

General practitioner awareness of sexual orientation among a community and internet sample of gay and bisexual men in New Zealand

Adrian H Ludlam MSc;¹ Peter J Saxton BSocSc (Hons), MPhil (Hons), PhD;¹ Nigel P Dickson MD;² Anthony J Hughes MSc (Hons)³

¹ Gay Men's Sexual Health Research Group, Department of Social and Community Health, Faculty of Medical and Health Sciences, The University of Auckland, Auckland, New Zealand

² AIDS Epidemiology Group, Department of Preventive and Social Medicine, University of Otago, Dunedin, New Zealand

³ New Zealand AIDS Foundation, Auckland

ABSTRACT

INTRODUCTION: General practitioners (GPs) can improve HIV and sexually transmitted infection (STI) screening, vaccination and wellbeing among gay, bisexual and other men who have sex with men (GBM) if they are aware of a patient's sexual orientation.

AIM: To estimate GP awareness of their GBM patients' sexual orientation and examine whether HIV and STI screening was associated with this.

METHODS: We analysed anonymous, self-completed data from 3168 GBM who participated in the community-based Gay Auckland Periodic Sex Survey (GAPSS) and internet-based Gay men's Online Sex Survey (GOSS) in 2014. Participants were asked if their usual GP was aware of their sexual orientation or that they had sex with men.

RESULTS: Half (50.5%) believed their usual GP was aware of their sexual orientation/behaviour, 17.0% were unsure, and 32.6% believed he/she was unaware. In multivariate analysis, GP awareness was significantly lower if the respondent was younger, Asian or an 'Other' ethnicity, bisexual-identified, had never had anal intercourse or had first done so very recently or later in life, and had fewer recent male sexual partners. GBM whose GP was aware of their sexual orientation were more likely to have ever had an HIV test (91.5% vs 57.9%; $p < 0.001$), specific STI tests (91.7% vs 68.9%; $p < 0.001$), and were twice as likely to have had an STI diagnosed.

DISCUSSION: Lack of sexual orientation disclosure is resulting in missed opportunities to reduce health inequalities for GBM. More proactive, inclusive and safe environments surrounding the care of sexual orientation minorities are needed in general practice to encourage disclosure.

KEYWORDS: Culturally competent care; general practice; HIV; HPV; sexual health; sexual orientation

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CORRESPONDENCE TO: Peter Saxton

Department of Social and Community Health, School of Population Health, Faculty of Medical and Health Sciences, The University of Auckland, PB 92019 Auckland, New Zealand
p.saxton@auckland.ac.nz

Introduction

While many gay, bisexual and other men who have sex with men (GBM) are doing well,^{1–3} and exhibit higher condom use than heterosexual males,⁴ as a population GBM experience multiple health inequalities.^{5–7} Disparities are particularly evident in sexual health.^{8–10} The prevalence of HIV among GBM in New Zealand is over 40 times that found among heterosexual men and women,¹¹ and recently there have been outbreaks of other sexually transmitted infections (STIs), such as syphilis, gonorrhoea and lymphogranu-

loma venereum (LGV).^{12,13} Furthermore, elevated rates of human papillomavirus (HPV) infection and its causative role in anal cancer have prompted calls for urgent targeted vaccination of GBM, as this group currently receives no cross-benefit from government-funded HPV vaccine programmes in young women.¹⁴

General practitioners (GPs) play an important role in reducing health disparities for GBM by offering comprehensive sexual health screening and vaccination.^{15,16} Knowledge of a patient's sexual orientation is a critical step if GPs are to provide

optimal care. However, sexual orientation is an invisible trait, and little is known about GPs' awareness of their patients' sexual orientation or sexual behaviour in contemporary New Zealand.

In 2004, a large self-selected national sample in New Zealand found that 35.3% of gay male respondents had not told their health care provider about their sexuality.¹ Since then, qualitative research by Adams et al. identified that gay men's disclosure of their sexuality to GPs was selective. Some men deliberately withheld this information, for example for privacy or anticipating negative reactions,¹⁵ while others waited for the right opportunity, or questioned why disclosure was relevant.¹⁷

A substantial body of local research has now highlighted the lack of policy consideration of gay men's health needs and an absence of inclusive practices in many services used by non-heterosexual individuals.^{18–21} More recently, the Auckland District Health Board commissioned a Rainbow Health Report.²² A priority recommendation from this report was the provision of consistent and culturally sensitive services for non-heterosexual individuals.²² Yet, as sexual orientation data are still not routinely collected in official statistics, progress on meeting the health needs of GBM in general practice cannot be easily monitored.²³

Elsewhere, such as the UK, 66% of GBM in a 2011 study had disclosed their sexual orientation to at least some of their health care professionals, including their GP.²⁴ Disclosure rates in the US appear to be similar, with 71% of GBM in one study stating that their primary health care provider knew their sexual orientation,²⁵ whereas another study found that disclosure varied from 61% among bisexual-identified respondents, to 90% among those identifying as gay.²⁶ Typically, non-disclosure of sexual orientation to health care providers significantly decreased the likelihood of providers recommending appropriate health services to their GBM patients.^{25,26}

The aims of this study were, therefore, to provide an updated estimate of GPs' awareness of their GBM patients' sexuality in the New Zealand context and to analyse sociodemographic and

WHAT GAP THIS FILLS

What we already know: A decade ago, New Zealand research estimated that over a third of gay and bisexual men had not disclosed their sexual orientation to their general practitioner (GP). Given improvements in legal equality since then, but no reduction in sexual health inequalities, we sought a contemporary estimate that could be monitored over time.

What this study adds: Half of gay and bisexual men sampled in a repeat behavioural surveillance programme were not confident that their GP knew about their sexual orientation, lower than previously found. Sexual orientation awareness was related to elevated sexual health and HIV screening, but the overall low level indicates many missed opportunities to improve health.

behavioural factors associated with disclosure among GBM. A further aim was to identify whether HIV and sexual health screening differs for GBM whose GP is aware of their sexual orientation compared to those whose GP is unaware. Our goal was also to collect reproducible data to monitor progress over time.

Methods

Recruitment and surveys

The study involved analysis of data from the 2014 round of the Gay Auckland Periodic Sex Survey (GAPSS) and the Gay Online Sex Survey (GOSS). These are repeat purposive cross-sectional surveys conducted in community settings and on internet dating sites since 2002, using consistent recruitment protocols over time.²⁷ This methodology conforms to WHO/UNAIDS guidelines for HIV behavioural surveillance in most-at-risk populations.²⁸ For the 2014 round, trained staff recruited GAPSS participants from a large gay community event, gay bars and sex-on-site venues in Auckland over one week. Subsequently, GOSS recruited GBM from internet dating sites and apps nationwide over five weeks via online banner advertisements that linked to the questionnaire. Eligibility criteria were identifying as male, being at least 16 years old, having had sex with a man in the past five years and having not participated in GAPSS or GOSS that year. Participation was voluntary, anonymous and self-completed at the time of recruitment and there were no study incentives. Completion took 5–12 minutes.

Questionnaire

GP awareness of participants' sexual orientation or same-sex sexual behaviour was determined from answers to the question 'Does your usual general practitioner (GP, doctor) know you are gay or bisexual or have sex with men?' Response options were: yes; no; not sure. Participants were asked if they had ever been tested for HIV antibodies and, if so, when their last test was. STI diagnosis in the last year was calculated by any positive responses to a check-mark list including gonorrhoea, chlamydia, non-specific urethritis, warts (genital or anal), herpes (genital or anal), syphilis, LGV. Participants were also asked if they had 'in the last year', 'over a year ago', or 'never' had each of the following: anal examination, anal swab, throat swab, penile swab, urine sample, blood test for syphilis. Questions were worded the same in both the GAPSS and GOSS surveys.

Data analysis

Responses to GP awareness were dichotomised into 'yes' responses and 'no/not sure' responses. Pearson's Chi-squared tests were used to identify whether GP awareness varied significantly by respondent characteristics, including sociodemographic and sexual behaviour variables with an alpha of 0.05. We then constructed a multivariate logistic regression model of factors independently associated with GP awareness. This included recruitment site, sociodemographic variables, and behavioural variables relating to first sexual experiences and recent sexual partnering. Finally, we examined whether HIV and sexual health screening histories differed between GBM whose usual GP was aware of their sexual orientation and those whose GP was not aware. This was conducted using Pearson's Chi-squared tests and logistic regression that controlled for recruitment site, age, ethnicity and number of male sexual partners. Analyses were conducted using STATA v.13.1 on non-missing data only and multivariate results are reported as adjusted odds ratios (AORs) with 95% confidence intervals (CIs).

Ethics approval was granted by The University of Auckland Human Participant Ethics Committee Ref. 010738.

Results

Overall, 3168 GBM provided information (missing data $n=46$ or 1.4%), of whom half (50.5%) believed their usual GP knew they were gay, bisexual or had sex with men; 17.0% reported that they were unsure; and a third (32.6%) believed their usual GP was not aware of their sexual orientation.

GP awareness of respondents' sexual orientation was significantly associated with all sociodemographic and behavioural characteristics shown in Table 1. In multivariate analysis, respondents were more likely to report their GP was aware of their sexuality if they had more than one recent male sexual partner, had a regular male partner at the time of the survey, had their first anal intercourse under the age of 16 years, had first had anal intercourse longer ago (five or more years ago), and did not recently have casual sex (Table 1).

Conversely, respondents were less likely to believe their GP knew their sexual orientation if they were aged under 30, identified as bisexual, had an Asian or 'Other' (not NZ European, Māori, Pacific or Asian) ethnicity, had never had anal intercourse or had their first experience of anal intercourse after the age of 25, or had had that first anal intercourse experience recently (within the last five years). Site of study recruitment was also independently associated with GP awareness, and respondents recruited from internet dating sites were less likely to believe their GP was aware of their sexual orientation.

Respondents whose usual GP knew they were gay or bisexual had more HIV and sexual health screening compared to respondents whose GP was unaware of their sexual orientation (Table 2). GBM whose GP was aware were more likely to have ever had an HIV test (91.5% vs 57.9%, $p<0.001$) and to have had one in the last 12 months (39.6% vs 18.7%, $p<0.001$), to have ever had specific STI screening tests (91.7% vs 68.9%, $p<0.001$) and to have had at least one of these performed in the last 12 months (64.5% vs 40.1%, $p<0.001$). Respondents whose GP knew they had sex with men were consequently more likely to

have had an STI diagnosed in the previous year (16.3% vs 8.3%, $p<0.001$). These findings remained significant after controlling for potential sources of confounding (Table 2).

Respondents were overall less likely to have gone to their usual GP for their last STI test (39.4%) than to a sexual health service, New Zealand Aids Foundation centre or somewhere else (60.6%). However, this difference was accentuated for GBM whose usual GP was not aware they had sex with men. Of these GBM, just 30.9% had been screened by their usual GP, compared to 45.6% of GBM whose GP was aware they had sex with men ($p<0.001$).

Discussion

In this New Zealand sample of GBM, half the respondents believed their usual GP knew they had sex with men and half did not or the men were unsure about this. Their GP was less likely to know this if the respondent was younger, Asian or of an 'Other' ethnicity, identified as bisexual, did not have a current regular male partner or had fewer male sexual partners, had delayed their first experience of anal intercourse, or was recruited into the study from an internet dating site.

Importantly, having a GP who was aware of one's minority sexual orientation was associated with receiving more comprehensive sexual health care, including HIV and sexual health screening. In contrast, the level of relevant HIV and sexual health screening received by respondents whose usual GP did not know they were GBM was substantially lower, resulting in missed opportunities to improve sexual health and wellbeing. Among these GBM, when sexual health services were received, the men were much more likely to have gone to an alternate provider for this, rather than to their usual GP.

Our study methodology and question phrasing limits comparisons to other studies. Nonetheless, the overall proportion of our respondents who believed their GP was aware of their sexuality (50.5%) is lower than the 65.7% found among gay and bisexual males in a previous New Zealand study.¹ It is, however, more similar if those who

were 'not sure' in our study are included (overall 67.4%). Our findings are also lower than found among studies from the UK²⁴ and the US.^{25,26}

We did not ask directly about disclosure to a GP, as disclosure can be indirect (using same-sex pronouns when referring to a partner), nor were we able to examine sexual orientation awareness among GPs themselves. Our study was cross-sectional, so we cannot establish a causal relationship between disclosure and improved health care. For some participants, an STI diagnosis in the previous year may have triggered their sexual orientation disclosure to their GP.

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Additional limitations include non-random sampling so we cannot generalise our findings to all GBM in New Zealand, and this could also apply to the studies we have used as a comparison. This is a standard obstacle to public health research on GBM internationally and is affected by low population prevalence, the non-inclusion of sexual orientation variables in official statistics, the absence of sampling frames, and invisibility and stigma leading to under-reporting.²⁹ The surveys focus on HIV and sexual health, so we have not examined mental health or substance abuse that are particularly relevant to the wellbeing of GBM.

Strengths are that our data come from a large and diverse cross-sectional sample of GBM recruited from multiple community settings and online. The survey was anonymous and self-completed, which encourages participation and reduces misreporting of sensitive behaviours. As GAPSS and GOSS are established ongoing behavioural surveillance studies employing consistent sampling methods, the question can be repeated in future to monitor change in GP awareness. By using this surveillance instrument, we were able to

Table 1. General practitioner (GP) awareness of gay and bisexual men's sexual orientation (n=3168), by respondent sociodemographic and behavioural characteristics

Respondent characteristic	N	Respondent believes GP is aware of sexual orientation		Chi-square p-value	(Multivariate p-value) AOR*	95% CI
		n	%			
Site of recruitment				<0.001	(<0.001)	
Community fair event	1065	653	61.3		2.1	1.7–2.6
Bar	125	82	65.6		2.5	1.5–4.1
Sex-on-site/sauna	192	100	52.1		1.1	0.7–1.6
Online dating app	1786	764	42.8		Ref	
Age (years)				<0.001	(<0.001)	
Under 30	1347	480	35.6		Ref	
30–44	907	525	57.9		2.1	1.7–2.7
45+	842	570	67.7		4.3	3.2–5.8
NS	72					
Ethnicity				<0.001	(<0.001)	
NZ European	2213	1211	54.7		Ref	
Māori	307	154	50.2		0.9	0.7–1.3
Pacific	115	49	42.6		0.9	0.5–1.5
Asian	350	103	29.4		0.4	0.3–0.5
Other ethnicity	125	52	41.6		0.4	0.3–0.7
NS	58	–	–			
Sexual Identity				<0.001	(<0.001)	
Gay	2516	1422	56.5		Ref	
Bisexual	497	103	20.7		0.3	0.2–0.4
Other	145	65	44.8		0.7	0.4–1.04
NS	10	–	–			
Highest qualification				0.017	(0.364)	
Less than tertiary degree	1680	813	48.4		Ref	–
Tertiary degree	1412	744	52.7		1.1	0.9–1.3
NS	76	–	–			
HIV test status				<0.001		
HIV positive	153	144	94.1			
HIV negative/never tested	2924	1404	48.0			
NS	26					
Number of male sexual partners <6 months				<0.001	(0.005)	
None	213	71	33.3		1.0	0.6–1.6
1	690	353	51.2		Ref	
2–5	1148	519	45.2		1.4	1.01–1.9
6–20	792	443	55.9		1.7	1.2–2.4
>20	262	173	66.0		2.2	1.4–3.4
NS	63	–	–			

Table 1 cont.

Respondent characteristic	N	Respondent believes GP is aware of sexual orientation		Chi-square p-value	(Multivariate p-value) AOR*	95% CI
		n	%			
Age of first anal intercourse				<0.001	(<0.001)	
Never had anal intercourse	158	25	15.8		0.3	0.1–0.5
<16 years old	438	255	58.2		1.3	0.9–1.7
16–19	1062	538	50.7		Ref	
20–24	714	385	53.9		0.8	0.7–1.1
25–29	271	145	53.5		0.6	0.4–0.8
30+	312	147	47.1		0.4	0.3–0.5
NS	213	–	–			
Years since first anal intercourse				<0.001	(<0.001)	
0–4 or never had anal intercourse	767	192	25.0		Ref	
5+	2080	1250	60.1		1.8	1.4–2.4
NS	321	–	–			
Current regular male partner				<0.001	(<0.001)	
Yes	1411	866	61.4		1.5	1.3–1.8
No	1678	688	41.0		Ref	
NS	79					
Condom use with casual partners <6 months				0.012	(0.034)	
No casual partner(s)	789	407	51.6		1.4	1.02–2.0
No anal intercourse	398	170	42.7		0.8	0.6–1.1
Always used a condom	947	479	50.6		Ref	
Any unprotected anal intercourse	941	490	52.1		0.9	0.7–1.1
NS	93	–	–			

NS Not stated

Ref Reference category

CI Confidence interval

AOR Adjusted odds ratio

Bold denotes statistically significant AOR

* The logistic regression model included all variables with the exception of HIV test status (n=2631 respondents with complete information)

link data on GP awareness of respondent sexual orientation with comprehensive demographic and sexual behaviour data from a small understudied population.

Our findings reveal two ‘classes’ of health care in general practice for GBM with different implications. Positively, GPs appear to be providing elevated levels of HIV and sexual health screening once they are aware their patient is gay or bisexual. Alternatively, GBM whose usual GP is

not aware of their sexual orientation are being substantially underserved. This is especially concerning given that legal equality has improved over the last decade but sexual health inequalities for GBM have not narrowed.

GPs can be an invaluable source of information, advice, vaccination and testing for combatting the HIV and STI epidemics among GBM. Half (48%) of sexual health check-ups or treatment in a 2011 survey of GBM occurred in general

Table 2. HIV and sexual health screening history, by whether general practitioner (GP) is aware of respondent's sexual orientation (n=3168)

	GP aware of sexual orientation		GP unaware		Chi-square p-value
Ever had an HIV test					
Yes	1312	91.5%	887	57.9%	<0.001
AOR (95% CI)	6.6 (5.2–8.3)		Ref		
Recent HIV testing					
<12 months ago	555	39.6%	283	18.7%	<0.001
AOR (95% CI)	3.3 (2.7–3.9)		Ref		
Ever had a specific sexual health check*					
Yes	1449	91.7%	1063	68.9%	<0.001
AOR (95% CI)	4.6 (3.6–5.7)		Ref		
Recent specific STI test*					
<12 months ago	1019	64.5%	619	40.1%	<0.001
AOR (95% CI)	2.8 (2.4–3.3)		Ref		
STI diagnosed <12 months†					
Yes	251	16.3%	124	8.3%	<0.001
AOR (95% CI)	2.1 (1.7–2.8)		Ref		

Ref Reference category

CI Confidence interval

AOR Adjusted odds ratio controlling for site of recruitment, age, ethnicity and number of male sexual partners <6 months

Bold denotes statistically significant AOR

* Any of the following: anal examination; anal swab; throat swab; penile swab; urine sample; blood test for syphilis

† Any of the following: gonorrhoea; chlamydia; non-specific urethritis; warts (genital or anal); herpes (genital or anal); syphilis; LGV

practice.¹⁰ However, questions remain about the comprehensiveness and frequency of screening in general practice that may be resulting in under-diagnosis.¹⁰ Although there is no national programme, New Zealand guidelines recommend sexual health screening for GBM at least once a year and up to four times a year for higher risk subsets.³⁰ Screening for asymptomatic rectal infections is a particular priority for this population.

The unknown quality of GP and health care workforce cultural competencies regarding care for non-heterosexual patients has been consistently raised in the literature.^{1,10,15} Many GPs feel they have received insufficient training on how to raise sexual health issues for men in a sensitive way.³¹ The situation for sexual health care of GBM is likely to be worse.³² Improving professional training opportunities in sexual health

and the health of non-heterosexual patients is a clear priority.

Unlike other demographic traits such as age and ethnicity, sexual orientation is invisible and therefore direct solicitation of this information by GPs is the only practical way of addressing unmet sexual health needs for GBM in general practice. Rather than placing the whole burden of disclosure onto GBM themselves, it is imperative that health care settings proactively create inclusive, supportive and culturally safe environments that encourage disclosure, and match this with sensitive practices.²¹ For example, sexual orientation, or sex of partner/s, could be asked of all patients at first consultation. The potential personal benefit of disclosing sexual orientation to GPs can also be promoted to GBM in terms of improved sexual health care. Doing so needs to be mindful of the way disclosure of sexual ori-

entation was shown as uneven between GBM in this study, being patterned by age, ethnicity and sexual identity (and possibly socioeconomic status, although we were unable to investigate this). This is consistent with New Zealand research revealing diversity in the expression of sexual identity.³³⁻³⁶ This may in turn reflect cultural differences and barriers to accessing and communicating with primary health care providers.

Finally, despite progress, sexual health and minority sexual orientations remain stigmatised in parts of society. In delivering sexual health care to GBM, as with delivering care to Māori and Pacific communities, it is important to avoid narratives that blame GBM for poorer health outcomes.¹⁷ Concepts such as minority stress and heterosexual privilege are valuable lenses through which the position of GBM relative to heterosexual populations can be understood.^{17,37} Sexual health vulnerabilities unique to GBM also need wider articulation to health professionals.³⁸ These include the higher biological efficiency of HIV and STI transmission through anal intercourse without a condom, the higher underlying prevalence of HIV and STIs among the male sexual partners of GBM, and the greater proximity to HIV and STIs, due to the GBM population being small and therefore highly sexually connected.

Further research should investigate the knowledge, attitudes and practices of GPs themselves in relation to sexual orientation minority patients. In addition, a nationally representative Government study on sexual and reproductive health is currently underway and data describing the health outcomes for GBM participants need to be analysed and disseminated to identify action priorities.

Even without additional information, this and previous work suggest that New Zealand needs policy responses, such as officially acknowledging the specific health needs of gay, lesbian, bisexual, transgender and intersex (GLBTI) communities, as the US has recently done.^{39,40} Developing appropriate and relevant models to respond to these identified health needs, and normalising discussions of sexual orientation and behaviour in primary health care, are also necessary.

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COMPETING INTERESTS

None declared.