes compared to their more out GBT2Q counterparts:

> **Lower sexual health literacy,** including less knowledge about the effectiveness of ARV medication for people living with HIV, and of the existence of PEP and PrEP (Sex Now 2014-2015)**.**

> **Less likely to be aware of their positive HIV status.** GBT2Q continue to constitute the majority of new and existing HIV diagnoses in British Columbia. GBT2Q men who are **less out** are less likely to know of their positive HIV status and may be having sex with others who similarly do not know their HIV status. (Blas et al., 2010).

> **Significantly less likely to have ever tested for HIV and other STBBIs,** and to have been tested in the last 12 months (Goldenberg et al., 2016; Sex Now 2014-2015).

> **Social inequities including unreported intimate partner violence and weak support networks, which are associated with increased feelings of isolation and participation in 'riskier' sexual activity.** Those who are **less out** report higher rates of condomless and unprotected anal sex with a person whose sexual health status is unknown, and are less likely to report when experiencing intimate partner violence when compared to GBTQ men who experience similar violence and isolation but are **more out** (Pitpitan et al., 2016; Goldenberg et al., 2016).

> **Inaccurately low perception of their risk of coming into contact with, or passing HIV based on their sexual activities and behaviours** (Shehan et al., 2003).

WE NEED TO SIMULTANEOUSLY RECOGNIZE THE UNIQUE STRESS RELATED TO BEING LESS-OUT WHILE UNDERSTANDING THAT THAT COMING OUT IS NOT THE SINGULAR SOLUTION.

BEST PRACTICES

The following practices on working with clients who are **less out** and/or have a complicated relationship with **outness** are based on: key-informant interviews and focus groups with **less out** community members, and focus groups with sexual health-care service providers.

WHEN DISCUSSING OUTNESS

CREATE A SPACE THAT WELCOMES THE CLIENT TO RETURN.

Regardless of the setting, it is important that the client feel as comfortable as possible and leaves wanting to come back to seek your support, or the support of another healthcare professional. This might mean using the client's own words/language to describe their situation, and/or learning current and appropriate language that demonstrates our commitment to compassionate understanding (more on that below).

CONCEPTUALIZE OUTNESS AS BEING ON A SPECTRUM RATHER THAN A BINARY OF 'IN' OR 'OUT' OF THE CLOSET.

For example, someone is not "in" one day and "out" the other, but rather is faced with the decision to disclose with every new person they meet. A spectrum that takes into account different situations better reflects this important nuance.

WHEN DISCUSSING OUTNESS IN PARTICULAR CIRCUMSTANCES OR WITH SPECIFIC PEOPLE, FRAME IT AS 'BEING OUT' RATHER THAN 'COMING OUT'.

"Have you come out to...?" or "Have you told your parents that…?" paint sexual disclosure as inevitable. "Are you out to…?" Or "Do your parents know…?" is descriptive and more accurate in that it is limited to the client's current reality.

A CLIENT'S EXPRESSION OF OUTNESS MAY LOOK MARKEDLY DIFFERENT THAN SOMEONE ELSE'S DEPENDING ON DIFFERENT FACTORS INCLUDING CULTURE, RELIGION, CLASS, CAREER, AMONG OTHERS.

We may make certain assumptions because a client is wearing makeup, or wearing a turban, if they work in construction, or works at a gay bar, but it is better to listen to them about what being out means to them, depending on where, with whom, and in what situations.

NORMS AROUND SEXUALITY AND OUTNESS VARY VASTLY AMONG DIFFERENT CULTURES.

Some people are private about their sexual and romantic lives in order to keep familial and community customs and traditions important to them. Others may belong to cultures in which a person can live a queer life but isn't expected to 'come out' to family and friends, or where people may have sex and share intimacy with others of the same gender-binary but not identify as queer or GBT2Q.

BEING LESS OUT DOESN'T MAKE A PERSON LESS THAN.

'Coming out' is often seen as an important milestone for every GBT2Q person. This monolithic idea affects **less out** GBT2Q people by minimizing or erasing their experiences and resiliencies. When supporting **less out** clients, recognize that there are many GBT2Q people who are in similar situations and **outness** does not determine a person's worth as members of a queer community, should they choose to see themselves as such.

WHEN DISCUSSING SEX

MIRROR THE CLIENT'S LANGUAGE ABOUT THEIR SEXUAL ACTIVITIES AND BEHAVIOURS.

While it is important to assess a person's sexual behavior to determine their healthcare needs, we can do so in a way that doesn't risk inaccurately labelling and alienating the client. For example, using "sex with a man/guy" rather than generalizing as "gay sex" allows clients to label themselves, or not. Once and if someone is clear about their sexual identity, it is appropriate to speak on those terms.

TRY NOT TO MAKE ASSUMPTIONS ABOUT A CLIENT'S SEXUALITY AND IDENTITY BASED ON THE SEX THAT THEY'RE HAVING.

Instead of relying on restrictive categories, give clients space to choose their words and identifiers. This may mean using unconventional labels such as 'brosexual' or 'heteroflexible' or not using any particular word at all for their identity.

DON'T ASSUME THAT THE SEX A CLIENT IS CURRENTLY HAVING IS SOMETHING THEY ALWAYS DO.

Sex with other men may only be a small or infrequent part of a client's sexual preferences. Or perhaps they only have sex with other men for work. Or maybe gender doesn't matter to them when choosing sexual partners.

TALK ABOUT SEX WITH CONFIDENCE AND COMPASSION.

By avoiding certain terms, or making heteronormative assumptions about sex and relationships, we can inadvertently create a relationship permeated with sex-negativity. When we speak freely about sex knowledgably and confidently, we create a space for the client to feel held and supported to speak freely.

CITATIONS

Blas MM, Alva IE, Carcamo CP, Cabello R, Goodreau SM, et al. (2010) Effect of an Online Video-Based Intervention to Increase HIV Testing in Men Who Have Sex with Men in Peru. PLoS ONE 5(5): e10448.

CBRC. (2019). Sex Now 2014-2015. Vancouver: Community Based Research Centre.

Goldenberg, T., Stephenson, R., Freeland, R., Finneran, C., & Hadley, C. (2016). 'Struggling to be the alpha': Sources of tension and intimate partner violence in same-sex relationships between men. Culture, health & sexuality, 18(8), 875-889.

Pitpitan, E. V., Smith, L. R., Goodmanmeza, D., Torres, K., Semple, S. J., Strathdee, S. A., & Patterson, T. L. (2016). "Outness" as a Moderator of the Association Between Syndemic Conditions and HIV Risk-Taking Behavior Among Men Who Have Sex with Men in Tijuana, Mexico, 20(2), 431-438.

Shehan, D. A., LaLota, M., Johnson, D. J., & Celentano, D. D. (2003). HIV/STD risks in young men who have sex with men who do not disclose their sexual Orientation—Six U.S. cities, 1994-2000. Jama, 289(8), 975-977.

outsideIN HIM HEALTH INITIATIVE FOR MEN

Visit **outness.ca** for more information.
Questions or queries? Contact us at **outness@checkhimout.ca**

Health Initiative for Men (HIM) is a peer-based organization that serves the unique sexual, mental, social, and physical health needs of GBT2Q in Vancouver's Lower Mainland and across British Columbia.

HIM operates five health centres where we offer sexual health testing (including vaccination, treatment and prevention options), as well as professional counselling, sexual health education, and support groups. HIM is dedicated to strengthening the health and wellness of GBT2Q through trusted, tailored, and targeted health promotion.