EMIS-2024 Ireland:

Findings from the European Men-Who-Have-Sex-With-Men and Trans People Internet Survey (Ireland)

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Foreword

I am pleased to introduce this report, presenting the Irish findings from the European Men-Who-Have-Sex-With-Men and Trans People Internet Survey (EMIS-2024). This report provides up-to-date insights on the sexual health, wellbeing and lived experiences of gay, bisexual and other men who have sex with men (gbMSM) and trans people in Ireland. The findings offer a valuable evidence base to inform policy, service planning and health promotion initiatives, and to support the continued development of Ireland's sexual health services.

Since the previous EMIS wave in 2017, the sexual health landscape has changed considerably. On a positive note, there is wider availability of HIV pre-exposure prophylaxis (PrEP) with the introduction of a national PrEP programme in Ireland in 2019. Doxycycline post-exposure prophylaxis is a relatively new intervention that can reduce some bacterial STIs, particularly syphilis and chlamydia. The wider availability of PrEP, developments in HIV treatment, changing patterns in the incidence of sexually transmitted infections and the emergence of mpox have all influenced the sexual health needs of gbMSM. EMIS-2024 provides an important opportunity to understand these changes, identify emerging gaps and monitor our progress.

The findings presented in this report support the implementation of Ireland's National Sexual Health Strategy (2025–2035) and contribute to ongoing efforts to reduce health inequalities, improve access to prevention, testing and treatment services, and improve and promote the sexual health and wellbeing of all MSM and trans people in Ireland.

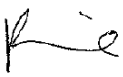
I would like to thank our international EMIS partners based at Deutsche Aidshilfe, Maastricht University and the Robert Koch Institute, in particular the co-principal investigators Dr Axel J. Schmidt, Prof. Kai J. Jonas, Dr Ulrich Marcus. Thank you to our partners for their leadership in designing and coordinating this large-scale international study and for making the Irish dataset available for analysis.

I also wish to express my sincere appreciation to all members of the EMIS-2024 Ireland Steering Group, both past and present. The group comprises a range of experts in clinical practice, community organisations, and epidemiological and academic research. Their input has strengthened this work throughout.

Thank you to the HSE Sexual Health Programme for supporting EMIS-2024 financially. The HSE Sexual Health Programme is committed to building a robust evidence base for sexual health policy and services in Ireland.

My sincere thanks to Dr Stephen Buckley and Prof Noel McCarthy who undertook analysis of Ireland's EMIS data and have written a comprehensive report that provides invaluable information to support us in our work in the years to come.

Finally, and most importantly, I extend my thanks to everyone who took the time to participate in EMIS-2024. By sharing their experiences, participants have made an important contribution to improving our understanding of the health, wellbeing and needs of gbMSM in Ireland and across Europe. Their contribution will help inform policies and services that are better equipped to support healthier lives in in Ireland.



Prof Fiona Lyons

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List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
ANOVA	Analysis of variance
ART	Antiretroviral therapy
AUD	Alcohol use disorder
CAI	Condomless anal intercourse
COVID-19	Coronavirus Disease 2019
DAH	Deutsche Aidshilfe
DSM	Diagnostic and Statistical Manual of Mental Disorders
EEA	European Economic Area
EMIS	European MSM Internet Survey
GBL	Gamma-butyrolactone
gbMSM	Gay, bisexual, and other men who have sex with men
GCN	Gay Community News
GHB	Gamma hydroxybutyrate
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSE	Health Service Executive
LGBT	Lesbian, gay, bisexual or transgender
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and other sexual orientations and gender identities
LGV	Lymphogranuloma venereum
LSD	Lysergic acid diethylamide
MDMA	Methylenedioxymethamphetamine
MISI	MSM Internet Survey Ireland
MSM	Men who have sex with men
N/A	Not applicable
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PHQ	Patient health questionnaire
PrEP	Pre-exposure prophylaxis
RKI	Robert Koch Institute
SD	Standard deviation
SHP	Sexual Health Programme
STI	Sexually transmitted infection
UK	United Kingdom
URL	Uniform resource locator
USA	United States of America
WHO	World Health Organization

Acknowledgements

We begin by thanking all of the men and trans individuals who took part in EMIS-2024, giving of their time generously.

We are grateful for the expertise and support provided by the Ireland EMIS-2024 Steering Group who provided invaluable guidance and support throughout this project.

The Steering Group members are:

Peter Barrett	Department of Public Health, HSE South West
David Field	Gay Men's Health Service
Sarah Jackson	Health Protection Surveillance Centre
Peter Keogh	Open University
Fiona Lyons	HSE Sexual Health Programme
Daniel McCartney	Gay Health Network
Fiona Murphy	HSE Sexual Health Programme
Nicola O'Connell	HSE Sexual Health Programme (Chair)
Mick Quinlan	Gay Health Network
Davy Quinlivan	HIV Ireland
Sinéad Woods	HSE Sexual Health Programme

We sincerely thank former members of the Steering Group who left over the course of the project but provided meaningful and valuable contributions, including Owen Brennan (HSE Sexual Health Programme), Éadaoin Butler (HSE Sexual Health Programme), Martin Davoren (Sexual Health Centre Cork), Jessie Ennis (Gay Men's Health Service), Bill Foley (Gay Health Network), Derval Igoe (HSE Public Health), Kate O'Donnell (Health Protection Surveillance Centre) and Adam Shanley (HIV Ireland).

Thank you to the Ireland EMIS-2024 communication sub-group responsible for survey promotion. Members were led by Mick Quinlan (Gay Health Network, Chair) and included Pádraig Burke (Gay Health Network), Éadaoin Butler (HSE Sexual Health Programme), David Field (Gay Men's Health Service) and Peter Keogh (Open University). Thank you to Aarya Bhutani, Kelly Earley and Stefano Pappalardo of Gay Community News for their support during recruitment for EMIS-2024 in Ireland.

Thank you to the co-principal investigators (Kai J. Jonas, Ulrich Marcus and Axel J. Schmidt) and co-ordinators of EMIS-2024 for their work, including Liana Aphami and Tamás Bereczky.

EMIS-2024 was co-funded by the European Centre for Disease Prevention and Control, along with Ireland (HSE Sexual Health Programme) and eleven other European countries.

EMIS-2024 Execution: EMIS-2024 was executed by a consortium of three partners: Deutsche Aidshilfe (DAH), Maastricht University and Robert Koch Institute (RKI). Team DAH: Dr Axel J. Schmidt (co-principal investigator), Dr Tamás Bereczky (coordinator EEA/CH/IL). Team Maastricht: Prof Dr Kai J. Jonas (co-principal investigator), Liana Aphami (data coordinator), Jules L. Casalini (trans sub-survey). Team RKI: Dr Ulrich Marcus (co-principal investigator), Dr Nikolay Lunchenkov (coordinator EECA).

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1

Introduction

Chapter 1 Introduction

The European Men-Who-Have-Sex-With-Men and Trans Persons Internet Survey 2024 (EMIS-2024) was an anonymous, multilingual, online sexual health survey conducted among gay, bisexual and other men who have sex with men (gbMSM) and transgender populations across 50 countries in Europe. EMIS-2024 was the first iteration of the survey to include non-binary people who are sexually attracted to men. EMIS-2024 is the third wave in this series, with the two previous waves conducted in 2010 and 2017. The purpose of the survey is to address the health, mental health and sexual health challenges faced by MSM, transgender and non-binary individuals.

Sexually transmitted infections (STIs) remain a significant public health challenge across the population. In Ireland and across Europe there has been a significant increase in STI notifications since the COVID-19 pandemic. Despite an 11% decrease in the STI notification rate from 2023 to 2024, the rate remains 31% higher than in 2019, the last full year before the pandemic.(1) For gonorrhoea the rate of notifications was 97% higher compared to 2019 (116 per 100,000 in 2024 compared to 59 per 100,000 in 2019). Although STIs affect the population as a whole, the burden of some infections remains disproportionately high among gbMSM. For example, the rate of gonorrhoea remained high among gbMSM to the end of 2024 (2,112 per 100,000), although it was stable compared to 2023.(1) An upward trend in notifications of early infective syphilis was observed in 2024, increasing by 9% when compared to 2023. Among cases where the mode of transmission for early infective syphilis was known (66% of cases in 2024), 91% of infections were reported among gbMSM.(1)

In Ireland and across participating countries, gbMSM and transgender people are recognised as key populations disproportionately affected by human immunodeficiency virus (HIV). In 2024, there were 239 first-time HIV diagnoses in Ireland, 40% of which occurred among gbMSM.(2) There has been a downward trend in the rate of new HIV diagnoses among gbMSM over the last decade, declining by 40% from a peak in 2015. This decline may reflect the expansion of combination prevention strategies, including HIV pre-exposure prophylaxis (PrEP). Ireland's national PrEP programme was launched in November 2019, providing free PrEP medication to individuals who meet clinical eligibility criteria and attend Health Service Executive (HSE) approved services.(3) Between November 2019 and December 2024, over 8,600 individuals accessed free PrEP medication through the programme. In 2024, 6,100 individuals received PrEP at least once, comprising 4,400 individuals receiving repeat prescriptions and 1,700 individuals receiving first-time prescriptions.(4)

While EMIS is primarily a sexual health survey, it also includes a range of broader factors that are known to influence sexual health, including mental health, experiences of homophobia and transphobia, and alcohol and drug use. Building on previous iterations of the survey, the EMIS-2024 questionnaire was designed to measure sexual health outcomes, prevention practices and unmet prevention needs to inform HIV and STI prevention strategies, service planning and treatment programmes tailored to the needs of MSM and transgender communities.

1.1 EMIS-2024 Ireland

The overall objectives of this EMIS-2024 Ireland analysis were to:

- assess reported ill health among the gbMSM and transgender population, including markers of mental health and HIV/STI diagnoses;
- describe safety strategies engaged in by gbMSM and transgender people in Ireland;
- identify needs in the gbMSM and transgender community, including safer sex, post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP) use, and HIV testing and treatment; and
- monitor the use of interventions intended to reduce HIV and STIs.

This report presents an overview of the main findings from the EMIS-2024 Ireland dataset. Chapter 2 describes the methodology used to undertake EMIS-2024 and analysis of the EMIS-2024 Ireland dataset. Chapter 3 describes the demographic profile of survey respondents. Chapters 4 to 7 explore a number of thematic issues and investigate some key questions in more depth. These themes reflect the core conceptual framework around which the EMIS-2024 survey questionnaire was structured. From Chapter 4 to 7, we conclude each chapter by conducting further analysis comparing survey responses across several key characteristics: age, employment status and HIV testing history. Chapter 8 summarises the key report findings and Chapter 9 makes recommendations for action and research.

The results of the survey are described throughout the following chapters:

- **Chapter 3 Demographic profile.**
- **Chapter 4 Reported ill health:** This chapter describes reported physical and mental ill health among gbMSM and transgender people in Ireland and may be of particular interest to healthcare providers and those planning health services and services to cater for this population group.
- **Chapter 5 Sexual health practices and safety strategies:** This chapter describes sexual health practices and safety strategies among respondents, including the use of HIV prevention methods, vaccination uptake, patterns of sexual partnerships, substance use and other factors relevant to sexual health outcomes.
- **Chapter 6 Attitudes, knowledge and behaviours:** This chapter describes a range of attitudes about and among the surveyed community and their perceived impact on health and health behaviours. This chapter may be of particular interest to statutory and non-governmental organisation (NGO) health promotion service providers who are planning, implementing and monitoring interventions.
- **Chapter 7 Interventions and services:** This chapter is aimed at those who plan, deliver and evaluate interventions and outlines use, access and promotion of certain health and sexual health interventions and services.

2

Survey design and methods

Chapter 2 Survey design and methods

2.1 Survey design

EMIS-2024 was an anonymous, online sexual health survey conducted among MSM and transgender populations across 50 countries in Europe. The survey was available in 35 languages. EMIS-2024 was designed to replicate the EMIS-2017 and EMIS-2010 waves.(5-7) Core questions remained largely unchanged. Ineffective or unclear items from EMIS-2017 were removed. There were additional new sections on hepatitis testing, STI treatment, antibiotic STI prophylaxis, human papillomavirus (HPV) and mpox. The draft survey was developed in English on Qualtrics XM (Qualtrics International Inc., Provo, Utah, USA) and pre-tested by the EMIS Network. The EMIS-2024 study received approval from Maastricht University's Ethics Review Committee Psychology and Neuroscience on 30 October 2023 (ref: ERCPN-OZL_262_08_01_2023).(8)

2.2 Recruitment

The HSE's Sexual Health Programme established an EMIS Promotional Working Group which coordinated recruitment to Ireland's EMIS-2024 study. Active promotion began in Ireland in January 2024. Ireland's Gay Community News (GCN) announced the study and described its launch in December 2023. GCN is a national, monthly free publication that exists in both print and online form.

Figure 1. An example of promotional material used in advance of EMIS-2024's launch

Recruitment occurred in partnership with GCN. This included the following recruitment strategies:

- Three advertisements in the print version of GCN in the December, February and April issues of the magazine.
- Digital advertorial and inclusion in GCN's online newsletter and digital promotion impressions on GCN's website.
- Printing of A3 posters and 10,000 business cards which were disseminated, predominantly in Dublin-based bars, as well as in other cities such as Cork.
- Promotion of the study in Dublin Pride's various channels.
- Digital advertising on several dating, hook-up and social media apps, including Squirt and other social hook-up sites, as well as paid adverts on Meta (Facebook and Instagram), LinkedIn, Twitter/X and Google ads.
- The European EMIS-2024 coordination, led by Dr Tamás Bereczky, provided multinational promotion via Grindr and on Grindr for Equality, accounting for 86% of participants in Ireland.
- Contact was made with social media influencers in Ireland to share reels about the survey online, but this strategy was not successful.

Ethical approval was granted for this study by the University of Maastricht. Promotion was not permissible via the Health Service Executive (HSE) or HSE-funded services without HSE ethical approval. Gaining ethical approval from multiple committees is neither feasible nor desirable in an international study such as this, so HSE promotion was not possible. This curtailed the promotional reach of the survey and likely contributed to a reduced number of respondents compared to previous iterations of the survey.

All promotion of EMIS-2024 included a unique 'source code' embedded at the end of the uniform resource locator (URL). This allowed researchers to track the source of recruitment for each respondent, and allowed the EMIS-2024 coordinators to monitor advertising success on a daily basis and make adjustments to the recruitment strategy as required.

Figure 2. An example of an EMIS-2024 promotional poster displayed in GCN in February 2024

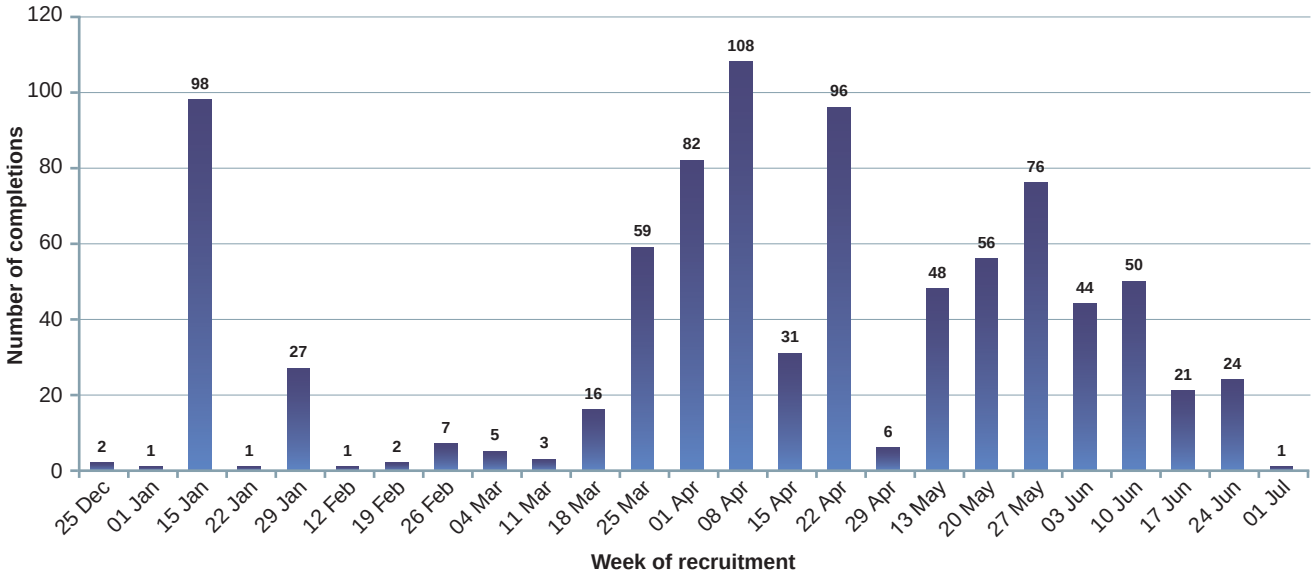

Figure 3. Number of 'eligible' survey responses by week of recruitment, 22 December 2023 to 1 July 2024 (n = 865)

The survey remained open for six months from 22 December 2023 to 1 July 2024. No incentives were offered for participation. Compared to previous EMIS waves, recruitment for EMIS-2024 shifted substantially to dating apps. Most respondents in Ireland (86%) were directed to the survey from the dating app Grindr. The remaining 14% were recruited through local NGO partners. This compares to a European Economic Area (EEA) average of 46% of respondents recruited through Grindr and 37% recruited through local NGO partners. The relative response rate in Ireland (per 10,000 males aged 15–64) was 5.3, which compared to an EEA average of 2.9. The number of 'eligible' survey completions per week can be seen in Figure 3. The EMIS-2024 Ireland dataset was completed in 17 different languages. Ninety-four per cent of survey responses were completed in English. The next three most common languages were Portuguese, Spanish and French, used by circa 1% of respondents each. The median length of time taken to complete the survey was 32 minutes.

2.3 Inclusion criteria

Respondents had to indicate that they consented to taking part in the EMIS-2024 survey by confirming they had read and understood the nature and purpose of the study. Participants needed to have met the age for sexual consent in the country where they lived, which in Ireland is 17 years. The survey was open to men, transgender people and non-binary people who have sex with men, who are attracted to other men or who think they may have sex with men in the future. Respondents to the EMIS-2024 survey who indicated that they lived in the Republic of Ireland were included in the Irish dataset. Respondents who indicated that they lived in Northern Ireland were included in the United Kingdom dataset and are not included in this report.

2.4 Discrepancies and data exclusions

The survey questionnaire allowed for logically inconsistent data, where respondents could give answers to two questions that could not both be valid. Respondents with inconsistent data on key variables (age, non-steady partners, transgender status) were excluded from the dataset to increase the quality of the data[1].(5) The process of excluding these survey responses was completed at the data cleaning stage, prior to the dataset being released to the Irish research team. In total, 937 respondents residing in Ireland completed the survey. Of these, 67 (7%) were excluded due to major discrepancies in key variables. This compares to a rate of 10% for major discrepancies across the whole EMIS-2024 dataset. A further five survey responses were excluded due to either completing each question in less than three seconds, showing no evidence of sexual desire or experience with men, or being less than 17 years old. This resulted in a total eligible sample of 865 for analysis in this report.

2.5 Analysis

The data were transferred to the EMIS-2024 Ireland research group in September 2025 and imported into R Studio where they were further recoded and analysed for this report. Percentages are provided to one decimal place in the tables; percentages in the text are rounded up to the nearest integer. The likelihood that differences among individuals in different groups were due to chance was established using chi-squared analysis or Fisher's exact test for categorical variables, and ANOVA or Kruskal-Wallis continuous variables as appropriate. Statistical significance was assessed at the 5% level ($p \leq 0.05$).

2.6 Strengths and limitations of the survey

Strengths and limitations of the survey are listed in Table 1.

Table 1. Strengths and limitations of EMIS-2024 in Ireland

Strengths	Limitations
• Built on the experiences of previous EMIS waves	• Convenience sample • Self-reported data • Cross-sectional survey and therefore cannot conclude that any relationships observed are causal
• Inclusion of non-binary people in this EMIS wave	• Reduced participation compared to EMIS-2010 and EMIS-2017 • Small sample size limits separate analysis of responses by subgroups such as trans and non-binary respondents at a national level • Unlike previous iterations of EMIS, following a decision by HSE Research & Development, the HSE and HSE-funded NGOs were not permitted to promote the survey, which may have impacted recruitment • Recruitment to all EMIS waves was primarily through dating apps which affects generalisability of findings
• Extensive survey available in 35 languages • Broad range of topics included • European-wide international survey allowing for some comparison between national datasets	• Long completion time (median 32 minutes) • Some questions on key topics inadvertently lost from the survey due to technical issues with the questionnaire (PrEP use intention, STI testing components) • Minimal input from individual countries was possible during the 2024 survey instrument update because of the limited funding available for this phase of the project

[1]*In three cases, inconsistent responses were given to two age questions. In the Irish analysis these participants were excluded, but they are included in the EU-level report.*

3

Demographic profile

Chapter 3 Demographic profile

Eight hundred and sixty-five respondents were included in the EMIS-2024 Ireland dataset.

3.1 Gender identity

This wave of EMIS has expanded, unlike EMIS-2017, to invite non-binary people who feel sexually attracted to men to take part in the survey. Table 2 shows gender identity among survey respondents. Ninety-six respondents' gender (11%) differed from their sex assigned at birth. This group were asked if they identify as part of the transgender community (Table 3). Eighty-three stated they identified as part of the transgender community while six did not and seven replied, 'I don't know'. Many transgender-specific questions were only shown to those respondents who identified as part of the transgender community rather than those indicating a trans or non-binary identity but not reporting identification as part of the transgender community. This makes 83 the effective denominator for analyses of responses on questions based on membership of the transgender community.

Table 2. Gender identity of EMIS-2024 Ireland participants

Gender identity (n = 865, missing = 0)	**n (%)**
Cis gbMSM	738 (85.3)
Cis non-gbMSM	31 (3.6)
Trans man	56 (6.5)
Trans woman	7 (0.8)
Non-binary (assigned male at birth)	22 (2.5)
Non-binary (assigned female at birth)	11 (1.3)

Table 3. Identification as part of transgender community

Where gender differs from your sex assigned at birth: Do you identify as part of the transgender community? (n = 96, missing = 0)	**n (%)**
No	6 (6.2)
Yes	83 (86.5)
I don't know	7 (7.3)

3.2 Passing as identified gender

Trans men, trans women and non-binary assigned female at birth respondents (n = 74) were asked how often they are perceived by strangers as the gender they identify as ('pass'). Forty-seven per cent of respondents replied that they are perceived by strangers as the gender they identify as either 'always' or 'most of the time'.

Table 4. Perceived by strangers as their identified gender

Perceived by strangers as their identified gender (n = 74, missing = 0)	n (%)
Always	20 (27.0)
Most of the time	15 (20.3)
Half of the time	16 (21.6)
Rarely or never	23 (31.1)

3.3 Sexual attraction

Participants were asked, 'Who are you sexually attracted to?' and to tick all that apply.

Seventy-seven per cent were exclusively attracted to men, 11% to men, women and non-binary people, and 6% to men and women.

Table 5. Sexual attraction

Sexual attraction (n = 865, missing = 0)	n (%)
Men only	665 (76.9)
Women only	3 (0.3)
Men and women	53 (6.1)
Men and non-binary people	39 (4.5)
Women and non-binary people	2 (0.2)
Men and women and non-binary people	99 (11.4)
I am not attracted to anyone	4 (0.5)

3.4 Sexuality

Participants were asked to select the option that best describes how they think of themselves with regard to their sexuality. Seventy-eight per cent of respondents identified as gay or homosexual and 15% as bisexual. Four per cent of respondents said they did not usually use a term to describe their sexuality, while 3% said they used another term that was not listed in the survey. Less than 1% of respondents identified as straight or heterosexual.

Table 6. Sexuality

Which of the following options best describes how you think of yourself with respect to your sexuality? (n = 865, missing = 0)	n (%)
Gay or homosexual	676 (78.2)
Bisexual	128 (14.8)
Straight or heterosexual	6 (0.7)
Any other term	23 (2.7)
I don't usually use a term	32 (3.7)

3.5 Outness

All respondents attracted to men (n = 856) were subsequently asked how open they were with all the people they knew about their attraction to men, 'outness'. More than half (59%) responded that all or almost all of the people they knew were aware of their attraction to men. Three-quarters of respondents stated they were out to more than half the people they knew (Table 7).

Table 7. Outness about attraction to men among those reporting sexual attraction to men

Proportion of people who are aware of sexual attraction to men (n = 855, missing = 1)	n (%)
All or almost all	503 (58.8)
More than half	153 (17.9)
Less than half	71 (8.3)
Few	90 (10.5)
None	38 (4.4)

Table 8 shows the association between outness and sexual identity. The majority of respondents (67%) who were attracted to men and identified as gay were out to all, or almost all, of the people they knew. A majority (54%) of those who identified as bisexual were out to fewer than half of the people they knew.

Table 8. Outness by sexual identity

Group out to:	Gay n (%) (n = 674)	Bisexual n (%) (n = 125)	Other* n (%) (n = 56)
All or almost all	451 (66.9)	34 (27.2)	18 (32.1)
More than half	113 (16.8)	24 (19.2)	16 (28.6)
Less than half	48 (7.1)	15 (12.0)	8 (14.3)
Few	48 (7.1)	32 (25.6)	10 (17.9)
None	14 (2.1)	20 (16.0)	4 (7.1)

** 'Other' includes 'Straight or heterosexual', 'Any other term' and 'I don't usually use a term'.*

3.6 Partnership status

Respondents were asked if they had a current 'steady partner', defined in the question as 'a lover or spouse that means you are not "single".' Forty-six per cent (n = 401) replied that they had a steady partner, 47% (n = 410) that they were single and 6% (n = 54) stated 'I'm not sure/it's complicated'.

Those who answered they had a steady partner (n = 401) were subsequently asked about their relationship. Eighty-five per cent were in a steady relationship with 'one man only', 8% with 'one woman only', 2% with 'more than one man' and 2% with 'one non-binary person only'.

3.7 Steady partner HIV status

Respondents reporting any steady male partner (n = 358) were asked about the HIV status of their partner. If they were in a steady relationship with more than one partner they were asked to answer regarding the longest relationship. Six per cent (n = 21) reported their partner was living with HIV.

All those in a relationship with a steady female partner (n = 39) reported that their partner was HIV negative. Of those in a steady relationship with a non-binary partner, 85% reported that they knew their partner was HIV negative, while 15% reported that they did not know the HIV status of their partner.

3.8 Age

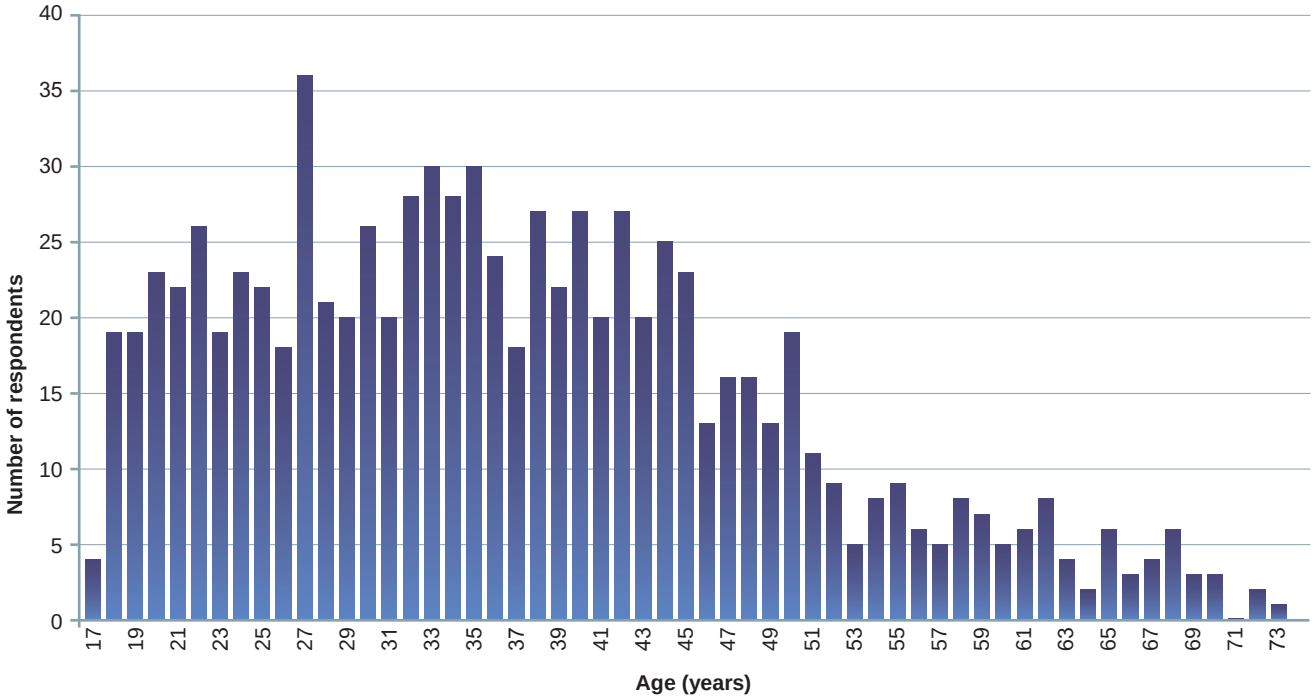

Figure 4. Age distribution of respondents (n=865)

The median age of respondents was 35 (range 17–73) and the mean age was 37. Eighteen per cent of respondents (n = 155) were young people aged 17–24 and 10% (n = 88) were aged 55 or older.

Table 9. Distribution of respondents by age group

Age group (n = 865)	n (%)
17–24 years	155 (17.9)
25–39 years	370 (42.8)
40–54 years	252 (29.1)
55+ years	88 (10.2)

3.9 County of residence and settlement size

Longford was the only county in the Republic of Ireland with no resident survey respondent (Figure 5). Response rate per 100,000 population (male and female aged 17–73 for each county). Six respondents did not give a county of residence, while 54% of respondents lived in County Dublin (city and county combined). Eleven per cent of respondents resided in Co. Cork and 5% in Co. Galway. Other respondents distribution across the remaining counties, ranged from 4% residing in Kildare to <0.5% each in Cavan, Kerry and Leitrim. Although the large bulk of respondents were male, a small proportion were female. The denominators used cover the full population from the lowest age group included in this report (age 17 in line with the age of consent) to the oldest respondent.

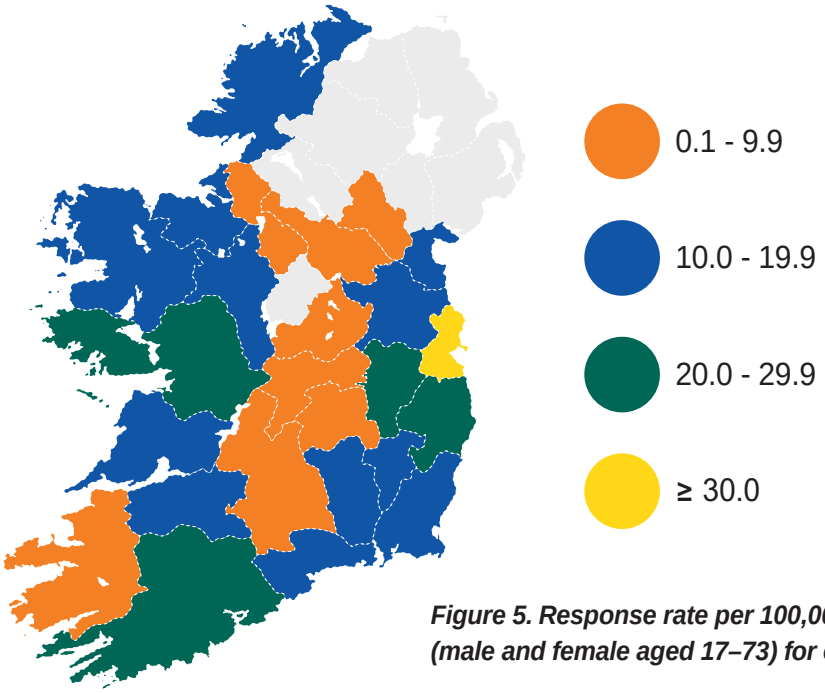

Figure 5. Response rate per 100,000 population (male and female aged 17–73) for each county

Respondents were asked, 'How would you describe the place you live in?' and were given a list options. The options given may be more applicable to larger European countries and do not necessarily reflect the size and frequency of Irish settlements. Forty-six per cent of respondents reported living in a city with a population of half a million or more, while 18% reported living in a village or the countryside (population 10,000 or less).

3.10 Country of birth, length of residence in Ireland and reason for migration

Seventy-one per cent (n = 610) of respondents were born in the Republic of Ireland and 2% listed Northern Ireland as their place of birth. Of those born abroad, the most common countries of birth were England (5%), Brazil (4%), USA (2%) and Poland (2%). Respondents came from 49 different countries.

Table 10. Distribution of respondents born outside the Republic of Ireland by World Health Organization (WHO) region of birth

Region of birth (n = 255, missing = 0)	n (%)
Europe (excluding UK)	102 (40.0)
Britain	44 (17.3)
Northern Ireland	13 (5.1)
WHO Region of the Americas: Latin America & Caribbean	43 (16.9)
WHO Region of the Americas: Canada, USA	19 (7.5)
WHO Western Pacific Region (excl. Australia & New Zealand)	10 (3.9)
WHO African Region	9 (3.5)
WHO Eastern Mediterranean Region (incl. Algeria)	6 (2.4)
WHO Western Pacific Region: Australia & New Zealand	6 (2.4)
WHO South East Asia Region	3 (1.2)

Of the respondents born outside Ireland, 43% (n = 111) had been living in Ireland for more than ten years, 20% (n = 51) had been living there for between six and ten years, and 36% (n = 93) had been living in Ireland for five years or less.

The most frequent reasons given for moving to Ireland were to work (54%), to study (31%) and to live more openly as gay/bisexual/trans/queer (20%). Five per cent reported moving to Ireland as either a refugee or to seek asylum. No respondent stated that they had moved to Ireland against their will.

3.11 Education

Respondents were asked how many years they had spent in full-time education since the age of sixteen. Almost all respondents reported some full-time education beyond the age of sixteen, with 89% having more than two further years. The median number of years spent in full-time education beyond the age of 16 was six.

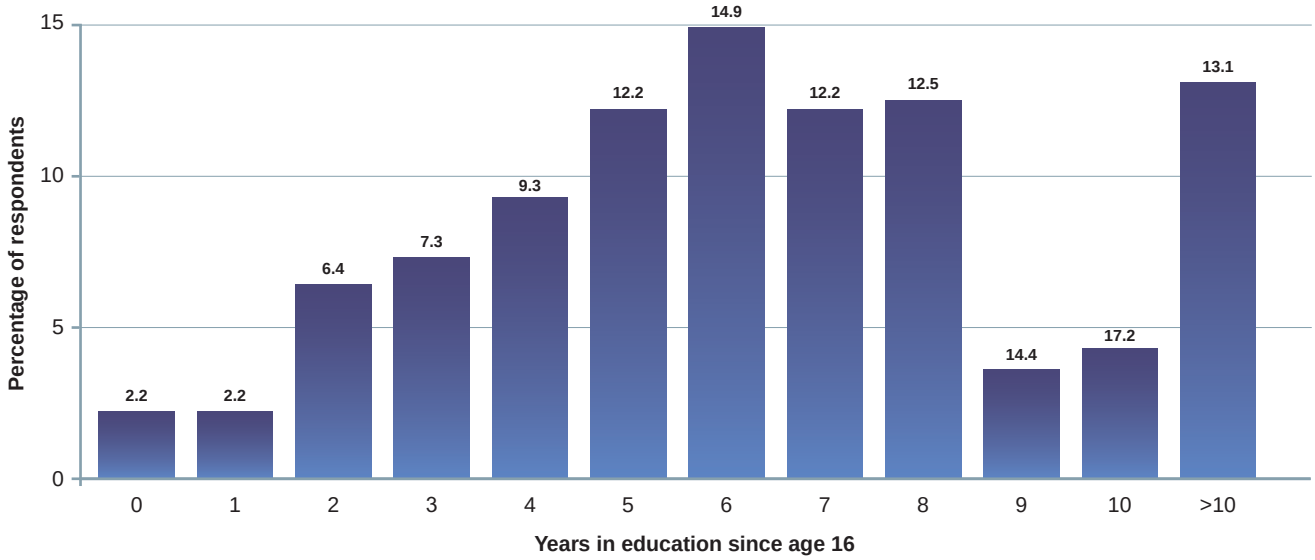

Figure 6. Years spent in full-time education since the age of 16 (n = 865, missing = 1)

3.12 Employment

Three-quarters of respondents (74%) were in employment, with 69% employed full-time or self-employed. Fourteen per cent were students, 5% worked part-time and 5% were unemployed. Four per cent stated they were retired, while 2% stated they were either on long-term sick leave or medically retired.

Table 11. Employment status

Employment status (n = 865, missing = 2)	n (%)
Employed full time	543 (62.8)
Employed part time	41 (4.7)
Self-employed	56 (6.5)
Unemployed	44 (5.1)
Student	122 (14.1)
Retired	34 (3.9)
Long-term sick leave/medically retired	19 (2.2)
Other	4 (0.5)

Half of respondents in employment were aged between 25 and 39 years (50%), while most students were aged between 17 and 24 years (76%).

Table 12. Employment status by age category

Age Group (n = 865, missing = 2)	Employed* (n = 640) n (%)	Unemployed (n = 44) n (%)	Student (n = 122) n (%)	Other** (n = 57) n (%)
17–24 years	45 (7.0)	13 (29.5)	93 (76.2)	4 (7.0)
25–39 years	319 (49.8)	20 (45.5)	21 (17.2)	9 (15.8)
40–54 years	229 (35.8)	9 (20.5)	7 (5.7)	7 (12.3)
55+ years	47 (7.3)	2 (4.5)	1 (0.8)	37 (64.9)

** 'Employed' includes full-time, part-time and self-employed.*
*** 'Other' includes retired, long-term sick/medically retired, other.*

3.13 Financial coping

Survey respondents were asked, 'Which of these phrases would you say comes closest to your feelings about your income these days?' A majority of participants (54%) responded that they were living either 'comfortably' or 'really comfortably' on their current income and 16% responded that they were either 'struggling' or 'really struggling' on their current income.

Table 13. Financial coping

Which of these phrases would you say comes closest to your feelings about your income these days? (n = 865, missing = 2)	n (%)
Living really comfortably on present income	137 (15.8)
Living comfortably on present income	331 (38.3)
Neither comfortable nor struggling on present income	254 (29.4)
Struggling on present income	106 (12.3)
Really struggling on present income	35 (4.0)

Among those in employment, 63% reported living comfortably or very comfortably on their current income. Forty-eight per cent of those who were unemployed stated that they were struggling or really struggling on their current incomes. Thirty per cent of students also reported that they were struggling or really struggling on their current incomes (Table 14).

Table 14. Financial coping by employment status

Financial coping (n = 862, missing = 3)	Employed* (n = 639) n (%)	Unemployed (n = 44) n (%)	Student (n = 122) n (%)	Other** (n = 57) n (%)
Living really comfortably on present income	123 (19.2)	-	6 (4.9)	8 (14.0)
Living comfortably on present income	277 (43.3)	5 (11.4)	33 (27.0)	15 (26.3)
Neither comfortable nor struggling on present income	173 (27.1)	18 (40.9)	47 (38.5)	16 (28.1)
Struggling on present income	58 (9.1)	11 (25.0)	25 (20.5)	12 (21.1)
Really struggling on present income	8 (1.3)	10 (22.7)	11 (9.0)	6 (10.5)

** 'Employed' includes full-time, part-time and self-employed.*
*** 'Other' includes retired, long-term sick/medically retired, other.*

4

Self-reported ill health

Chapter 4 Self-reported ill health

4.1 Indicators of anxiety and depression

The Patient Health Questionnaire for Anxiety and Depression (PHQ-4) is an ultra-brief screening tool for both anxiety and depression and is validated for use in the general population.(9) The PHQ-4 was used to screen for possible depression and anxiety among survey respondents. All respondents were asked, 'Over the last two weeks, how often have you been bothered by the following problems:

1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Little interest or pleasure in doing things
4. Feeling down, depressed, or hopeless'

Response options were: not at all (0 points); some days (1 point); more than half the days (2 points); nearly every day (3 points). The total score is determined by adding together the score of each item. Scores range from 0 to 12, with categories of possible psychological distress being: normal (0–2), mild (3–5), moderate (6–8) and severe (9–12). All four items must be answered.

Questions 1 and 2 form an anxiety subscale and questions 3 and 4 form a depression subscale. A score of 3 or greater on either subscale is considered positive for screening purposes. The PHQ-4 (including subscales) are screening tools. An elevated score is not diagnostic but is instead an indicator for further clinical assessment to establish a diagnosis of either anxiety or depression.

Using the PHQ-4 screening tool, 41% of gbMSM and 11% of respondents identifying as members of the transgender community showed no indication of psychological distress. Ten per cent of gbMSM respondents and 22% of transgender respondents reported a PHQ-4 score of 9 or more, indicating possible severe psychological distress (Table 15).

Table 15. PHQ-4 score distributions among gbMSM and transgender respondents

PHQ-4 score category for psychological distress	gbMSM respondents (n = 782, missing = 9) n (%)	Transgender respondents (n = 83, missing = 0) n (%)
Normal (0–2)	324 (41.4)	9 (10.8)
Mild (3–5)	255 (32.6)	27 (32.5)
Moderate (6–8)	120 (15.3)	29 (34.9)
Severe (9–12)	74 (9.5)	18 (21.7)

Applying the sub-scales, 31% of respondents screened positive for possible anxiety and 25% screened positive for possible depression. Table 16 and Table 17 show the subscale results broken down for gbMSM and transgender respondents. A higher proportion of transgender respondents screened positive for anxiety and depression.

Table 16. Anxiety sub-scale score distributions by screening threshold, for gbMSM and transgender respondents

Anxiety sub-scale	gbMSM respondents (n = 782, missing = 6) n (%)	Transgender respondents (n = 83, missing = 0) n (%)
Normal range (0–2 points)	558 (71.4)	31 (37.3)
Possible anxiety (3 points)	218 (27.9)	52 (62.6)

Table 17. Depression sub-scale score distributions by screening threshold for gbMSM and transgender respondents

Depression sub-scale	gbMSM respondents (n = 782, missing = 5) n (%)	Transgender respondents (n = 83, missing = 0) n (%)
Normal range (0–2 points)	595 (76.1)	48 (57.8)
Possible anxiety (3 points)	182 (23.3)	35 (42.2)

4.2 Reported suicidal ideation

All survey respondents were asked if over the previous two weeks they had been bothered by thoughts that they would be better off dead. Three-quarters experienced no such thoughts while one-quarter did. In total, 5% experienced such thoughts on more than half the days and 3% experienced them nearly every day. Respondents were also asked about being bothered by thoughts of taking their own life, with 2% stating they experienced such thoughts on a daily basis. Responses can be seen in Table 18 broken down for gbMSM and transgender respondents, with substantially higher reported suicidal ideation among transgender respondents.

These questions together form a single item on the nine-item PHQ-9 screening and diagnostic tool for depression, but are not a validated screening tool on their own.(10)

Table 18. Frequency of thoughts of self-harm or being better off dead in the last two weeks for gbMSM and transgender respondents

Frequency over last 2 weeks	gbMSM respondents (n = 782, missing = 2)		Transgender respondents (n = 83, missing = 0)	
	Bothered by thoughts better off dead n (%)	Bothered by thoughts of taking own life n (%)	Bothered by thoughts better off dead n (%)	Bothered by thoughts of taking own life n (%)
Not at all	610 (78.0)	664 (84.9)	36 (43.4)	46 (55.4)
Some days	120 (15.3)	90 (11.5)	34 (41.0)	27 (32.5)
More than half the days	33 (4.2)	16 (2.0)	6 (7.2)	2 (2.4)
Nearly every day	17 (2.2)	10 (1.3)	7 (8.4)	8 (9.6)

4.3 Possible alcohol use disorder

Alcohol use disorder (AUD) includes a range of problematic alcohol consumption including alcohol dependence and alcohol abuse.(11) The CAGE-4 screening measure was used to screen for possible alcohol use disorder. The CAGE-4 questionnaire has been previously validated for use in the general population.(12) Respondents who indicated they drank alcohol in the last 12 months (n = 793, 92% of the total sample) were asked, 'Thinking about drinking alcohol in the past 12 months:

1. Have you tried to cut down on your drinking?
2. Have people annoyed you by criticising your drinking?
3. Have you felt bad or guilty about your drinking?
4. Have you taken a drink first thing in the morning to steady your nerves or get rid of a hangover?'

CAGE-4 is a screening tool, where 'yes' to two or more statements indicates possible alcohol use disorder requiring further evaluation.

Table 19. CAGE-4 alcohol use disorder screening results

In the last 12 months have you… (n = 793, missing = 7)	Yes n (%)
Tried to cut down on your drinking?	379 (47.8)
Been annoyed by people criticising your drinking?	122 (15.4)
Felt bad or guilty about your drinking?	260 (32.8)
Taken a drink first thing in the morning to steady your nerves or get rid of a hangover?	64 (8.1)
Possible alcohol use disorder (two or more positive responses)	243 (30.6)

Based on the responses to the CAGE-4 screening tool, 243 respondents indicated possible alcohol use disorder. This represents 28% of all respondents, 29% of respondents who report ever consuming alcohol and 31% of respondents who drank alcohol in the last year.

4.4 HIV

All survey respondents (n = 865) were asked if they had ever received a human immunodeficiency virus (HIV) test result. Eighteen per cent (n = 157) reported they had never been tested for HIV. Seventy-five per cent stated they had been tested for HIV and their most recent test was negative.

Six per cent (n = 55) had received a HIV diagnosis. Of the subset of respondents who had ever tested for HIV (n = 705), 8% had received a HIV diagnosis.

Of respondents who had a diagnosis of HIV (n = 55), 20% had received their diagnosis within the last five years, 36% within the last ten years, and 67% within the last 15 years.

Table 20. HIV testing history

Testing status (n = 865, missing = 3)	n (%)
Never tested	157 (18.2)
Diagnosed HIV	55 (6.4)
Last test negative	650 (75.1)

Among the 650 respondents who reported their last test was negative, 73% (n = 473) had tested for HIV within the previous 12 months.

Among the 157 respondents who had never tested for HIV, one-fifth reported condomless anal intercourse (CAI) in the preceding 12 months.

Among HIV-negative respondents reporting CAI with a non-steady partner in the last 12 months (n = 349), 84% reported taking a HIV test in the previous 12 months.

4.5 Sexually Transmitted Infections

4.5.1 Chlamydia/LGV, gonorrhoea, and syphilis diagnoses

Respondents were asked if they had ever been diagnosed with a bacterial STI. Thirty-one per cent reported ever having been diagnosed with gonorrhoea, 24% with chlamydia or lymphogranuloma venereum (LGV) (reported as a combined variable in the EMIS-2024 dataset) and 16% with syphilis.

Overall, 17% of all respondents (n = 146) reported being diagnosed with any bacterial STI in the last 12 months. Eleven per cent received a gonorrhoea diagnosis in the last year, 9% had a diagnosis of chlamydia/LGV, and 3% received a syphilis diagnosis.

Table 21. Recency of STI diagnosis

Time period	Chlamydia or LGV (n = 865, missing = 2) n (%)	Gonorrhoea (n = 865, missing = 3) n (%)	Syphilis (n = 865, missing = 0) n (%)
Within the last 4 weeks	12 (1.4)	9 (1.0)	4 (0.5)
1–6 months ago	30 (3.5)	35 (4.0)	9 (1.0)
7–12 months ago	33 (3.8)	51 (5.9)	16 (1.8)
1–5 years ago	82 (9.5)	85 (9.8)	51 (5.9)
More than 5 years ago	48 (5.5)	89 (10.3)	56 (6.5)
Ever	205 (23.7)	269 (31.1)	136 (15.7)

Among the subset of respondents who had tested for an STI in the last 12 months (n = 492), 19% reported a gonorrhoea diagnosis, 15% a chlamydia/LGV diagnosis and 6% a syphilis diagnosis.

4.5.2 Reason for gonorrhoea and chlamydia/LGV testing

Those who had been diagnosed with gonorrhoea (n = 95) or chlamydia / LGV (n = 75) in the previous 12 months were asked what was the reason they had arranged an STI test. Results can be seen in Table 22 below.

Table 22. Reason for testing among those diagnosed with gonorrhoea or chlamydia/LGV

Reason for STI test if diagnosed with gonorrhoea or chlamydia/LGV in previous 12 months	Gonorrhoea (n = 95, missing = 0) n (%)	Chlamydia / LGV (n = 75, missing = 0) n (%)
I had symptoms (pain, discharge, etc.)	38 (40.0)	17 (22.7)
I checked for STIs without having symptoms	41 (43.2)	41 (54.7)
I was notified by a partner who had gonorrhoea or chlamydia/LGV	15 (15.8)	16 (21.3)
None of the above	1 (1.1)	1 (1.3)

4.5.3 Anal or genital warts

All respondents were asked if they had ever been diagnosed with anal or genital warts (n = 865, missing = 2). In total, 14% reported that they had ever been diagnosed with anal or genital warts, with less than 1% being diagnosed in the last year.

4.5.4 Hepatitis B infection

All respondents were asked if they had ever been diagnosed with hepatitis B (n = 865). Two per cent reported ever having hepatitis B (n = 16) and <1% (n=3) reported chronic hepatitis B infection.

4.5.5 Hepatitis C infection

All respondents were asked if they had ever been diagnosed with hepatitis C (n = 865), with 1.4% (n = 12) reporting they had previously been diagnosed with hepatitis C. More than 50% of those diagnosed with hepatitis C had been diagnosed more than five years ago.

4.5.6 Mpox infection

All respondents were asked if they had been diagnosed with mpox since 2022. Ninety-seven per cent (n = 842) reported they had not been diagnosed with mpox and that they had no symptoms suggestive of a diagnosis. Only 0.6% reported being diagnosed with mpox by a doctor, and 0.5% reported having had mpox but that it was not diagnosed in a healthcare setting. A further 1% of respondents stated that while they were never diagnosed with mpox, they had had symptoms which may have been caused by mpox.

Table 23. Diagnostic and self-assessed history of mpox infection since 2022

Medical and self-assessed mpox history (n = 865, missing = 0)	Yes n (%)
No mpox diagnosis, and 'no symptoms suggestive of mpox infection'	842 (97.3)
No mpox diagnosis, but 'I had symptoms which might have been caused by mpox'	9 (1.0)
Mpox diagnosis, and I was diagnosed by a doctor	5 (0.6)
Mpox diagnosis, but I was not diagnosed in a healthcare setting	4 (0.5)
I don't know	5 (0.6)

4.6 Reported ill health by key characteristics

Reported ill health and mental ill health among survey respondents were compared across several key characteristics: age, employment status and HIV testing history. The likelihood that differences among individuals in different groups were due to chance was established using chi-squared analysis or Fisher's exact test for categorical variables, and ANOVA or Kruskal-Wallis for continuous variables. If the significance value was ≤ 0.05, there was deemed to be a statistically significant difference between the groups.

Table 24. Reported ill health by age category

Type of ill health reported	Age groups (n = 865)					
	17–24 (n = 155)*	25–39 (n = 370)*	40–54 (n = 252)*	55+ (n = 88)*	All*	*p* value
Syphilis diagnosis (last 12 months)	1.3%	4.3%	2.8%	4.5%	3.4%	0.289
Gonorrhoea diagnosis (last 12 months)	5.8%	15.1%	9.9%	5.7%	11.0%	0.004
Chlamydia/LGV diagnosis (last 12 months)	3.9%	11.9%	7.9%	5.7%	8.7%	0.015
HIV diagnosis (ever)	-	4.3%	11.1%	12.5%	6.4%	<0.001
Possible alcohol use disorder*	28.4%	29.8%	27.8%	21.6%	28.1%	0.494
Thoughts of being better off dead or taking own life (last 2 weeks)	32.9%	14.6%	13.9%	14.9%	17.7%	<0.001
'Severe' PHQ-4 anxiety and depression score	20.3%	11.4%	6.0%	4.7%	10.7%	<0.001

** This is based on CAGE-4 questions and results are from cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 25. Reported ill health by employment status

Type of ill health reported	Employment status (n = 863)					
	Employed (n = 640)*	Unemployed (n = 44)*	Student (n = 122)*	Other (n = 57)*	All*	*p* value
Syphilis diagnosis (last 12 months)	4.1%	2.3%	-	3.5%	3.4%	0.146
Gonorrhoea diagnosis (last 12 months)	13.1%	2.3%	5.7%	5.3%	11.0%	0.008
Chlamydia/LGV diagnosis (last 12 months)	10.2%	6.8%	4.1%	3.5%	8.7%	0.069
HIV diagnosis (ever)	6.7%	-	1.6%	17.5%	6.4%	<0.001
Possible alcohol use disorder*	28.0%	38.6%	26.2%	26.3%	28.2%	0.437
Thoughts of being better off dead or taking own life (last 2 weeks)	13.0%	40.9%	34.4%	17.5%	17.7%	<0.001
'Severe' PHQ-4 anxiety and depression score	7.7%	20.9%	23.1%	10.7%	10.8%	<0.001

** This is based on CAGE-4 questions and results are from cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm*

Table 26. Reported ill health by HIV testing history

Type of ill health reported	HIV testing history (n = 862)				
	Never tested (n = 157)*	Last test negative (n = 650)*	Living with HIV (n = 55)*	All*	*p* value
Syphilis diagnosis (last 12 months)	-	3.8%	7.3%	3.4%	0.142
Gonorrhoea diagnosis (last 12 months)	1.9%	12.8%	14.5%	10.9%	<0.001
Chlamydia/LGV diagnosis (last 12 months)	2.5%	9.8%	10.9%	8.6%	0.011
Possible alcohol use disorder*	29.5%	27.2%	34.5%	28.1%	0.467
Thoughts of being better off dead or of taking own life (last 2 weeks)	31.4%	14.3%	20.0%	17.8%	<0.001
'Severe' PHQ-4 anxiety and depression score	19.2%	9.0%	7.4%	10.8%	<0.001

** This is based on CAGE-4 questions and results are from cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

5

Sexual health practices and safety strategies

Chapter 5 Sexual health practices and safety strategies

5.1 Seeking and taking HIV post-exposure prophylaxis (PEP)

Respondents not living with a HIV diagnosis (n = 807) were asked if they had ever taken PEP.

Almost three-quarters of eligible respondents reported that they had never tried to get or felt the need to take PEP. Fifteen per cent reported taking at least one course of PEP, while 8% reported not being able to get PEP.

Table 27. Reported past PEP access and use among respondents not living with a HIV diagnosis

Ever taken or tried to get PEP (n = 807*, missing = 0)	n (%)
'No, never felt the need to take it'	600 (74.3)
'No, I could not get it'	64 (7.9)
'No, I had the opportunity but decided not to take it'	21 (2.6)
'Yes, I've taken one course of pills'	78 (9.7)
'Yes, I've taken more than one course of pills'	43 (5.3)
'I don't know'	1 (0.1)

** PrEP and PEP questions not shown to respondents living with HIV.*

5.2 Seeking and taking HIV pre-exposure prophylaxis (PrEP)

Respondents not living with a HIV diagnosis (n = 807) were asked, 'Have you ever tried to get PrEP?' Thirty-eight per cent (n = 303) of this group reported that they had previously tried to get PrEP. Of those, 76% indicated they had previously taken PrEP, with one-quarter never having taken PrEP. Among those without a known HIV diagnosis (n = 807), 14% were taking PrEP on a daily basis and 10% on an event-based basis.

Table 28. PrEP use history among respondents not living with a HIV diagnosis

PrEP use history (n = 807*, missing = 3)	Respondents who had tried to get PrEP (n = 303, missing = 0) n (%)	Respondents not living with HIV diagnosis (n = 807, missing = 3) n (%)
Never took PrEP	73 (24.1)	574 (71.1)
Yes, on a daily basis and still taking it	114 (37.6)	114 (14.1)
Used to on a daily basis but no longer taking it	37 (12.2)	37 (4.6)
Yes, when needed it but not daily	79 (26.1)	79 (9.8)

** PrEP and PEP questions not shown to respondents living with HIV.*

In the last year, 210 respondents reported taking PrEP at least once, with more than half of this group currently taking it on a daily basis (see Table 29).

Table 29. Use of PrEP type in the last 12 months

PrEP use type in last 12 months (n = 210, missing = 0)	n (%)
Yes, on a daily basis and still taking it	114 (54.3)
Used to on a daily basis but no longer taking it	19 (9.0)
Yes, when needed it but not daily	77 (36.7)

** PrEP and PEP questions not shown to respondents living with HIV.*

Respondents who reported any PrEP use in the last year (n = 210) were asked what year they first started taking PrEP. Almost half reported taking PrEP for the first time in the preceding two-and-a-half years (Table 30).

Table 30. Year of PrEP initiation among those taking PrEP in the last 12 months

Year initiated (n = 210, missing = 0)	n (%)
2012–2016	10 (4.8)
2017	10 (4.8)
2018	21 (10.0)
2019	25 (11.9)
2020	19 (9.0)
2021	24 (11.4)
2022	41 (19.5)
2023–24	60 (28.6)

Respondents who reported any PrEP use in the last year were asked if they had ever experienced an involuntary cessation of their PrEP medications. Almost three-quarters indicated they had not (Table 31). Among the 60 respondents who reported first taking PrEP in 2023 or 2024, 23% (n = 14) reported an involuntary interruption to their medication in the same time period.

Table 31. Last involuntary cessation of PrEP medications among those taking PrEP in the last 12 months

Most recent involuntary interruption of your PrEP (n = 210, missing = 0)	n (%)
Never	151 (71.9)
before 2019	2 (1.0)
2019–2020	9 (4.3)
2021–2022	12 (5.7)
2023–2024	36 (17.1)

Among those reporting having used PrEP in the last 12 months (n = 210), 97% had taken a HIV test during those 12 months.

5.3 Doxy-PEP

All respondents were asked if they had taken antibiotics (e.g. doxycycline) before or after having sex to reduce the risk of getting some sexually transmitted infections ('doxy-PEP'). Fifty-three respondents (6%) reported that they had used antibiotics for bacterial STI prevention within the previous 12 months.

5.4 Vaccinations

5.4.1 Hepatitis A and B vaccination

Fifty-six per cent of respondents were fully vaccinated against hepatitis A and 2.8% reported natural immunity to hepatitis A. Thirty-eight per cent did not know their hepatitis A immune status. For hepatitis B, 58% of respondents were fully vaccinated against hepatitis B and 1.8% reported natural immunity to hepatitis B. Thirty-five per cent did not know their hepatitis B immune status (Table 32). All respondents were asked if they had ever been offered any hepatitis vaccination by a health service. Seventy per cent reported that they had. Among those who had not received any hepatitis vaccine before, 18% reported being offered a hepatitis vaccine by a health service.

Table 32. Hepatitis A and B vaccination status

Hepatitis vaccination status (n = 865, missing = 2, hepatitis A only)	Hepatitis A n (%)	Hepatitis B n (%)
No, I've had hepatitis A/B (and am now naturally immune)	24 (2.8)	16 (1.8)
No, I have chronic hepatitis B infection	N/A	3 (0.4)
Yes, and I completed the course	482 (55.7)	503 (58.2)
Yes, but I did not complete the course	29 (3.4)	30 (3.5)
Yes, but I did not respond to the vaccinations	N/A	11 (1.3)
No, and I don't know if I'm immune	184 (21.3)	164 (19.0)
I don't know	144 (16.6)	138 (16.0)

5.4.2 Mpox vaccination

All respondents were asked if they had been vaccinated against mpox since May 2022. Twenty-seven per cent of respondents stated that they were fully vaccinated against mpox, having received two doses of the vaccine. Forty-two per cent stated they were not vaccinated and did not want to get the vaccine, while 25% stated that though they were not vaccinated, they had wanted to get the vaccine but it was not available to them.

Table 33. Mpox vaccination since May 2022

Mpox vaccination status (n = 865, missing = 0)	n (%)
No, I did not want to	364 (42.1)
No, I wanted to but it was not available to me	221 (25.5)
Yes, with one dose	23 (2.7)
Yes, with two doses	231 (26.7)
Yes, but I am not sure how many doses	6 (0.7)
I don't know	20 (2.3)

5.4.3 HPV vaccination

Respondents who stated that they were aware there were vaccines available against HPV (n = 674) were asked about their vaccination status. Forty per cent of all respondents stated they had received at least one dose of a HPV vaccine. Twenty-one per cent of respondents stated that they had wanted to get vaccinated but that the vaccine was not available to them on account of their age or gender.

Table 34. HPV vaccination awareness and vaccination status among those aware

Vaccination awareness and vaccination status (n = 865, missing = 7 for either awareness, status, or both)	n (%)
I received at least one shot	347 (40.1)
Not aware there were vaccines available against HPV (not shown HPV vaccination question)	185 (21.4)
No, I wanted to but it was not available to me because of my gender or my age	182 (21.0)
No, I did not want to	56 (6.5)
No, I wanted to but I could not afford it	14 (1.6)
I don't know	74 (8.6)

5.5 Sex with men

Definitions for the terms 'sex', 'intercourse', 'steady partner' and 'non-steady partner' were provided in the survey questionnaire:

- 'Sex' was defined as 'physical contact to orgasm (or close to orgasm) for one or both partners'.
- 'Intercourse' was defined as 'sex where one partner puts their penis into the other partner's anus or vagina, whether or not this occurs to ejaculation. Intercourse does not include oral sex or the use of dildos.'
- 'Steady partner' was defined as 'a lover or spouse that means you are not single'.
- 'Non-steady partner' was defined as 'men you have had sex with once only, and men you have sex with more than once but who you don't think of as a steady partner (including one night stands, anonymous and casual partners, regular sex buddies).'

5.5.1 Age first sexual encounter/intercourse with a man

Ninety-seven per cent (n = 839) of all respondents reported ever having any kind of sex with a man. The median reported age of first sexual encounter with a man was 18 years. Ninety-three per cent (n = 801) of all respondents reported ever having had intercourse with a man. The median age of first intercourse was 19.

5.5.2 Steady partner sex and intercourse in the last 12 months

Respondents who were sexually attracted to men and had previously had sex with men (n = 830) were asked about the last time they had sex with a steady male partner. Sixty-eight per cent reported having sex with a steady male partner within the last 12 months.

Respondents who were sexually attracted to men and had previously had intercourse with men (n = 788) were asked about the last time they had intercourse with a steady male partner. Sixty-six per cent (n = 519) reported having intercourse with a steady male partner within the last year.

5.5.3 Non-steady partner sex and intercourse in the last 12 months

Among respondents who were sexually attracted to men and had previously had sex with men (n = 830), 71% (n = 593) reported having sex with a non-steady male partner within the last year.

Among respondents who were sexually attracted to men and had previously had intercourse with men (n = 788), 63% (n = 497) reported having intercourse with a non-steady male partner in the last 12 months. Among these 497 respondents, over a quarter reported having intercourse with between two and four non-steady partners, while 42% (n = 207) reported having ten or more non-steady partners in the last 12 months (more detail in Table 35).

Table 35. Number of non-steady intercourse partners in the last 12 months among those who had intercourse with a non-steady partner in the last year

Number of non-steady intercourse partners in last 12 months (n = 497, missing = 6)	n (%)
1	55 (11.1)
2–4	140 (28.2)
5–9	89 (17.9)
10	207 (41.7)

5.5.4 Non-steady partner condomless anal intercourse in the last 12 months

Among respondents who were sexually attracted to men and had previously had intercourse with men (n = 788), 49% (n = 383) reported having condomless anal intercourse (CAI) with a non-steady male partner in the last 12 months. The proportion of respondents who had CAI with a non-steady partner among respondents who had intercourse with a non-steady partner in the previous 12 months are summarised in Figure 7 below.

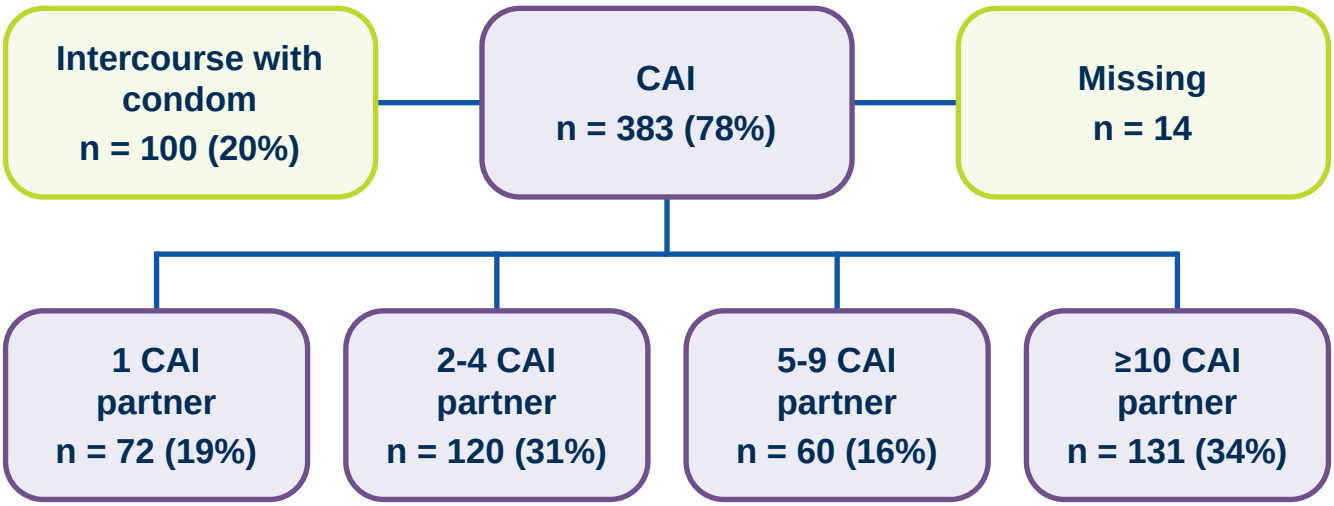

Figure 7. Number of condomless anal intercourse (CAI) partners in the past year among those who had intercourse with a non-steady partner (n = 497, missing = 14)

In total, 497 respondents reported having intercourse with a non-steady partner in the previous 12 months. Twenty per cent (n = 100) only reported intercourse with a condom (no CAI partners). Seventy-eight per cent (n = 383) reported having CAI. Of these, 19% reported CAI with one partner, 31% reported CAI with 2–4 partners, 16% reported CAI with 5-–9 partners while 34% reported CAI with 10 or more non-steady partners in the previous 12 months.

5.5.5 Condom use frequency among non-steady partners

Participants who reported having intercourse with one or more non-steady partners within the last 12 months (n = 497) were asked how often they used condoms. Eighteen per cent reported always using condoms and 21% reported never using condoms.

Table 36. Condom use with non-steady partners in the previous 12 months

In the last 12 months, how often were condoms used when you had intercourse with non-steady male partners? (n = 497, missing = 6)	n (%)
Never	103 (20.7)
Seldom	109 (21.9)
Sometimes	87 (17.5)
Mostly	101 (20.3)
Always	91 (18.3)

5.6 Buying and selling sex

All respondents were asked the two questions, 'When was the last time you paid a man to have sex with you?' and 'When was the last time you were paid by a man to have sex with him?' 'Paid' was defined in both questions as, 'he gave you/you gave him money, drugs, gifts or favours in return for sex'.

Twelve per cent of respondents reported ever paying for sex. Four per cent (n = 34) reported paying for sex in the last year. Of these, one-quarter had done so three or more times, while three-quarters did so one or two times. Nine per cent reported ever being paid for sex. Two per cent reported being paid for sex in the last year. Of those who had been paid for sex in the last year, 78% reported being paid for sex one or two times, while 22% reported being paid for sex three times or more.

5.7 Sex with women

Respondents who indicated they were attracted to women (n = 157) were asked, 'When did you last have any kind of sex with a woman?' Forty-one per cent of these (n = 64) indicated they had sex with a woman within the previous 12 months. Those who reported having sex with women within the previous 12 months were asked about the number of partners they had intercourse with in the preceding 12 months. Forty-eight per cent had intercourse with one female partner, 27% with two to five female partners, and 13% reported having intercourse with between six and ten female partners (13% non-response).

5.8 Use of alcohol, tobacco and drugs

5.8.1 Alcohol tobacco, poppers and prescription drugs

All respondents were asked 'When was the last time you consumed alcohol/tobacco products/ poppers (nitrate stimulants)?' They were asked the same question regarding 'Viagra, Cialis, Levitra or other substances that help to get or keep an erection' and 'sedatives or tranquilizers (Valium, Rivotril, Rohypnol, Xanax, Seduxen, Phenazepam)'.

Over 90% of respondents reported consuming alcohol in the last 12 months, while almost half of respondents reported using each of tobacco products or poppers.

Table 37. Reported last use of alcohol, tobacco, poppers and prescription drugs

Substance	Last 4 weeks cumulative n (%)	Last 12 months cumulative n (%)	Ever cumulative n (%)
Alcohol (n = 865, missing = 1)	737 (85.2)	793 (91.8)	846 (97.8)
Tobacco products (n = 865, missing =1)	310 (35.8)	418 (48.3)	612 (70.8)
Poppers (nitrate inhalants) (n = 865, missing = 1)	254 (29.4)	413 (47.8)	606 (70.1)
Erectile dysfunction drugs (n = 865, missing = 1)	144 (16.7)	220 (25.4)	311 (36.0)
Sedatives/tranquilisers (n = 865, missing = 2)	54 (6.2)	134 (15.5)	265 (30.6)

5.8.2 Recreational or illicit drugs

Respondents were asked if they had ever taken any recreational or illicit drugs. The emphasis in the question was on when someone has last taken the substance and not around habitual usage: 'How long has it been since you last consumed the following substances in any context? Please say when you last did something, even if this was not typical for you.' Two-thirds of respondents (n = 563) reported ever using any recreational drug or illicit drugs, with 44% (n = 385) reporting use of any drug in the previous 12 months. The results are shown in Table 38.

Table 38. Reported last use of recreational or illicit drugs

Substance	Last 4 weeks cumulative n (%)	Last 12 months cumulative n (%)	Ever cumulative n (%)
Cannabis (n = 865, missing = 0)	155 (17.9)	318 (36.8)	538 (62.2)
Cocaine (n = 865, missing = 2)	77 (8.9)	201 (23.2)	360 (41.6)
Ecstasy (n = 865, missing = 0)	60 (6.9)	172 (19.9)	346 (40.0)
Ketamine (n = 865, missing = 0)	30 (3.5)	91 (10.5)	208 (24.0)
Synthetic cannabinoids (n = 865, missing = 0)	20 (2.3)	44 (5.1)	117 (13.5)
Crystal methamphetamine (n = 865, missing = 2)	17 (2.0)	43 (5.0)	85 (9.8)
GHB/GBL* (n = 865, missing = 0)	8 (0.9)	31 (3.6)	55 (6.4)
LSD (acid) (n = 865, missing = 1)	4 (0.5)	39 (4.5)	146 (16.9)
Amphetamine (n = 865, missing = 1)	1 (0.1)	10 (1.2)	25 (2.9)
Mephedrone (n = 865, missing = 2)	8 (0.9)	26 (3.0)	71 (8.2)
Synthetic stimulants other than mephedrone (n = 865, missing = 4)	1 (0.1)	13 (1.5)	39 (4.5)
Crack cocaine (n = 865, missing = 1)	2 (0.2)	8 (0.9)	19 (2.2)
Heroin (n = 865, missing = 4)	-	4 (0.5)	12 (1.4)
Alpha-PhP (n = 865, missing = 3)	-	-	2 (0.2)

** GBL = gamma-butyrolactone; GHB = gamma hydroxybutyrate.*

The most commonly used drugs in the last 12 months were cannabis (37%), cocaine (23%) and ecstasy (20%). Within the previous four weeks, 18% had used cannabis, 9% cocaine and 7% ecstasy.

5.8.3 Drug use concern

Respondents who reported any illicit drug use in the previous 12 months (n = 563) were asked if they agreed with the statement, 'I worry about my recreational drug use.' Sixty-six respondents replied that they agreed or strongly agreed with that statement, which represents 17% of those who had used recreational or illicit drugs in the previous year and 8% of the total study population.

5.8.4 Injecting drugs

Respondents who were assigned male at birth (n = 798) were asked, 'Have you ever injected anabolic steroids (testosterone), or had someone else inject them into you?' All respondents were asked 'Have you ever injected any drug to get high (other than anabolic steroids or prescribed medicines)?'; those responding yes were asked to indicate how recently these had been used (Table 39).

Table 39. Injecting drug use and recency, split into anabolic steroids and drugs to get high

When did you last inject…?	Anabolic steroids (n = 798, missing = 2) n (%)	Any drug to get high (n = 865, missing = 4) n (%)
Within the last 12 months	7 (0.9)	3 (0.3)
More than 12 months ago	18 (2.3)	15 (1.7)
Never	771 (96.6)	843 (97.5)

Fewer than 1% of respondents reported injecting either testosterone or any drug to get high within the last 12 months. Those who injected drugs to get high in the previous 12 months reported doing so three to four times. The only illicit drug respondents reported injecting to get high was crystal meth.

Ketamine was used by 18% of respondents who injected drugs to get high in EMIS-2017. It was not a listed option in the EMIS-2024 questionnaire. No respondent who had ever injected drugs reported doing so with a used needle or syringe.

5.9 Sex under intoxication

Respondents who had sex with a man in the previous 12 months (n = 759) were asked, 'In the last 12 months, how much of the sex you've had with men has been under the influence of alcohol or any other drug?' Slightly under a third (30%) reported having no sex under the influence of alcohol or any other drug while 11% reported that all or almost all of the sex they had in the previous 12 months was under the influence of alcohol or drugs.

Table 40. Proportion of sex under intoxication in the last 12 months (alcohol and/or drugs)

Proportion of sex with men that has been under the influence of alcohol or any other drug (last 12 months) (n = 759, missing = 0)	n (%)
None of it	229 (30.2)
Almost none of it	219 (28.9)
Less than half	119 (15.7)
About half	61 (8.0)
More than half	44 (5.8)
Almost all of it	60 (7.9)
All of it	27 (3.6)

5.9.1 Use of stimulant drugs during sex – 'chemsex'

Respondents who indicated that they had ever taken illicit or recreational drugs (n = 563) were asked, 'When was the last time you used stimulant drugs to make sex more intense or last longer?'

Stimulant drugs were defined in the question as including ecstasy/MDMA, cocaine, amphetamine (speed), crystal methamphetamine (Tina, Pervitin), mephedrone, ketamine and alpha-PhP.

It should be noted that 'chemsex' was not directly asked about, and stimulant drug use during sex is used as a proxy for this.

Table 41. Last use of stimulant drugs to make sex more intense or last longer, i.e. chemsex

Time Period	n	Whole sample (n = 865) %	Respondents who ever used illicit drugs (n = 563) %
Within the last 4 weeks	49	5.7	8.7
1–6 months ago	40	4.6	7.1
7–12 months ago	20	2.3	3.6
1–5 years ago	50	5.8	8.9
More than 5 years ago	38	4.4	6.8
Ever	197	22.8	35.0

Among respondents who indicated they had ever used illicit drugs, 35% had used stimulant drugs to make sex more intense or last longer, while almost a fifth had done so in the last year.

5.9.2 Multi-partner chemsex

Respondents who had used stimulant drugs during sex in the last 12 months (n = 109) were asked, 'When was the last time you combined stimulant drugs and sex with more than one partner at the same time?' Sixty per cent (n = 65) of those who had used stimulant drugs during sex in the last year reported doing so with more than one partner at the same time in the last 12 months.

Of respondents who used stimulant drugs during sex with more than one partner at the same time in the last 12 months (n = 65), 84% reported doing so in a private dwelling.

Respondents who used stimulant drugs during sex with more than one partner at the same time in the last 12 months (n = 65) were asked how long they had been combining stimulant drugs and multiple-partner sex. Half reported doing so for three years or less, while 19% (n = 12) had been doing so for ten years or more.

5.10 Safety strategies by key characteristics

Sexual health practices and safety strategies among survey respondents were compared across several key characteristics: age, employment status and HIV testing history (see Table 42, Table 43, and Table 44 respectively).

The likelihood that differences among individuals in different groups were due to chance was established using chi-squared analysis or Fisher's exact test for categorical variables, and ANOVA or Kruskal-Wallis for continuous variables. If the significance value was ≤ 0.05, there was deemed to be a statistically significant difference between the groups.

Table 42. Sexual health practices and safety strategies by age category

Sexual health practices and safety strategies	Age groups (n = 865)					
	17–24* (n = 155)	25–39* (n = 370)	40–54* (n = 252)	55+* (n = 88)	All*	*p* value
Ever taken PEP*	6.5%	18.4%	15.8%	14.3%	15.0%	0.007
Ever taken PrEP*	6.5%	35.7%	34.2%	24.7%	28.6%	<0.001
Ever taken doxy-PEP	3.2%	7.3%	6.8%	4.5%	6.1%	0.293
Fully vaccinated/naturally immune to Hepatitis A	26.6%	62.1%	70.2%	67.0%	58.6%	<0.001
Fully vaccinated/naturally immune to Hepatitis B	29.7%	62.5%	73.4%	66.7%	60.2%	<0.001
Fully vaccinated against mpox	3.9%	30.5%	34.5%	28.4%	26.7%	<0.001
Received at least one dose HPV vaccine	34.2%	52.7%	34.7%	13.6%	40.2%	<0.001
CAI with ≥ 2 non-steady partners in last 12 months	20.9%	40.5%	36.7%	44.7%	36.3%	<0.001
Concerned about illicit/recreational drug use	10.3%	7.9%	6.3%	5.7%	7.6%	0.444
Chemsex in last 12 months	9.7%	14.6%	11.9%	11.4%	12.6%	0.428
Multi-partner chemsex in last 12 months	3.9%	9.2%	7.5%	6.8%	7.5%	0.211

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 43. Sexual health practices and safety strategies by employment status

Sexual health practices and safety strategies	Employment status (n = 863)					
	Employed* (n = 640)	Unemployed* (n = 44)	Student* (n = 122)	Other* (n = 57)	All*	*p* value
Ever taken PEP*	16.8%	13.6%	7.5%	10.6%	14.9%	0.054
Ever taken PrEP*	33.5%	25.0%	10.8%	17.0%	28.7%	<0.001
Ever taken doxy-PEP	6.4%	4.5%	5.7%	5.3%	6.2%	0.941
Fully vaccinated/naturally immune to Hepatitis A	65.2%	38.6%	33.6%	52.6%	58.5%	<0.001
Fully vaccinated/naturally immune to Hepatitis B	66.4%	36.4%	37.7%	56.4%	60.1%	<0.001
Fully vaccinated against mpox	31.1%	13.6%	8.2%	26.3%	26.7%	<0.001
Received at least one dose HPV vaccine	44.8%	20.5%	34.4%	17.5%	40.3%	<0.001
CAI with ≥ 2 non-steady partners in last 12 months	39.5%	23.3%	25.6%	33.9%	36.4%	0.007
Concerned about illicit/ recreational drug use	7.7%	4.5%	9.8%	5.3%	7.7%	0.673
Chemsex in last 12 months	14.2%	13.6%	6.6%	7.0%	12.6%	0.066
Multi-partner chemsex in last 12 months	8.6%	6.8%	2.5%	7.0%	7.5%	0.133

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 44. Sexual health practices and safety strategies by HIV testing history

Sexual health practices and safety strategies	HIV testing history (n = 862)				
	Never tested* (n = 157)	Last test negative* (n = 650)	Living with HIV* (n = 55)	All*	*p* value
Ever taken PEP*	1.9%	18.2%	-	15.0%	<0.001
Ever taken PrEP*	5.1%	34.3%	-	28.6%	<0.001
Ever taken doxy-PEP	0.6%	6.8%	14.5%	6.2%	<0.001
Fully vaccinated/naturally immune to Hepatitis A	21.0%	65.6%	85.5%	58.7%	<0.001
Fully vaccinated/naturally immune to Hepatitis B	25.0%	66.6%	87.0%	60.3%	<0.001
Fully vaccinated against mpox	5.1%	30.8%	41.8%	26.8%	<0.001
Received at least one dose HPV vaccine	20.4%	43.3%	60.0%	40.2%	<0.001
CAI with ≥ 2 non-steady partners in last 12 months	13.5%	40.4%	50.9%	36.2%	<0.001
Concerned about illicit/recreational drug use	5.7%	7.9%	10.9%	7.7%	0.42
Chemsex in last 12 months	7.0%	12.5%	29.1%	12.5%	<0.001
Multi-partner chemsex in last 12 months	3.2%	7.8%	14.5%	7.4%	0.016

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

6

Attitudes, knowledge and behaviours

Chapter 6 Attitudes, knowledge and behaviours

This chapter describes a range of attitudes about and among the surveyed community and their perceived impact on health and health behaviours.

6.1 Homophobia

6.1.1 Homophobic discrimination

Table 45 shows the recency of homophobic discrimination as reported by cis-male survey respondents (n = 769). Respondents were asked if they ever felt excluded or rejected by friends or family because they have sex with men. Approximately 15% of respondents felt excluded from family activities and 16% rejected by friends within the last five years.

Table 45. Recency of homophobic discrimination by family and friends

Most recent occurrence (n = 769, missing = 5)	Excluded from family activities n (%)	Family members make discriminatory remarks n (%)	Felt rejected by friends n (%)
Within the last 4 weeks	19 (2.5)	39 (5.1)	20 (2.6)
1–6 months ago	19 (2.5)	28 (3.6)	15 (2.0)
7–12 months ago	28 (3.6)	48 (6.2)	22 (2.9)
1–5 years ago	54 (7.0)	94 (12.2)	54 (7.0)
More than 5 years ago	72 (9.4)	92 (12.0)	121 (15.7)
Ever	192 (25.0)	301 (39.1)	232 (30.2)

6.1.2 Homophobic healthcare discrimination

Table 46 shows the recency of healthcare homophobic discrimination as reported by cis-male survey respondents. Respondents were asked if they had experienced homophobia as a result of someone discovering or knowing that they have sex with men. Seventeen per cent of respondents reported feeling they were 'not treated well' in a health centre because someone knew they had sex with men, while 5% reported hearing health care providers gossip about them because they have sex with men.

Table 46. Recency of healthcare associated homophobic discrimination experiences

Most recent occurrence	Felt afraid to go to healthcare services (n = 769, missing = 9) n (%)	Avoided going to healthcare services (n = 769, missing =7) n (%)	Felt they were not treated well in a health centre (n = 769, missing = 8) n (%)	Heard healthcare providers gossiping about them (n = 769, missing = 24) n (%)
Within the last 4 weeks	33 (4.3)	19 (2.5)	7 (0.9)	4 (0.5)
1–6 months ago	27 (3.5)	21 (2.7)	12 (1.6)	2 (0.3)
7–12 months ago	29 (3.8)	17 (2.2)	13 (1.7)	4 (0.5)
1–5 years ago	66 (8.6)	49 (6.4)	42 (5.5)	11 (1.4)
More than 5 years ago	94 (12.2)	82 (10.7)	54 (7.0)	15 (2.0)
Ever	249 (32.4)	188 (24.5)	128 (16.6)	36 (4.7)

6.1.3 Homophobic law enforcement discrimination

Nine per cent of cis-male survey respondents (n = 70) reported ever feeling that the police refused to protect them because they have sex with men, while 1% of respondents (n = 10) reported feeling this within the last 12 months.

6.1.4 Homophobic intimidation, assault

Cis-male respondents (n = 769) were asked a series of questions about how recently they had experienced homophobic abuse. They were asked how recently they had felt scared to be in a public place, and when they had last been verbally harassed, physically hurt or blackmailed because someone knew or presumed they were attracted to men. In addition they were asked a question about if they had ever been forced to have sex when they did not want to. Forced was defined as 'physically forced, coerced to have sex, or penetrated with an object when you did not want to.' Survey responses are outlined in Table 47.

Table 47. Recency of homophobic harassment, assault and sexual violence

Most recent occurrence	Felt scared to be in public places (n = 769, missing = 25) n (%)	Verbally harassed (n = 769, missing = 26) n (%)	Physically hurt (n = 769, missing = 24) n (%)	Been blackmailed (n = 769, missing = 24) n (%)	Physically forced or coerced to have sex (n = 769, missing = 22) n (%)
Within the last 4 weeks	80 (10.4)	45 (5.8)	3 (0.4)	2 (0.3)	2 (0.3)
1–6 months ago	65 (8.5)	51 (6.6)	5 (0.7)	3 (0.4)	4 (0.5)
7–12 months ago	71 (9.2)	68 (8.8)	13 (1.7)	5 (0.7)	10 (1.3)
1–5 years ago	107 (13.9)	157 (20.4)	49 (6.4)	27 (3.5)	35 (4.6)
More than 5 years ago	95 (12.4)	191 (24.8)	156 (20.3)	47 (6.1)	97 (12.6)
Ever	418 (54.4)	512 (66.6)	226 (29.4)	84 (10.9)	148 (19.3)

A majority of respondents reported ever having felt scared to be in a public place (54%) and being verbally harassed (67%), with 29% reporting ever being physically hurt. Eleven per cent stated that they had been blackmailed in the past, while 19% of respondents reported that they had been forced or coerced to have sex when they did not want to.

6.2 Internalised homonegativity

Having negative feelings towards one's own homosexuality has been shown to be related to higher sexual risk-taking and lower rates of HIV testing, and has also been associated with anxiety and depression among MSM.(13, 14) The results for anxiety and depression for this survey are summarised in Table 16 and Table 17 earlier in this report.

The Short Internalised Homonegativity Scale is a validated scale to measure the internalisation of negative attitudes and assumptions about homosexual people by homosexual people themselves.(15)

Cis males (n = 769) were asked, 'Do you strongly disagree (1 point) or strongly agree (7 points) with the following seven statements?'

1. I feel comfortable in gay bars.
2. I feel comfortable being seen in public with an obviously gay person.
3. I feel comfortable discussing homosexuality in a public situation.
4. I feel comfortable being a homosexual man.
5. Homosexuality is morally acceptable to me.
6. Even if I could change my sexual orientation, I wouldn't.
7. Social situations with gay men make me feel uncomfortable.

The above seven items form a single scale measuring 'internalised homonegativity'. This score was computed by rescaling the items from 1–7 to 0–6, and reversing the scores for the first six items.

The seven responses sum to a score of between 0 and 42 which was divided by 7 to give a total score between zero and six, with a score of zero representing no internalised homonegativity.

A score could only be calculated if all seven items were rated.

The average (mean ± standard deviation (SD)) score on the internalised homonegativity scale was 1.18 (±1.08) out of 6.

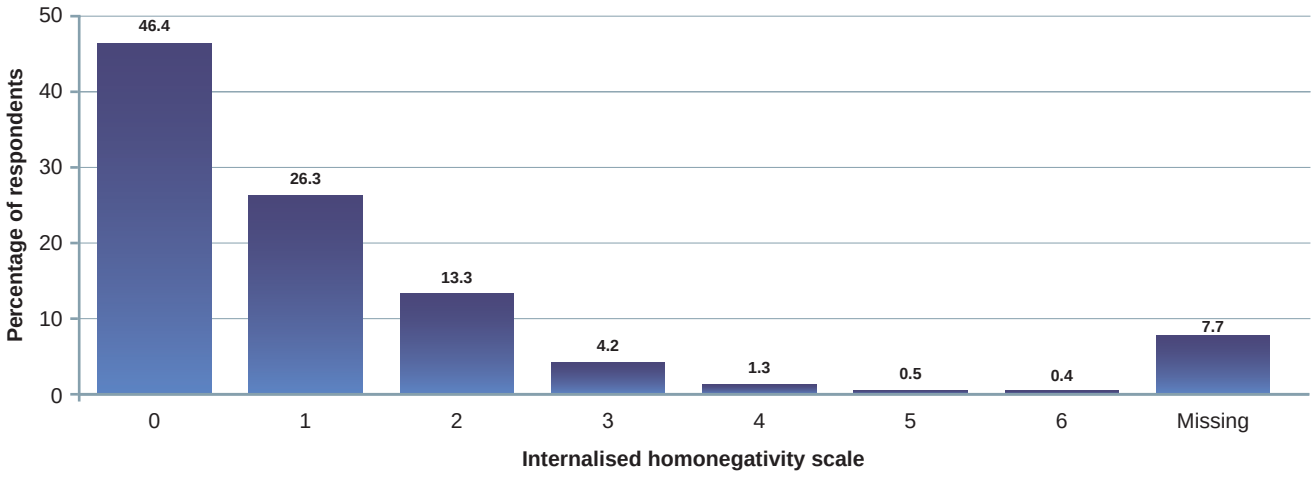

Figure 8 shows how the scores were distributed. Ideally, individuals would be on the left of this scale. Forty-six per cent of eligible respondents scored zero, representing the 'best' possible score.

6.3 Transphobia

6.3.1 Transphobic discrimination

Table 48 shows the frequency and recency of transphobic discrimination as reported by survey respondents who identified as members of the trans community (n = 83). Respondents were asked if they ever felt excluded or rejected by friends or family because they are transgender. Almost three-quarters of respondents felt excluded from family activities and 60% felt rejected by friends at some point in the past because they are transgender.

Table 48. Recency of transphobic discrimination by family and friends

Most recent occurrence	Excluded from family activities (n = 83, missing = 1) n (%)	Family members make discriminatory remarks (n = 83, missing = 0) n (%)	Felt rejected by friends (n = 83, missing = 0) n (%)
Within the last 4 weeks	27 (32.5)	22 (26.5)	1 (1.2)
1–6 months ago	10 (12.0)	6 (7.2)	7 (8.4)
7–12 months ago	10 (12.0)	7 (8.4)	4 (4.8)
1–5 years ago	12 (14.5)	7 (8.4)	8 (9.6)
More than 5 years ago	2 (2.4)	1 (1.2)	1 (1.2)
Ever	61 (73.5)	43 (51.8)	21 (25.3)

6.3.2 Transphobic healthcare discrimination

Table 49 shows the reported recency of transphobic discrimination in a healthcare setting. Respondents were asked if they had experienced transphobic discrimination because someone discovered or knew that they are transgender. Over half of respondents reported they felt 'not treated well' in a health centre because someone knew they were transgender, while 25% reported hearing health care providers gossip about them because they were transgender.

Table 49. Recency of healthcare transphobic discrimination

Most recent occurrence	Felt afraid to go to healthcare services (n = 83, missing = 0) n (%)	Avoided going to healthcare services (n =83, missing=0) n (%)	Felt not treated well in a health centre (n=83, missing=0) n (%)	Heard healthcare providers gossiping (n = 83, missing = 0) n (%)
Within the last 4 weeks	27 (32.5)	22 (26.5)	12 (14.5)	1 (1.2)
1–6 months ago	10 (12.0)	6 (7.2)	15 (18.1)	7 (8.4)
7–12 months ago	10 (12.0)	7 (8.4)	12 (14.5)	4 (4.8)
1–5 years ago	12 (14.5)	7 (8.4)	7 (8.4)	8 (9.6)
More than 5 years ago	2 (2.4)	1 (1.2)	-	1 (1.2)
Ever	61 (73.5)	43 (51.8)	46 (55.4)	21 (25.3)

6.3.3 Transphobic law enforcement discrimination

Respondents who were members of the transgender community were asked when they last felt that the police refused to protect them because they were transgender. Twenty-three per cent of respondents (n = 19) reported ever feeling that the police refused to protect them because they were transgender while 8% of respondents (n = 7) reported feeling this within the last 12 months.

6.3.4 Transphobic intimidation and assault

Respondents who stated they were part of the transgender community (n = 83) were asked a series of questions about how recently they had experienced transphobic abuse. They were asked how recently they had felt scared to be in a public place, and when they had last been verbally harassed, physically hurt or blackmailed because someone knew or presumed they were transgender. In addition, they were also asked a question about if they had ever been forced to have sex when they did not want to. As above, forced was defined as 'physically forced, coerced to have sex, or penetrated with an object when you did not want to.' Responses are outlined in Table 50.

Table 50. Recency of transgender harassment, assault and sexual violence

Most recent occurrence	Felt scared to be in public places (n = 83, missing = 0) n (%)	Verbally harassed (n = 83 missing = 0 n (%)	Physically hurt (n = 83, missing = 0) n (%)	Been blackmailed (n = 83, missing = 0) n (%)	Physically forced or coerced to have sex (n = 83, missing = 1) n (%)
Within the last 4 weeks	36 (43.4)	14 (16.9)	-	3 (3.6)	1 (1.2)
1–6 months ago	6 (7.2)	15 (18.1)	2 (2.4)	3 (3.6)	4 (4.8)
7–12 months ago	14 (16.9)	11 (13.3)	2 (2.4)	3 (3.6)	3 (3.6)
1–5 years ago	15 (18.1)	25 (30.1)	4 (4.8)	13 (15.7)	21 (25.3)
More than 5 years ago	2 (2.4)	5 (6.0)	2 (2.4)	5 (6.0)	10 (12.0)
Ever	73 (88.0)	70 (84.3)	10 (12.0)	27 (32.5)	39 (47.0)

A large majority of transgender respondents reported ever feeling scared to be in a public place (88%) and being verbally harassed (84%), with 12% reporting ever being physically hurt. Thirty-three per cent stated that they had been blackmailed in the past, while almost half of transgender respondents (47%) reported that they had been forced or coerced to have sex when they did not want to, with 10% reporting that the most recent time this had happened to them was in the last year.

6.4 Internalised transnegativity

Internalised transnegativity – negative feelings towards one's own transgender identity – has been associated with higher rates of anxiety and depression, higher levels of substance misuse and worse sexual and physical health outcomes among members of the transgender community.(16, 17) The results for anxiety and depression for this survey can be found earlier in this report in Table 16 and Table 17.

The Short Internalised Transnegativity Scale was adapted from the Short Internalised Homonegativity Scale outlined above in section 6.2 on internalised homonegativity.

Respondents who identified as members of the transgender community (n = 83) were asked, 'Do you strongly disagree (1 point) or strongly agree (7 points) with the following seven statements?'

1. I am proud of being a transgender person.
2. I am comfortable revealing to others that I am transgender.
3. I feel comfortable being out in public with transgender people.
4. Being transgender makes me feel like a freak.
5. I don't mind being perceived as transgender.
6. I often ask myself: why can't I just be normal?
7. I am comfortable with the reality that I am transgender.

The above seven items form a single scale measuring 'internalised transnegativity'. The score was computed by rescaling the items from 1–7 to 0–6; reversing the scores for items 4 and 6; and taking the mean score for the seven items. The scale therefore ranges from 0 to 6, with a score of zero representing no internalised transnegativity. Scores can only be computed if all seven items were rated.

Figure 9 shows how the scores were distributed. Ideally, individuals would be on the left of this scale. Only 3.61 per cent of eligible respondents scored zero, representing the no internalised transnegativity. The average (±SD) score on the internalised transnegativity scale was 3.88 (±1.34) out of 6.

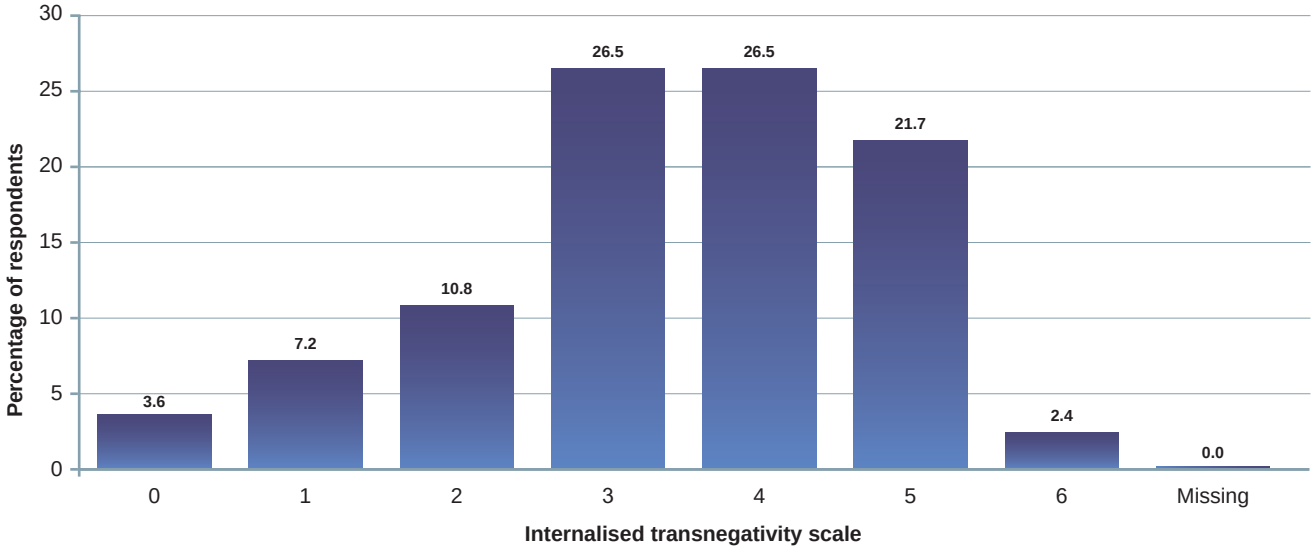

Figure 9. Internalised transnegativity scale, percentage distribution (n = 83, missing = 1)

6.5 Sexual happiness

Participants were asked, 'On a scale of 1 to 10 (where 1 is the most unhappy and 10 is the most happy), how happy are you with your sex life?' (n = 865, missing = 1). Figure 10 shows the frequency distribution for the survey population. The average (±SD) score for sexual happiness was 6.3 (±2.3).

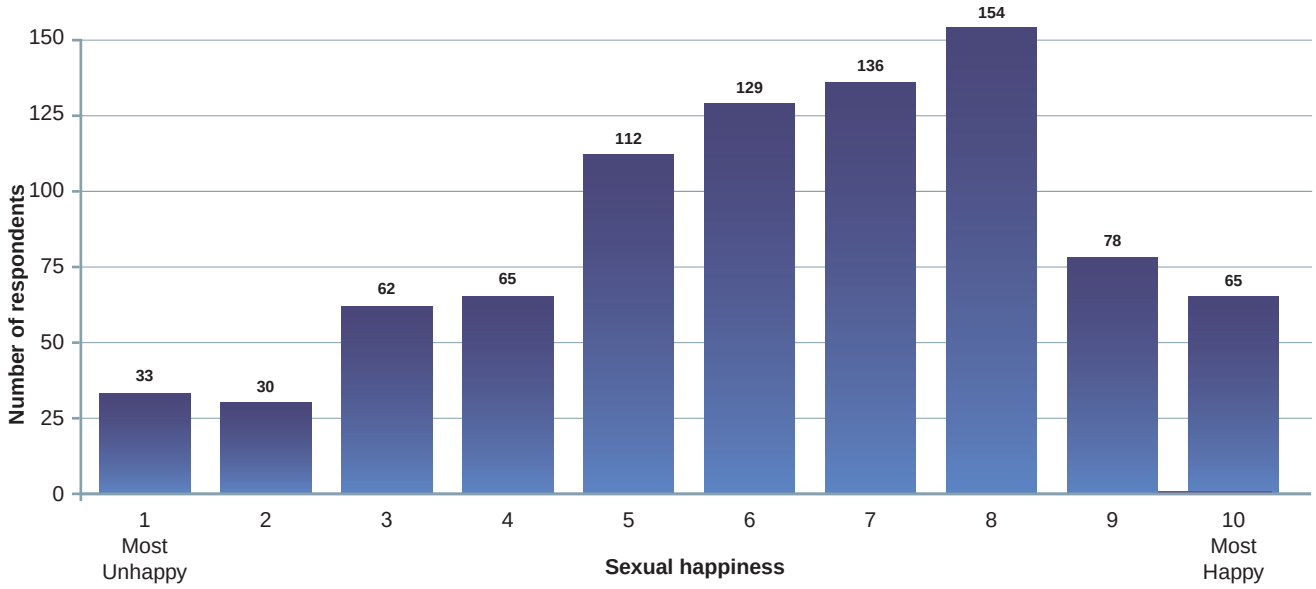

Figure 10. Sexual happiness score distribution

6.6 Sexual assertiveness for safer sex

All respondents were asked if they agreed or disagreed with the following two statements: 'The sex I have is always as safe as I want it to be' and 'I find it easy to say 'no' to sex I don't want'.

Responses are shown in Table 51. Sixteen per cent did not agree that the sex they have is always as safe as they want to it be and 13% did not agree that they find it easy to say 'no' to sex they don't want.

Table 51. Sexual assertiveness for safer sex

	The sex I have is always as safe as I want it to be (n = 865, missing = 0) n (%)	I find it easy to say 'no' to sex I don't want (n = 865, missing = 0) n (%)
Strongly disagree	43 (5.0)	33 (3.8)
Disagree	95 (11.0)	80 (9.2)
Neither/not sure	58 (6.7)	48 (5.5)
Agree	269 (31.1)	267 (30.9)
Strongly agree	400 (46.2)	437 (50.5)

6.7 Self-reported sexual health knowledge and awareness

Six statements were used to assess knowledge about HIV and STI transmission by asking respondents whether or not they knew the statements were true. Respondents were given the following options: 'I knew this already'; 'I wasn't sure about this'; 'I didn't know this already'; I don't understand this'; and 'I do not believe this'. Those who answered 'I knew this already' were considered to have pre-existing knowledge and the rest were defined as the proportion with knowledge gaps and classified as 'Didn't know'. This same knowledge response set was used throughout the questionnaire to quantify respondents' self-assessed knowledge of various sexual health topics. It should be noted that these are self-reported values and that the questionnaire does not directly test knowledge of individual topics.

6.7.1 Self-reported HIV and STI transmission knowledge

Overall, basic knowledge about HIV/STI transmission was generally high. Less than 1% of respondents (0.6%) did not know any of the six HIV/STI transmission facts and 82% knew at least five of the six facts. The average number of facts known about HIV/STI transmission was five out of six. Table 52 shows the knowledge gaps for HIV and STI transmission.

Table 52. Self-reported knowledge about HIV and STI transmission

Knowledge statement	Already knew n (%)	Didn't know* n (%)
HIV cannot be passed during kissing, including deep kissing, because saliva does not transmit HIV (n = 865, missing = 4)	758 (87.6)	103 (11.9)
You can pick up HIV through your penis while being 'active' in anal or vaginal sex without a condom (n = 796, missing = 4)	703 (88.3)	89 (11.2)
You can pick up HIV through your rectum/vagina while being 'passive' during sex (n = 865, missing = 5)	824 (95.3)	22 (2.5)
Most STIs can be passed on more easily than HIV (n = 865, missing = 7)	649 (75.0)	209 (24.2)
Because they sometimes have no symptoms, people can have STIs without knowing it (n = 865, missing = 6)	804 (92.9)	55 (6.4)
The correct use of condoms throughout intercourse reduces the likelihood of picking up and passing on STIs (including HIV) (n = 865, missing = 11)	841 (97.2)	13 (1.5)

** Including those who didn't know, didn't understand the statement, or didn't believe the statement.*

6.7.2 Self-reported pre-exposure prophylaxis knowledge and awareness

Respondents not living with a HIV diagnosis (n = 807) were asked if they had ever heard of PrEP, with 96% stating they had. Three statements assessed respondents' knowledge of PrEP, using the same response options as above concerning HIV. Table 53 shows the knowledge gaps for PrEP. These questions were not shown to survey respondents who indicated they were living with HIV.

Table 53. Self-reported knowledge about PrEP

Knowledge statement	Already knew n (%)	Didn't know* n (%)
PrEP involves someone who does not have HIV taking pills before as well as after sex to prevent them getting HIV (n = 807, missing = 1)	688 (85.3)	118 (14.6)
PrEP can be taken as a single daily pill if someone does not know in advance when they will have sex (n = 807, missing = 4)	654 (81.0)	149 (18.5)
If someone knows in advance when they will have sex, PrEP needs to be taken as a double dose approximately 2 to 24 hours before sex and then at both 24 and 48 hours after the double dose (n = 807, missing = 2)	366 (45.4)	439 (54.4)

Fifteen per cent of respondents did not know the purpose of PrEP and 10% did not know any of the knowledge statements about PrEP. The average number of facts known about PrEP was two out of three.

6.7.3 Self-reported knowledge about PrEP and gender-affirming hormones

Members of the transgender community were asked specifically about PrEP and gender-affirming hormone therapy. Of those assigned female at birth and taking or considering taking gender-affirming hormones (n = 57), most did not know (n = 36, 63%) that gender-affirming hormone therapy with testosterone does not affect PrEP efficacy.

Of those assigned male at birth and taking or considering taking gender-affirming hormones (n = 9), a majority (89%) did not know that taking oestrogen as part of gender-affirming hormone therapy means PrEP is effective only if taken in the modality of a daily dose.

6.7.4 Self-reported knowledge around HIV testing and treatment

All respondents were shown seven statements to test their knowledge regarding HIV using the same knowledge response set. Overall, there was good basic knowledge around the HIV testing and treatment facts shown to survey respondents (see Table 54). Ninety-eight per cent of respondents were aware that HIV can be controlled with medications and 89% that someone with an undetectable viral load cannot pass the virus to someone else during sex.

Table 54. Self-reported knowledge about HIV testing and treatment

Knowledge statement	Already knew n (%)	Didn't know* n (%)
AIDS is caused by a virus called HIV (n = 865, missing = 3)	847 (97.9)	15 (1.7)
You cannot be confident about whether someone has HIV or not from their appearance (n = 865, missing = 6)	839 (97.0)	20 (2.3)
There is a medical test that can show whether or not you have HIV (n = 865, missing = 5)	844 (97.6)	16 (1.8)
If someone becomes infected with HIV it may take several weeks before it can be detected in a test (n = 863, missing = 2)	708 (81.8)	155 (17.9)
There is currently no cure for HIV infection (n = 863, missing = 2)	727 (84.0)	136 (15.7)
HIV infection can be controlled with medicines so that its impact on health is much less (n = 863, missing = 2)	843 (97.5)	17 (2.0)
A person with HIV who is on effective treatment (called 'undetectable viral load') cannot pass their virus to someone else during sex (n = 863, missing = 4)	771 (89.1)	90 (10.4)

** Including those who didn't know, didn't understand the statement, or didn't believe the statement.*

6.7.5 Self-reported knowledge about where to get a HIV test among those never tested

In total, 157 survey respondents stated they had never been tested for HIV. This group were asked if they knew where they could go to get a HIV test. A majority (57%) replied that they did know where to get a HIV test, but 22% stated they did not know where they could get a HIV test.

Table 55. Self-reported knowledge of where to access HIV testing among those never tested

Knows where to get tested (n = 157, missing = 0)	n (%)
Yes	89 (56.7)
No	35 (22.3)
Not sure	33 (21)

6.7.6 HIV prevention strategies

All respondents were asked about what HIV prevention strategy they use most frequently. Forty-two per cent reported using condoms, 21% reported using PrEP, while 11% reported asking about HIV status as their main HIV prevention strategy. Almost a fifth of respondents reported not using any particular HIV prevention method. Responses are shown stratified by HIV status in Table 56.

Table 56. Most frequent HIV prevention strategy by HIV status

What HIV prevention strategy do you use most frequently?	Not living with HIV diagnosis (n = 807, missing = 3) n (%)	Living with HIV (n = 55, missing = 0) n (%)
Condoms	344 (42.6)	16 (29.1)
I rely on U = U (Undetectable = Untransmittable)	13 (1.6)	24 (43.6)
I use PrEP	180 (22.3)	n/a
PrEP surfing (I rely on PrEP use of my partner(s))	19 (2.4)	3 (5.5)
Asking about HIV status	94 (11.6)	2 (3.6)
No particular prevention method	154 (19.1)	10 (18.2)

6.7.7 Self-reported knowledge of viral hepatitis and where to access vaccination

All respondents were shown four statements to test their knowledge regarding hepatitis using the knowledge response set 'knew', 'didn't know', 'didn't understand' and 'didn't believe'. The responses are shown in Table 57.

Thirty-one per cent of respondents did not know that doctors recommend men who have sex with men are vaccinated against both hepatitis A and B. The average number of facts known about viral hepatitis was three out of four.

Table 57. Self-reported knowledge about viral hepatitis

Knowledge statement	Already knew n (%)	Didn't know* n (%)
Hepatitis means inflammation of the liver (n = 865, missing = 1)	486 (56.2)	378 (43.7)
Hepatitis is often caused by hepatitis viruses, named after the letters of the alphabet (n = 865, missing = 4)	602 (69.6)	259 (29.9)
Vaccines exist for both hepatitis A and hepatitis B (n = 865, missing = 8)	717 (82.9)	140 (16.2)
Doctors recommend men who have sex with men are vaccinated against both hepatitis A and hepatitis B viruses (n = 825**, missing = 5)	568 (68.8)	252 (30.5)

** Including those who didn't know, didn't understand the statement, or didn't believe the statement.*
*** This question was only asked of men (cis and trans).*

Respondents who were not fully vaccinated or naturally immune to hepatitis A or hepatitis B (n = 391) were asked if they knew where they could get vaccinated against hepatitis A and or B. Less than half of those not vaccinated or immune (41%) reported that they knew where they could go to get vaccinated.

6.7.8 Self-reported HPV knowledge

All respondents were shown three statements to test their knowledge regarding HPV using the same knowledge response set outlined above in section 6.7. Forty per cent of respondents did not know that HPV causes anal and genital warts, and 30% did not know that HPV causes some types of cancer, while 21% were unaware there were vaccines available against HPV. Overall, 17% of respondents did not know any of the facts about HPV. The responses are shown in Table 58.

Table 58. Self-reported knowledge about HPV

Knowledge statement	Already knew n (%)	Didn't know* n (%)
Human Papilloma Virus (HPV) causes anal and genital warts (n = 865, missing = 3)	520 (60.1)	342 (39.5)
Human Papilloma Virus (HPV) causes some types of cancer (n = 865, missing = 7)	601 (69.5)	257 (29.7)
Vaccines exist for Human Papilloma Virus (HPV) (n = 865, missing = 6)	674 (77.9)	185 (21.4)

** Including those who didn't know, didn't understand the statement, or didn't believe the statement.*

6.7.9 Self-reported mpox knowledge and where to access vaccination

Respondents were shown three statements to test their knowledge regarding mpox using the same knowledge response set outlined above for HPV. Eighty-one per cent of respondents knew there was a vaccine available against mpox. The responses to the knowledge statements are shown in Table 59.

Table 59. Self-reported knowledge about mpox

Knowledge statement	Already knew n (%)	Didn't know* n (%)
Since the novel outbreak in 2022, 'monkeypox' (mpox) has predominantly affected men who have sex with men and transgender people (n = 852, missing = 4)	701 (82.3)	147 (17.3)
Mpox is mainly transmitted during sex or close physical contact (n = 865, missing = 7)	729 (84.3)	129 (14.9)
There is a vaccine against mpox that significantly reduces the risk of contracting the disease (n = 865, missing = 7)	703 (81.3)	155 (17.9)

** Including those who didn't know, didn't understand the statement, or didn't believe the statement.*

Respondents who had not been vaccinated against mpox (n = 585) were asked if they knew where they could go to get vaccinated against mpox. Thirty-nine per cent of this group indicated they did know where they could go to get vaccinated against mpox.

6.8 Attitudes, knowledge and behaviours by key characteristics

Knowledge, attitudes and behaviours among survey respondents was compared across several key characteristics: age, employment status and HIV testing history (see Table 60, Table 61 and Table 62 respectively).

The likelihood that differences among individuals in different groups were due to chance was established using chi-squared analysis or Fisher's exact test for categorical variables, and ANOVA or Kruskal-Wallis for continuous variables. If the significance value was ≤ 0.05, there was deemed to be a statistically significant difference between the groups.

Table 60. Attitudes, knowledge and behaviours by age category

Age groups (n = 865) Knowledge, attitude or behaviour	17–24 (n = 155)*	25–39 (n = 370)*	40–54 (n = 252)*	55+ (n = 88)*	All*	*p* value
Average internalised homonegativity (out of 6)*	1.49	1.1	1.16	1.22	1.18	0.03
Average internalised trans-negativity (out of 6)*	3.6	4.2	4.4	6.0	3.88	0.076
Sex not as safe as I want it to be	17.4%	17.8%	14.3%	10.2%	16.0%	0.272
Did not find it easy to say 'no' to unwanted sex	16.8%	13.5%	10.7%	11.4%	13.1%	0.335
Inconsistent condom use with non-steady partner(s) in the last 12 months‡	70.8%	84.4%	83.8%	78.0%	81.5%	0.054
Unaware of PrEP*	9.0%	2.0%	0.9%	5.2%	3.4%	<0.001
Average number of 3 PrEP facts already known*	1.59	2.37	2.19	2.04	2.14	<0.001
Average number of 6 HIV/STI transmission facts known	4.74	5.42	5.55	5.15	5.31	<0.001
Average number of 6 HIV test and treat facts already known	5.15	5.61	5.7	5.67	5.56	<0.001
Knew a person with undetectable viral load cannot pass on HIV	79.4%	94.0%	90.8%	85.2%	89.5%	<0.001
Did not know where to get an HIV test*	54.5%	37.5%	23.1%	33.3%	43.3%	0.023
Average number of 4 hepatitis facts known*	2.01	2.82	2.97	3.05	2.74	<0.001
Did not know where to get vaccinated for hepatitis A and/or B*	69.8%	54.2%	56.8%	47.4%	58.7%	0.025
Average number of 3 mpox facts known	1.85	2.58	2.67	2.52	2.47	<0.001
Did not know where to get mpox vaccine*	72.4%	61.0%	54.8%	49.1%	60.8%	0.025

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 61. Attitudes, knowledge and behaviours by employment status

Employment status (n = 863) Knowledge, attitude or behaviour	Employed (n = 640)*	Un-employed (n = 44)*	Student (n = 122)*	Other (n = 57)*	All*	*p* value
Average internalised homonegativity (out of 6)*	1.13	1.48	1.39	1.31	1.18	0.073
Average internalised trans-negativity (out of 6)*	4.15	4.3	3.47	4.29	3.88	0.12
Sex not as safe as I want it to be	16.1%	13.6%	18.9%	8.8%	15.9%	0.369
Did not find it easy to say 'no' to unwanted sex	11.2%	15.9%	20.5%	15.8%	13.1%	0.038
Inconsistent condom use with non-steady partner(s) in the last 12 months*	83.2%	77.8%	73.0%	79.3%	81.5%	0.23
Unaware of PrEP*	1.7%	4.5%	10.0%	4.3%	3.2%	<0.001
Average number of 3 PrEP facts already known*	2.28	1.77	1.7	1.94	2.14	<0.001
Average number of 6 HIV/STI transmission facts known	5.44	4.66	4.91	5.11	5.31	<0.001
Average number of 6 HIV test and treat facts already known	5.67	5.14	5.16	5.47	5.56	<0.001
Knew a person with undetectable viral load cannot pass on HIV	92.2%	79.5%	81.0%	86.0%	89.5%	<0.001
Did not know where to get an HIV test*	33.8%	52.9%	54.7%	33.3%	42.9%	0.076
Average number of 4 hepatitis facts known*	2.89	2.00	2.21	2.79	2.74	<0.001
Did not know where to get vaccinated for hepatitis A and/or B*	57.1%	71.4%	63.9%	46.9%	58.7%	0.18
Average number of 3 mpox facts known	2.6	2.09	1.95	2.42	2.47	<0.001
Did not know where to get mpox vaccine*	55.3%	86.5%	76.0%	53.8%	60.7%	<0.001

** Results of cross-tabulation analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 62. Attitudes, knowledge and behaviours by HIV testing history

HIV testing history (n = 862) Knowledge, attitude or behaviour	Never tested (n = 157)*	Last test negative (n = 650)*	Living with HIV (n = 55)*	All*	*p* value
Average internalised homonegativity (out of 6)*	1.49	1.12	1.17	1.18	0.008
Average internalised trans-negativity (out of 6)*	3.83	3.93	-	3.88	0.762
Sex not as safe as I want it to be	13.4%	16.6%	14.5%	15.9%	0.585
Did not find it easy to say 'no' to unwanted sex	9.6%	14.0%	12.7%	13.1%	0.333
Inconsistent condom use with non-steady partner(s) in the last 12 months*	75.6%	80.8%	94.6%	81.4%	0.069
Unaware of PrEP*	10.2%	1.7%	-	3.4%	<0.001
Average number of 3 PrEP facts already known*	1.43	2.31	-	2.14	<0.001
Average number of 6 HIV/STI transmission facts known	4.87	5.38	5.65	5.31	<0.001
Average number of 6 HIV test and treat facts already known	5.00	5.66	5.87	5.56	<0.001
Knew a person with undetectable viral load cannot pass on HIV	74.4%	92.4%	98.2%	89.5%	<0.001
Did not know where to get an HIV test[1]	43.3%	-	-	43.3%	-
Average number of 4 hepatitis facts known*	1.88	2.92	3.15	2.75	<0.001
Did not know where to get vaccinated for hepatitis A and/or B*	73.8%	52.6%	27.3%	58.8%	<0.001
Average number of 3 mpox facts known	1.79	2.62	2.58	2.47	<0.001
Did not know where to get mpox vaccine*	82.6%	55.3%	40.0%	61.0%	<0.001

** Results of cross-tabulation analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

7

Interventions and services

Chapter 7 Interventions and services

7.1 Access to condoms

Condom distribution is a key intervention for increasing access to condoms, and condom packs often carry health promotion information on and in their packaging. All respondents were asked 'Where have you got condoms from in the last 12 months?' and were asked to tick as many as applied to them from a range of sources. Table 63 shows the responses given. The most common source of condoms was buying them in a physical shop (41%), followed by getting them free from a clinic (31%) or a gay/LGBT+ bar or club (31%).

Table 63. Source(s) of condoms in the last 12 months

Source of condoms (n = 865, missing = 2)	Yes n (%)
I bought them at a physical shop (not online)	356 (41.2)
I received them for free from clinics	270 (31.2)
I received them for free from gay/LGBTQ+ bars/clubs	269 (31.1)
I did not get condoms in the last 12 months	176 (20.3)
I received them for free from gay/LGBTQ+ or HIV community organisations	131 (15.1)
I received them from friends/sex partners	121 (14.0)
I received them for free from saunas	111 (12.8)
I bought them online	86 (9.9)
Other answer	25 (2.9)
I bought them from a vending machine	18 (2.1)

Fifty-three per cent of respondents (n = 458) reported accessing free condoms within the last year. Among the 497 respondents who reported intercourse with a non-steady partner in the previous 12 months, 63% (n = 315) reported accessing free condoms in the last year and 10% didn't access any condoms.

7.2 STI and HIV campaign awareness

Cis-gender males and transgender males (n = 833) were asked, 'When was the last time you saw or heard any information about HIV or STIs specifically for men who have sex with men?' A large majority (92%) reported seeing MSM-specific information about HIV or STIs in the last 12 months and 66% had done so in the last four weeks.

Trans men, trans women and non-binary people (n = 96) were asked, 'When was the last time you saw or heard any information about HIV or STIs specifically for transgender people?' A third of transgender respondents reported seeing transgender-specific information about HIV or STIs in the last 12 months and 8% had done so in the last four weeks.

7.3 HIV interventions

7.3.1 HIV test offered by health services

Eighteen per cent of respondents (n = 157) had never tested for HIV. This group were asked if they had ever been offered a HIV test by a health service. Twenty-two per cent reported that they had been offered a HIV test, while 71% reported they had not.

All respondents were asked if they had ever been tricked into taking an HIV test when they did not want to take one, with 2.5% responding that they had been tricked into taking an HIV test in the past.

7.3.2 HIV diagnosis and care

Respondents living with HIV were asked where they were initially diagnosed with HIV. One-third were initially diagnosed in a hospital clinic as an outpatient (33%), 29% in a community health service or drop-in and 13% by a doctor in private practice. Respondents with a diagnosis of HIV were asked 'When you were diagnosed HIV positive, how satisfied were you with the support and information you received?' Two-thirds of those diagnosed in a hospital or outpatient clinic and 75% of those diagnosed at a community health service or drop-in were satisfied with the information and support they received at the time of diagnosis.

The 55 respondents who indicated they had received a diagnosis of HIV were asked if they had ever taken anti-retroviral therapy (ART). Overall, 95% of people living with HIV had ever taken ART and all respondents who had ever taken ART were currently taking ART. Those who reported ever taking ART were asked, 'How much time was there between your HIV diagnosis and you starting treatment?' Table 64 shows the average length of time to treatment in months by year of diagnosis. The sample size here is small (n=37), as 15 respondents with a HIV diagnosis indicated a time frame that was 'out of range' and were automatically excluded. For those with valid data, 43% (n=16) indicated they started ART within three months of diagnosis. Those with later diagnoses had substantially shorter time between diagnosis and treatment initiation.

Table 64. Average number of months from diagnosis to starting antiretroviral therapy

Year of diagnosis	n*	Average number of months to treatment
1984–2005	10	53.1
2006–2010	13	41.8
2011–2015	8	18.2
2016–2024	6	1.5

**n = 37, as 15 respondents indicated a time frame that was 'out of range'*

Of the 55 reporting a HIV diagnosis, 98% (n = 54) reported that they had ever had their HIV monitored and were also currently having their HIV monitored by a medical professional. Fifty-two respondents reported that they were currently taking ART. (Two respondents replied that they were not sure if they had ever taken ART and were therefore not shown the question asking if they were currently taking ART.) Fifty-four respondents stated that their last viral load was undetectable. Therefore all respondents who had their HIV medically monitored, and 98% of those who reported having a HIV diagnosis, reported being virally suppressed.

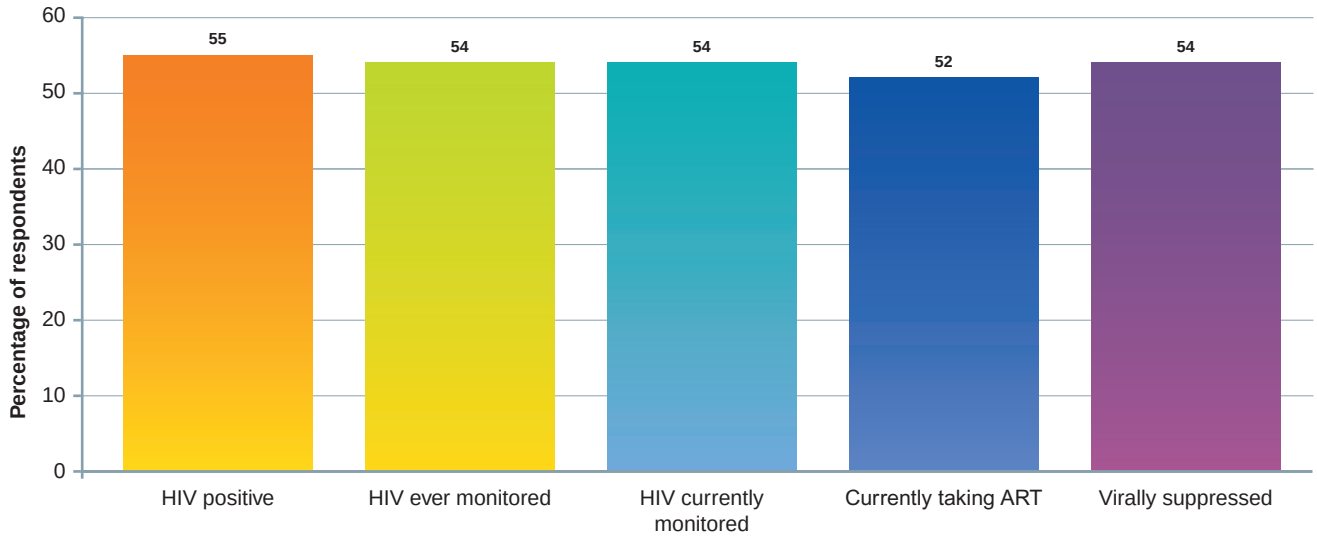

Figure 11. Care status for respondents diagnosed with HIV [3]

The 52 respondents who replied that they were currently taking ART were asked when was the last time they had experienced an involuntary interruption of their HIV medication. Ninety-six per cent (n = 50) replied that they had never experienced an involuntary interruption in their ART.

7.3.3 HIV testing among HIV-negative respondents

HIV-negative respondents (n = 650) were asked, 'Where did you go for your last HIV test?' Responses can be seen in Table 65. The most frequent setting for the last HIV test was using a self-sampling kit (30%), followed by hospital outpatient clinic (29%).

Among HIV-negative respondents who had tested for HIV during the previous 12 months (n = 473), the most common sites or method for HIV testing were a self-sampling kit (35%), hospital outpatient clinic (31%), or a community health service or drop-in (11%).

Table 65. Setting for most recent HIV test among HIV-negative respondents

Location of last HIV test (n = 650, missing = 0)	n (%)
I used a self-sampling kit (I took my own sample then sent it away to be analysed)	195 (30.0)
At a hospital or clinic as an outpatient	191 (29.4)
At a community health service or drop-in (not in a hospital or clinic)	91 (14.0)
A doctor in private practice	60 (9.2)
General practitioner/family doctor	56 (8.6)
I used a self-testing kit (I found out the result on the spot)	23 (3.5)
At a hospital as an in-patient	10 (1.5)
In a bar/pub, club or sauna	4 (0.6)
At a mobile testing unit	4 (0.6)
At a blood bank, while donating blood	2 (0.3)
Elsewhere	14 (2.2)

[3] *In order to reach viral suppression a person living with HIV must be on ART. In Figure 11, two respondents stated they were not sure if they had ever taken ART and were therefore not asked if they were currently taking ART. However those two respondents did report that they were virally suppressed.*

7.3.4 HIV testing preference

Respondents whose last HIV test result was negative (n = 650) were asked, 'What would be your first choice for HIV testing, if you could choose freely?' Responses are shown in Table 66. A quarter selected a self-sampling kit that is sent away for analysis. Around a fifth of respondents opted for hospital outpatients, community health service or self-testing kit (results available on the spot).

Table 66. Preferred HIV testing location and modality

What would be your first choice for HIV testing, if you could choose freely? (n = 650, missing = 0)	n (%)
Use a self-sampling kit (taking my own sample, then send it away for analysis)	162 (24.9)
At a hospital, clinic or institute as an outpatient	129 (19.8)
At a community health service or drop-in centre (not in a hospital or clinic)	124 (19.1)
Use a self-testing kit (to find out the result on the spot)	118 (18.2)
General Practitioner/family doctor	54 (8.3)
A doctor in private practice	33 (5.1)
In a bar/pub, club or sauna	7 (1.1)
At a gender-affirming care service	7 (1.1)
At a hospital as an inpatient	5 (0.8)
Mobile testing unit	4 (0.6)
Elsewhere	4 (0.6)
At a blood bank, while donating blood	3 (0.5)

HIV-negative respondents were then asked what the reason was for their preferred HIV testing setting. Respondents were allowed to tick all the answers that applied to them. Results can be seen in Table 67. The most common reasons given for their choice of HIV testing setting were that it is non-judgemental and LGBT-friendly, followed by ease of access and affordability.

Table 67. Reasons for preferred HIV testing location among HIV-negative respondents

What are the main reasons for your previous choice regarding HIV testing? (Tick as many as apply) (n = 653, missing = 29)	Yes n (%)
It is non-judgmental	406 (62.2)
It is LGBT-friendly	380 (58.2)
It is easy to reach	372 (57.0)
It is affordable	329 (50.4)
It is led by medical professionals with expertise on sexual health	295 (45.2)
It offers additional services to HIV testing	273 (41.8)
It is anonymous	257 (39.4)
I receive personal advice	150 (23.0)
It is led by peers with expertise on sexual health	77 (11.8)
It is possible to communicate in my native language	42 (6.4)

7.4 Pre-Exposure Prophylaxis services

Respondents not living with a HIV diagnosis (n = 807) were asked if anyone at a health service in Ireland had ever spoken to them personally about PrEP. Forty-three per cent (n = 350) replied that someone at a health service in Ireland had spoken to them about PrEP. Table 68 lists the types of health services in Ireland where they were spoken to about PrEP. Respondents were asked to tick as many as applied. Most commonly, respondents reported being spoken to at a hospital clinic, as an outpatient (69%) or at a community service or drop-in (33%).

Table 68. Health services in Ireland where PrEP was discussed with respondents

Health service (n = 350, missing = 0)	Yes n (%)
A hospital or clinic as an outpatient, or an institute	243 (69.4)
A community service or drop-in (that is, not in a hospital or clinic)	117 (33.4)
A doctor in private practice	59 (16.9)
General practitioner/family doctor	42 (12.0)
Other	9 (2.6)

Among respondents who had ever taken PrEP (n = 230), 94% reported they had spoken to a healthcare professional before taking PrEP. Those who had ever taken PrEP were asked where they got their PrEP medications. Respondents could select more than one option. Most frequently, respondents got their PrEP medications from a hospital clinic (57%) or from a doctor in private practice (20%).

Table 69. Source(s) of PrEP among respondents ever using PrEP

Source(s) of PrEP (n = 230, missing = 0)	Yes n (%)
A hospital outpatient clinic	130 (56.5)
A doctor in private practice	45 (19.6)
A community health service or drop-in	25 (10.9)
An online pharmacy/abroad	16 (7.0)
Given by friend or partner	16 (7.0)
As a participant in a research study	7 (3.0)
A general practitioner/family doctor	15 (6.5)
Other	3 (1.3)
I used PEP pills as PrEP	2 (0.9)
I used someone else's anti-retroviral therapy (ART) pills as PrEP	2 (0.9)

7.5 Doxy-PEP Services

Fifty-three respondents reported that they had used antibiotics for STI prevention within the previous 12 months (doxy-PEP). This group was asked where they got their antibiotics; they could choose more than one option. Responses are given in Table 70 below. The two most common sources of prophylactic antibiotics were through a prescription from a healthcare provider (specifically for STI prevention) (40%) or bought online/abroad 26%.

Table 70. Source(s) of antibiotics for STI prevention

Source(s) of antibiotics (n = 53, missing = 0)	n (%)
Prescribed by healthcare provider (for STI prevention)	21 (39.6)
Bought online or abroad	14 (26.4)
Leftover medication prescribed to me for an infection I had in the past	12 (22.6)
Bought it in a pharmacy without prescription[2]	8 (15.1)
From a sexual partner, friend or acquaintance	5 (9.4)
Other source	3 (5.7)

[2]*Doxy-PEP cannot be purchased in a pharmacy in Ireland without a prescription*

7.6 Drug and alcohol services

Respondents who said they had previously used drugs were asked if they ever consulted a health professional over drug use concerns. Four per cent of those who stated they had previously used drugs reported consulting a health professional about their drug use in the last 12 months, which represents 3% of the total study population.

Respondents who had previously used drugs were asked if they had ever attended a self-help group, harm reduction programme or counsellor about their drug use, with 3% having done so in last 12 months, representing 2% of the total study population. A third of respondents who had consulted with a health professional regarding their drug use in the previous 12 months had also attended a self-help group, harm reduction programme or counsellor in the same period.

Respondents who indicated that they had drunk alcohol within the last 12 months (n = 793) were asked if they had ever consulted a health professional regarding concerns about their alcohol use, with 5% indicating they had.

7.7 STI testing services

All respondents were asked, 'When did you last have a test for STIs other than HIV?' Table 71 shows the recency of STI testing among respondents. A majority (57%, n = 492) reported having an STI test in the previous 12 months. Of those respondents, 85% were asymptomatic at the time of testing.

Table 71. Timing of most recent STI testing

Most recent STI test other than HIV (n = 865, missing = 1)	n (%)	Cumulative %
Within the last 4 weeks	162 (18.7)	18.7
1–6 months ago	250 (28.9)	47.6
7–12 months ago	80 (9.2)	56.9
1–5 years ago	134 (15.5)	72.4
More than 5 years ago	73 (8.4)	80.8
Never	165 (19.1)	

Among respondents who reported taking an STI test in the past 12 months (n = 492), data were collected on the specific components of the testing process they experienced. Table 72 shows the responses given.

Table 72. STI tests and examinations experienced by respondents who had an STI test in the previous 12 months, with denominators based on participant anatomy*

During an STI test in the last 12 months have you experienced any of the following?	n (%)
Urethral swab (penis) (n = 464, missing = 0)	78 (16.8)
Penis examination (n = 460, missing = 0)	121 (26.3)
Vaginal swab (n = 22, missing = 0)	19 (86.4)
Vaginal examination (n = 22, missing = 0)	5 (22.7)
Anal swab (n = 492, missing = 1)	434 (88.2)
Anal examination (n = 492, missing = 2)	107 (21.7)

** The comparable questions in EMIS-2017 additionally considered blood and urine test questions, which were omitted from EMIS-2024.*

Cis-gender males who had an STI test in the previous 12 months (n = 460) were asked if their healthcare provider knew about their sexual orientation. Seventy-nine per cent stated their healthcare provider definitely knew their sexual orientation.

7.7.1 Partner notification gonorrhoea diagnoses

Respondents who had been diagnosed with gonorrhoea in the previous 12 months (n = 95) were asked whether, the last time they had been diagnosed with gonorrhoea, they (or their healthcare provider) had informed their recent sexual partner(s) of their diagnosis and the need for testing/treatment. No definition for 'recent sexual partner' was provided in the survey question. Forty-five per cent told all of their recent sexual partners about their diagnosis, 30% told some of their recent sexual partners and 20% told none of their recent sexual partners.

7.8 Transgender services

7.8.1 Gender-affirming hormones

Trans men, trans women and non-binary people who identify as part of the transgender community (n = 83) were asked if they were currently taking gender-affirming hormones. Fifty-seven per cent reported that they were.

Respondents currently taking gender-affirming hormones (n = 47) were asked when they had started taking them (Table 73). Seventeen per cent of those taking gender-affirming hormones had started taking them in the last 12 months.

Table 73. Time of initiation of gender-affirming hormones among those currently using these.

Initiation of gender-affirming hormones (n = 47, missing = 0)	n (%)
Within the last 12 months	8 (17.1)
1–5 years	33 (70.2)
More than 5 years ago	6 (12.8)

Respondents who were taking gender-affirming hormones were asked where they got the hormones. Respondents could select multiple answers (see Table 74).

Table 74. Source(s) of gender-affirming hormones

Where have you got your gender-affirming hormones from? (n = 47, missing = 0)	n (%)
Medical specialist (e.g. endocrinologist)	24 (51.1)
At a gender-affirming care service	21 (44.7)
From a physical pharmacy in the country I live in	17 (36.2)
General practitioner/family doctor	16 (34.0)
From an online pharmacy/abroad	14 (29.8)
At a hospital, clinic or institute	9 (19.1)
From a 'drug dealer' or on the 'black market'	3 (6.4)
From a friend and/or partner	3 (6.4)
Alternative use of hormone medication (e.g. anti-conception pills)	1 (2.1)

Among trans women, the two most common sources of gender-affirming hormones were from a gender-affirming service or from an online pharmacy/abroad (both 43%). Among trans men, the two most common sources of gender-affirming hormones were from a medical specialist (58%) and from a gender-affirming care service (45%).

Respondents who were currently taking gender-affirming hormones (n = 47) were asked if they were currently being monitored by a healthcare provider. Responses can be seen in Table 75. Fifty-one per cent of respondents were being monitored by a medical specialist, 30% by their general practitioner and 15% were monitoring their gender-affirming therapy themselves.

Table 75. Monitoring of gender-affirming hormone therapy

Gender-affirming hormone treatment monitored by a healthcare provider (n = 47, missing = 0)	n (%)
Yes, by a medical specialist (e.g. endocrinologist)	24 (51.1)
Yes, by my general practitioner/family doctor	14 (29.8)
No, I am monitoring my gender-affirming therapy myself	7 (14.9)
No, I am being helped by someone else (who is not my healthcare provider)	2 (4.3)

Respondents who identified as part of the transgender community but who had never taken gender-affirming hormones were asked if they 'plan on taking gender-affirming hormones in the future?' Fifty-eight per cent stated that they did plan on starting gender-affirming hormones, while 18% stated they did not (Table 76).

Table 76. Intended future use of gender-affirming hormones among transgender community members who had not used these medicines before

Intention to start gender-affirming hormones in the future (n = 33, missing = 0)	n (%)
No	6 (18.2)
Yes	19 (57.6)
Not sure	8 (24.2)

Transgender respondents were asked a series of questions about their anatomy. No respondent in this survey had undergone gender-affirming surgery (neo-vagina, neo-vulva, metoidioplasty or phalloplasty).

7.9 Interventions and services by key characteristics

Interventions among survey respondents were compared across several key characteristics: age, employment status and HIV testing history. The likelihood that differences among individuals in different groups were due to chance was established using chi-squared analysis or Fisher's exact test for continuous variables, and ANOVA or Kruskal-Wallis for categorical variables. If the significance value was ≤ 0.05, there was deemed to be a statistically significant difference between the groups.

Table 77. Interventions and services by age category

Interventions and services	Age groups (n = 865)					
	17–24 (n = 155)*	25–39 (n = 370)*	40–54 (n = 252)*	55+ (n = 88)*	All*	*p* value
Accessed free condoms in last 12 months	52.6%	55.6%	49.6%	53.4%	53.1%	0.542
Did not get condoms in last 12 months	17.5%	19.0%	25.8%	15.9%	20.4%	0.077
Spoke to health professional about drug use in last 12 months	3.9%	3.5%	1.6%	1.1%	2.8%	0.334
Spoke to health professional about alcohol use in last 12 months*	2.6%	2.7%	3.6%	1.1%	2.8%	0.762
Ever spoken to about PrEP at health service	22.6%	50.4%	48.0%	40.3%	43.4%	<0.001
Saw or heard information about HIV or STIs for MSM in last 12 months*	85.7%	93.8%	93.1%	90.8%	91.8%	0.021
Saw or heard information about HIV or STIs for transgender people in last 12 months*	27.3%	44.1%	16.7%	100.0%	33.3%	0.121
Never tested for HIV	49.7%	13.0%	10.3%	6.8%	18.2%	<0.001
Used community-based testing at last HIV test*	78.2%	56.7%	56.6%	42.3%	57.7%	<0.001
Offered any hepatitis vaccine by a health service	40.6%	73.8%	80.6%	75.0%	69.9%	<0.001
Tested for STI in the last 12 months	39.6%	64.1%	56.7%	58.0%	56.9%	<0.001
Verbally harassed because attracted to men in last 12 months*	43.4%	23.9%	15.3%	8.6%	22.1%	<0.001
Verbally harassed because transgender in last 12 months*	51.9%	37.5%	66.7%	-	48.2%	0.364

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 78. Interventions and services by employment status

Employment status (n = 863) Interventions and services	Employed (n = 640)*	Un-employed (n = 44)*	Student (n = 122)*	Other (n = 57)*	All*	*p* value
Accessed free condoms in last 12 months	53.4%	43.2%	57.4%	47.4%	53.0%	0.334
Did not get condoms in last 12 months	21.1%	27.3%	14.8%	19.3%	20.4%	0.27
Spoke to health professional about drug use in last 12 months	2.3%	4.5%	3.3%	5.3%	2.8%	0.269
Spoke to health professional about alcohol use in last 12 months*	2.5%	6.8%	2.5%	3.5%	2.8%	0.274
Ever spoken to about PrEP at health service	48.4%	34.1%	26.7%	34.0%	43.5%	<0.001
Saw or heard information about HIV or STIs for MSM in last 12 months*	93.6%	87.5%	86.0%	87.5%	91.8%	0.013
Saw or heard information about HIV or STIs for transgender people in last 12 months*	32.6%	18.2%	36.8%	50.0%	33.3%	0.618
Never tested for HIV	12.5%	38.6%	43.4%	10.5%	18.1%	<0.001
Used community-based testing at last HIV test*	57.4%	55.6%	71.6%	39.0%	57.6%	0.01
Offered any hepatitis vaccine by a health service	75.9%	52.3%	48.4%	63.2%	70.0%	<0.001
Tested for STI in last 12 months	61.4%	38.6%	44.6%	47.4%	57.0%	<0.001
Verbally harassed because attracted to men in last 12 months*	20.5%	12.5%	44.0%	10.0%	22.1%	<0.001
Verbally harassed because transgender in last 12 months*	44.4%	44.4%	57.1%	-	48.2%	0.271

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

Table 79. Interventions and services by HIV testing history

HIV testing history (n = 862) Knowledge, attitude or behaviour	Never tested (n = 157)*	Last test negative (n = 650)*	Living with HIV (n = 55)*	All*	*p* value
Accessed free condoms in last 12 months	37.2%	56.9%	54.5%	53.1%	<0.001
Did not get condoms in last 12 months	26.3%	18.2%	29.1%	20.3%	0.02
Spoke to health professional about drug use in last 12 months	3.8%	2.5%	3.6%	2.8%	0.519
Spoke to health professional about alcohol use in last 12 months*	3.8%	2.6%	1.8%	2.8%	0.647
Ever spoken to about PrEP at health service	9.6%	51.6%	N/A	43.4%	<0.001
Saw or heard information about HIV or STIs for MSM in last 12 months*	77.6%	94.6%	98.1%	91.8%	<0.001
Saw or heard information about HIV or STIs for transgender people in last 12 months*	26.8%	38.2%	N/A	33.3%	0.28
Never tested for HIV	100.0%	N/A	N/A	18.2%	N/A
Used community based testing at last HIV test*	N/A	57.7%	N/A	57.7%	N/A
Offered any hepatitis vaccine by a health service	28.0%	78.0%	94.5%	70.0%	<0.001
Tested for STI in last 12 months	12.7%	65.6%	80.0%	56.9%	<0.001
Verbally harassed because attracted to men in last 12 months*	34.2%	20.7%	11.3%	22.0%	0.001
Verbally harassed because transgender in last 12 months*	47.4%	48.9%	N/A	48.2%	0.999

** Results of cross-tab analysis between two variables. As a result the figure may differ slightly from what was reported in the previous sections due to variance in numbers, eligibility and questionnaire algorithm.*

8

Summary of main findings

Chapter 8 Summary of main findings

8.1 Mental health

Using the validated PHQ-4 screening tool for anxiety and depression, 11% of respondents showed markers of severe psychological distress. On the anxiety and depression subscales, 31% screened positive for anxiety, and 25% for depression. Higher rates of psychological distress on the PHQ-4 were observed in particular groups. Among respondents identifying as a member of the transgender community (n = 83), 22% showed markers of severe psychological distress, 63% screened positive for anxiety and 42% for depression. A positive screening result is not diagnostic, with clinical assessment required to establish a diagnosis of depression or anxiety. These substantial differences in screening results are nonetheless striking. The findings are also in keeping with findings from previous studies. An LGBT Ireland study also reported higher rates of mental distress among trans people than among the general population or among lesbian, gay and bisexual people.(18)

Similarly, 20% of younger respondents (aged 17–24) showed markers of severe psychological distress on the PHQ-4 screening tool compared to the average across the whole survey sample of 11%. High rates of diagnosis of depression and anxiety among younger people have also been reported in other studies across the general population in Ireland. The Growing Up in Ireland study reported that one-quarter of respondents had been diagnosed with either depression or anxiety by age 25.(19, 20)

8.2 Alcohol use

Although differences between recruitment and samples limit direct comparisons between rounds of the EMIS survey, screening results for alcohol use disorder using the CAGE-4 screening tool were very similar in EMIS-2024 and EMIS-2017: 31% of respondents who consumed alcohol in the preceding 12 months in both surveys screened positive for possible alcohol dependency. As a comparator, the 2019–2020 Irish National Drug and Alcohol Survey estimated alcohol use disorder (AUD) using the Diagnostic and Statistical Manual of Mental Disorders version 5 (DSM-5) criteria at 15% of the general population in Ireland aged 15 years and older, equating to 20% of those who consume alcohol. Among male drinkers the prevalence of AUD was estimated at 25% and among female drinkers at 15%.(21)

8.3 Sexualised substance use

Among respondents who had sex with a man during the previous 12 months (n = 759), 48% reported that at least some of this sex had taken place under the influence of alcohol or another drug. Ten per cent reported that all or almost all of the sex they had with men during this period had taken place under the influence of alcohol or drugs.

EMIS-2024 also included questions on stimulant drug use during sex as a proxy measure for chemsex. Among respondents who had ever used illicit or recreational drugs (n = 563), 35% reported ever using stimulant drugs to make sex more intense or last longer, and 19% had done so during the previous 12 months. Among respondents who reported stimulant drug use during sex during the previous 12 months (n = 109), 60% reported combining stimulant drug use with sex involving more than one partner at the same time. Most respondents reporting recent multi-partner stimulant drug use during sex indicated that this had taken place in a private dwelling. Approximately half had been engaging in this practice for three years or less, while 19% reported doing so for 10 years or more.

8.4 HIV testing

Among respondents without a known HIV diagnosis (n = 807), 81% had previously tested for HIV. Among the 18% who reported never having tested for HIV (n = 157), 21% reported condomless anal intercourse with a non-steady partner during the previous 12 months and 43% did not know or were not sure where to get a HIV test. Among HIV-negative respondents who had tested for HIV during the previous 12 months (n = 473), the most common sites or method for HIV testing were a self-sampling kit (35%), hospital outpatient clinic (31%), or a community health service or drop-in (11%). Among HIV-negative respondents reporting CAI with a non-steady partner in the last 12 months (n = 349), 84% reported taking a HIV test in the last year. Among those reporting having used PrEP in the last 12 months (n = 210), 97% had taken a HIV test in the previous 12 months.

8.5 PrEP

Since the national PrEP programme was launched in 2019, providing free PrEP medication to individuals who meet clinical eligibility criteria and attend HSE-approved services, over 8,600 individuals have accessed free PrEP medication through the programme. In 2024, 6,100 individuals received PrEP at least once, comprising 4,400 with repeat prescriptions and 1,700 first-time prescriptions.(4) One hundred and ninety-one survey respondents reported currently using PrEP and 210 respondents reported any PrEP use in the previous 12 months. Twenty-four per cent of respondents not living with a HIV diagnosis were currently using PrEP. This compares to current PrEP use reported in other EMIS-2024 participating countries of 41% in the UK, 39% in France, 31% in Denmark, 32% in the Netherlands, 18% in Italy and 13% in Sweden.(5)

Among the 210 respondents who reported any PrEP use during the previous 12 months, 71% reported never experiencing an involuntary interruption to their PrEP medication, while 17% reported an involuntary interruption within the previous year. The dataset does not provide further context or explore the reasons behind these involuntary interruptions. Comparable data from other national EMIS-2024 datasets are not yet available.

8.6 Condom use and condomless anal intercourse

Condoms were the most commonly used HIV prevention strategy reported by respondents at 42%. Fifty-seven per cent of respondents (n = 497) reported having intercourse with a non-steady partner in the previous 12 months. Among this group 43% (n = 212) reported 'never' or 'seldom' using a condom during intercourse with non-steady partners. Forty-four per cent of respondents (n = 383) reported having CAI with a non-steady partner in the preceding 12 months, with one-third of those (n = 131) reporting CAI with ten or more non-steady partners.

Just over half of respondents reported accessing free condoms in the previous 12 months, while 20% reported not getting any condoms (free or purchased) in that time. Among those who reported having intercourse with a non-steady partner in the previous 12 months, 63% accessed free condoms in that period and 10% didn't access any condoms.

8.7 Sexually transmitted infections and doxy-PEP

During the previous 12 months 17% of respondents (n = 146) reported a diagnosis of at least one bacterial STI (syphilis, chlamydia/LGV, or gonorrhoea), with 11% reporting at least one diagnosis of gonorrhoea, 9% of chlamydia or LGV, and 3% of syphilis. Among the subset of respondents who had tested for an STI in the last 12 months (n = 492), the percentage reporting any STI increased to 30%. Younger respondents (under age 25) reported lower rates of STI diagnoses and of testing for STIs, with 40% testing for an STI in the previous 12 months versus an average of 57% among all respondents. Among respondents who reported CAI with a non-steady partner in the previous 12 months, 81% had tested for an STI with 32% reporting at least one bacterial STI diagnosis.

Six per cent of respondents reported using doxy-PEP to prevent bacterial STIs. Although a healthcare provider prescription was the most common source of doxy-PEP, 26% reported accessing treatment online or abroad and 23% had used left-over medication for a past infection.

8.8 Vaccinations

EMIS-2024 included questions on vaccinations to prevent hepatitis A, hepatitis B, HPV and mpox. Among those eligible for hepatitis vaccination (i.e. excluding those reporting previous hepatitis A or B infections), 61% of respondents had received at least one dose of vaccine against hepatitis A and 64% at least one dose of vaccine against hepatitis B. Among those reporting CAI with a non-steady partner in the previous 12 months and eligible for hepatitis A vaccination (n = 370), 74% reported receiving at least one hepatitis A vaccination, and for hepatitis B (n=374, eligible), 75% reported at least one hepatitis B vaccination. Among those eligible for vaccination reporting any PrEP use in the previous 12 months (n = 203), 93% reported receiving at least one hepatitis A vaccination and 94% at least one hepatitis B vaccination.

Thirty per cent of all respondents reported receiving at least one vaccination against mpox. This rose to 47% among those reporting CAI with a non-steady partner in the previous 12 months (n = 383), and 69% among those reporting any PrEP use in the last 12 months (n = 210). Forty per cent of all respondents reported receiving at least one vaccination against HPV and 71% among those reporting any PrEP use in the last 12 months (n = 210).

8.9 EMIS strengths and weaknesses

EMIS is a large multinational collaborative study that collected comparable data across 50 countries and covers a broad range of factors that may influence sexual health outcomes. A key strength of the project is its ability to facilitate comparisons across countries and to situate national findings within a wider European context. However, the scale and scope of the survey also present some limitations. The common questionnaire for each round is designed to collect information that is relevant across diverse settings and, as a result, cannot fully adapt to differences in sexual health systems, services, policies, and emerging issues within individual jurisdictions. Consequently, EMIS-2024 was not tailored to evaluate specific Irish policies, programmes or priority issues. The breadth of topics covered also results in a lengthy questionnaire, with a median completion time of 30 minutes across participating countries and 32 minutes in Ireland. Participation was substantially lower in EMIS-2024 than EMIS-2017, both across Europe (approximately 50,000 respondents compared to 130,000) and in Ireland (865 respondents compared to 2,083). Despite the reduced participation, the scale and complexity of the multinational project means that considerable time is required for data processing and analysis. Data collection took place more than two years prior to publication. This is particularly relevant for dynamic or rapidly developing areas of sexual health including incidence of STIs, HIV PrEP and doxy-PEP. These considerations highlight the utility of targeted and timely national surveys complementing any future participation in EMIS rounds to describe the current sexual health needs and experiences of gbMSM and transgender communities in Ireland and to evaluate national programmes to address these needs.

9

Conclusions to guide action and research

Chapter 9 Conclusions to guide action and research

EMIS-2024 provides a breadth of information on the sexual health of gbMSM and trans people in Ireland in 2024, with potential to guide both actions and further research. A particularly striking contrast with EMIS-2017 is the 24% of respondents reporting current use of PrEP compared to 4% seven years earlier. This period coincided with the launch of the national PrEP Programme in 2019, which continues to expand. Even acknowledging that sampling is not identical across countries, substantially higher rates of use in some other comparable countries are consistent with a likely demand for ongoing increase in provision in Ireland. Within Ireland the findings also suggest gaps and inequities in access. PrEP use was substantially and significantly lower among younger respondents and those born outside Ireland. Although not statistically significant, PrEP use was also substantially lower among those who are unemployed and those living in rural areas. Some respondents also described inability to access PrEP and interruptions to their supply of PrEP. These findings support an overall and targeted increase in service capacity to improve equitable access, and further research to understand reasons for specific gaps in provision and how to address them.

Most respondents without a diagnosed HIV infection had previously tested for HIV, and recent HIV testing was more common among those using PrEP and reporting indicators of increased likelihood of HIV acquisition. Nevertheless, almost one in five respondents reported never having tested for HIV, including some who reported condomless anal intercourse with non-steady partners. A substantial proportion of those who had never tested also reported not knowing where to obtain an HIV test. These findings support continued efforts to promote accessible and acceptable HIV testing through a range of service models, and to improve awareness of available testing options and reducing barriers to testing among groups with lower uptake.

Condoms remain an important component of HIV and STI prevention, and were the most commonly used HIV prevention strategy reported by respondents. There has been significant expansion of the HSE condom distribution service since the previous EMIS survey. Most survey respondents reported accessing free condoms in the previous 12 months, increasing to almost two-thirds among those who reported intercourse with a non-steady partner during that time. These findings highlight both success and the need to continue to ensure condoms are accessible as part of a comprehensive approach to HIV and STI prevention.

EMIS-2024 added questions on the use of doxy-PEP, in line with this emerging as a safety strategy to prevent bacterial STIs. These findings – including a substantial proportion of doxy-PEP users reporting accessing treatment online, abroad or repurposing left-over medicine from past treatment of infections – may be the most out of date given the rapid increase in doxy-PEP use and integration into sexual health service provision. As a rapidly evolving practice, doxy-PEP use is an important area for timely research on the extent and pattern of use and to guide policy and provision in this area, including antimicrobial stewardship.

Vaccination rates are very high among those attending ongoing sexual health service provision, as evidenced by rates among respondents who reported HIV care or PrEP. This highlights the effectiveness of integrated sexual health service provision for those accessing these services. However, there are also substantial gaps in protection by vaccination among respondents across all vaccines assessed. For hepatitis B (introduced into infant vaccination in 2008 in Ireland) and HPV (extended to boys in 2019 and with a catch up in 2023 for young men up to age 21), the Irish and other national programmes of universal vaccination will largely address these issues going forward. Priority gaps for action are therefore among older age groups, and in particular among those not currently accessing regular sexual health services.

Although EMIS-2024 included an expansion to allow fuller inclusion of trans people, the achieved sample in Ireland does not allow analysis for different groups in the trans community and only limited robust analysis across the full trans community. However, even within these limitations, some findings are striking. The screening estimates, at 22%, for severe anxiety or depression are far higher than for the cis-gbMSM respondents in this survey, or broader population estimates from the same screening tool. The substantial reported experiences of exclusion and sexual violence also far exceed those among non-transgender respondents. These findings highlight the need for substantial services and social change, as well as the need for fuller information to guide policies and provision to support members of this community.

The proportion of respondents screening positive for possible alcohol use disorder was similar to that reported in EMIS-2017. It remained substantially higher than estimates reported for the general population, although differences in study populations and screening methods should be considered when interpreting these comparisons. Sex under the influence of alcohol or other drugs was commonly reported, including by a smaller group for whom all or almost all sex with men during the previous 12 months took place under the influence of substances. EMIS-2024 also identified recent stimulant drug use during sex among a substantial minority of respondents with a history of illicit drug use. Multi-partner sex and stimulant drug use during sex were common among those reporting recent use. The survey did not explore whether substance use was experienced as problematic or harmful by individual respondents. A more detailed HSE study of chemsex is currently underway in Ireland.

Analysis of the Irish data from EMIS-2024 has provided substantial useful information to understand the sexual and wider health experiences of men who have sex with men and trans people in Ireland, and can help guide sexual health interventions and areas for wider societal change. The findings demonstrate important progress in several areas while highlighting continuing inequalities in access to prevention, vaccination and care, as well as broader social determinants affecting health and wellbeing. The study also highlights gaps in information, groups and issues where information gaps are most pressing, and the value of bespoke surveys and qualitative research on the national context, policy and practice environment.

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Appendix A: Comparisons between EMIS-2024 Ireland, EMIS-2017 Ireland, MISI-2015 and EMIS-2010 Ireland

EMIS-2010

EMIS-2010 was a multi-country, cross-sectional survey of MSM. It involved 38 countries, including Ireland. A total of over 180,000 men were recruited, with Ireland contributing 2,303 respondents. The survey was available in 25 languages and was promoted using a number of dating websites where direct messages were sent to their members to complete the survey. In addition, promotional campaigns were organised in most participating countries via Facebook. The European report, the Irish community report and information regarding the project can be found at here.

MISI-2015

MSM Internet Survey Ireland (MISI) 2015 was a cross-sectional survey of MSM living in Ireland carried out in 2015, and included 3,090 men in the analysis. The survey was available in English only and was promoted on gay community and health promotion websites, through social media sites, and on promotional cards for social and community venues and services. The report can be found at here.

EMIS-2017

EMIS-2017 was an online multi-country cross-sectional survey of MSM. It collected data across 50 countries including Ireland. 137,000 people completed the survey, with 2,083 Irish respondents. The survey was available in 33 languages. EMIS-2017 was promoted in Ireland using national statutory and NGO websites for MSM, social networking sites and dating apps.

The Irish report is available here.

European data and reports are available here.

EMIS-2024

EMIS-2024 was an anonymous, multilingual, online sexual health survey conducted among gbMSM and transgender populations across 50 countries in Europe. EMIS-2024 was the first iteration of the survey to explicitly include transgender women and non-binary people who are sexually attracted to men. The survey was available in 35 languages. 55,000 people completed the survey, with 865 Irish respondents. The majority of respondents in Ireland (86%) were directed to the survey from the dating app Grindr, which is a significant change in recruitment compared to previous iterations of the survey.

EMIS-2010, MISI-2015, EMIS-2017 and EMIS-2024 were independent, cross-sectional surveys and cannot be directly compared without accounting for differences in the age of respondents, their country of birth, and recruitment methods in the different surveys. Any comparison of the reported prevalence of risks, behaviours and interventions needs to take these differences into consideration.

Table 80. EMIS and MISI reports comparison table

Variable (% unless stated otherwise)	EMIS-2010 (n = 2,303)	MISI-2015 (n = 3,090)	EMIS-2017 (n = 2,083)	EMIS-2024 (n = 865)
Demographic profile				
Median age (years)	31	30	33	35
Aged < 25 years	24	31	23	18
Residing in Dublin	46	49	57	54
Living in a city > 500,000 inhabitants	50	-	48	46
Born outside of Ireland	23	14	25	30
Unemployed	9	7	5	5
Steady relationship with a man	29	39	31	40
Steady relationship with a woman	7	8	3	4
Identify as gay/homosexual	78	79	81	78
Out to all or almost all	40	51	51	58
Paid for sex in last 12 months	5	-	6	4
Been paid for sex in last 12 months	4	-	4	2
Reported ill health				
Positive HIV diagnosis (whole sample)	6	5	7	6
Positive HIV diagnosis (among those tested)	10	8	9	8
Positive HIV diagnosis in last 12 months	3	1	1	<1
Diagnosed any STI in last 12 months (whole sample)*	9	9	14	17
Diagnosed any STI among those tested in last 12 months	21	21	26	30
Syphilis diagnosis in last 12 months (whole sample)	2	-	3	3
Gonorrhoea diagnosis in last 12 months (whole sample)	2	-	9	11
Chlamydia diagnosis in last 12 months (whole sample)	3	-	6	9
First diagnosis of anal/genital warts in last 12 months	3	-	1	<1

** Any STI in MISI-2015, EMIS-2017and EMIS-2024 was defined as syphilis, gonorrhoea and/or chlamydia. EMIS-2010's definition is not clear and may include all of the above and anal/genital warts.*

Percentages are rounded in the table.

Table 80. EMIS and MISI reports comparison table (cont)

Variable (% unless stated otherwise)	EMIS-2010 (n = 2,303)	MISI-2015 (n = 3,090)	EMIS-2017 (n = 2,083)	EMIS-2024 (n = 865)
Sexual health practices and safety strategies				
Currently on ART (for those HIV positive)	75	79	94	95
Ever used PEP (for those not HIV positive)	-	4	10	15
Currently use PrEP (either daily or event-based) (for those not HIV positive)	-	2	4	24
Ever had anal intercourse with a man (among men who had sex with men)	94	88	93	95
Sex with women in last 12 months	14	14	9	5
CAI with steady male partner in last 12 months (among men who had sex with steady partner in last 12 months)	66	68	75	not asked
CAI with non-steady male partner in last 12 months (among men who had sex with non-steady partner in last 12 months)	40	42	55	65
History of drug injecting (drugs and/or anabolic steroids)†	3	2	4	4
Alcohol consumed in last 24hrs‡	41	-	40	33
Tobacco consumed in last 24 hrs‡	36	-	26	24
Poppers use in last 12 months◊	-	33	46	48
Cannabis use in last 12 months◊	-	28	34	37
Ecstasy use in last 12 months◊	-	17	19	20
Cocaine use in last 12 months◊	-	13	20	24
Attitudes				
Internalised homonegativity score (average)	2	-	1	1
Concerned about drug use (among those who took drugs in last 12 months)	6	-	8	12
Verbally insulted in last 12 months because someone knew/thought you were attracted to men+	33	-	28	22

† EMIS-2010 only asked about self-injecting. MISI-2015, EMIS-2017 and EMIS-2024 asked about self-injecting or someone injected you.

‡ MISI-2015 asked about daily use of alcohol and tobacco. EMIS-2010, EMIS-2017 and EMIS-2024 asked about alcohol and tobacco consumption in the last 24 hours.

◊ MISI-2015 respondents were asked to tick from a list of drugs they had used in the last 12 months. EMIS-2010 and EMIS-2017 asked about each drug separately and asked about their recency of use (i.e. last 24 hours, last 6 months, last 12 months, ever). Ecstasy use in EMIS-2017 refers to ecstasy pills. Ecstasy use in EMIS-2024 refers to ecstasy as a pill, crystal or powder.

Percentages are rounded in the table.

Table 80. EMIS and MISI reports comparison table (cont)

Variable (% unless stated otherwise)	EMIS-2010 (n = 2,303)	MISI-2015 (n = 3,090)	EMIS-2017 (n = 2,083)	EMIS-2024 (n = 865)
Interventions and services				
CAI because no condom in last 12 months	16	16	27	not asked
Accessed free condoms in last 12 months	-	39	56	53
Seen HIV/STI information specifically for MSM in last 12 months+	85	-	91	92
Never tested for HIV	37	37	23	18
HIV ever monitored	-	99	100	98
HIV monitored in past 6 months	93	93	99	98
Receiving ART (of those whose HIV was monitored in past 6 months)	75	85	95	96
Undetectable viral load (among those on ART)	80	91	97	100
Full course of hepatitis B vaccination	48	-	53	58
STI test in last 12 months	38	39	55	57

Percentages are rounded in the table.

EMIS-2024 Ireland:

Findings from the European Men-Who-Have-Sex-With-Men and Trans People Internet Survey (Ireland)

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
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